Investigation into the circumstances surrounding the death of a man at HMP Chelmsford in October 2006

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Chelmsford in October 2006. The man was found hanging in his cell. He had been remanded into custody the previous day.

The loss of any family member is distressing, but especially so in these circumstances. I offer my sincere condolences to the man's family and friends.

The investigation was undertaken by two of my colleagues. I would like to thank the Governor of Chelmsford for making my investigators welcome, and for arranging the necessary facilities to enable them to carry out their work. Particular thanks go to the liaison officer and her colleagues for gathering all relevant documentation and ensuring it was made available in a timely way. Their assistance and support throughout the investigation was invaluable.

The Primary Care Trust carried out an independent clinical review into the care and treatment the man received at HMP Chelmsford. I am grateful to the clinical reviewer for completing the review. My investigators also contacted the office of HM Coroner for the district and the investigating police representative. I am grateful to both for providing relevant and useful information.

The man had a history of alcohol and drug misuse, and had developed mental health problems. He had been released from HMP Chelmsford in early 2006, having completed a short sentence. Whilst serving that sentence, he had set fire to his cell.

The man was arrested and again remanded to Chelmsford in October 2006. He arrived in the early evening, went through the reception process and was located on a wing in the main prison. This was contrary to the prison's practice of placing all new prisoners on the induction wing. The man died during the night but was not discovered until 9.00am, the morning roll check not having been carried out properly if at all. An internal Prison Service investigation is underway to establish why this occurred.

My report makes six recommendations for the Prison Service and highlights one example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2007**

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SUMMARY

Early in October 2006, North East Essex Magistrates' Court remanded the man into custody, following his arrest for driving whilst disqualified and driving with excess alcohol. He was ordered to reappear in court late October.

Following his arrival at HMP Chelmsford, the man went through the First Night in Prison (FNIP) interview and reception process. This included a cell sharing risk assessment (CSRA). The officer completing the CSRA assessed the man as low risk and recorded this on the form. It also showed that the man had previously been in custody at Chelmsford. No drug or alcohol issues were noted, and the man disclosed no special needs to staff. As part of the reception process, he was interviewed by a FNIP Officer, and information from the interview was documented. Officers detailed to carry out this work are primarily located in E wing, the first night in prison induction wing.

The man was also seen by the registered mental health nurse (RMN) who completed a first reception health screen. No issues or concerns were recorded.

It is normal practice for new prisoners to be located in the first night wing, E Wing, following their reception. This is a relatively new building. However, the man was located on C wing in the original Victorian part of the prison. He was given a flask for hot water and placed on his own in a cell on the third landing. En route to his cell, the man expressed no concerns to the senior officer who escorted him.

The night Operational Support Grade (OSG) completed the evening roll check at approximately 8.45pm, before the man arrived on the wing. The next roll check was scheduled for 6.00am the following morning, but it was not carried out at the correct time if at all. At about 9.00am, a senior officer on C wing received a telephone call instructing her to collect the man and take him to healthcare for the remainder of his induction. The duty was delegated to an officer who made his way to the third landing. When the officer went into the cell, he saw the man hanging by a ligature from the window bars. The alarm was raised and three prisoners helped the officer. Other staff then arrived and took over the emergency response. The officers checked for signs of life, and began to administer cardio pulmonary resuscitation (CPR) until healthcare staff and the paramedics arrived. All attempts to revive the man failed and he was pronounced dead at 10.10am.

My investigation into the man's death started in October 2006. As part of my investigation, I have looked into the concerns of his family about what might have led to him apparently taking his own life and whether more could have been done to prevent it.

THE INVESTIGATION PROCESS

1. In October 2006, one of my investigators opened the investigation and met the Deputy Governor, Prison Family Liaison Officer, Prison Liaison Officer and the Head of Healthcare at HMP Chelmsford. My investigator was briefed about the circumstances leading to the man's death and a number of relevant files and records were examined. My investigator also met a member of the local branch of the Prison Officers' Association (POA), and with a member of the Independent Monitoring Board (IMB), to brief them about the investigation process. They were informed that they could speak with my investigator at any time during the course of the investigation, should they or others have any further information.

2. My investigator visited the wing and cell where the man was discovered, and viewed the window bars used to secure the ligature. He also visited the prison reception area and the First Night in Prison (FNIP) wing. He observed the environment and clarified the procedure for prisoners who cannot be located in a first night cell when the wing is at full capacity.

3. The Governor commissioned a separate investigation to ascertain the last time that the man's cell was checked. The internal investigation was launched with immediate effect following verbal evidence that C wing's roll check had not been carried out at 6.00am that morning of October 2006. A member of staff was suspended from duty as part of this ongoing investigation.

4. My investigators wrote to a number of prison staff and two prisoners, inviting them for interview. They also wrote to the suspended member of staff to provide them with the opportunity to participate in the investigation. Interviews took place between November 2006 and January 2007. A third prisoner, present when the man was found, had moved prisons and other witnesses have referred to his role.

5. Later in November, my investigators met the Governor for a debriefing when the emerging findings and recommendations were discussed. The Governor welcomed the feedback and confirmed that he had instigated his own investigations. I welcome the Governor's prompt actions.

6. A Medical Records Reviewer of the Primary Care Trust carried out a clinical review into the care and treatment the man received at HMP Chelmsford.

7. One of my Family Liaison Officers (FLOs) contacted the man's next of kin shortly after the investigation was opened. My FLO explained the role of the Ombudsman's office and provided information about the investigation process. My FLO also offered the dead man's family the opportunity to meet her and one of my investigators to discuss issues or

concerns. My FLO and one of the investigators later visited the man's family at their home where the following concerns were raised:

- The family told us about the man's previous period at Chelmsford during which they said he became depressed and suffered a breakdown. He set his cell alight, was hearing voices, and did not eat for some days. They contacted the prison on several occasions and asked for him to be moved to the healthcare centre. He was eventually relocated to the healthcare centre where he harmed himself and was placed on a 'suicide watch'. They said he was not assessed by a psychiatrist, and was only prescribed a sedative. The family raised concerns about the lack of care they said the man had received on his last time in the prison.

- The family said that the man's mental health needs were assessed after he was released. He was diagnosed as paranoid schizophrenic and prescribed medication, which he took until his arrest. The family said they informed the police the he was on medication, but believe that he did not receive it between being arrested and his death. They do not think that the information was passed to the prison and are addressing the matter independently of this investigation.

- They asked for information about the likely effects of withdrawal of the medication.

- The family asked whether the man had legal representation at Court.

- The family said that prison staff had failed to identify the man's mental health needs on this occasion. They argued that his previous imprisonment was so eventful that staff should have remembered him and known about his needs. The family said the man was assessed by the same healthcare professional on both occasions, and the member of staff should have remembered him, regardless of what the man said. They believe the man would have displayed visible signs that should have been recognised.

