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

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

This is the report of an investigation into the circumstances surrounding the death of a man who died apparently by his own hand at HMP&YOI Chelmsford aged 22 years. He was an illegal entrant to the UK and arrived in the country sometime between November 2007 and April 2009, when he was arrested for offences relating to the cultivation of cannabis. At the time of his death he was remanded to Chelmsford pending further similar charges and was also being held under the terms of the Immigration Act 1971 pending deportation to Vietnam.

The investigation was led by a senior investigator and a family liaison officer was appointed. The local Primary Care Trust appointed a clinical reviewer to provide a clinical review of the healthcare offered to the man in Chelmsford. I am grateful to the Governor and staff of HMP&YOI Chelmsford for their co-operation with this investigation.

The man appears to have paid money to enter the country illegally. As a consequence he was obliged to work in a succession of cannabis factories in different parts of the UK. He was provided with a false identity and the Prison Service believed him actually to be only 18 years of age. He was well cared for at Chelmsford, with commendable efforts made to use translation services when required. He appeared to be looking forward to returning to Vietnam and, at the time of his death, was awaiting removal under the terms of the Facilitated Return Scheme. On the day he died his cellmate, another Vietnamese prisoner, was transferred to an Immigration Removal Centre. Staff and prisoners told the investigator that, unusually for him, he appeared to be upset that day. However, he had no history of self-harm or suicidal thoughts and his death came as a shock to those who knew him best. Accordingly, I do not criticise staff for not opening suicide prevention arrangements. While his death was not reasonably foreseeable, I make two recommendations about ensuring access to emergency equipment and improving internal serious incident reviews by the prison healthcare department.

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

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

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SUMMARY

1. The man was an illegal entrant to the UK from Vietnam arriving in the country at some point between November 2007 and April 2009. He told the authorities that he had paid money to be brought here and had come in the hope of a better life. He assumed the identity of an eighteen year old. In fact he was 22 years old.

2. Because of the circumstances in which he entered the UK the man was obliged to work in cannabis factories in various parts of the country. He was arrested in Norwich in April 2009 but charges were dropped because it was accepted that he had been trafficked into the UK and had not intentionally committed an offence. He was arrested again in another cannabis factory in October 2010. This time he received an 18 month prison sentence. Because of his false identity he was treated as a Young Offender during his time in prison.

3. On 6 April the man was issued with a notice that he was liable to be deported at the end of his sentence. On 13 May, he transferred to HMP&YOI Chelmsford because he faced further charges relating to the production of cannabis in Essex. On 14 June, he told an immigration officer his real identity and date of birth and applied to return to Vietnam under the terms of the Facilitated Return Scheme. (Prisoners can volunteer to return to their country of origin in return for a cash payment and a reduction in sentence time.) His application was accepted and a Deportation Order was issued on 27 June.

4. The man was described as a quiet prisoner who did not mix much on the wing. He spoke broken English but had quite a good understanding of the language. Staff and prisoners reported that he was usually in good humour but seemed to be happier when he started sharing a cell with another Vietnamese prisoner. He had no known history of mental illness or self harm.

5. In July, the man's cellmate was transferred to an Immigration Removal Centre. He was visibly upset by this and was reassured by staff and prisoners that he too would be moving soon. They were not worried about his safety but resolved to keep an eye on him over the next few days. Sadly he was found hanging from his window bars at about 7.16pm that evening. Staff attempted to resuscitate him and paramedics were called.

6. We do not conclude that staff should have regarded the man as at risk of self harm or suicide on 4 July. The attempt to resuscitate him was efficient and co-ordinated. There were examples of good practice at Chelmsford. Staff routinely used the Big Word telephone translation service when having significant interaction with him. The prison family liaison in this case was also of a high standard.

7. The clinical review judges that the man received a satisfactory standard of healthcare. We make two recommendations about access to emergency equipment and internal serious incident reviews provided by prison health care to the PCT.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on 4 July 2011. The investigation was allocated to an investigator the next day. Notices were issued to staff and prisoners at Chelmsford telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. She did not receive any response to these notices.

9. The investigator visited Chelmsford to open the investigation on Monday 11 July. She spoke to the Governor and collected copies of the man's prison record and the statements made by staff concerning the circumstances of his death. She visited his cell and spoke informally to the first officer to find him. She also spoke to the Co-ordinating Chaplain and obtained details of his next of kin and the progress made by the Chaplain in his role as prison family liaison officer.

10. A clinical review of the man's medical care was commissioned from the local PCT. A clinical reviewer was appointed to undertake the review. Her report was received on 24 October. The investigator subsequently spoke to a DI of Chelmsford CID and was provided with a translation of a letter removed from the cell after his death. This was not a suicide note. She also spoke to the Youth Justice Board, the Senior Policy Development Officer for the Children's Commissioner and the UK Border Agency.

