Investigation into the circumstances surrounding the death of a man at HMP Chelmsford in 27 November 2007

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

The man was 36 years old when he died on 27 November 2007 having been found hanging in his cell at HMP Chelmsford. The man was in the first week of a sentence of 12 weeks imprisonment. My investigator and I offer our sincere condolences to the man's family and friends for their sad loss.

My report shows that the man had been treated for mental illness. He had fabricated stories about the death of his mother and had told prison staff that two of his brothers had killed themselves in prison. Although his mother is still alive, sadly he did have one brother who had killed himself in prison over nine years previously. To lose one member of the family in prison must be very difficult. To lose a second in similarly tragic circumstances must be even more painful. I have at least been pleased to learn from the man's family, that on this occasion, they have felt better supported by the prison than they had experienced in the past.

At the time of his death, the man was being monitored under the Prison Service's suicide and self harm support and monitoring procedures. I believe these procedures were being operated properly and that, short of a one-to-one watch, all that could reasonably have been done to support and monitor the man was in fact done. On the basis of what was known at the time, I do not judge that a one-to-one watch would have been justified.

I wish to thank the Governor of Chelmsford for making the necessary facilities and information available to my investigator, and for the assistance of the Liaison Officer. In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment the man received in custody. I am grateful for her assistance in providing this review.

Since taking over responsibility for investigating all deaths in prisons in April 2004, there have been eight apparently self-inflicted deaths at Chelmsford including that of the man. Five of these deaths occurred in the period between November 2007 and March 2008. My report into one of those deaths contained an identical urgent finding to one in this report into the death of the man.

I must apologise for the delay in issuing this document. This was partly due to the clinical review being delayed and partly to pressures of work within my own office.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2009**

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SUMMARY

The man was discovered hanging in his cell at HMP Chelmsford on the morning of 27 November 2007. He had been sentenced to 12 weeks imprisonment and had been in prison for just six days when he died.

When he arrived at HMP Chelmsford, he was quickly identified as being at risk of self harm or suicide. A nurse assessing him decided to arrange for the man to be monitored under the Prison Service's suicide and self harm support and monitoring procedures known as ACCT (Assessment, Care in Custody and Teamwork). The man told prison staff that he was withdrawing from drugs and that he had lost two brothers who he said had killed themselves in prison. The nurse arranged for him to be interviewed by a specialist detoxification nurse the following day. In the meantime, arrangements were made for him to share a cell as it was felt inappropriate for him to be alone.

During the night, the man asked to speak to a Listener (a prisoner trained by the Samaritans). When this could not be done straight away, he became aggressive, banging and kicking his cell door. However, arrangements were made for him to be supplied with a Samaritans telephone which he accepted. Over the next few days, the man made a number of requests to speak to Listeners, but they withdrew their service because they said he only wanted tobacco from them.

At about 12.30am on 27 November, the night patrol officer checked the man. Although the man was still alive at that stage, the officer noticed that he was unusually quiet. The officer returned to the cell 40 minutes later, which was earlier than his scheduled time, and discovered the man hanging. He immediately summoned assistance from other staff and attempted to wake the man's cell mate. Unfortunately the prisoner concerned had taken prescribed medication which made him sleep, and he did not hear the officer knocking on the cell door. However, the officer did manage to wake him up, and he was able to support the man's body for a short time.

Once assistance arrived, the man's cell was unlocked and prison staff entered and cut him down. They immediately began resuscitation procedures and continued until a nurse arrived. The nurse also assisted and resuscitation continued until paramedics arrived. After carrying out their own tests, the paramedics decided that the man had died.

I conclude that prison staff responded well to the problems that the man evidenced in prison. I also believe that, on the facts as they were known at the time, it would not have been justified to have placed him on a constant watch.

My report includes six recommendations including one that I regard as urgent and which repeats a recommendation made in another report into a hanging at HMP Chelmsford.

THE INVESTIGATION PROCESS

1. Once my office had been notified of the man's death, the investigation was allocated to one of my investigators. He contacted the Deputy Governor of HMP Chelmsford, and arranged to travel to the prison on 29 November 2007 to open the investigation.

2. On 29 November, my investigator met the Governor. Also at the meeting was the clinical reviewer, Clinical Governance Lead for Mid Essex Primary Care Trust, the prison liaison officer, and the Deputy Governor. The Governor gave my investigator an overview of what had occurred on the morning the man was discovered. He said that following the man's death he had personally contacted the person identified in the man's prison record as his next of kin. However, when he spoke to the lady concerned, she told him that she did not wish to be involved. He then looked in the record for any information about the man's parents and discovered that the man had told prison staff that his mother had died. This was later found not to be true. In the meantime, the man's father had heard of his son's death and contacted the Governor for more information.