- The family consider that staff should have had access to the man's previous prison records.

- The family think that the man should not have been in a single cell or one with ligature points.

- The family are concerned that the man was not checked more often in the night and morning.

- They asked us to clarify what time the man was found.

- They asked us to say what the man had used as a ligature as they had been given conflicting information.

- The family were concerned that one of the prisoners who assisted with the emergency response had now moved prisons and would not be able to speak to the investigators.

HMP CHELMSFORD AND YOUNG OFFENDER INSTITUTION (YOI)

8. HMP Chelmsford is a category B local male prison holding remand, unsentenced and sentenced adult men and young offenders. It predominantly serves the courts of Essex and adjoining areas, but also takes some young offenders from London. Chelmsford is essentially two prisons made up of original Victorian wings and newly built residential units. Wings A to D, in the Victorian part of the prison, contain the segregation unit, two adult male and young offender wings and a vulnerable prisoner unit (VPU). The new part of the prison contains C wing, which is mixed with 132 young offenders and adult men, E Wing, which has the First Night in Prison (FNIP) wing, and G wing for employed and enhanced status prisoners.

9. As a local prison, Chelmsford receives a large number of prisoners direct from the courts and there are constant population pressures. The new wings were designed to relieve overcrowding and increased the prison's capacity by 75. The overall capacity is now 575 but the jail remains one of the most overcrowded in England and Wales.

10. Her Majesty's Chief Inspector of Prisons (HMCIP) inspected Chelmsford in 2002 and 2004. The second inspection was unannounced and reported a prison making good progress after a difficult history. A number of recommendations had been achieved or partly achieved, including the introduction of an effective first night in custody risk assessment, although a lack of information from the courts still hindered Chelmsford's attempts to carry out thorough assessments.

11. The reception area is currently under development to enlarge and improve it. HMCIP reported in 2004 that, despite the number of prisoners coming through each day, reception was staffed well and was a welcoming place for new arrivals. The inspectors witnessed approximately 100 movements on any given day, and noted that the figure increased on Fridays (the day the man arrived at Chelmsford). Inspectors were impressed with the priority given to cell sharing risk assessments and noted further improvements in staff-prisoner relations. (The man was not identified in the reception checks as someone who posed a risk to himself or others.)

12. The induction wing (E wing) is staffed at night by prison officers, but C Wing (where the man was located) is staffed by an Operational Support Grade (OSG). No prisoners on either wing are checked at night unless they are on the escape list or being monitored under suicide and self harm procedures.

13. Unlike the original residential wings, E wing is a modern building with newer cells, both single and double, though none is designated as a safer cell. It holds a maximum of 126 prisoners, the majority of whom will be new arrivals. Staff are specifically selected to work on the wing, and it has its own consistent management team. There is a 24 hour

Listener service. (Listeners are prisoners trained by Samaritans to offer help to their peers.)

14. A welcome pack containing a pen, a bowl, plastic cutlery and a tea pack, is placed on the bed for new prisoners. New prisoners located elsewhere in the prison may not receive the welcome pack straightaway.

15 The HMCIP report said that the prison's induction programme had improved and areas of good practice had emerged. There was a full programme for new prisoners, irrespective of where they were initially held and whether they had been in custody previously. Clear information was available from booklets, notices and the Insiders (prisoners trained to support and assist those newly arrived from court) who made presentations using their own materials. The Insiders travelled around the wings to repeat their induction presentation to prisoners held on other wings. They helped to identify prisoner's needs and assist with any concerns.

16 Suicide and self harm prevention at Chelmsford had improved and HMCIP reported positively on the monitoring systems in place for those identified as at risk.

17 HMCIP found a noticeable commitment to reducing self harm and suicide in the prison. They observed that prison staff adopted a caring approach to prisoners at risk.

Suicide and self harm monitoring

18. The F2052SH was a Prison Service document used to assess and observe prisoners at risk of self harm. The F2052SH has now been replaced by the Assessment Care in Custody and Teamwork (ACCT) system. An ACCT form carries out a similar function to the F2052SH, but additionally highlights the problems and possible trigger points of a prisoner at risk of self harm, and develops a multi disciplinary plan to give support and help through a period of crisis. When the prisoner is no longer considered at risk, the form is closed.

Reception

19 On arrival at the prison, all paperwork for prisoners is checked before they are taken off the escort vehicle. Staff check warrants to ensure they have the correct prisoners in custody, and then set up the necessary records. The prisoner is taken from the vehicle and booked in by the senior officer on the front reception desk. Personal and offence details are taken, along with any known or identified concerns. Reception staff do not have access to any previous custodial history at this time.

20 All prisoners see the first night in prison officer (FNIP), reception officers, and the nurse on duty. During this process, staff obtain address and next of kin details. The new arrivals are allocated a new prisoner number, irrespective of whether they have been in prison before. Prisoners are strip searched, their property is logged, and they are health screened, before being placed in a holding cell, ready for locating staff to take them to a wing.

Local inmate database system (LIDS)

21 All prisons use a local database computer system to store basic details about a prisoner from their arrival to their release. It holds personal details along with movements of the prisoner whilst in custody, for example dates he or she went to court.

Emergency alarm codes

22. The alarm system used in Chelmsford is a two tone system. If a member of staff presses an alarm bell, it is transmitted over the hand-held radios. A code 1 alert indicates a life threatening situation.

Locating officers

23. When prisoners complete the reception process, locating officers assess them by checking the records and the cell sharing risk assessment before taking them to a wing. Locating officers usually come from A wing but, when the reception is busy, staff from other wings may assist. They are expected to work in pairs in accordance with the Local Security Systems instructions (LSS). Prisoners returning from court usually go back to the wing where they came from earlier in the day. New prisoners are usually located in the First Night in Prison wing. The duty governor or principal officer is informed when high risk or vulnerable prisoners are received.

Movement officers

24. During the course of the day, movement officers are used to move prisoners to other parts of the prison and create space, primarily on E wing, for new prisoners.

Insiders and Listeners

25. As noted and in common with most prisons, Chelmsford uses experienced prisoners to operate as Insiders and Listeners. Insiders welcome new prisoners, highlight any concerns and explain the processes they will encounter in the early days of custody. Listeners assist those prisoners who require additional support at any time in their period in custody. They are provided with training from the Samaritans to support them in this role.

Roll Check

26. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day, and staff must sign that the roll is correct. The prison's local instruction states that:

    1. Roll checks will take place and be signed for at the following times:

        - By the night staff before handing over to the oncoming day staff at approximately 0600hrs.
        - The end of the morning activities at approximately 12.30hrs.
        - The end of afternoon activities at approximately 17.00hrs.
        - The end of the evening activities at approximately 20.30hrs.