11. The investigator visited Chelmsford on 19 July and 9 August and interviewed eight members of staff and four prisoners. Following the majority of the interviews she wrote to the Governor, on 20 July, and gave him feedback on emerging issues.

12. One of the Ombudsman's family liaison officers contacted the man's cousin using an interpreter. The cousin was nominated by the man next of kin in Vietnam to act as a point of contact with the family. The family liaison officer explained the nature and purpose of the investigation and offered the cousin the opportunity to raise any questions she had about the death. No issues were raised at the outset. However, the man's family in Vietnam received a translated copy of this report as part of the consultation period. In their response they said they were sad and upset that he died while in prison custody and feel the prison could have done more to protect him given their duty of care towards his safety and wellbeing. They feel somehow the prison failed him given his previous history of self harm. We are grateful to the family for their consideration of the report.

HMP&YOI CHELMSFORD

13. Chelmsford is a local prison and young offender institution accepting prisoners direct from the courts within its catchment area. 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). B wing, where the man lived, holds a mix of convicted, remand and unsentenced prisoners. Young offenders are not held separately but are not allowed to share cells with adult prisoners. A number of education courses are provided via a contract with Milton Keynes College and a variety of workshops are also available offering courses in woodwork, electrics, plumbing and bricklaying. There is an award winning Learn Direct centre.

14. Her Majesty's Inspectorate of Prisons (HMIP) most recently inspected Chelmsford in a full announced inspection in May 2011. HMIP found that there was a comprehensive suicide prevention strategy that was understood by, and available to, staff and prisoners and which focused on the needs of prisoners in a local prison. A full-time suicide prevention co-ordinator was supported by a full-time safer custody manager, residential managers and a safer custody committee. HMIP found that individual cases were discussed appropriately and the specific needs of prisoners were met. Inspectors observed staff who genuinely cared about prisoners and had an appropriate focus on their needs.

15. HMIP found that provision for foreign national prisoners was reasonable. A foreign national co-ordinator was appointed in December 2010. The prison had good links with the UK Border Agency (UKBA) and forums for all foreign national prisoners took place monthly. Access to airmail and telephone calls was good. The foreign national co-ordinator reviewed all new arrivals and liaised with immigration officers based at HMP Bullwood Hall (another prison in Essex which caters solely for foreign national prisoners). Chelmsford had a service level agreement with a local solicitor who provided information and guidance on immigration issues and whose number was automatically added to the PIN phone accounts (the telephone system used in prisons) of foreign national prisoners.

16. HMIP also found that the Big Word translation service was used regularly and that interpreters were used in formal setting such as adjudications (prison disciplinary hearings) and when monitoring and reviewing prisoners thought to be at risk of suicide or self-harm. (The Big Word is a service that offers translation over the telephone. In Chelmsford the phone is passed between the member of staff and the prisoner and the interpreter translates. The prison plan to invest in new telephones that allow three-way conversation.) HMIP found the availability and range of translated documents to be variable.

17. At the time of the investigation, Chelmsford held 130 foreign national prisoners, of which between 25–30 could not speak English.

18. HMIP's observations of staff prisoner relationships were consistently favourable. Staff presented as helpful, interested and engaged and prisoners

spoke positively about how staff treated them. These observations accord with the investigator's experience of staff interviewed during this investigation. The comments made by the prisoners interviewed were also very positive.

19. Every prison has an Independent Monitoring Board (IMB) made up of local independent volunteers whose job it is to monitor standards to make sure prisoners are being treated fairly and humanely. Each IMB is required to report every year on their findings. In the last report on the period between September 2009 and August 2010, the Chelmsford IMB observed that the introduction of regular visits by UKBA staff and specialist solicitors had removed a lot of uncertainty among the prison's foreign national prisoners. The board was concerned, however, that foreign national prisoners were put at a disadvantage because important notices were not always translated.

20. There have been ten self-inflicted deaths at Chelmsford since the Ombudsman took over responsibility for investigating deaths in 2004. The death immediately preceding that of the man was in May 2011. Before that, the last self-inflicted death at Chelmsford was in 2008. We have identified no common issues between his death and those immediately preceding it.

KEY EVENTS

21. The man was born in 1988 in Vietnam. Nothing is known about his life there or when he left for Europe. According to the UKBA, he attempted to claim asylum in Germany in 2006. In September 2007, he was intercepted by UKBA staff in Calais while trying to enter the UK in the back of a lorry. He gave a false name and was fingerprinted. He was handed over to the French authorities. He, using his false identity, next came to the attention of the authorities when he was arrested in Norwich in April 2009 and charged with offences relating to the cultivation of cannabis. He was discovered living in a house where he tended a significant number of cannabis plants. He received no money, did not leave the property and his food and the household bills were paid for by someone else.

