PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP & YOI Chelmsford in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

December 2012

This is a report of an investigation into the circumstances surrounding the death of a man in May 2011, in the segregation unit at HMP &YOI Chelmsford. He was found hanging in his cell. The man was 31 years old. I offer my condolences to his family and others affected by his death.

The investigation was carried out by one of my investigators. The mental health clinical governance manager for Mid-Essex Primary Care Trust provided a clinical review of the man's healthcare at Chelmsford. Chelmsford prison cooperated with the investigation. I apologise for the delay in issuing this report.

The man arrived at Chelmsford on 22 March 2011 following an incident at Norwich prison and was held in the segregation unit. In early May, he appeared at a Crown court and attempted to escape, assaulting staff in the process. He had made violent threats against his ex-partner and their unborn child, resulting in the end of their relationship but said he had been anxious about their future and wanted to be with them. Officers in the segregation unit supported the man well with his evident distress about his situation.

Four days before he died, because of concern about his mood, suicide and self-harm monitoring procedures were begun. He repeatedly said he had no intention of harming himself. However, on a night in May, he was discovered hanging in his cell. Attempts to resuscitate him were unsuccessful.

I agree it was appropriate to begin suicide monitoring procedures. I acknowledge that the man appeared to receive some good support from staff in the segregation unit, but I am concerned that no one appeared to have considered whether the unit was an appropriate place for a man assessed as at risk of suicide or self harm. Monitoring checks on the night he died were at predictable hourly intervals, which is poor practice. While there were some complicating circumstances and staff attempted to be caring towards the man's pregnant ex-partner, his family should have been informed more promptly of his death.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2012**

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SUMMARY

1. The man arrived at HMP Chelmsford on 22 March 2011. He had previously been in custody at Norwich prison, but became involved in a serious incident and transferred to Chelmsford.

2. During his reception at Chelmsford, there were no indications that the man had any physical or mental health problems or that he intended to harm himself. He was assessed as fit to be located in the segregation unit.

3. On 3 May, the man appeared before a Crown court. In an attempt to escape custody he threatened and assaulted court staff with a bladed weapon but was apprehended by staff. He said he had made the attempt because his ex-partner was due to give birth to their child shortly and he wanted to leave the country with them both. He returned to the segregation unit where he began to talk to staff about his concerns and worries about his unborn child. He feared social services were going to take the baby into their care.

4. On 5 May, the Governor of Chelmsford saw the man in the segregation unit. He was concerned about the man's mood and asked staff to begin suicide monitoring procedures. The man seemed surprised by this and maintained he had no intention of harming himself.

5. On a night in May 2011, an officer in the segregation unit carried out routine checks on prisoners. At approximately 11.55pm, he arrived at the man's cell. He saw through the observation panel that the man was hanging from a sheet tied to the window. Officers entered the cell and attempted to resuscitate him, but were unsuccessful. At 12.53am it was confirmed he had died.

6. This report makes five recommendations. These cover the use of the segregation unit for prisoners at risk of suicide and self harm and monitoring arrangements, ensuring staff know where first aid equipment is stored, recording prisoners' telephone contacts and the need to notify a prisoner's family of a death as quickly as possible.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death a few hours after he had been discovered in his cell at Chelmsford prison. The investigation was allocated to one of my investigators later that day. Notices were issued to staff and prisoners at Chelmsford, informing them of the investigation and inviting anyone who wished to speak to the investigator to make themselves known. The investigator did not receive a response to these notices.

8. The investigator visited Chelmsford on 13 May 2011. She spoke to the Governor and the Chair of the Independent Monitoring Board (IMB). She toured the prison and saw the man's cell in the segregation unit. The security governor, who was also the prison's family liaison officer gave an account of what he understood had happened to the man and his contact with the man's family. The investigator collected relevant prison documents.

9. The investigator wrote to the Governor on 21 October. She apologised for the delay with the investigation and also requested information about the man's telephone contacts. The prison was unable to provide this information, even after a second request from an Assistant Ombudsmen on 23 November. This meant we were unable to identify the people the man had telephoned before his death. On 9 March 2012, the investigator sought advice from Security Group at Prison Service Headquarters and, on 15 March, spoke to the new Head of Security at HMP Chelmsford who explained the difficulties in obtaining this information, but was finally able to supply the details the investigator required.

10. The investigator visited the prison on 28 June and 19 July 2011, and interviewed 15 members of staff and a prisoner who knew the man when they were at Norwich prison together. After the interviews, the investigator met the Governor to provide initial feedback, which she followed up in writing on 29 June.

11. A clinical review of the man's medical care commissioned by NHS Mid Essex was carried out by a clinical reviewer. Her report was received on 14 October 2011.

12. We apologise for the late issue of this report which was caused by pressures of work in the office leading to a backlog of cases which are now being dealt with.