    2. Night staff will conduct Roll Checks at the following times:
        - At the start of duty prior to the day staff finishing their duty.
        - At 06.00hrs.

Safer cells

27. Chelmsford has a number of 'safer cells', which are specially designed to contain as few ligature points as possible. They are used for prisoners assessed to be at risk of harming themselves.

Detoxification addiction team

28. Chelmsford has a team of addiction nurses whose role is to work with prisoners who are withdrawing from drugs or alcohol. They offer detoxification programmes, look at harm minimisation, harm prevention and blood borne viruses. Prisoners may be referred to other agencies, including the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team and doctors and drug services in the community.

29. The prison's general protocol for prescribing medication to new prisoners is that, if they do not bring medication with them, none is prescribed until the following morning when they see a doctor and/or detoxification nurse. Staff then contact the prisoner's doctor or hospital to check the details. Medication is removed from prisoners so that staff can check that the label is correct.

Weekend regime

30. The weekend prison regime differs from weekdays. Staff numbers are reduced at weekends and employed prisoners do not go to work. A small number of prisoners may attend workshops or an education class in the morning, or attend the chapel and visits. Their cells are opened

at around 8.30am and the wing cleaners are unlocked around 9.00am. Others are unlocked according to whether they are using the gym or on association.

KEY FINDINGS

The man's previous imprisonment at HMP Chelmsford

31. The man was arrested in November 2005 and remanded in custody at Chelmsford. He was assessed as a low risk prisoner. He saw the healthcare staff as he suffered from sleeplessness, and was prescribed zopiclone. In January 2006, the man went to court. Staff commented that he was in good spirits and presented no concerns. He was further remanded in custody until the start of his trial in February, and returned to Chelmsford where he was located on E wing.

32. On 18 January, a F2052SH document was opened on the man and he was described as low in spirits, possibly because his court case was imminent. Although the man was described as demanding, staff said that he caused no problems. He was placed on an hourly observation watch, and was in a shared cell.

33. The F2052SH remained open until 26 January. The man told staff that he was depressed, had heard voices telling him to kill himself, and was not eating or sleeping very well. The staff ensured that the man had access to Listeners and the Samaritans. They also monitored his eating patterns. A mental health assessment was carried out by a Registered Mental Health Nurse on 22 January. No mental health concerns were noted. The man told her that he was stressed because of his forthcoming court appearance, and he constantly kicked the cell door and rang the cell bell. His moods fluctuated from good to bad. Some days he mixed with other prisoners and presented no concerns, but on others he reported hearing voices, failed to eat and stayed in his cell.

34. On 27 January, the man was assessed by a consultant psychiatrist and disclosed that he had been sectioned to a hospital approximately four years earlier for what he described as "drugs and things". He said he was a heavy user of alcohol, cannabis and cocaine, was hearing voices and thinking of taking his life. The man said he had been seeing things, such as animals, which he believed was because he had not had any alcohol or drugs for several days. The psychiatrist recommended that the man undergo a detoxification regime and be referred to the CARAT team. The consultant also suggested requesting a second opinion, as he was doubtful about the authenticity of the man's statement that he was hearing voices.

35. The man saw a doctor the same day. This second doctor assessed that his descriptions of hearing voices and seeing things were very vague. The doctor said that, whilst it was possible that the man was experiencing hallucinations, he wondered what his agenda was and whether he was trying to gain anything such as medication. The doctor concluded that the man should remain on medication to keep him relaxed, and suggested that a drug test should be undertaken. Should the test produce a negative result, the nurse should treat him with

rispiradone, which is usually used to treat psychosis, schizophrenia and hypomania.

36. Later that day, the man barricaded himself in his cell and set it alight. He failed to comply with staff instructions, and entry to his cell was forced. Control and Restraint procedures were then used to remove him. He was taken to healthcare, where the F2052SH was re-opened and he was constantly watched by healthcare staff. Again, staff reported the man as depressed and at risk of suicide or self harm. He said he was hearing voices. The next day, the observations were reduced to 15 minute intervals and he was monitored regularly by nurses, the doctor, and consultant psychiatrist, but displayed no obvious psychotic symptoms.

37. The man stayed in healthcare until 20 February, and the F2052SH remained open. Weekly case reviews took place and his mood was generally more settled, although staff said that occasionally he had bad days. On 20 February, the man was escorted to appear in court where the charges against him were dropped and he was released.

Final period of imprisonment

38. The man was arrested again one evening in October 2006 for a drink-driving offence. Police custody records confirm that he was taken to a Police Station and remained in custody. His sister said that she went to the police station the following day and told the custody officer that the man was on medication. She was assured that the man had seen a doctor and was being looked after. She was also told that her brother would undergo a thorough health assessment in prison. (From the police documentation provided to my investigators, there was nothing to confirm that her visit had taken place.) The man was charged with driving whilst disqualified and driving with excess alcohol, and remained in police custody until a court date was set.

39. The man was taken from the police cells to the Magistrates' Court at around 9.00am. The escort records indicate that he presented a risk of violence, but had no known risk of medical problems or any other issues. The court records show that the man was checked approximately every ten minutes whilst in the holding cells. No concerns were noted. The records indicate he was also visited twice during the course of the day by the duty solicitor. The man was checked continually until he was placed in the escort vehicle at 5.45pm for his transfer to Chelmsford. The magistrates remanded him into custody for one week.

40. The escort van arrived at Chelmsford at 6.20pm. The evening was described as a typical busy Friday night, with approximately 41 prisoners arriving. My investigators were unable to identify how many were new prisoners and how many were returning from court appearances.

41. The man was seen at the reception desk and booked in at approximately 6.50pm by a Senior Officer (SO). The Senior Officer told my investigators that the man did not stand out, and no issues were raised when she spoke to him. She received all the relevant paperwork from the escort staff for him. None contained issues or concerns from the court or from the police custody records. The Senior Officer passed the man to the second stage of the reception process, the First Night in Prison (FNIP) interview, which takes place whether or not the prisoner is newly received or returning from court. The man was interviewed by an officer for five to ten minutes and was asked for basic details which were recorded in a FNIP "Passport".

42. The officer told my investigators that information for the "passport" is obtained from the prisoner, and so the quantity and quality of the record depends on how forthcoming the prisoner is. The "passport" contains five pages and asks about drug or alcohol problems, next of kin details and housing issues. It also introduces prisoners to the prison's regime and tells them what they can expect to happen. The "passport" is passed through the reception and induction process. Should the prisoner need help or have any special needs, they are identified and recorded. The prisoner is then referred to the necessary agencies.