3. The Governor told my investigator that he had also arranged for all prisoners being monitored under the Assessment, Care in Custody and Treatment (ACCT) procedure to be reviewed. (ACCT is the Prison Service's monitoring and support system for prisoners at risk of suicide or self harm.) This was in line with Prison Service guidance (vulnerable or at risk prisoners can sometimes become anxious following the death of someone else and may require additional support from staff or Listeners).

4. On 2 January 2008, the Coroner for Essex and Thurrock issued my investigator with a copy of the post mortem report. The report, written and prepared by a Home Office Registered Pathologist, notes the cause of death as (1a) suspension.

5. The following month, one of my family liaison officers telephoned the man's sister, who was acting as the man's next of kin. My family liaison officer explained my role and offered the man's family the opportunity to meet her and the investigator. The purpose of offering the meeting was to enable the family to contribute towards my report and ask any questions they would like examined. The man's sister decided that she did not require a visit, but did have one question and asked to see the investigation report. She said the family had been told by prison staff that an officer had noticed that the man looked distressed at 12.50am and he decided to check him again earlier than usual. The man's sister wondered why, if her brother looked distressed, the officer left him alone. I am pleased to say that my report has been able to add further detail to the original information.

6. The man's sister told my family liaison officer that the prison had offered assistance with the man's funeral expenses. She added that her older brother

had also killed himself in prison, nine years previously, and described the support from the prison at that time as being very little. On this occasion much had improved. She said this had helped the family considerably.

Witnesses who have contributed to my investigation

7. A Senior Officer is a trained ACCT assessor and has been in the Prison Service for four years. At the time of the man's death, she had just been promoted to Senior Officer (SO).

8. A prison officer has been in the Prison Service since July 2004. When he was interviewed in connection with this investigation he was an officer, although he has since been promoted to SO. For the purpose of this report I refer to his rank as Officer.

9. A second Senior Officer is a trained ACCT assessor and, together with another assessor at the prison, was responsible for rolling out the ACCT implementation and training at the prison.

10. A second prison officer is one of the E wing officers. He has been employed by the Prison Service for about 15 months.

11. A third prison officer has been employed by the Prison Service for over five years.

12. Another officer has been in the Prison Service for three years. On 27 November 2007, his duty was to assist the night manager.

13. A fourth officer is an ACCT assessor. He has been employed by the Prison Service for four years and, at the time of the man's death, was an officer on E wing.

14. A Registered General Nurse (RGN) has been employed by the Prison Service for 16 years at Chelmsford.

15. A second qualified Registered General Nurse (RGN). She has been employed by the Prison Service for over 11 years and works permanently on nights.

16. Another nurse employed at the prison as the Substance Misuse Team leader and interviewed the man on 22 November.

17. A prisoner arrived at the prison on the same day as the man and was allocated to the same cell.

HMP CHELMSFORD

18. HMP Chelmsford is situated close to the town centre and serves the courts of Essex and the surrounding areas. Much of the fabric of the prison is Victorian, but there has been both some refurbishment of the original buildings and modern residential units have been added to the main building. Accommodation is provided for both sentenced and unsentenced male prisoners, with about a third of the population being young offenders aged between 18 and 21 years.

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be seen by an assessor and have a case review meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT document and attend case reviews.

Code one and code two

20. In the event of urgent medical assistance being required, the prison has a radio code system to alert medical staff to the emergency situation. Code one informs staff that the patient has breathing difficulties; code two informs them that the patient is bleeding. The system ensures that medical staff take the correct emergency equipment with them and is intended to provide the necessary medical care as quickly as possible.

Counselling, Assessment, Referral and Throughcare service (CARATS)

21. The Counselling, Assessment, Referral and Throughcare service (CARATS) supports prisoners who have a history of drug or alcohol abuse. The service can be accessed by healthcare or by the prisoner referring themselves.

First Reception Health Screen

22. The first reception health screen document is the national screening tool used by the Prison Service. It is designed to highlight any medical or mental health issues with new prisoners when they arrive at the prison.

Listeners

23. Listeners play an important part in supporting prisoners identified of being at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow

prisoners in distress. This is overseen by the prison's own Safer Prisons Officer and by the Samaritans.

24. The Listeners scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can access a Listener easily by asking a member of staff who will then make arrangements for a Listener to speak to them. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can make the request from the night staff on duty. I explain the scheme in more detail later in my report.

Police investigations of deaths in custody

25. Every death in prison custody is reported to the police as soon as it is discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. When the police are satisfied that the death is not suspicious, my investigators are able to begin their own investigation.

Prison officer grades

26. There are three levels of uniformed officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

27. Senior officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

28. Principal officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

Prison Service Orders (PSOs)

29. Prison Service Orders are long term, mandatory instructions which are intended to be in place for an indefinite period. Any mandatory instructions to Governors are written in italics. Each PSO is given a title and unique reference number.