13. One of the Ombudsman's family liaison officers and the investigator met the man's mother and sister on 19 August 2011. They raised a number of issues they wanted included as part of the investigation. These were:

    - Who did their relative telephone before his death, and were these calls monitored?
    - Why did it take so long to notify them of his death?
    - Why were they not told he was subject to suicide monitoring procedures?

- Had there been other deaths at Chelmsford that were similar to their relative's?

14. The solicitor representing the man's mother wrote to this office on 28 September with further questions and comments. These included the decision to segregate the man, training of staff at the prison, ACCT procedures, monitoring of telephone calls, response on finding the man and previous deaths at the prison. This office responded in writing on 11 December 2012 with a detailed response and the report has been amended where necessary.
The man's father also received a copy of the draft report and also made a number of comments. These included highlighting the requirement for carrying a face mask and the time this could have saved. Also that observations for prisoners on an ACCT should not be carried out at predictable times, and that the man should have been checked more frequently. The man's father also commented on the lack of communication between the Chelmsford and Norwich prison, with telephone records not being passed on.

HMP & YOI CHELMSFORD

15. Chelmsford is a local prison and young offender institution accepting prisoners directly from courts within its catchment area, mainly in Essex and London. It holds up to 695 prisoners. Accommodation is provided in four residential wings (A, B, C and D) in the older Victorian part of the prison and in three separate new units (E, F and G).

Her Majesty's Inspectorate of Prisons (HMCIP)

16. Her Majesty's Inspectorate of Prisons most recently inspected Chelmsford in a full announced inspection in May 2011. The Inspectorate found that there was a comprehensive suicide prevention strategy which focussed on the needs of prisoners in a local prison. A suicide prevention co-ordinator was supported by a full time safer custody manager, residential managers and a safer custody committee. The Inspectorate found that individual cases were discussed appropriately and the specific needs of prisoners were met.

17. Inspectors described living conditions in the segregation unit as poor and a lack of natural light made the atmosphere dark and gloomy. However, management arrangements were found to be very good and safety was given a high priority. Inspectors described very good relationships between staff and prisoners with a high level of care. Entries in the unit's files demonstrated high levels of engagement and in-depth knowledge of prisoners' personal circumstances. The prisoners they spoke to in the segregation unit described staff as kind and helpful.

Independent Monitoring Board (IMB)

18. The IMB is made up of independent, unpaid members of the local community who monitor life in the prison to ensure standards of care and decency are maintained. In their report for the period between September 2010 and August 2011 the IMB noted:

> "The importance of Safer Custody is apparent throughout all areas of the prison … The Safer Custody team has been observed to be working effectively. Self harm data is well recorded and analysed and then discussed at the monthly Safer Custody meetings where future developments for working practices are decided".

19. The IMB also referred to the segregation unit. In the report they said that:

> " … staff/prisoner relationships are supportive as evidenced in the many comments in the Board's weekly Rota Reports on how well difficult and troubled prisoners are handled, especially those with suspected mental health issues."

Previous deaths at HMP Chelmsford

20. Before this man's death, the last self-inflicted death at Chelmsford was in 2008. The man's family wanted to know whether there had been any deaths similar to his at Chelmsford. There were no direct similarities between this man's death and the one three years earlier.

KEY EVENTS

21. The man was released from a prison sentence in July 2010 but recalled to HMP Norwich on 20 October 2010 for a breach of licence and charged with a further offence.

22. In January 2011, intelligence at Norwich indicated that the man was involved in arranging the smuggling of drugs and mobile telephones into the prison. At the beginning of February 2011, a man was arrested for throwing a package containing a mobile telephone over the prison wall, which was believed to be for the man.

23. Also in January 2011, Norfolk police requested that prison staff intercept letters from the man to his ex-partner and two other people. This was because they had received letters from him threatening to kill his ex-partner and her unborn baby.

24. On 16 January, a telephone call between the man and his ex-partner was monitored. During the call she mentioned the threatening letter she had received and the conversation became heated, resulting in her terminating the call. He attempted to telephone her another 19 times, but there was no answer. The prison's Police Liaison Officer was informed of this.

25. Following a serious incident in March 2011 at Norwich, the man and another prisoner transferred to Chelmsford. The man was not directly involved in the incident, but it was claimed that he had incited other prisoners to riot and had made threats of violence against staff. He arrived at Chelmsford on 22 March 2011.

26. On arrival at Chelmsford, the man was seen by a prison nurse for a routine reception health screen. He reported no physical or mental health issues. He said he did not have any alcohol or drug problems, had never taken any medication for his mental health or been seen by a psychiatrist or attended hospital for mental health problems. He gave no indication that he had any thoughts of harming himself.

27. A cell sharing risk assessment (CSRA) was carried out in reception to assess how safe it would be for the man to share a cell with another prisoner. His risk was assessed as medium risk and it was noted that he initially said he did not want to share a cell, but changed his mind. Because of the circumstances of his move it was decided that he should be held initially in the segregation unit[1] in which all cells are single. The prison nurse assessed the man as suitable to be held in the segregation unit. After two days of appropriate conduct in the segregation unit, the man moved to a standard residential wing.