43. The man was asked whether he had been in prison before, and told the officer that he had. My investigators asked the officer whether he had access to previous prison records, and he said that he did not. The man denied having any drug or alcohol problems, and said that he had no worries or special needs. The man provided no next of kin details, something which the officer said was quite normal for a lot of prisoners. He signed the passport, stating that he had received a timetable for the next 24 hours, an induction booklet, a reception visiting order, and copies of the standard compact, education and employment compact. The man confirmed that all the information he had provided was correct. The officer explained the terms and conditions for the PIN phone system, as well as providing information about his history sheet, Listeners, Insiders and Samaritans, the prison's diversity and violence reduction policies, together with the use of the emergency cell bell. When the interview was complete, the man was placed in the front holding cell to await a further interview with the reception officers.

44. Another officer interviewed the man to gather further information about his background, history, and whether he had any outstanding court dates. A core record document (F2050A) was opened and information, including his next of kin details, previous period in custody at Chelmsford and release date (February 2006) were recorded.

45. The officer also completed the cell sharing risk assessment form (CSRA). The man told her that he had previously abused alcohol and drugs and was currently dependent on both. The officer recorded this in Section 2 of the CSRA, before assessing the man as a low risk prisoner

who was suitable to share a cell. The officer told my investigators that, although staff may know that a prisoner has been in custody previously, it is at least the next day before previous files are retrieved. The man was given the opportunity to make a telephone call and my investigators were told by his family that he telephoned his mother. He said that he was okay and told her not to worry. She told him not to do anything stupid, and the man said he would phone her again soon.

46. For the next stage of the reception process, the man was interviewed in private by a Registered Mental Nurse (RMN). The nurse completed a screening of the man's immediate physical and mental health needs and the relevant section of the CSRA. She asked if he had sustained any injuries over the last few days, which he denied. The nurse told my investigators that the man's record showed that he had been released from Chelmsford in February 2006, but she did not remember him and had no access to his previous records at that time.

47. The nurse asked the man a number of questions, with the aim of assessing the level of risk he posed to himself and others. She recorded on the CSRA that no risks had been identified. She ticked the "Low" indicator, meaning the man was suitable for a shared cell. The nurse said that she had no concerns about self harm and said that, if she had known his history, she would have questioned him further and considered opening an ACCT document. She said that two high risk factors on the CSRA were whether it was an individual's first time in prison, and the type of offence. The man had been in prison before, and was on remand for a driving offence, both indicating that he was low risk of suicide or self harm.

48. The nurse asked the man a number of questions about his general health. He denied having seen a doctor in the last few months, having any outstanding hospital or doctor's appointments, receiving any prescribed medication or having any concerns about his physical health. Under the section headed Substance Use, the nurse asked the man if he had a drug or alcohol problem and he said that he had taken benzodiazepines, amphetamines and cocaine approximately two days before coming into prison. She asked if this was a problem. He said it was not and refused the offer of a referral to the prison doctor. She said that he showed no symptoms of withdrawing from drugs or alcohol, such as shaking, shivering or sweating.

49. The final part of the CSRA relates to Mental Health, and the man told the nurse that he had never received medication for mental health problems or been treated by a community psychiatrist. He said that he had never harmed himself and had no current thoughts of doing so. The nurse completed the man's assessment by referring him to see the substance misuse nurse the following morning.

50. After the interview with the nurse, the man waited in the back holding cell until a location officer was available to escort him to a cell.

51. The man's induction booklet said that he would see an Insider either on the induction wing or wherever he was located. The Insiders live and work on E Wing, and do not work in reception. There is no record that the man came into contact with an Insider.

52. Another officer came on duty as a locating officer at about 5.30pm. He said that he expected new prisoners to be placed on E Wing, the induction wing. He had experience of the wing being full, but said that staff made every effort to make space available and accommodate the new prisoners. This occurred throughout the day and into the evening when prisoners arrived late. The officer explained that E wing staff moved prisoners who had completed their induction to other wings in the morning and afternoon.

53. A Principal Officer (PO) was the Orderly Officer on this day in October, which meant he was in charge of the prison. He came on duty at about 5.45pm and began visiting various parts of the prison. He remembered receiving a telephone call soon afterwards from an officer who was working in reception as a locating officer. The locating officer was asked to locate a different new prisoner on C Wing. The prisoner was well known and, during previous occasions in custody, had been held in the vulnerable prisoners unit.

54. The Principal Officer said that he was strict about the locating procedures, and so told the locating officer that under no circumstances should a new prisoner be located anywhere other than on the Induction Unit. The Principal Officer said that staff should seek the permission of the Orderly Officer before digressing from the established protocol, the Chelmsford Locating Policy. He believed that the protocol was commonsense, because the first days were the most worrying time for new prisoners and the infrastructure in the unit provided better support.

55. The locating officer began his reception locating duty at around 6.15pm. He described it as a busier night than normal because it was necessary to move some prisoners about to make space. He said that, shortly before he went off duty at 9.15pm, he located a prisoner onto E Wing and so was aware that limited space was available. He remembered moving a prisoner who was on his own to share with another prisoner and free up a space. This was because a single cell was needed for a new prisoner.

56. The locating officer told my investigators that he knew that the majority of new prisoners should go to E Wing. As he came on duty, he would contact the wing to ask the number and type of spaces available. On arrival in reception, he would therefore be able to compare the E Wing capacity with the number of new prisoners. If it was apparent that there was insufficient space, it would be highlighted to staff and the Orderly Officer. Measures would then be taken to make space available. The locating officer said he was not aware of a written procedure for what to

do when E Wing was full, but he had been instructed to identify prisoners who had completed their induction and could be moved. The prisoners would be told to pack their belongings and move to wings B and C. This had previously happened late into the evening and early part of the night.

57. The Operational Support Grade (OSG) came on duty at 8.30pm and was working on C wing. He told my investigators that this was his first set of nights after training, which had consisted of shadowing another OSG for one night then doing another night by himself. He said that his training was limited, and he had not been trained on ACCT or the use of the Local Inmate Database (LIDS). He knew that he had to check prisoners on ACCT or on the escape list, but did not check others. He also knew that two roll checks were required in the course of each night. His duty rota begun the previous Sunday, and so the Friday was his sixth consecutive night. He said he was feeling very tired, but described the night as normal compared with his experience so far.

58. When the OSG arrived on C Wing, he noticed three or four officers booking in what he believed were a couple of new prisoners. They completed their paperwork and updated the information board in the office. The OSG asked where the prisoners on ACCT and escape list were, and noted their location. The officers did not draw any matters to his attention, and when they left the wing the OSG began to carry out the evening roll check of C wing.