Her Majesty's Chief Inspector of Prisons

30. On 9 July 2007, Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, carried out a five day announced inspection of HMP Chelmsford. In the opening paragraph of her report (published in November 2007), Ms Owers said Chelmsford suffered from all of the problems of an overcrowded prison system. The paragraph goes on to say that the inspection revealed some serious underlying issues requiring urgent attention.

31. As part of the inspection process, prisoners are surveyed and asked to comment on how safe the prison is. The results of the survey showed that around 40 per cent of the prisoners felt unsafe at the time. The Chief Inspector noted a number of contributory factors, including the reception procedures which did not provide sufficient protection or support for vulnerable prisoners. Additionally, there were some serious deficiencies in suicide and self harm arrangements and access to Listeners. Finally, the survey showed that the relationship between staff and prisoners on the young adult wing was not "sufficiently positive".

32. Healthcare provision was described as mixed with some good primary care services. However, "worrying deficits" were noted in mental healthcare and the regime for inpatients.

33. The Chief Inspector described her report as disappointing, noting that previous inspections had shown considerable improvement in performance and culture. However, the latest inspection had shown that the prison had been unable to withstand the combination of population pressures, increased numbers, staff shortages and turnover. Ms Owers concluded that "managers need to grip the key issues of safety, decency and activity, in order to make the best use of the resources they have".

Independent Monitoring Board (IMB)

34. Each prison has an Independent Monitoring Board (IMB) whose role is to monitor the prison and report any concerns that they have about the way prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Board produces an annual report that is submitted to the Secretary of State for Justice.

35. The Chelmsford Board has not raised similar issues in their latest report to those identified in this report.

FINDINGS

36. Following the man's appearance at Chelmsford Magistrates Court on 21 November, he was remanded into custody as a convicted prisoner pending sentence. In the same vehicle en route to HMP Chelmsford was another prisoner. When they arrived at the prison, they were placed into a holding cell in the reception area where they waited until staff were ready to begin the reception process.

37. The RGN was on duty in the reception department. Her duty that evening was to screen and assess all new receptions into the prison, looking specifically at the prisoners' physical and mental health. The RGN was also responsible for identifying any medical needs that a prisoner might have and, if necessary, arranging for continuation of medical treatment.

38. During the screening procedure (which the RGN told my investigator took about 20 minutes), the man said that he was withdrawing from drugs. At interview, the nurse said the man was talkative and asked for medication to deal with pain. She checked the man's notes and read that he had been seen by a police doctor when in police custody and had been prescribed medication to help reduce the pain. Unsure what to do, the RGN telephoned Essex Ambulance Service for advice. The person she spoke to said the man could have the medication that he had asked for. The nurse described the man as "over the moon" when told he could have the medication. The RGN said she gave him the medication whilst he was in the reception department and that his anxiety reduced as a result. As part of her assessment, and having taken into consideration the man's information that he was withdrawing from drugs, the RGN arranged an appointment for him to be seen by a prison detoxification nurse the next day.

39. In addition to his medical issues, the man told the RGN that his brother had committed suicide in HMP Leicester three weeks previously. The nurse said the man was anxious and, because she had some concerns for his safety, she opened an ACCT document. The document, which was opened at 7.40pm, shows that the RGN made the following entry: "States he is feeling suicidal due to drug withdrawal. Brother hung himself three weeks ago in Leicester prison." She then passed the document to a senior officer for further action. At interview, the RGN said she had not been given any training in how to complete an ACCT document and had done her own research into how it should be done.

40. The senior officer completed the immediate action plan section of the ACCT document at 7.45pm. Having assessed the information given to him, he gave written instructions to staff for the man to be allocated to a shared cell and observed at least hourly during the night and three times during the day. Additionally, he gave instructions for the man to have access to a telephone as required and, similarly, access to Listeners.

41. Before being taken to a cell, the man once again waited in the holding room. Whilst there, the night patrol officer for E wing, the fourth officer, went into the room and spoke to him. At interview, the fourth officer said he asked the man how he was and he replied that he was fine. They had a brief conversation during which the man told the officer that he was having a few problems, and was waiting for another prisoner to be allocated to the same cell.

42. My investigator asked the fourth officer what he and the man had spoken about. The officer said the man told him that his brother had killed himself in prison two weeks earlier. The man also told him that he was not feeling well due to the effects of withdrawing. The fourth officer said the man was making good eye contact during the conversation and spoke in "an upbeat manner". He said the man was interested in what was going to happen over the following days and gave him no cause for concern. He added that he asked the man if he had any suicidal thoughts or intentions at that time, and the man had said he did not. The man told the fourth officer that he was okay at that point in time and, although he had had suicidal thoughts in the past, he did not have any at that time. Because the man was being monitored on an ACCT form, the fourth officer had explained to him what would happen during the night, and told him that he would be checking him.

43. The man was allocated to cell E 1-28, along with another prisoner. As it was late in the day, they had little time to familiarise themselves with the wing. Within a short period of time, they were locked up for the night.