22. The man told the authorities that he was 14 years old, and gave a false date of birth. In May 2009, the manager of the County Asylum Team officially assessed his age as 17 and changed his date of birth. The local Youth Offending Team (YOT) were told by UKBA via the Crown Prosecution Service that 'His fingerprints matched those taken from another person in November 2007. Throughout his time in the prison system, he was known as his original name and his date of birth was believed to be another date. He was therefore categorised as a young offender.

23. The man was remanded to HMYOI Warren Hill (a closed prison for male juvenile offenders). He told staff there that he had arrived in the UK in the back of a lorry with the hope of a better life. The charges against him were dropped on 16 June 2009, when the Crown Prosecution Service accepted his account that he had been trafficked into the UK and had not intentionally committed an offence. He was released from Warren Hill and Norwich Children's Services provided him with a place in a shared house and gave him a small amount of money for food. They also provided him with clothing because he only owned what he was wearing. He was also provided with English lessons and it was intended that he start education in September 2009. He was subject to weekly reporting to the Asylum Team.

24. In a later pre-sentence report, the man told West Yorkshire Probation Service that he had travelled to London in October 2009 to get work as a waiter. There is no corroborative evidence of his whereabouts during this time. Correspondence from UKBA says that he absconded from his weekly reporting and the police circulated his details on the Police National Computer. He was arrested in Leeds on 4 October 2010. He was charged with being concerned in the production of cannabis at the address he was arrested at and remanded into custody at HMP&YOI Doncaster. He was subsequently charged with further offences relating to the production of cannabis in Boreham, Essex, between 9 October and 7 December 2009.

25. The man was interviewed with an interpreter on 8 October. He revealed his real name and date of birth. He was served with form IS151A – a notice informing him that he was considered to be an illegal entrant to the UK.

26. On 21 January 2011, the man was convicted of the charges relating to the production of cannabis in Leeds. On 15 February, he was sentenced to 18 months detention in a YOI and transferred to HMYOI Glen Parva on 4 March 2011. On 6 April, he was served with a notice explaining his liability to automatic deportation at the end of his sentence.

27. The man appeared at Magistrates' Court on 13 May in connection with the charges of cannabis cultivation in Essex in 2009. He was remanded into custody and taken to HMP&YOI Chelmsford. His first reception health screen was completed by a nurse, a registered mental health nurse (RMN), on the same day. (This is a face to face confidential interview with a nurse consisting of a series of questions, the answers to which are recorded on the patient's electronic medical record.) She used the Big Word translation service during her interview with him.

28. The man told the nurse that he had suffered from "fits" at night and had received injections at Glen Parva to treat these. She was unable to gain any further detail from him and referred him for an appointment with the prison doctor the following day. He denied that he had any thoughts of self-harm or suicide. However, he told her that he had been tortured in Vietnam and had received head injuries. He said he could not tolerate heat and suffered from headaches and dizzy spells as a result. He also told her he was anxious as he had not been able to see an Immigration Officer. She referred him for an appointment with a member of the mental health team.

29. The man was seen by a prison doctor on 15 May. The doctor used the Big Word translation service and decided that further information was required from the health care department at Glen Parva. He was seen by another doctor the following day who concluded the same thing. That afternoon, the second doctor rang Glen Parva and was told that the only injections he had received were innoculations and that he was not on any medication for night time fits.

30. The man completed his induction on 17 May and was allocated to B3 landing on the top floor of B wing. An officer was assigned as his personal officer. (Personal officers are the first point of contact if the prisoner has a question or any issues. They are also required to make regular entries on P-NOMIS - the prisoner's electronic prison record.) On 27 May, the officer wrote an entry on P-NOMIS that he had settled on the wing well. He said he went to the English for Speakers of Other Languages (ESOL) class in education, conformed to the regime, kept his cell clean and tidy and was polite to staff. The officer wrote that he had problems with English but made an effort to communicate. On the same day the Foreign National Co-ordinator wrote that she had received an application from him to see an Immigration Officer when they were next in the prison. She noted she had arranged this for the week beginning 31 May and had informed his personal officer by email.

31. She made another entry on P-NOMIS on 6 June. She wrote that she had received another application from him saying he was upset and did not want to come out of his cell. He had ordered a radio two weeks ago and it had not

arrived. She said she had emailed the personal officer and asked him to speak to him about his issues using The Big Word translation service. She also said she had re-directed his application to the canteen so they could address the issue of his missing radio. She said she had sent him a Prison Information Booklet translated into Vietnamese.