59. At around 8.30pm, a Prison Officer assisted in reception where he was very familiar with the routine. He had not been informed that the prison wing capacity was limited and so had not made any arrangements to create space on E wing.

60. A Senior Officer (SO) completed her normal C wing duties and made her way to the gate to leave for the day. She was told that reception was still busy and prisoners were still waiting to be located. She agreed to stay on duty to assist, and reported to reception shortly afterwards. She took on the role of a locating officer, along with three other locating staff who remained on duty. She spoke to one of them (whose name, in interview, she could not recall) who told her that E wing was full. She and another officer immediately began to locate prisoners. The officer was an A Wing officer who was also assisting in reception. He told my investigators that he accompanied the SO to locate two other prisoners, and that locating in pairs was the prison's policy.

61. The officer from A wing did not recall seeing the man who died in reception, but did remember him from a previous period in custody. When he and the Senior Officer returned to reception, they collected another prisoner who was returning from court and was to be located on B Wing. They left reception again and returned at around 9.05pm. The officer from A wing went off duty at 9.15pm after about 45 minutes locating prisoners, none of whom went to E wing.

62. At about 9.00pm, the locating officer returned from locating prisoners on E wing where he had checked the roll board. He told the officer, who was helping with the location, that there were five empty adult spaces in shared cells on the wing. He left reception with more prisoners at about 9.20pm, and then went off duty.

63. The Senior Officer told my investigators that she had located prisoners on B wing, and was aware of the wing capacity. She said it was normal to try and keep the numbers on B and C wing equal, and so she expected the next two prisoners to be located on C wing. An officer asked her to hand out food packs, and she went to the servery to check how many meals were in stock. She became aware of the man who died standing next to her, and passed him a sandwich pack and some cake which he put in his bag with his cereal and bedding pack.

64. The senior officer told the man that, if he waited where he was, she would locate him instead of putting him in the back holding cells. Whilst she was attending to the man, another prisoner whom she knew finished seeing the nurse. She picked up another sandwich pack, handed it to him, and told both men that she would locate them to C wing straightaway. The other prisoner was a young offender who was returning from court. Because of his status, he would automatically return to the wing he had left.

65. The Senior Officer escorted both prisoners to C wing at around 9.30pm. In interview, she confirmed that officers usually worked in pairs, but on this occasion she went alone as nobody else was available to assist her. She said that she was happy to do this and, although she did not know the man, she did know the other prisoner. She described the man who died as quiet, well behaved and observant. He was communicating and responded when he was spoken to.

66. When the Senior Officer and the two prisoners arrived at C Wing, it was quiet as all prisoners had been locked in their cells from around 6.45pm that evening. The Senior Officer did not see the OSG on duty and thought that he was dealing with a prisoner on another landing. The Senior Officer first took the young offender to his cell on the first landing where the majority of the young offenders were located, and the man who died stood and waited for her. It was now around 9.40pm.

67. The Senior Officer told the man that there was a cell for him on the third landing, and told my investigators that he responded saying, “ok miss.” She said that en route to the cell they did not discuss whether he preferred to share a cell or not. However, a single cell was available, and she identified it for him. It was a normal prison cell, rather than a safer cell.

68. On arriving at the cell, she opened the door, turned the light on and asked the man if he had a cup. He said, “no, I haven’t.” The Senior

Officer then left, and went to the office where she found a flask for the man to use. She returned and said that the man could use the flask until the following day when his cutlery was sorted out. She said that the man responded, “that is fine miss.” He went into the cell, and the Senior Officer shut and locked the door behind him. She said that the man seemed fine.

69. The Senior Officer went to attend to another prisoner who had been banging his door opposite the cell where the man was located. She then went downstairs to the wing office and recorded both the man’s and the young offender’s names on the wing board and wing book to inform the OSG that there were two additional prisoners. She spoke to the OSG and helped him with some difficulties with another prisoner. The Senior Officer said that she eventually left the wing around 10.10pm and returned to reception. Although there were some prisoners still waiting to be located, she was told that she could go home and eventually left the prison at approximately 10.15pm.

70. The OSG told my investigators that his memory of the evening was vague, and he thought that the man and another prisoner were brought to the wing by a male officer at approximately 9.30pm. He said that he might have been on one of the landings or in the office when the officer arrived. He recalled the officer asking if there were any free cells, and replied that the board in the office would provide the information. He checked the board and found that there was a space on the ground floor. The OSG said he did not know the prisoner located on the ground floor landing, but did know that the man was located on the third landing because the information board in the office had been updated. He also knew that neither prisoner was subject to ACCT or on the escape list. The OSG also remembered speaking with the SO on the third landing, and said that she assisted him with a prisoner who had asked to see a nurse. He described the night as a normal night duty shift, and he was busy doing paper work and other tasks which he said were part of the OSG role. The OSG said no call bell went off for the man’s cell throughout the night.

71. The OSG said that the local procedure was that the morning roll check should be carried out at approximately 6.00am. However, because he was tired, he decided to carry out the roll check earlier between 4.00am and 4.30am. He said that he checked the man’s cell and he was asleep. After completing the roll check, the OSG signed the roll sheet to confirm that the numbers were correct for each landing. The roll check sheet would signify that the 6.00am roll check had been done.

72. The Night Orderly Officer on duty the evening the man was admitted to Chelmsford visited all the wings throughout the night as a matter of course. She recalled visiting C wing and no issues or concerns were brought to her attention. She spoke to the OSG who was a little flustered, as he said he had some personal problems, but said he was fit to carry out his duties. As the roll check figures have to be in by

6.00am, she visited each wing beforehand to collect the wing roll sheets. She arrived at C Wing at 5.35am, and remembered the OSG saying that he had not yet completed the check.

73. My investigators checked the wing roll sheet to see if it had been completed and signed to confirm that all prisoners in cells had been checked. It was signed by the OSG who had recorded that the check was completed at approximately 6.00am.

74. The OSG finished his night duty at 7.35am. He was relieved by another officer and the relieving officer was updated on the ACCT and escape list prisoners as well as the roll count.

75. An officer came on duty at 7.45am to take over from the OSG who reported that there were no problems. She checked the prisoners on ACCT and the escape list, but was not required to carry out a further roll check. She realised that the canteen sheets had not been handed out during the night, and went to every cell to slide the sheets underneath the door. The officer said that all seemed quiet on the wing, and she returned to the office after completing the task. Other staff started to arrive at around 8.30am and the Senior Officer briefed them on their responsibilities.

76. The Senior Officer came on duty at 8.30am on Saturday morning and briefed her staff. At about 9.00am, she received a telephone call for an officer to escort the man to the healthcare centre to continue his induction programme. She passed the request onto an officer who had just unlocked the cleaners and was about to escort an escape list prisoner to chapel with another officer.