[1] A prisoner may be segregated for many reasons. Examples include a prisoner who has been found guilty of breaking discipline rules or if a prisoner's behaviour is so disruptive that keeping them in their normal location may be unsafe.

28. The same day, 24 March, the man signed a disclaimer to say he did not wish to take part in the prison's induction programme or receive information about the range of resettlement services. He gave his ex-partner as his next of kin and supplied a mobile telephone number. He signed the document to agree that he was not a vulnerable prisoner and had not been subject to suicide monitoring procedures in the past.

29. The man was given information about the prison's PINphone[2] system, a smoker's pack of tobacco and cigarette papers, a visiting order, and other material. He confirmed that he had been given information about Listeners, Samaritans and the use of cell bells.

30. From 1 April to 15 May, the man made telephone calls to a range of numbers. Some calls were listened to by prison staff who noted that he was worried that his child would be taken into care when he or she was born. The man's last recorded use of the PINphone system was on 2 May, when he made twelve calls to two different numbers but got no response. .

31. On 3 May 2011, the man appeared at a Crown court to answer a number of charges. At approximately 2.05pm, he threatened court staff with a weapon made from a razor blade in a bid to escape. He made it as far as the court concourse, before he was restrained. He assaulted four prison custody officers in the process. One officer received cuts to his hands which required stitches. All four members of staff were taken to hospital for treatment. Because of his escape attempt the man's court hearing was adjourned.

32. The man admitted that he took parts of a razor blade to court, concealed in his body. At court, he made them into a weapon and hid it in his shoe. His motivation for the escape was the expected birth of his child. It was suggested that he intended to leave the country with his ex-partner and their child.

33. On return to Chelmsford, on 3 May, the man was placed on the 'escape list' (E list) and was held in the segregation unit again. (The consequence of being an E list prisoner meant that when outside of his cell, he had to wear distinctive clothing that clearly distinguished him from other prisoners. His clothes were taken each night and he was given a pair of prison pyjamas. He also always had to be located in a single cell.) It was decided that his cell should not be unlocked without three officers present, and that this would be reviewed. There is no evidence in the records that this had been reviewed or changed before his death.

34. Another assessment confirmed that the man was fit for segregation. It was noted that he had been quiet and compliant and no concerns were raised about him at this point. As required under Prison Rules, he was visited each day in the segregation unit by healthcare staff, members of the chaplaincy

[2] Prisoners have access to telephones on the wing. Each prisoner is given a unique personal identification number (PIN) to access their account, and they are only able to dial authorised numbers. Calls can be monitored and recorded, although the recordings are only kept for a limited period.

and a governor. He was given a radio but said he probably would not listen to it.

35. A segregation unit officer said that, on his return to the unit, the man seemed very distressed and close to tears at one point. He said the man complied with the segregation unit's regime. Another segregation unit officer said he built up a positive relationship with the man and spoke to him at length about his problems. The man told him that his ex-partner was due to have a baby on 17 May and he had tried to escape from court so he could be there at the birth. He said they were then going to make their way to Ireland and then on to Spain. Now his plan had fallen through, he said he did not know what to do. The officer agreed to see what information he could get the man about his parental rights and spent some time discussing this with him.

36. The segregation unit officer said the man was anxious that his baby might be taken into care and told him that he had tried to speak to his ex-partner. However, the officer was not sure whether he had spoken to her or not. He said he had heard from other prisoners that the man's former partner had a new boyfriend but, as it was only a rumour, he did not mention it to him. The man told the officer that he had acted in desperation at court and as a result had ended up in even more trouble.

37. The segregation unit officer said that initially the man would just spend time in his cell, and only came out for a shower. However, once he realised he had support from staff in the segregation unit, he began to interact a little more. The officer gave him reading material and spent time sitting in his cell talking to him. Eventually, he began to go to the exercise yard and chatted with the officer when he was on duty there, including about his life outside prison. He was allowed to exercise with another prisoner as he enjoyed his company.

38. The investigator asked the officer whether he had ever been concerned about the man's mental health. He said that every time he spoke to the man he assured him he was fine and that, although he had "things to sort out", he intended to do so. The officer said he kept a close eye on him and frequently sat in his cell and chatted with him and made sure he had tea and coffee.

39. On 4 May, a member of staff from the offender management unit phoned one of the prison officers. She had received a telephone call from probation explaining that the man had attempted to escape from court as he wanted to find his ex-partner and perhaps take her abroad with him. He had threatened to kill his ex-partner and her baby and had said that the only way a child of his could enter the world was if he were the carer. She warned that the man had an issue with probation because they had referred his case to children's services (part of social services). The member of staff from the offender management unit was concerned that the man might become more desperate as the birth of the baby approached and he might attempt to harm himself.