32. A few days after the co-ordinator's entry, another rofficer became the man's personal officer. On 12 June, she wrote on P-NOMIS that she had introduced herself to him. She said he spoke very little English but appeared to understand the basics. She said she had only known him a few days. Initially he was very quiet and did not come out of his cell much but he had recently got a new cellmate who was also Vietnamese. The officer said this had made a tremendous difference to him and he had "really come out of himself". She said he was "walking around with a smile on his face" and spent a lot of time making origami and playing cards with his cellmate.

33. On 14 June, the man was interviewed by an Immigration Officer in the presence of an interpreter. He gave his true identity and date of birth. The Immigration Officer explained about the Facilitated Return Scheme (FRS - a scheme whereby prisoners subject to deportation volunteer to return home in exchange for a sum of money and a reduction in their sentence). He applied for FRS and signed a disclaimer to say he would like to return to Vietnam. His application was approved and a deportation order was sent out on 27 June (signed by him on 1 July). He was not taken to an Immigration Removal Centre because of the outstanding charges against him.

34. On 15 June, the man asked to see a male nurse and complained of penile discomfort. He had apparently inserted two glass objects some months previously. The following day a prison doctor removed one of the objects from his penis and referred him to hospital for removal of a second object. He was taken there the same day and returned to Chelmsford following a minor operation under local anaesthetic.

35. On 17 June, the man and his cellmate were charged with fighting with another prisoner in the exercise yard. He did not sustain any injuries. The following day he was seen by a mental health nurse who recorded that he was fit and well and able to attend an adjudication (an internal disciplinary hearing held when prisoners are charged with breaking prison rules). The adjudication was opened by the Governor but adjourned when the man and his cellmate told him they did not understand the process. The hearing resumed on 21 June in the presence of a Vietnamese interpreter.

36. On 24 June, the man appeared via video link at Magistrates' Court and was further remanded until 8 August when he was scheduled to appear at Crown Court for trial. Following his appearance, a health care assistant (HCA) visited him in is cell to check that he was OK. The HCA recorded in his medical record that he appeared to be "doing just fine". The following day, his personal officer wrote on P-NOMIS that he continued to work in education and attend the English language class. She said he was sometimes reluctant to go to work. He spoke English only sometimes and appeared to choose not to

(as opposed to not being able to). She said she had asked him if he wanted to discuss his video link court appearance but he had said no.

37. On the morning of 4 July, the man's cellmate was transferred to Morton Hall Immigration Removal Centre pending deportation. A landing officer on his landing told the investigator that he had asked her why he was not being transferred too. The officer said she told him that his cellmate was ahead of him on the list but he would be transferring soon. She said he replied, "good". After his cellmate had left she saw him sitting on the floor of his cell playing cards.

38. The man's personal officer also spoke to him that morning. She told the investigator that he had told her that he did not want his cellmate to leave and he wanted to go as well. She said she told him that he would have to wait his turn but that he would be going too. She said she had not been concerned about his state of mind.

39. Prisoner A who lived next door to the man told the investigator that he got on well with him and they were friends. He said the man was usually in good spirits and used to make him laugh. He helped him understand his legal letters. He said the man spoke only broken English but had a good understanding of the spoken language. He said that his mood was very different after his cellmate left the prison. He described him as "down" and said he did not come out for breakfast or go to his morning art lesson. At lunchtime, he asked the prisoner for some tobacco and told him that he would pay him back from his next canteen order. The prisoner said he told him he did not need to pay him back but he was insistent that he would.

40. The prisoner said that at about 2pm he was on the landing because he was employed as a wing cleaner. He saw the man's personal officer trying to persuade him to go to his afternoon lesson. Officer A asked him to talk to him, so he went into his cell. He said that he told him that he was sad, didn't want to be in prison and that he wanted to go home. He said he reminded him of the letter he had received telling him that he was going to be deported and told him that he did not have long to go before he would be going home. He told him to relax and not to worry. He said he still refused to go to his lesson so he told him that the officer would have to take his TV if he did not go. At this point he said he unplugged his TV, handed it to the officer and said that he did not want it and just wanted to go to sleep. (The officer did not in fact remove his TV.)

41. The prisoner said the officer asked him to keep an eye on the man during the afternoon. At some point between 2.00pm and 4.00pm he went to his cell, opened the flap and called his name a few times. He said he had hung a sheet between the bunks, which was his usual practice when he was sleeping. He assumed he was asleep and left him alone. The last time he saw him was when he went to collect his meal at teatime.