77. The officer to whom the Senior Officer's instruction was given asked another officer to unlock the ecape list prisoner, while he unlocked the man. Security instructions state that two officers are required to escort an escape prisoner from one location to another. The officer said he would bring the man downstairs and would meet the other officer back in the office. The Senior Officer would take the man to healthcare and the two officers would escort the escape list prisoner to chapel.

78. The officer told my investigators it was approximately 9.30am when he got to the man's cell door on the third landing. On unlocking the door, he said that it did not immediately register that the man was hanging and thought it took a couple of seconds for him to realise what had happened. The officer shouted at the two cleaners on the landing to come and help, and put out an "urgent message" over the radio to say that assistance was required. They ran in and he lifted the man while the prisoners untied him from the window bars and lowered him to the floor.

82. Three prisoners carrying out their cleaning duties responded to the officer's shout. They ran into the man's cell and also saw him hanging

from the window bars. The two prisoners helped the officer support the man's body, whilst the third jumped up onto the top bunk bed and untied the sheet from the window bars.

83. The other officer, who was supposed to meet the first in the office, was on the second landing and heard on another officer's radio that an alarm had gone off. (The alarm system is a two tone system that means that, if a member of staff presses an alarm bell, it comes over the radio.) The officer saw the other officer running towards him, shouting that the alarm was on level three. The officer ran to the third landing and saw a prisoner enter the man's cell. He followed the prisoner in, saw the first officer struggling, and put his arms around the officer and the man's body and lifted them both up. The officer saw three prisoners in the cell, and that one was on the top bunk trying to untie the sheet from the window bar. The officer told my investigators that, once the bed sheet was freed, they laid the man on the floor as gently as possible. He described the man's body as cold and he looked dead. The first officer then began to carry out cardio pulmonary resuscitation (CPR).

84. The officer was closely followed by a Principal Officer (PO) who was orderly officer that day. The Principal Officer told the prisoners to return to their cells to make way for staff. (Although I make no formal recommendation on this point, the Governor should endeavour to pass on my commendation of the actions of those prisoners who assisted staff.)

85. A Prison Officer who had been in the governor's office when the alarm came over his radio responded immediately and went to the man's cell. He told my investigators that, as he got to the third landing on C wing, the alarm changed to a Code 1 which indicated that the incident was life threatening. He arrived at the man's cell where there were several staff. The man was on his back on the floor and being moved to the centre of the cell. The Prison Officer saw that he still had a bed sheet around his neck. He was given a fish knife (a knife specifically designed for cutting ligatures). The Prison Officer began to cut the ligature from the man's neck, and noticed that it was already loose and not restricting his airway. He then noticed a thin line or mark around the man's neck and saw a shoe lace hanging from the bars.

86. The Prison Officer explained to my investigators that he experienced great difficulty in opening the man's airway, and said his main priority was to open his mouth and give mouth to mouth resuscitation. He was unable to unlock his jaw, which was rigid, even with the assistance of another officer to tilt the man's head back.

87. Another officer also heard the alarm over the radio, and arrived at the cell with Physical Education Instructor as the man was laid on the floor. He assisted the Prison Officer by tilting the man's head back to try and get some air into the man. However, there was still no movement and

the officer said that the man's body was very stiff and rigor mortis appeared to have set in.

88. The officer removed a respiratory aid (a small breathing instrument) from his belt pouch, and put it over the man's lips and mouth to aid resuscitation. The Duty Governor arrived at the cell and saw the officers carrying out chest compressions on the man. (The duty governor had overall responsibility for the prison, taking charge of the death in custody contingency plans.)

89. Two nurses arrived at the same time as a Senior Officer and he told three of the five prison officers in the cell to leave the cell so the nurses had room to work. The other two officers stepped aside so the nurses could try to resuscitate the man but would assist occasionally, at their request. Although all officer grade staff who attended to the man felt competent in trying to resuscitate him, none had had any recent first aid training.

90. The Prison Officer continued CPR until the nurses took over. One of the nurses also struggled to open the man's airway while the other nurse passed a nasal tube to insert through his nose before connecting an oxygen tank. She continued CPR until the paramedics arrived. One of the nurses told my investigators that when she received the emergency call over the radio, she met another nurse who followed her to C wing. As they made their way to the wing, they saw the third nurse who also joined them. The nurse collected the emergency bag and took it to the man's cell. The nurse recalled that the man was very cold to the touch and had been incontinent of urine. The nurses remember seeing three officers on the floor and two were administering CPR. The nurse gave one officer a face mask and told him to administer mouth to mouth resuscitation, using the nose, until another nurse inserted a tube and linked the man to the oxygen.

91. The Duty Governor did not know whether an ambulance had been called, as the staff in the cell were trying to treat the man. He called for an ambulance over his radio via the control room, and spoke with the emergency services. The Duty Governor assigned log keeping responsibilities to the Senior Officer and remained outside the cell.

92. A Prison Officer told my investigators that they had been working on the man for about six minutes before the paramedic arrived. When the nurses had arrived, he decided to step back to allow them to continue trying to revive the man, and he began to instigate the crisis management procedures, liaising with the governor as necessary. The Prison Officer said that the paramedic took charge when he entered the cell, telling the nurses to stop what they were doing. He examined the man, and said (at approximately 9.50am) that he had died. The Prison Officer recalled that the paramedic then used his radio to inform the ambulance crew, who were following behind him, that he no longer needed assistance.

93. The Duty Governor told my investigators that he and his staff suspected that the man was already dead when they arrived at the cell, but as it was unconfirmed he had not called the police until he was sure of the type of incident he was dealing with. He said that he was disappointed when the paramedic said that he thought that the man had been dead for five or six hours.

94. The post mortem report confirmed that the cause of the man's death was suspension. There was a thin ligature mark running around his neck described as consistent with that of a ligature such as a shoe lace. The toxicology report found that the man was not under the influence of any drugs or alcohol at the time he died. There was also no trace of olanzapine, a commonly used drug in the treatment of schizophrenia, which the man had apparently been prescribed. However, the report does say that olanzapine is unstable in post mortem blood tests. The result therefore does not necessarily indicate that the man was not taking his medication.

After the man's death

95. As soon as the paramedic pronounced the man's death, the Duty Governor informed the police and the locum doctor (who was already in the prison). The doctor certified the man dead at 10.10am. The Duty Governor ensured that full contingency plans were implemented, gathered as much information as possible about the man's short time at Chelmsford, before opening the command suite. He told my investigators that, because it was a Saturday and he had fewer staff, it was difficult to ensure that the contingency plans were followed. Staff normally deployed to log activities, inform statutory bodies of a death in custody and draft a timeline of events, were not in the prison and he had to explain to weekend staff what was needed. The Duty Governor was relieved of his duties in the command suite when the Deputy Governor arrived at the prison.