44. My investigator spoke to the other prisoner and asked him to describe the man's behaviour during the short time they were together. The prisoner said that, when he arrived at the prison, he and the man had been allocated to the same cell. The other prisoner described the man as erratic and volatile and said he spoke daily about killing himself. He said the man was experiencing problems withdrawing from drugs, adding that the man had told him he had been using heroin, cocaine and anything else he could obtain. The prisoner said the man first began talking openly about killing himself about a day after they arrived at HMP Chelmsford. During the time they had been at court, the man had not said anything similar.

45. At about 2.00am the following morning (22 November 2007), the other prisoner pressed the cell emergency bell as the man had apparently collapsed onto the cell floor. The clinical review notes that, when the night nurse examined the man, she found him to be alert and orientated. The clinical review adds that the man told the nurse he had collapsed twice previously, although the review does not identify when he said this happened. The man told the nurse that he was unable to sleep. The clinical review notes that there was no evidence of withdrawal identified by the nurse at that time.

46. The fourth officer told my investigator that the man was due to return to court for sentencing later that morning. However, when prison staff went to unlock him, he refused to attend and said he was unwell. The officer contacted healthcare and the nurse said that the man was fit to be taken to court. Prison staff spoke to the man, but once again he refused to leave his cell and

attend court. As a result, the man was formally charged with an offence under the Prison Rules.

47. The RGN had asked for the man to be assessed by a member of the detoxification team and so the substance misuse team leader met him at 8.30am. At interview, the team leader said the man was fine and she had seen nothing about his behaviour to cause her undue concern. She said he told her that he was a little low in mood, which she told my investigator was associated with withdrawal. The team leader said her assessment of the man was that he required detoxification and a care plan. The clinical review notes that, following the assessment, the man was placed on a detoxification programme.

48. The substance misuse team leader told my investigator that a copy of the care plan was given to the man, so that he could write anything that might affect him during the detoxification period. The team leader also referred the man to the prison CARATS team for additional support. She said at interview that the man told her he wanted to give up drugs and that he appreciated the help being offered to him.

49. At 2.50pm that day, the first officer carried out an ACCT assessment interview with the man. The purpose of the interview was to prepare a feedback report for a case review, which had been arranged to take place immediately following the assessment. At interview, the officer told my investigator that he went to the man's cell to meet him. He described the man as looking dishevelled, shaking, very tearful and unkempt. His cell was untidy, with dirty clothing on the floor.

50. In order to interview the man, the first officer took him to a quiet room in another part of the prison where they discussed the ACCT document and the concerns raised by the RGN. The man told the officer he had a "chronic drug habit" and was withdrawing from a wide range of class A drugs. The first officer told my investigator that the man was happy to talk to him.

51. In his assessment report, the first officer wrote, "Very emotional and tearful. Suffering from chronic bereavement of two brothers who committed suicide in HMP Leicester and his mother who died of MRSA in Derby. He has three children to estranged ex partner. Heavily detoxing from a wide range of class A drugs, very heavy out of control habit." The first officer also noted that the man had told him that he had not made any recent attempt to harm himself, but had done so about one year previously when he had taken an overdose of amitriptyline. (Amitriptyline is prescribed as both a pain killer and antidepressant.) The man added that, as a result of the overdose attempt, he had been placed into hospital as an in patient under Section 2 of the Mental Health Act 1983 for a 28 day observation period. The officer asked the man how he felt about not having died. The man said he was pleased to still be alive. The officer described the man as being animated, low in mood, weak and "rattling" (an expression used in relation to drug withdrawal symptoms).

52. When the first officer assessed the man's ideas of suicide at that time, the man told him he did have current thoughts which he described as fleeting. He said his thoughts were always aimed at using a ligature, which he said would speed up his death. On the positive side, the man said his reason for living was his three children who he said he loved dearly. He added that he wanted to make a new life with them when released from prison.

53. The final part of the assessment was to discuss and agree a care plan with the man. It was agreed between them that bereavement counselling might be required. It was also agreed that he should complete his detoxification programme and then gain employment in the prison.

54. During the assessment, the man asked the officer to be allowed to remain on E wing as he felt supported there. After speaking with the E wing manager, the first officer was able to tell the man that he could remain on the wing as it was felt better for him to be close to a detoxification nurse than might otherwise be the case. At interview, the officer said the man was much happier at this stage because the support systems were in place. He said the man was tearful and, before leaving the room, he gave the officer a hug and thanked him.

55. Once the ACCT assessment is completed, the next stage is to review the assessment and care at a case review meeting. The purpose of the case review is to consider the assessment and agree, as far as possible, how best to keep the prisoner safe. It is chaired by a case manager, who in this case was the first senior officer. Also at the meeting were the first officer and the man himself.

56. At interview, the first senior officer said she had previously seen the man in the wing. She described him as a "nice chap" who after a couple of days had begun to "perk up". She said he would often be seen wandering from cell to cell trying to obtain "burn" (prison jargon for tobacco). The first senior officer said the man would speak to staff and ask them normal everyday questions.