42. Prisoner B told the investigator that he worked on the servery on B wing. He said he did not know the man well but it was possible to engage him in a bit of

"banter". He said that on the night of 3 July either the man or his cellmate had been making banging noises in their cell. He said this had annoyed him because it had disturbed his sleep. On 4 July, he said he was working in the servery at teatime when the man came to collect his meal. He said another servery worker began to load his plate with extra food. Prisoner B said he asked the other prisoner if he was "loading him up" and they laughed about it. He said the man then "squared off" so he began to walk around the servery to confront him. Other prisoners persuaded him not to however, and the man left the servery and threw his meal in the bin. He said he had not meant to upset him.

43. Officer A said that she always said goodnight to the prisoners on her landing when she goes off duty. When she went to say goodnight to the man he was sitting at his table watching his TV. She said she was always telling him to eat more because he was very slightly built. She said to him, "Make sure you eat your greens!" and he replied "OK". She then said "Goodnight and I'll see you in the morning" and he again replied "OK."

The events of the evening

44. Officer B told the investigator that she was on duty on B wing that evening. At approximately 7.16pm she was counting the number of prisoners on the wing as part of the evening roll call. She looked through the observation flap in the door of the man's cell and saw him hanging from his cell window bars. He had used a bed sheet to make a ligature. She used her radio to call a code one emergency (code one is the code used at Chelmsford when a prisoner is found not breathing). She waited for assistance and was joined very quickly by Officer C. She told the investigator that she had her cell key and anti-ligature knife ready and, as soon as she saw the other officer coming up the stairs, she unlocked the cell door and went in.

45. Officer C told the investigator that he was assisting nursing staff giving medication to a prisoner in the centre treatment room when he heard a code one call for assistance to B3 landing on his radio. The door onto B wing is adjacent to the treatment room and Officer Watson estimated that it took him a matter of seconds to arrive on B3 landing. He said he saw Officer B standing outside the man's cell. He said she told him a prisoner was hanging and unlocked the cell door. He followed her into the cell and saw the man suspended from his cell window bars. He supported his weight whilst she used her anti-ligature knife to cut through the sheet. He said he carried the body out on to the landing where nursing staff were waiting.

46. Three nurses all told the investigator that they were on duty in the centre treatment room with Officer C at approximately 7.15pm when they heard the code one emergency call on their radios. A student nurse was also present. Nurse A was designated radio call sign Hotel 5 signifying that she was the duty emergency response nurse. Nurses A and B went immediately to B3 landing and Nurse A took the centre emergency bag with her. The student nurse accompanied them and collected another bag of equipment from the B

wing office. Nurse Betts finished treating a prisoner who had a cut arm and then quickly joined his colleagues on B3.

47. Nurse B told my investigator that she arrived on B3 as Officer C was carrying the man out of his cell. She said that she could see immediately that he was not breathing. She found no pulse and his pupils were fixed and dilated. Nurse A said that she immediately used her radio to call for an ambulance. Nurses A and B began cardio-pulmonary resuscitation (CPR) and attached a defibrillator to him. (A defibrillator is a portable electronic devices that measures a patient's heart rhythm.) On closer inspection of the bag brought by the student nurse it was found that the ambu-bag was missing. (An ambu-bag is a hand held bag and facemask used to get oxygen into patients who have stopped breathing. The device can be used on its own or attached to an oxygen cylinder.) Nurse B instructed both officers to collect an ambu-bag from C wing.

48. Nurse B said that she was unable to open the man's airway sufficiently to insert an i-gel airway (the most effective means of keeping a patient's airway open during CPR) because his jaw was too stiff. She used a smaller airway instead and then replaced it with an i-gel once he had received enough oxygen to enable her to move his jaw. She began mouth to mouth rescue breaths using a face mask while Nurse C did cardiac compressions. Both officers arrived quickly with the ambu bag from C wing and Nurse B began using this and 15 litres of oxygen. Nurse A relieved Nurse C doing cardiac compressions. Nurse C then inserted a cannula into his arm (a tube used to give the patient fluids – in this case Nurse C was preparing him for the administration of adrenalin by the paramedics).

49. Nurse B said that the defibrillator advised 'no shock' throughout the CPR process. (This is because the machine cannot detect a shockable rhythm in the heart.) Nurse D took over cardiac compressions from Nurse A and Nurse B continued to maintain the man's airway using the bag and mask. Nurse B said the first response paramedics arrived at about 7.25pm. A second team of paramedics arrived at about 7.30pm and took over care of him. They attached their own defibrillator and gave him oxygen. The ambulance crew decided to take him to hospital.