40. As a result, the officer, a governor, and an officer from the segregation unit who was trained as an ACCT[3] assessor spoke to the man. He again explained that he had attempted to escape from court because he wanted to take his "girlfriend" abroad so they could keep their baby after it was born. He said that social services intended to take the baby into care. The officer who originally took the call from the offender management unit said it was clear that the man blamed probation staff for his predicament. Although he was angry, they did not consider he was at risk of harming himself at that time as he spoke positively about the future. They decided not to make him subject to ACCT monitoring procedures. Because he was still considered an escape risk and was in the segregation unit, he was in any event checked hourly.

41. The next day the Governor of Chelmsford visited the segregation unit. He spoke to the man and was concerned about his low mood. He spoke to staff and it was agreed that the man should be made subject to ACCT monitoring. An officer from the segregation unit carried out the man's ACCT assessment. An ACCT assessment interview is an opportunity for staff to have a detailed conversation with the prisoner about what is troubling them.

42. The officer said that the man seemed bemused that ACCT procedures had begun and asked the reason. The officer explained that staff were concerned about him and it was a way of offering him support. He said that the man appeared to shrug it off and assured him he was alright. During the assessment, he once again explained the situation about his ex-partner and unborn child. He reiterated that he had never harmed himself in the past and had no intention of doing so. He said he did not have "the bottle" to do anything.

43. During the assessment, the man and the officer agreed a plan of action, known in the ACCT process as the 'caremap'. The man said he had concerns about social services and the officer agreed to find out what he could about them and how they work. The man said he was not allowed to work as he was an E list prisoner. Due to this, he had no income in prison and nobody sent him any money from outside. The officer said he would ask for someone from the education department to come to see him and arrange some in-cell activity for which he could be paid. He seemed content with that. As he had no money, the officer gave the man two smoker's packs. It was also agreed that he should have a mental health assessment. It was agreed that he should be observed hourly until his next case review (scheduled for 12 May) and that staff should record three meaningful conversations with him daily. The man's risk was assessed as low but it was decided that he should remain on an ACCT until the baby had been born.

44. It is noted in the man's ACCT documentation that, on 7 May, he was unlocked at 8.45am. He was offered the segregation unit regime (shower, exercise and telephone) but he said he just wanted a shower. The duty manager spoke to him at 10.25am and reported no concerns. As he had declined to take

[3] Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used by the Prison Service to help monitor and support prisoners identified as being at risk of self harm or suicide.

exercise earlier that day he was given the opportunity again, but he declined. He eventually went for exercise at 2.45pm.

45. Also on Saturday 7 May, a registered mental health nurse (RMN) was asked to carry out the mental health assessment. She looked at the man's prison and medical history and spoke to staff about him before she visited him. She said that the man was surprised he was on an ACCT and needed a mental health assessment. She said his interactions were quite limited, but he answered all of the questions she put to him.

46. The RMN recalled that his body language was relaxed and his eye contact and concentration were good. She remembered him saying that he had "absolutely no concerns at the current time" and was not worried about being in the segregation unit. The only issue he raised was that he was not sleeping very well but when she suggested he spoke to the doctor about this on his next rounds he said it was not that bad. He made it clear to the nurse that he had no intention of harming himself and had never done so in the past. She noted in the ACCT document: "On assessment there appeared to be no evidence of mental illness in the form of severe and enduring." This was also noted in his medical records. He told the nurse that he felt "happy" and maintained a calm manner throughout the assessment.

47. It was noted at 4.25pm that although the man appeared chatty when engaged in conversation, when he was being observed by staff he appeared to be deep in thought.

Events of the day preceding the man's death and the day of the man's death

48. It was noted that the man seemed a little happier when he was unlocked on the morning the day before his death. He asked if he could take some exercise and a shower. He also asked for materials to clean his cell. He collected his lunch at 11.35am.

49. At 2.15pm, it was noted in the ACCT records that the man had had a "busy afternoon". He had a shower, a change of clothes and then attended an ACCT review.

50. The ACCT review was carried out that day by an officer from the segregation unit, a senior officer and another officer. The man seemed a lot more upbeat and had already received information about social services and had been seen by education staff. The review noted that he seemed engaged and relaxed, and cheerful throughout but was not happy to answer any in-depth questions. He said he had no thoughts of harming himself but it was agreed that the ACCT would remain open. The next review was scheduled for 12 May where the level of observations set at the meeting (one an hour) on 5 May remained the same. His level of risk was reviewed and remained assessed as low.

51. The ACCT review did not mention whether the man needed support from his family. While it is not usual for staff to make contact with a prisoner's family, it

is advised that staff encourage the prisoner to make contact with supportive family members, or offer to do so on their behalf. There is no evidence that staff did so in this case, however, he had time out of cell to make phone calls and speak to family members if he wished to do so.

52. The officer from the segregation unit was not involved in any further ACCT assessments or formal reviews for the man, but observed him on the unit. The man thanked him for the smoker's packs and they had a joke about the officer constantly asking if he was alright. He saw the man on the exercise yard that day and they chatted with a prisoner and another officer. The officer from the segregation unit said the man laughed and joked and seemed upbeat.