96. During the course of the day, the Senior Officer interviewed on a one to one basis all the prisoners subject to ACCT, ensuring that their thoughts and feelings were listened to. This was extended to any other prisoner who had concerns. The chaplaincy also visited the wing, making sure all the prisoners were aware that help and support could be offered.

97. An officer spoke to one of the prisoners who assisted another officer in the dead man's cell. The prisoner asked to be moved off the wing where he found it hard to cope. The officer spoke to him about the importance of sticking together after a serious incident. He said that the chaplain and the Samaritans spoke to the prisoners who assisted the officer, and they each received canteen packs.

98. The Governor held a hot de-brief meeting later that morning, attended by all the staff involved. Written statements of their involvement were

completed and they talked through the events of the morning. An officer remembered a discussion about E wing, and whether it had been full or not when the man arrived. Despite not being on duty, a member of the care team attended the prison to offer support to staff. I consider this good practice and very timely. All staff who were interviewed, including senior staff, said they were more than happy with the level of support available to them.

99. The man's cell was sealed until the police arrived to carry out their investigations.

100. The prison's family liaison officer, who was off duty, was informed by telephone of the man's death. She attended the prison as soon as possible, so that arrangements could be made to visit and inform the family.

101. At approximately 2.45pm, the prison's family liaison officer and the Deputy Governor visited the man's family to inform them of his death. The man's sister was listed as next of kin, and she was at home with her partner and their child. The man's brother arrived a short time afterwards. The circumstances surrounding the man's death were explained, and his brother said that the prison should have been aware of the man's mental health problems. They discussed the release of the man's body and when family could see him. The prison's family liaison officer told the family that she would be in touch with the coroner's office to see when this would be possible. Funeral arrangements were also discussed.

102. Undertakers arrived at the prison around 3.00pm and the man's body was removed and taken to the local hospital mortuary. At about 5.20pm, the man's elder sister telephoned the Deputy Governor and arranged to visit the prison the following day. She also asked when the man's body would be released. She told my investigators that prison's family liaison officer told her that this was not possible and that they were not allowed to see the man until the mortuary gave permission. The man's mother was understandably distressed and desperate to see her son. His sister contacted an acquaintance who owns a funeral parlour. The funeral director telephoned Chelmsford Police who contacted the mortuary, and it was agreed that the man's mother could see the man. The funeral director drove the man's mother to the mortuary to see him that evening, and whilst there they arranged for the rest of the man's family to view the body on Sunday morning. The prison was unaware of the visit.

103. Later that evening, around 5.45pm, the Duty Governor telephoned the OSG at home, and informed him of the man's death. During their conversation, the OSG said that he had not actually carried out the roll check that morning. He said he was asked to put this in writing along with the events for the evening. He submitted a statement to the

Governor confirming this. This statement was only made available to my investigators in February 2007.

104. At 9.20am the next day (Sunday), the prison's family liaison officer telephoned the man's elder sister and said she had contacted the hospital to arrange for the family to view the man's body and needed to know when they could do this. The family liaison officer was unaware that the man's mother had already seen the body the previous night. The man's sister was unhappy about the delay, but later confirmed that she would visit the prison at 12.00pm, after which she and other members of her family would go to the mortuary to view the man's body. The prison's family liaison officer said she would contact the coroner's office to inform them of the time that the family intended to arrive. She also told the man's sister that his property could not be released until the police gave their authority.

105. The family visited the prison at approximately 12.00 noon, and spoke with the family liaison officer and the Governor. They asked a number of questions, which are detailed in this report. The role of the Prisons and Probation Ombudsman was also explained to the family, and they were told that they would be contacted shortly about the investigation into the man's death.

106. Later, the family contacted the prison regarding the man's funeral. The prison assisted with the funeral costs and offered to lay a wreath and send an officer to the funeral, if it was acceptable to the family.

ISSUES CONSIDERED

Clinical Care

107. The man's family say that he was receiving prescribed medication at the time of his arrest, but it is not known whether he was given any to take whilst he was in police custody. When he was escorted to court, and during the course of the day at court, there is no reference to medication in the man's possession, or his having to take medication. There are also no prison records to suggest that he arrived at HMP Chelmsford with any medication. No concerns were reported by the escorting staff when the man was handed over to prison staff. This evidence, along with the man's own admission that he was not receiving any medication, leads me to suggest that he did not arrive at Chelmsford in possession of any medication and had not taken any since being arrested.

108. A clinical review was conducted on the man's healthcare at the prison. No criticisms are made about the healthcare reception screening, and the reviewer notes that the man did not admit to any previous mental health problems or attempts to harm himself. Despite the number of prisoners arriving at Chelmsford, nursing staff said that they do not rush their interviews. All the necessary information was requested of the man and, as far as the nurse could ascertain, he replied accurately. He admitted using drugs and was appropriately referred to the detoxification nurse the next day. The nurse understood the risks of suicide and self harm, and assessed on the basis of the available information and the man's demeanour that he was not at risk.

109. The Prison Service does not have the technology to provide staff with immediate access to the previous records of returning prisoners, and it takes between 24 and 48 hours to retrieve historical data. Staff therefore have to rely on prisoners being honest about any physical or mental ailments, together with their own visual observations.

110. The clinical reviewer writes in strong terms about the absence of systems or programmes that can identify those who may be at risk of self harm. Had such a system been in place, the reception nurse would have been aware of the man's previous history of harming himself, his prescribed medication and the psychiatric assessments. She would have been able to use the information as part of her assessment of the man's current health, and might have reached a different decision about his risk of deliberate self harm.

111. The clinical reviewer was unable to answer conclusively whether the man would have shown any effects of withdrawal from his medication, which it appears he had not been taking since his arrest. However, there was no evidence in any of the prison records or from interviews with officers or healthcare staff that he displayed any signs of withdrawal or of mental health symptoms.

Assessment of risk of suicide and self harm

112. Reception staff had no knowledge of the man's previous periods in custody or of the events which had led to suicide and self harm monitoring, and none of the staff recognised him. He was assessed on the basis of his presentation and the information he provided. None of the reception staff identified any risk, and neither did the experienced member of staff who escorted him to the wing that night. The records and their statements in interview for this investigation consistently say that opening an ACCT document was not considered appropriate because they assessed the man as low risk.

Locating staff working in pairs

113. The man and another prisoner were located by a single member of staff. This was contrary to Chelmsford's Safe Systems of Work policy (OpRSO9) which states that escorting prisoners to and from wings is a task to be carried out by a minimum of two staff.