57. The first senior officer said that when the man joined the case review meeting he was unsteady on his feet, but there was a noticeable improvement in how he had previously looked. The case review, which was held at around 3.00pm that same afternoon (22 November), appears from the notes to have been constructive. The summary, written by the senior officer, noted that the man should complete the detoxification programme before a further assessment could be made. She also wrote that the man should complete an educational assessment before applying for employment. The first senior officer recommended that the man should be referred for day care. She also agreed and confirmed the level of hourly observations which had already been put in place. Finally, she noted that the man had agreed to contact staff for support if his mood dropped. Before closing the review meeting, the first senior officer scheduled a further case review meeting for 28 November.

58. When the review meeting ended, the first officer telephoned HMP Leicester and asked for information about the death of the man's brother three weeks earlier. The person to whom he spoke told him that the information was not true. (My investigator has since learnt from the man's sister that, very sadly, her older brother had indeed killed himself in HMP Leicester nine years earlier.)

59. At interview, the fourth officer said that at about 9.30pm that evening the man asked to speak to a Listener. The fourth officer was on night duty and was not carrying keys, so he contacted the night manager, a second senior officer, and asked him to unlock a Listener. In the meantime, whilst waiting for the night manager to make his way to the wing, the fourth officer spoke to a Listener through the cell door and told him that the man wanted to speak to him. The fourth officer told my investigator that the Listener began to get dressed in preparation for going to the man's cell. The fourth officer then returned to the man's cell and told him that it would be a while before the Listener would be with him, due to the night unlocking procedure. The man apparently accepted this. However, after about ten minutes he rang his emergency cell bell and asked the fourth officer how long it would be before a Listener was with him. The fourth officer repeated that he would have to wait until the night manager had unlocked the Listener's cell. The fourth officer said in interview that, over the next 30 minutes, the man became increasingly agitated and began kicking and banging his cell door.

60. Due to the man's behaviour, the fourth officer telephoned the night manager and told him what the man was doing. The night manager said he could not place a Listener with the man, as he had to consider the Listener's safety. The fourth officer returned to the man's cell and told him that he was unable to allow a Listener into the cell, but that he could use the Samaritans telephone instead. The man agreed. The fourth officer arranged with the night manager to unlock the cell door and pass the telephone to the man, which he did at 10.20pm.

61. As the man was being monitored under the ACCT arrangements, prison staff were required to make a note in the ACCT document of any contact with him and observations. The fourth officer recorded in the ACCT document that the man had been banging his cell door. The officer made a further entry at 10.20pm noting that the night manager had been to see the man to issue the Samaritans telephone. Two further entries were made between 10.30pm and 11.00pm. Both entries note that the man had reported that he was having difficulty with the telephone. The night manager returned to the cell and checked the telephone. It was found to be working correctly.

62. At 11.30pm, the other prisoner rang the emergency cell bell and told the fourth officer that the man had cut his wrists. The officer immediately contacted the night manager and he arranged for the night nurse to be taken to the cell to deal with the injury. When the nurse saw the man, she was able to treat and dress the injuries which she noted in his medical record as superficial. As a precaution, and because he was being monitored, the night manager increased the frequency of observations on the man that night from

hourly to every 30 minutes. The clinical review notes that the man told the nurse that he felt the detoxification programme was not working. The nurse referred the man's case back to the detoxification nurse for further review.

63. On 23 November at about 8.30am, the man was seen by the substance misuse team leader and a member of the CARATS team. The reason for the meeting was to discuss and assess the reasons for the self harm the previous evening. The man told the nurse that he had not cut his wrist as a result of the detoxification programme, but because he was in low mood due to the suicide of his brother. The substance misuse team leader told my investigator that after assessing the man again that she had no concerns relating to his detoxification care plan and so made no changes to it.

64. My investigator asked the team leader if the man had been asked why he had harmed himself. She said he told her that he had become frustrated at not seeing a Listener. The nurse said that as he was not showing signs of withdrawal, they had talked about alternative ways to deal with frustration rather than self harm. The mood of the meeting was positive. The substance misuse team leader and the CARATS team had no further dealings with the man.

65. The investigator asked the man's cell mate the other prisoner if he knew why the man had cut his wrists. He described the injury as a cry for help and not a serious attempt to end his life. He said the man had wanted to speak to a Listener, but they had refused to speak to him. The other prisoner said the reason Listeners would not see the man was because the man was always asking them for tobacco.

66. Later that day, at about 7.30pm, the man asked again to speak to a Listener but they refused to see him. In the ACCT document it was noted that, whenever the man saw a Listener, he would ask them for tobacco which was why they refused his request. As the Listeners did not make themselves available to the man, the officer dealing with the request offered him the Samaritans telephone which he accepted.