53. The last time the officer from the segregation unit saw the man was when he gave him his dinner at the servery in the unit. He said that the man seemed fine at this point. The officer said he gave him an extra tea pack and gave him an extra large helping of food. The man said "see you tomorrow" and returned to his cell.

54. The investigator asked the man's fellow prisoner whether he could recall anything about the man on the evening before he died. He said that the man had spoken to him through their cell windows about taking his own life, but laughed as he said it. He said that the man had commented: "Me being down the block in an 'E' (escape) man suit and on an ACCT document, if I was to kill myself the Governor would get ripped apart". The fellow prisoner said he took it as a joke and they laughed about it. He also said that although the man had seemed depressed during the day, he was back to his normal self that evening.

55. They stopped chatting at approximately 9.30pm. His fellow prisoner recalled that at about 10.30pm, the man called out to him. He said that he did not want to get out of bed so ignored him, something he now felt guilty about. He heard nothing more from the man.

56. An officer was working in the segregation unit that evening and carried out ACCT checks at approximately 9.55pm and 10.52pm. His next check was at approximately 11.55pm. He came to the man's cell, looked through the observation panel and turned the cell light on from outside. The officer saw the man suspended from the cell window by a bed sheet. The officer immediately called out to the man and attempted to put out an emergency call over his radio but his battery was flat. He put his spare battery into the radio, but did not need to repeat the emergency call as other staff had arrived.

57. An officer was working as an assistant to the Night Orderly Officer (assisting in the running of the prison overnight) and was based on B wing. He was making his way onto A wing to see the officer who had found the man when he heard the officer call out and ran to the cell. Another officer, who was working on C wing, heard part of the officer's emergency call before the radio went dead, and decided to go over to the segregation unit to see if there was a problem. Both officers arrived within seconds of their colleague's call. They

informed the senior officer who was Oscar One (the senior officer in charge of the prison that night) over the radio that they intended to enter the man's cell.

58. The three officers entered the cell. The Assist Night Orderly Officer took hold of the man by his chest and attempted to alleviate the pressure from the ligature. Meanwhile, the officer who had originally found the man stood on a water pipe which runs along the back of the cell, and used his anti-ligature knife[4] to cut the bed sheet. The accounts of the staff involved from this point onwards differ slightly about the emergency procedures and cardio-pulmonary resuscitation (CPR). This is not unusual in a highly pressured situation such as this. It is not clear which member of staff requested the ambulance, or whether this was done in response to the partly heard radio call. The prison's incident log confirms that an ambulance was requested at 12.06am and an officer in the control room telephoned for it. The officer also telephoned the duty governor to inform her of what had happened.

59. The officers laid the man on his bed while the officer who arrived from C wing checked for signs of life. The man was not breathing but still felt warm to the touch so the officers commenced CPR while he was on the bed. The officer from C wing called out for somebody to get her a resusi-aid (a mask used for administering mouth to mouth). Nobody had one so she ran to the wing office to look for one, without success. She returned to the cell and somebody (she could not remember who) passed her a mask. The man was lowered onto the floor from the bed as it is recommended that CPR is carried out on a firm, flat surface where effective chest compressions can be applied.

60. The officer began administering rescue breaths, while the Assist Night Orderly Officer began chest compressions. Their recollection was that they worked at a ratio of two breaths to 15 compressions. (The agreed ratio is two breaths to 30 compressions.) The officer from C wing said that her first aid certificate had expired, but she had received training in the past and had also previously completed some nurse training.

61. Oscar One's account was different. He was the Night Orderly Officer and responsible for the prison that night and was in the Administration building collecting mail. He recalled that he heard the officer's emergency call and then the Assist Night Orderly Officer radioed that the three members of staff were about to enter the man's cell. He went immediately to the segregation unit. He said he arrived at the cell, immediately assessed the situation and began to carry out CPR with the officer who had arrived from C wing. He said they worked on a ratio of two breaths to 30 compressions. He confirmed he was first aid trained.

62. The investigator was unable to interview the nurse, who was not available during any of her visits. However, the nurse did make a statement in which she said she had heard the emergency call over the radio and brought with her an emergency bag and a defibrillator. When she arrived at the cell, the

[4] Each officer and member of staff who is in contact with prisoners carries an anti-ligature knife. These are knives which are specially designed to cut through ligatures in a safe manner.

officer from C wing was carrying out rescue breaths. The nurse does not refer to the Night Orderly Officer assisting with CPR. The nurse told her that she should continue and began to set up the defibrillator. She also gave the officer a breathing tube, to insert into the man's mouth and a bag to attach to the end of the tube. This is another way to administer breaths. The nurse put the defibrillator pads onto the man's chest and turned the machine on, but it gave a reading that indicated that his heart could not be shocked into starting a normal heart rhythm again.

63. At 12.15am, a paramedic arrived, followed by an ambulance three minutes later. One paramedic took over compressions while the Assist Night Orderly Officer relieved the officer who had arrived from C wing and took charge of administering the air bag. Once the Assist Night Orderly Officer was relieved by another paramedic, they continued to try to resuscitate the man until it was clear he had died. At 12.53am, the paramedics confirmed that he had died.