50. The control room incident log shows that Officer B called a code one on B3 at 7.16pm. Nurse A used her radio to call for an ambulance at 7.17pm. At 7.24pm, the Duty Governor instructed the gate to override the locking system to allow the emergency ambulances to enter the prison quickly. The first response paramedics entered the prison at 7.24pm shortly followed by an ambulance. The ambulance left the prison with the man at 7.54pm. His personal officer travelled with him. The police and the Coroner were informed immediately. The IMB, the Chaplain, the prison care team and the Samaritans were all contacted shortly after 8.15pm and asked to come to the prison. At about 8.20pm the hospital contacted the prison to tell them that he had died.

51. The Governor attended the prison and liaised with officers from Chelmsford CID. The Duty Governor gathered the relevant staff together once the man had been taken to hospital for a hot debrief. The Governor, Duty Governor, members of the Care Team and the Chaplaincy were all present. The Co-ordinating Chaplain visited Prisoner A and the other prisoners who had known him and told them of his death. The staff who were involved agreed to be interviewed by police that evening and the last member of staff left the prison at about 3.00am on Tuesday 5 July. Staff were offered the opportunity to be accompanied during their police interviews.

Family liaison

52. A Chaplain was appointed as family liaison officer. The man had not given the name of his next of kin when he arrived at Chelmsford. The next day The Chaplain rang the Vietnamese Embassy and began the process of trying to contact the family. A letter was found in hiss cell from another prisoner. The Chaplain looked on P-NOMIS and eventually identified the sender of the letter as the man's first cousin who was being held in Yarl's Wood Immigration Removal Centre. He spoke to her by telephone using the Big Word. During this conversation he became aware that she had already been contacted by the man's cellmate who had told her of his death.

53. The Chaplain was told by UKBA that the man was in fact known by another name. The Vietnamese Embassy provided details of his family in Vietnam. The Chaplain called them, using the Big Word, to break the news of his death and spoke to one of his brothers. He said that the family had already been informed of the death but he was not sure whether they had been told by the cousin he had spoken to in Yarl's Wood or by the Embassy. The family gave him the contact details of another cousin who was at that time in the UK. He invited her to come in to the prison, which she did on 9 July. She visited the cell and spent some time there burning incense and marking her cousin's passing. She was also given his property from his cell.

54. The man's family asked for his body to be repatriated to Vietnam for burial. The Chaplain arranged this with the help of the Vietnamese Embassy and the prison made a financial contribution to cover the cost of the collection of the body and the funeral arrangements. The Chaplain visited the man's cousin in August to return other property from the prison including some letters removed from the cell by the police.

ISSUES

The man's time at Chelmsford and the events preceding his death

55. The man spent some six weeks in Chelmsford. Staff and prisoners told the investigator that he was a quiet individual who did not mix much with other prisoners. He did not speak good English but appears to have had a good understanding of the spoken language. Those that knew him best were shocked and upset by his death. His friend, Prisoner A, spoke to him on the day he died and, though he described him as "down" he was not worried that he would try to harm himself. He told the investigator that the man was insistent that he would pay him back the tobacco he had given him and cited this as an example of planning for the future.

56. Officer A and the man's personal officer had most contact with the man because they were based on B3 landing. At interview both officers obviously knew him well, were fully aware of his circumstances, spoke to him daily and were demonstrably bewildered and upset by his death. On the day he died, they were aware that he was upset because his cellmate had been transferred. Each officer spoke to him and reassured him that he too would be 'going home' soon. Officer A contacted the foreign national co-ordinator to ask if there were any other Vietnamese prisoners in Chelmsford who could be moved to B wing. There were none in the prison at that time. She also asked Prisoner A to talk to him. Neither officer regarded him as at risk of harming himself but intended to keep an eye on him in the days that followed.

57. In our experience foreign national prisoners who are unable to speak English can find prison a bewildering, frustrating and lonely place. In the man's case we are pleased to see that the significant formal interactions that he had with staff all took place using either the Big Word telephone translation service or an interpreter. These included his first reception health screen, both appointments with prison doctors and his adjudication hearing. At the earliest opportunity he was paired in a cell with another Vietnamese prisoner. He was visited personally by the Foreign National Co-ordinator in response to the two wing applications he made and he was checked by a healthcare assistant and his personal officer after he had appeared by video link at court. Staff and prisoners who knew him well said that his understanding of English was quite good and he could also speak 'broken' English. We consider that his status as a foreign national prisoner did not unduly affect his treatment in prison.