114. The staff interviewed were aware that there were health and safety reasons why they should not locate alone. It is unfortunate that Chelmsford regularly receives large numbers of prisoners on Friday evenings and can struggle to find adequate numbers of staff at busy periods. The usual practice is to rely on the goodwill of staff to remain on duty and assist with locating, even though it is not one of their regular duties. (The willingness of staff to take on these extra duties is very worthy of note and of commendation.) In this case, no harm was done to the officer or the prisoners, but a second colleague might have allowed more opportunity to engage and assess the prisoners' frame of mind.

The Governor should remind staff carrying out locating duties of the policy of escorting prisoners between wings.

Locating new prisoners

115. In a prison where cells are at a premium, it was evident from interviews that even though the first night centre was occasionally full, new prisoners should and could be located there. This would happen even if it meant that other prisoners had to change wings late in the evening. Staff were also aware that the authorisation of a senior member of staff on duty was necessary if a new prisoner was to be located anywhere other than E wing.

116. The man was correctly classed as a new prisoner but was not located on E Wing, supposedly because E Wing was full. However, when my investigators checked the records they confirmed that this was not the case and there were spaces on the wing. The orderly officer confirmed that no staff sought permission to locate the man on C Wing, and he had refused the request for another prisoner earlier in the evening.

117. I cannot dispute the Senior Officer's account that another, unidentified, member of staff told her that E wing was full. Nevertheless, this was about an hour before she located the man, and there is no evidence that a further enquiry was made before he was located. My investigators were told that about half an hour before the man went to C wing, there were five adult spaces on E wing.

118. The Head of Residence was asked about the normal procedure for allocating new prisoners to single and double occupancy cells. He expected all new prisoners, especially on their first night, to be located in a shared cell with another prisoner, unless they were identified as high risk under the CSRA. He said that, more often than not, low risk prisoners had no choice about whether they would share a cell. The prison was very busy and under enormous pressure to take new prisoners every day, and it was important to utilise all available space.

119. Had the man been in E wing rather than C wing, there would have been no difference to his level of supervision except that it would have been by an officer rather than an OSG. He would still not have been subject to enhanced levels of observation during the night. However, it might have affected his attitude to his location, and he might have thought that more support would have been available the next day.

The Governor should remind staff of the importance of locating new prisoners appropriately to the induction wing. This should be formalised in policy, and should include a clear instruction that staff must obtain authorisation to locate new prisoners anywhere outside of the First Night Centre.

In the unusual event of a new prisoner being located on any other wing, the Governor should ensure that they are placed in a shared cell and that prisoners who cannot share cells are always located in the induction wing.

Training for night duty

120. At the time when the man died, some wings were staffed at night time by officers, and others by OSGs who are not expected to have contact with prisoners. The OSG on duty on C wing expressed concerns about the level of training he had received, and whether it was adequate for his duties. No formal training is provided by the prison and he said that his knowledge was gained during a single night shadowing another OSG. He said that he had no knowledge of the ACCT procedures, even though he had to monitor the welfare of ACCT prisoners and should have known how to recognise when the procedures should be initiated.

The Governor should review the local procedures regarding training for Officer Support Grades, including their understanding of the ACCT procedures.

Roll Checks

121. Few tasks can be more critical in prison than roll checks, including signing to say that they are correct. However, there is confusion about whether the check was carried out during the morning of the day of the man's death, and if it did, the time that it took place. The OSG told the principal officer that morning that he had not yet done the check. He subsequently signed the roll check log to say that it was carried out in accordance with the 6.00am due time. When told about the man's death, the OSG admitted failing to do the check at all. At interview with my investigators, he said he had carried out the check two hours early, around 4.00am - 4.30am.

122. I am aware that the Governor is investigating the actions of the OSG. Since my investigation began, I am also pleased to learn that the Governor has issued a revised local instruction to improve the process of weekend roll checks.

Contact with the family

123. The man's body was taken from the prison at about 3.00pm on the day of his death, some five hours after he was found. At the same time, his family was told that he had died. I strongly believe that next of kin should be informed as quickly as possible. I understand that there was an issue about the immediate availability of staff (notably the family liaison officer) to do this. I also appreciate how important it is that the news of a death in custody is handled sensitively (and family liaison officers have been appropriately and very well trained to do this). However, timing is an important element in sensitivity, and I regret the delay in telling the man's family of his passing.

124. When the family was informed of the man's death, they understandably wanted to see his body quickly and relied initially on the prison to inform them of the arrangements. No immediate information was forthcoming and so the family made independent arrangements. I do not think that the delay by the prison was intentional, rather that circumstances and timings transpired against a quicker reply. Nevertheless, immediate provision of the mortuary contact details would have assisted the man's next of kin.

The Governor should review the death in custody contingency plan in relation to the contacting of next of kin to ensure they are told as quickly as possible.

The family liaison officer should ensure that the next of kin are provided with all necessary information after the death of a prisoner, including information about how they can see their loved one in the Chapel of Rest.

Staff Support

125. The death of a prisoner is very traumatic for staff as well as prisoners. The willingness of a member of the care and support team to come into the prison on her day off to offer support to staff immediately following the man's death is to be noted.

The Governor should commend this particular staff member for her compassionate approach.

CONCLUSION

126. The man showed no obvious signs of unease, no mental health problems, no illnesses, no symptoms of taking medication, and no indications of drug withdrawal when he arrived at Chelmsford. No difficulties were reported by the police, court or escort officers. I acknowledge that during the man's previous spell of imprisonment his behaviour was disturbed, and this may have been related to mental health problems. However, the information was not available to reception staff, and he was I believe correctly assessed.

127. Regrettably, the man was not located in the induction wing, where he would have been with other new prisoners and with experienced and specially selected staff.

128. A proper morning roll check would have found the man earlier on the day of death. This might have meant that the valiant attempts by staff and prisoners to resuscitate him would have had a better chance of success.

RECOMMENDATIONS

1. The Governor should remind staff carrying out locating duties of the policy of escorting prisoners between wings.

2. The Governor should remind staff of the importance of locating new prisoners appropriately to the induction wing. This should be formalised in policy, and should include a clear instruction that staff must obtain authorisation to locate new prisoners anywhere outside of the First Night Centre.

3. In the unusual event of a new prisoner being located on any other wing, the Governor should ensure that they are placed in a shared cell and that prisoners who cannot share cells are always located in the induction wing.

4. The Governor should review the local procedures regarding training for Officer Support Grades, including their understanding of the ACCT procedures.

5. The Governor should review the death in custody contingency plan in relation to the contacting of next of kin to ensure they are told as quickly as possible.

6. The family liaison officer should ensure that the next of kin are provided with all necessary information after the death of a prisoner, including information about how they can see their loved one in the Chapel of Rest.

Good Practice

7. The Governor should commend a particular staff member for her compassionate approach to duty.