Results of the post mortem report

64. The post mortem examination indicated that the man died as a result of hanging with no sign of third party involvement.

Contact with the man's family

65. The deputy governor said during an interview with the investigator that he spoke to the Governor of Chelmsford at approximately 1.25am to discuss informing the man's next of kin. They agreed to take no immediate action as the person recorded as the next of kin was his ex-partner who was heavily pregnant (he had nominated his ex-partner as his next of kin on 24 March). The deputy governor said that they decided to delay speaking to her until they had contacted social services the next morning as they wanted to ensure that it was appropriate, given her advanced pregnancy, and the circumstances of her relationship with the man.

66. A governor at Chelmsford acted as the prison's family liaison officer and was asked to contact the man's ex-partner. He first spoke to an offender manager (probation officer) who was aware of the man's case. He then rang social services and also spoke to the man's offender manager. They arranged to meet that morning before the prison's FLO contacted the man's ex-partner. At the meeting, the prison's FLO was told that because of the man's threats towards her and her unborn child, social services had applied to the court to seek removal of the baby once it was born. However, they were also considering allowing the man's ex-partner to keep the child, subject to certain conditions (including that she had no contact with the man). The FLO also met the local police to assess any risk involved when informing the man's family.

67. Following this meeting, the prison's FLO, the prison's imam and a senior officer decided to visit the man's ex-partner at her home along with two managers from social services. When they arrived at 2.15pm she was not there. The social services managers established that she was at a pre-natal

class at the local community centre. They went there and the prison's FLO explained what had happened. Her mother was contacted immediately to come and support her.

68. The prison's FLO next attempted to contact the man's mother. He was told (it is not clear by whom) that she worked until 7.00pm in the evening, and by this time it was 3.00pm. He was concerned that he should inform the man's family as soon as possible so he decided to contact his sister. They visited her at approximately 3.20pm and informed her of what had happened to her brother. They left after approximately ten to fifteen minutes and the man's sister agreed to let other family members know about her brother's death.

69. The Governor wrote to the man's family to offer his condolences and offered to contribute to their relative's funeral expenses. On 10 May, a senior officer telephoned the man's ex-partner to ask if she would like to visit the prison to see where the man lived. She declined and she told him that his immediate family would deal with things from then on. However, she was aware that she could contact the senior officer or the prison's FLO at any time. The man's mother did not want to deal with the prison, so further communication was made through a solicitor. .

Support for prisoners

70. The Governor issued a notice to all prisoners informing them what had happened. A prison officer called a meeting for the prisoners on the segregation unit and adjoining A wing the morning after the man's death. He told them what had happened and where they could go to for support. Prisoners who were monitored under ACCT procedures had their ACCTs reviewed immediately and all prisoners were offered the support of staff, the chaplaincy, Listeners[5] or the Samaritans if they felt affected by his death. A memorial service conducted by a member of the chaplaincy was held for both prisoners and staff.

Support for staff

71. A governor held a debrief for the involved immediately after the man died. No formal record of the meeting was taken, and the governor said that everyone just talked through what had happened while having "a coffee". They discussed what had happened, the ACCT monitoring and how the man had seemed the day before. They also discussed the process for a death in custody investigation and what staff could expect to happen. Staff wrote reports about what had happened from their perspectives. The governor said that no issues arose from the debrief.

72. However, the officer who had arrived from C wing upon hearing her colleague's radio call told the investigator that she had raised at the debrief the problem that she had not known at the time where to find a face mask when she needed it. She now knew but added that she has been at the

[5] Listeners are prisoners trained by Samaritans to offer confidential and emotional support to other prisoners. Listeners can be called on by other prisoners needing someone to talk to at any time during the day or night.

prison two and a half years and had not had the opportunity to attend first aid training courses. The prison have since issued a personal face mask to all operational and healthcare staff

73. Most staff felt supported by their colleagues and by the care team (a team of staff trained to counsel and support their colleagues during emergency incidents) during the incident and afterwards, and most felt that that contact and support was extended to them after they left the prison and were off duty. Some said senior managers had telephoned them at home to check on them. However, one of the officers involved in the emergency response was not on duty for the next week and no one from the prison contacted her. When another colleague brought this to the attention of a senior manager, he telephoned her and from then on the officer described the support she received as “fantastic”.

74. A critical incident debrief was held on 10 June. This was to ensure that staff who had been involved with the man had the opportunity to reflect on what had happened and to raise any issues of concern. The Assist Night Orderly Officer recalled that one issue suggested was that face masks should be issued to staff routinely, in the same way that anti-ligature knives are issued.

ISSUES

ACCT procedures

75. Staff in the segregation unit at Chelmsford built up a good relationship with the man and were aware of the issues that concerned him. One officer in particular spent time with the man listening and discussing his problems and tried to get information to help him.