67. Over the next few days, the entries in the ACCT document show that the man made numerous requests to see a Listener but, as before, they declined to see him. Several entries in the ACCT document show that staff felt that the man was being a nuisance by making numerous demands on their time and ringing his emergency cell bell for frivolous reasons. For example, he would ask officers for tobacco and then demand it when they refused to give him any. But whilst a number of entries are negative, one officer noted that the man was interacting well with other prisoners and had become more independent. In contrast, another officer had noted that he was quiet.

68. On 26 November, the second officer's duty began at 1.30pm and was scheduled to finish at 10.00pm that evening. However, due to night staff shortage, he was asked by a manager to remain on duty overnight and agreed to do so. This meant that he would not be expected to leave the

prison until about 8.00am the following morning, over 18 hours from when he started his duty.

69. After completing his normal scheduled duty, the second officer went to E wing to take over as night officer. At interview, he said he carried out routine night security checks and also checked all those prisoners on E wing being monitored under ACCT. He said he spoke to all those being monitored and introduced himself, telling them that he would be checking them during the night. The second officer said that the man, who was being monitored hourly, immediately asked for the Samaritans telephone. Another prisoner was using it, so the second officer told the man that he would provide it once the other prisoner was finished. Although he did not ask why the man wanted the telephone, the second officer said he did ask him if he was okay and the man replied that he was. The second officer made a note of the request in the ACCT document, recording the time as 9.50pm.

70. At 10.45pm, the second officer went to the man's cell to carry out a routine hourly check. When he looked into the cell, the man asked him once more for the Samaritans telephone, but it was still unavailable. At interview, the second officer said the telephone was given to the man about 15 minutes later.

71. The other prisoner told my investigator that the man used the Samaritans telephone at about 11.00pm. During the conversation with the Samaritan, the man had said that he was going to kill himself. The other prisoner said this is what the man had told the Samaritans before during previous conversations with them. He added that, due to being prescribed medication himself, he did not hear the full conversation as he fell asleep. However, he believes that the man was on the telephone for about an hour.

72. About 40 minutes later (11.40pm), the second officer carried out a further check on the man. He told my investigator that when he looked into the cell the man was not using the telephone. The man spoke to him and wanted to apologise for the way he had spoken earlier. The second officer said that the man had been agitated earlier when the telephone was unavailable and that the man felt he needed to apologise to him.

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73. At about 00.30am, the second officer carried out a routine ACCT check on the man. He told my investigator that when he looked into the cell he saw the man sitting on his bed looking at the cell wall. He described the man as looking thoughtful. The second officer told my investigator that, although the man had nodded to him, he had not spoken which was unlike his previous response.

74. The second officer said that, because the man had acted differently to when he had last seen him, he decided to carry out a further check. He did so at 1.10am (about 20 minutes earlier than the required hourly check). When the second officer looked into the man's cell he saw him hanging by a ligature that

had been attached to the top right hand side of the cell window. The second officer said he could see that the man's mouth was open and that his tongue was protruding. His hands were clasped and his feet were on the ground, with his knees bent.

75. At interview, the second officer said he banged on the cell door in an attempt to wake the other prisoner, but was unable to do so. Using his prison radio, the second officer told the radio operator that the man was hanging. He immediately heard the night manager and the night nurse acknowledge the message. The second officer said he banged on the cell door again and this time woke the other prisoner. He asked the other prisoner to hold the man up so that the pressure would be released from his neck. The other prisoner did as asked. Whilst lifting the man, the other prisoner said to the second officer, "He's gone."

76. The other prisoner confirmed to my investigator that he was woken up by the second officer who asked him to look at the man. He said he jumped out of bed and felt the man's neck to check for a pulse, but could not find one. He added that the man's body was cold, describing it as "stone cold". The other prisoner said the man was hanging from the top of the cell window frame, with his feet off the ground. He said the man had used the hem of a bed sheet as a ligature. The other prisoner said he had seen the material before, when another prisoner in a cell above his had used it to lower tobacco through the cell window to the man the previous day. (The use of so-called 'lines' to transfer items from cell to cell is an illicit but mainstream feature of prison culture, especially in jails where the design of the windows facilitates it.) The other prisoner said the man had rolled the material up and placed it in his locker.

77. The third officer, who had been carrying out other duties, told my investigator that he heard a code one message on his prison radio. The message told staff that a prisoner was hanging on E wing. He immediately ran to E wing, which he said is about 20 metres away from where he had been at the time. He said that, when he arrived at the cell, he saw the second officer standing outside. Using his own prison radio, the third officer asked the night manager for permission to enter the cell. The night manager gave his permission and, after breaking the seal on his emergency cell key pouch, the third officer unlocked the door. As he opened the door he saw the man suspended by a ligature. The third officer said he told the other prisoner to leave the cell, which he did.