58. We have not seen any evidence that, prior to his death, the man presented a risk to himself. He had no history of self-harm or suicidal ideation. He appears to have been even tempered and mostly in good humour throughout his time at Chelmsford. Prisoner A, Officer A and his personal officer believed that he would have come to them if he had any problems. He knew that his return to Vietnam had been approved and was reminded of this by both officers and Prisoner A. He was clearly upset on the day he died but we do not consider that there was evidence that he intended to harm himself. We consider that staff were aware that he was upset and intended to monitor him

over the next few days. In the circumstances, we do not consider that there were sufficient grounds to begin self-harm monitoring procedures.

The prison's response to finding the man hanging

59. Officer B used her radio promptly to call a code one emergency signifying a life threatening situation. She waited until she was joined by Officer C before opening the door to the man's cell. She explained to the investigator that staff are instructed to wait for a colleague before entering a cell in an emergency situation. This is for reasons of safety in case the prisoner is pretending to be hurt. We believe that her decision to wait for a colleague was reasonable in the circumstances. She was in any case joined by another officer in a matter of seconds and was poised with the key in the lock ready to open the door as soon as she saw him arrive on the landing.

60. Emergency response nurses were in close proximity to B wing when the emergency was called and arrived at the cell in less than a minute. Nurses A and B both told the investigator that when they assessed the man he was cyanosed (blue in colour due to lack of oxygen), had no pulse and was not breathing. In the light of his presentation both nurses were of the opinion that it would have been extremely unlikely for him to be resuscitated.

61. It was discovered immediately that the ambu-bag had not been brought to the cell along with the other emergency equipment. An emergency bag is kept on each wing in the wing office and also in the treatment room on the centre. The ambu-bag is in a separate bag and is connected by Velcro to the emergency bag. In this case the ambu-bag had become detached from the emergency bag and was later discovered in the B wing office. Nurse B told the investigator that since the man's death each emergency bag had been checked and the ambu-bags were now placed inside the emergency bag. This was the case when the investigator visited the B wing office.

62. Clearly it is far from ideal for staff to be missing important equipment in situations when they are trying to preserve life. However, in the absence of the ambu-bag an airway was promptly used instead and breaths were administered until another ambu-bag was collected by both officers. We do not consider that the delay in accessing the ambu-bag can reasonably be said to have contributed to the man's death. Nevertheless, we consider it is important that the measures already taken to place ambu-bags inside emergency response bags have been consistently applied and regular checks on the integrity of emergency equipment are made. We there fore recommend that:

The Governor should satisfy himself that all ambu-bags have been placed inside emergency bags and that the integrity of emergency equipment is checked on a regular basis.

63. All three nurses who administered CPR had received referesher training within the previous six months. They appear to have worked efficiently as a team and were able to simultaneously administer CPR and prepare the man

for the arrival of the paramedics and their treatment. An ambulance was called promptly and the Duty Governor immediately authorised an over-ride of the vehicle gate to facilitate it's entry into the prison. We consider the attempt to resuscitate him was prompt, co-ordinated and efficient and that everything possible was done to preserve his life.

Care for staff and prisoners

64. The overwhelming majority of staff interviewed by the investigator described the care and support offered to them that evening and in the weeks following as excellent. Those staff who were not on duty in the days following the man's death were contacted by telephone at home. Officer A, who was not on duty when the man was discovered hanging in his cell, was also contacted by telephone and in person by members of the Care Team and the Chaplaincy. All members of staff interviewed said that they had been offered independent counselling.

65. A single member of staff, while acknowledging the excellent support received from the Care Team, Chaplaincy and colleagues, thought that the Senior Management Team might have done more to speak to her personally. These comments were fed back to the Governor for his information.

66. All of the prisoners interviewed told the investigator that they had received the offer of independent counselling and were happy with the support they had received. Two prisoners said they were told personally the same day by the Chaplain of the man's death. A memorial service was held in the chapel later that week and was well attended. We consider that overall the standard of care offered to staff and prisoners was very good.

Family liaison

67. The man died without providing the prison with a next of kin. This is understandable given the circumstances in which he entered the country and the fact that he was using an assumed identity. Starting on 5 July the Chaplain contacted a long list of people including the Vietnamese Embassy, UKBA, the man's Offender Manager (community probation officer) and Social Services. He also began tracking down the sender of a prison letter retrieved from his cell.

68. The role of family liaison officer was far from straightforward in this case. Despite the difficulty of identifying the man's next of kin and the fact that they live in Vietnam, the Chaplain called them to break the news of his death to them in person. He also contacted his first cousin in Yarl's Wood by telephone. Once provided with a point of contact for the family in the UK (another cousin) the Chaplain, arranged for, and escorted her during, her visit to the prison and visited her personally to return property.

The efforts made by the Chaplain to identify the man's next of kin and his personal contact with them, especially calling the family in Vietnam using the Big Word, is an example of good practice.