76. The Governor noticed that the man's mood was low when he visited the segregation unit and decided that he should be placed on ACCT monitoring. Reviews were carried out, and he had a mental health assessment. He expressed surprise that he should be subject to suicide monitoring procedures and assured staff that he had no thoughts of harming himself.

77. The level of observations determined in the man's ACCT (hourly checks) seemed appropriate. However, there was a clear pattern close to the hour each time and thus the checks were too predictable. These ought to have conducted at different times and intervals within the hours so that he would not have been able to predict when the next observation would take place.

78. Given the events in the man's life and the Governor's concern for his low mood, it was appropriate for ACCT procedures to be opened. One review was held which, although not multi-disciplinary, appropriately considered progress against the actions in his caremap. At no point did the man suggest that he might harm himself. Only a fellow prisoner heard the man speak of such matters, and he did not bring it to the attention of staff before the man's death. However, his ACCT observations were carried out at times which were too predictable.

The Governor should ensure that ACCT checks are conducted at unpredictable intervals and the requirement to do so is recorded on the front of ACCT documents.

The man's location in the segregation unit while on an ACCT

79. The Prison Service order (PSO) covering segregation says:

> "A prisoner on an open ACCT plan must only be kept in segregation under exceptional circumstances whereby they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate."

80. PSO 2700 Suicide and Self harm management, also requires:

> "*Location of an at-risk prisoner in the Segregation Unit must be authorised by the Duty Governor, who must record in the ACCT document that this has been done and the reasons it was considered necessary*" [Italics in the order indicate a mandatory instruction.]

81. There is no evidence to suggest that any thought was given to moving the man from the segregation unit and there is nothing recorded about this in his ACCT document.

82. The man remained an E list prisoner and staff were concerned about his unpredictability. A mental health assessment was carried out by a nurse the day after the ACCT was opened for the man and she had no concerns about him attempting to harm himself or about him being located in the segregation unit. Further health assessments were undertaken for the man on 6 and 8 May and authority for him to be held in the segregation unit was granted on 4, 6 and 7 May.

83. Despite these checks, it was against the mandatory requirements of the PSO for the prison not to consider his location explicitly, and ensure that he was only there because of exceptional circumstances or because he was "such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate." No consideration of this was recorded.

The Governor should ensure that prisoners on an ACCT are located in the segregation unit only in exceptional circumstances in line with the requirements of Prison Service instructions. The decisions and reasons should be clearly documented.

PINphone records

84. The man's family wanted to know who he had telephoned in the days before his death. Unfortunately, at both Norwich and Chelmsford the records were incomplete and showed the telephone numbers only and not the people they related to. Chelmsford prison said this was how the information had come to them from Norwich prison and had not been queried.

85. When a prisoner enters custody he is required to sign the prison's communications compact before he can use the PINphone system. This requires the prisoner to list the people and the numbers he wishes to call. However, this did not happen at Norwich. When a prisoner transfers to another prison, it should be possible to take the list of numbers with them although the receiving prison does not have to accept them automatically. The new Head of Security at HMP Chelmsford said that the telephone numbers had been approved by the prison, but that the persons' names had not been recorded.

86. This oversight was attributed to human error at both Norwich and Chelmsford prisons and Head of Security at Chelmsford reiterated that the man would have been unable to telephone any number which was not on the approved list. He made further enquiries and identified that the last telephone calls the man made were on 2 May. He made two calls to his brother and ten calls to his ex-partner. He did not receive a reply on any occasion.

87. There are separate arrangements for prisoners considered at risk of escaping (E List prisoners) or in the Segregation Unit in terms of monitoring telephone calls, although the telephone numbers are submitted for approval in the usual way. Local instructions set out the arrangements for recording and monitoring telephone conversations of E List prisoners. These can include listening to all telephone calls (but it may be less). Any recordings or monitoring must be kept for three months after the telephone call.

88. The advice provided to the investigator indicates that there was a failure at both Norwich and Chelmsford to record the identities of the persons whose telephone numbers the man was telephoning. This failing is heightened by his status as an escape list prisoner, located in the segregation unit and subject to ACCT procedures.

The Governors of Norwich and Chelmsford prisons should ensure that PINphone records are completed fully and accurately.

Delay in notifying the man's family

89. There was a considerable delay between the man's death and his family being told that he had died. The Governor and deputy governor made a decision shortly after he had died that checks would be made the following morning with a number of people before contacting his family. The family liaison officer made a number of telephone calls to the man's offender manager and the social services staff involved with his ex-partner. He then met the social services staff and subsequently the police before attempting to contact the man's ex-partner and then subsequently his immediate family.

90. While it was appropriate for the prison to take into account the sensitivities of the man's relationship with his ex-partner, and her pregnancy, efforts should have been made to contact her and his family sooner. It is unclear why any discussions with the police and social services could not have been dealt with by telephone or why the man's mother and his other close family could not have been told before his ex-partner. There is no requirement to ensure that the nominated next of kin is informed before anyone else and in some circumstances it would not be possible or it would be inappropriate. The man died at 12.53am, yet his ex-partner was not informed until the following afternoon at 2.15pm. His family were not told until nearly 4pm. If the prison believed it was essential to speak to other agencies before breaking the news, they should have ensured that matters were resolved as soon as possible the following morning so that any delay was minimised.