78. The second officer said he entered the cell and cut the ligature, using his anti-ligature knife. The man fell to the floor. Due to a lack of space in the cell, the two officers moved the man onto the landing. Once on the landing, the officers began checking for signs of life but did not detect any. The second officer said he began performing chest compressions whilst the third officer lifted the man's chin up to open his airway.

79. Whilst the two officers were trying to resuscitate the man, the second RGN, who was the night nurse and who had heard the radio message, waited in

healthcare to be collected and taken to the cell. She told my investigator that she does not carry keys at night. The only way for her to leave healthcare is to wait for either the night manager or the assistant to let her out. At interview, the second RGN said she heard the radio message and, after collecting an emergency resuscitation equipment bag, she made her way to the ground floor of healthcare to await the night manager. She said the bag contained oxygen, an ambu bag (a facial mask used to push air into the patient's airways) and intravenous equipment. The second RGN added that, although a defibrillator was available, she did not take it with her as it did not work correctly because of a problem with the battery and she was unsure how to operate it. (A defibrillator can restart the heart in some cases of cardiac arrest by giving a electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer on what to do.)

80. The second RGN said the assistant night manager arrived at healthcare and unlocked the gate. He then escorted her to E wing, which she estimated to be about 90 metres away. When she entered the wing she saw the two officers performing CPR and went to assess the man's condition. She said she checked his pulse and looked for any sign of breathing, but did not detect anything. At the same time she asked for an ambulance to be called.

81. The assistant night manager told my investigator that he was in the communications room when the code one message was made. He said he immediately began to make his way to E wing, but was diverted by the night manager who told him to unlock healthcare and collect the second RGN. The assistant night manager said that healthcare is a long way from where he was when the call was made; he estimated that it took between one and a half to two minutes to reach the cell.

82. When he arrived, the second RGN was waiting by the healthcare gate. The assistant night manager unlocked the gate and escorted her to E wing, which is alongside healthcare. He estimated that it took a further two minutes to get to the man (thus a total of between four and four and a half minutes from the first call).

83. My investigator asked the assistant night manager how long it would have taken the second RGN to get to E wing, had she been able to leave healthcare using her own keys. He estimated it would have taken between one and one and a half minutes.

84. The assistant night manager said that when he arrived at the man's cell he saw two officers performing cardio pulmonary resuscitation (CPR). Satisfied that the officers and the nurse were dealing with the man, he decided to move the other prisoner to another cell. He said he checked that the other prisoner was okay and then returned to the man's cell. He was then diverted by the night manager to go to the gate to prepare for the ambulance to arrive. He said an emergency response vehicle arrived first, followed by an ambulance. The assistant night manager estimated the time to be 1.20am or 1.25am.

85. At about 1.25am, paramedics arrived at the cell and began carrying out their own checks. The assistant night manager saw them take over CPR and then make two or three attempts to place a tube down the man's throat. He said he was told later that they had difficulty due to the man's larynx being broken. The assistant night manager said he was then instructed by the night manager to return to the communications room to ensure the local contingency plans for dealing with a death in custody were in hand. At 1.45am, the paramedics stopped any further attempt to resuscitate the man and confirmed that sadly he had died.

After the man's death

86. The assistant night manager said that the Coroner's office completed their work and the man was taken from the prison to the mortuary. He said the time was 4.05am.

87. Following the man's death, prison managers ensured that all those prisoners being monitored under ACCT were seen and reviewed. Additionally, they issued a notice to prisoners telling them what had happened. Managers also reminded prisoners about the availability of Listeners. The prison care team were made available to any member of staff affected by the man's death.

ISSUES

Assessment, Care in Custody and Teamwork

88. It is a Prison Service requirement that all staff working in prisons with direct contact with prisoners receive basic training in how to open an ACCT document and complete the relevant section. Overall, my investigator judged the quality of the ACCT procedures was good. However, the RGN said at interview that she had asked a manager earlier in the year for the training but nothing had been arranged for her.

89. On 21 December 2007, my investigator wrote to the Governor telling him that the RGN had not been trained in ACCT. The investigator suggested that the Governor should satisfy himself that all his staff are trained in ACCT. At the time of submitting this report, the Governor has not given any indication of the remedial action he might take or has taken in relation to ACCT training. I therefore make the following recommendation:

The Governor should ensure that all new and existing staff at Chelmsford, including agency staff, receives basic training in ACCT.

Listeners

90. It appears that, after a number of callouts, Listeners refused to see the man. The reason for their refusal was concerns about his behaviour and constant requests for tobacco. The Listeners considered that the man was misusing the system and withdrew their support. A night manager felt that the man's aggressive behaviour was such that it was unsafe to place a Listener in a cell with him. One entry in the ACCT document notes that the man was considered to be manipulative.