Issues raised by the clinical review

69. In the clinical reviewer's summary, her findings are that the man had no record of involvement with mental health services and no history of self harm. His physical health and presentation with the exception of a few minor ailments were unremarkable. He told staff he had fits in the night and had received medication for this but enquiries made at Glen Parva revealed these to be inoculations. He said that he had received head injuries in the past, had been a victim of torture in Vietnam and experienced headaches when in over-heated conditions. He was also treated for penile discomfort.

70. We are pleased to see that when the man was interviewed for his first reception health screen and at his two subsequent appointments with prison doctors, staff used the Big Word telephone translation service. When this failed to provide staff with the details they needed, further information was immediately sought from Glen Parva. The use of the Big Word by health care staff is not in our experience as common as it should be. We therefore consider that this is an example of good practice.

The extensive use of the Big Word translation service by nurses and doctors at Chelmsford when assessing the needs of patients who do not speak good English is an example of good practice.

71. The man was referred to the mental health team because of the information he gave that he had been tortured. We note that he subsequently declined to see a mental health nurse. We have seen no evidence other than from his verbal account that he complained of suffering from headaches and dizziness. The evidence from staff and prisoners interviewed was that, apart from on the day he died, he appeared to be in good health and good spirits.

72. We also note that the man's problem with penile discomfort was dealt with extremely promptly. The day after alerted staff to his problem he was seen by a prison doctor and taken to hospital for a minor operation. We asked the clinical reviewer to consider whether his insertion of glass objects should have been regarded as an act of self-harm. Her view was that there was no conclusive evidence to suggest it was self-harm.

73. The clinical reviewer concludes that the man's death was neither foreseeable nor preventable. She further concludes that the clinical care received by him at Chelmsford was satisfactory. As noted above, we consider that some things were done very well, namely the use of the Big Word and the attempt to save his life. However, while acknowledging all these points, the clinical reviewer raises concerns about the detail of the report provided by prison health care to the PCT. She is concerned that the internal review process is not robust enough and that too much reliance is placed on the clinical review commissioned by the PPO. The investigator heard evidence from nursing staff that measures had been put in place after his death to reduce the likelihood of equipment becoming detached from emergency bags. We are satisfied that this was the major learning point from the attempt to save his life

and that it was addressed in a timely manner. Nevertheless, we draw her comments to the attention of the clinical governance lead at the PCT and make the following recommendation:

The Head of Clinical Governance at the Primary Care Trust, in conjunction with the Head of Healthcare at HMP&YOI Chelmsford, should satisfy themselves that all serious incident reviews comply with NHS guidance and that the outcomes, actions and learning are reported and monitored.

CONCLUSION

74. The man entered the UK by illegal means and was therefore at the mercy of the persons who arranged to bring him here. His experience of being required to work in a succession of cannabis factories can not have been a happy one and resulted in his imprisonment.

75. We are pleased to have seen evidence that the man received a good standard of care in Chelmsford. Efforts were made to provide him with a cellmate he could talk to and relate to and all the significant interactions he had with staff were conducted using the Big Word. He was visited after a court appearance and his only medical problem was dealt with promptly. The staff interviewed who knew him best evidently cared about him and were saddened by his death.

76. Although he was clearly upset by the transfer of his cellmate on 4 July we are satisfied that staff intended to keep an eye on him. We think that it was reasonable not to have opened an ACCT booklet and there was no immediate reason to think that he would harm himself that evening.

RECOMMENDATIONS

1. The Governor should satisfy himself that all ambu-bags have been placed inside emergency bags and that the integrity of emergency equipment is checked on a regular basis.

   This recommendation was accepted at draft report stage and the prison commented:
   "The Oxygen and ambu bag are secured together and checked daily. All emergency equipment is located off the floor in the S/O office & in view of staff to ensure the bags remain secure and easily accessible. It is checked daily by a member of the health care team and if tampered with or not in its location an S.I.R is completed. Manager's checks are weekly."

2. The Head of Clinical Governance at the Primary Care Trust, in conjunction with the Head of Healthcare at HMP&YOI Chelmsford, should satisfy themselves that all serious incident reviews comply with NHS guidance and that the outcomes, actions and learning are reported and monitored.

   This recommendation was accepted at draft report stage and the prison commented:
   "The PCT has undertaken 4 training sessions on the SI process for all Healthcare staff. However, this process remains to be embedded within the service."

Good practice

1. The efforts made by the Chaplain to identify the man's next of kin and his personal contact with them, especially calling the family in Vietnam using the Big Word, is an example of good practice.

2. The extensive use of the Big Word translation service by nurses and doctors at HMP&YOI Chelmsford when assessing the needs of patients who do not speak good English is an example of good practice.