91. Following the issue of the draft report, the prison said that the situation had not been reported accurately and submitted additional information. They said;

> "A multi-agency case conference took place at Children Services at 1pm on 9 May 2011. The reason this could not take place before is because ([the man's] Offender Manager) had been at a non-associated child protection meeting all morning. It was also felt that the Social

Worker for ([the man's] former partner) also needed to be at the conference.

The case conference took place with a governor at Chelmsford who also acted as the Prison FLO in this case, the Prison Chaplain, the Families Officer, the man's offender manager, the man's former partner's social worker and the social worker's line manager and a Team Leader at Social Services)".

Following this meeting the governor then went with the man's former partner's social worker to see his former partner. The social worker remained with her until a family member could be contacted. The prison's FLO then went to see the man's mother.

The man's offender manager is of the opinion that this multi-agency approach was essential in managing the potential risk to the man's former partner and that it was all arranged at the earliest opportunity.

The man nominated his former partner as his next of kin. HMP Chelmsford believe they had a duty to inform his family but "did not wish to antagonise the situation or cause any unnecessary hurt by highlighting that [the man] had not nominated them as next of kin.

Chelmsford believe that they resolved matters as soon as possible. However, they agree that initial documentation provided to the investigator explaining the delay was incomplete. They request that the final report reflects the information now presented."

92. Prison Service guidance in Prison Service Order 2710 (Follow up to a death in custody), makes it clear that the news should be broken as soon as possible. We accept that the delay stemmed from a desire to ensure the prison had the most accurate information possible, but we consider that this approach resulted in an unreasonable delay in informing the man's family of his death.

93. While accepting the prison's explanation of why the delay occurred, with hindsight it may have been better for the meeting on 9 May to have gone ahead with representatives attending on behalf of those who were unable to meet earlier than 1pm. One of the reasons for the delay was that the social worker for the man's former partner needed to be at the meeting. However, it is noted that her line manager attended as well.

The Governor should ensure that, in any future death in custody, the family is informed without undue delay.

First aid

94. When resuscitation began the officer did not have immediate access to a face mask and did not know where to find one on the unit. This delayed her ability to provide emergency aid and she raised it as an issue at the hot debrief. A prison nurse said at interview that every wing has a first aid kit, a grab bag

and an oxygen bag, in which face masks are kept. Defibrillators are kept in the grab bag and therefore there is a defibrillator on each wing in the senior officer's room. Not all staff were aware of this. CPR was originally started on the bed, and although the Night Orderly Officer was first aid trained, others on the scene were not.

The Governor should ensure that there are sufficient first aid trained staff on duty at night and that all staff know how to access emergency equipment.

Support for staff

95. One of the officers was overlooked when it came to contacting staff involved in the emergency after the man's death. This was an unfortunate oversight, as other staff spoke positively about the support and contact they received. No recommendation is made as this was clearly an unfortunate individual oversight rather than a procedural failing. Once managers had been alerted to the officer's situation she was offered immediate and ongoing support which she found excellent.

CONCLUSION

96. The prisoner was clearly a troubled man. His relationship with his partner broke down after he made violent threats towards her and their unborn child. This apparently led him to attempt to escape from court custody and was constantly on his mind at Chelmsford. Staff recognised this and tried to engage with him and offer him help and support, which they did with a degree of success for a time. One officer in particular took time to listen to him and tried to provide him with the information he required about his future rights as a father.

97. Although the man received good support in the segregation unit the prison did not fully consider whether this was an appropriate place to hold a man they had assessed as at risk of suicide or self-harm. We agree that ACCT procedures were appropriate once his low mood had been identified, even though he continued to say that he had no intention of harming himself. The timing of his observations in the segregation unit were too predictable.

98. Although the circumstances were complicated and staff meant well, there was too much delay in informing the man's family of the news of his death.

RECOMMENDATIONS

1. The Governor should ensure that ACCT checks are conducted at unpredictable intervals and the requirement to do so is recorded on the front of ACCT documents.

   This recommendation was accepted by the prison

2. The Governor should ensure that prisoners on an ACCT are located in the segregation unit only in exceptional circumstances in line with the requirements of Prison Service instructions. The decisions and reasons should be clearly documented.

   This recommendation was accepted by the prison

3. The Governors of Norwich and Chelmsford prisons should ensure that PINphone records are completed fully and accurately.

   This recommendation was accepted by both prisons

4. The Governor should ensure that, in any future death in custody, the family is informed without undue delay.

   Not accepted. The prison submitted an explanation included at paragraph 92

5. The Governor should ensure that there are sufficient first aid staff on duty at night and that all staff know how to access emergency equipment.

   The prison accepted this recommendation.