91. My investigator contacted a member of staff from the Prison Service's Safer Custody and Offender Policy (SCOP) Group to seek advice on the procedure when a Listener refuses a request to speak to a prisoner or the service is withdrawn. I understand that this does not happen frequently, but the decision of Listeners not to see a prisoner should be managed with the assistance of prison staff, such as the prison's Safer Prisons Officer (or equivalent postholder). The guidance my investigator received from SCOP was that the prison should record that the prisoner does not have access to Listeners and ensure they can use the dedicated Samaritans telephone.

92. Additionally, SCOP told my investigator that the Samaritans 'Guide to prisons' contains a section on 'Misuse of the Listener service'. It states that in some circumstances it may no longer be appropriate for Listeners to have contact with a prisoner, who can be reassured that they may have access to the Samaritans telephone as an alternative. The guidance says that, if Listener support is withdrawn, this should be managed with the help of the Safer Prisons Coordinator.

93. SCOP advised that Listener training, which is delivered by the Samaritans, tells Listeners to explain to callers what they do and do not do (for example, they do not provide tobacco).

94. SCOP confirmed that there is currently no specific guidance in PSO 2700, which is the Prison Service's policy on suicide prevention and self harm management, as to what prisons should do when Listeners withdraw their support to prisoners who have misused the service. I have been pleased to learn that SCOP will consider updating the guidance on this issue.

95. In light of that undertaking, I make no formal recommendation on this matter. However, I trust it will be taken forward in the action plan the Prison Service will develop in response to this report. The Governor will also wish to satisfy himself that Listeners at Chelmsford are not more likely to refuse to see fellow prisoners than those in comparable jails.

96. I am satisfied that the night staff ensured that the man was offered the alternative of the Samaritans telephone when it became clear that the Listeners would not see him. It is not certain whether they were following local guidance, or simply acting on their own initiative. Whichever it was, the important thing is that the correct actions were taken.

Night nurses' access to keys

97. Night nursing staff do not carry keys that would allow them to leave healthcare and make their own way to a patient. Instead, they are required to wait for the night manager or the assistant night manager to unlock healthcare and provide an escort. In this case, it is estimated that it took over four minutes before the nurse was with the man, although the nurse believes it to be longer. In the worst case scenario, it could be that the night manager, or the assistant, might be at the opposite end of the prison when required, increasing the delay even further.

98. Whilst carrying out his enquiries at Chelmsford, my investigator immediately raised the matter with the Governor as an urgent finding. On 20 December 2007, he followed this up in writing to the Governor as follows:

"Urgent. The nurse on duty in healthcare at night does not carry keys. If urgent medical assistance is required, the nurse has to wait for either Oscar one or two to unlock healthcare and then escort the nurse to the scene. In The man's case, Oscar two had to leave the communications room and run to healthcare to collect the nurse, after which, they then went to E wing. The officer estimated the journey took about four minutes.

"I understand that you will deal with this immediately and issue both Oscar two and the night nurse with keys secured in a sealed pouch."

(Oscar one and Oscar two are the radio call signs for the night manager and assistant night manager.)

99. On Christmas Day 2007, within a month of the man's death, another Chelmsford prisoner was found hanged in his cell. This was after the investigator's concerns about nurses' access to keys had been reported to the Governor both orally and in writing as a matter of urgency. However, as it was Christmas and therefore a heavy demand on the postal system, I cannot be certain as to which day he received the letter.

100. As my investigator was only a month into investigating the man's death, I asked him to investigate the second hanging as well. During this second investigation my investigator found that, despite an assurance that immediate action would be taken and the night nurse issued with keys, the procedure had not been introduced.

101. The investigator gave immediate feedback to the Governor and also wrote to him on 14 February 2008 regarding this matter. The letter said, "Once the code one message on 25 December had been made, it took the Nurse eight minutes to arrive at the patient. The delay was caused by her not having keys and having to wait for healthcare to be unlocked." In my subsequent investigation report, I said I was not satisfied that the procedure at night was safe and made the following recommendation: "The Governor in partnership with the PCT should review as a matter of urgency the policy of not allowing the night nurse to carry keys."

102. Before issuing my report, the investigator contacted the Governor to ask him what he had done in relation to the urgent finding. The Governor apologised for not responding to the December letter. He told him that he had issued the night nurse with a "Class 2" key and that this would speed up the response time. (Class 2 keys allow free movement around the interior of the main prison, but not access or egress from the main accommodation building. Neither does the key allow the nurse to leave healthcare.) He went on to say that due to healthcare being outside of the main accommodation building, it was still the case that the nurse would have to wait for either the night manager, or the assistant night manager, to unlock using the master key. The Governor said that due to Prison Service national security restrictions, he is not allowed to have more than one set of master keys in the prison grounds at night. He said that unless he could obtain funding for an additional nurse to be on duty at night and located in the main prison accommodation area, he could do little to resolve the issue.

103. Although I have some sympathy with the dilemma that the Governor is faced with, I still believe the current practice to be unsafe. I urge the Governor, PCT and the Prison Service to examine the difficulties faced at Chelmsford (and any other prison with similar issues), and find a resolution to the problem.

The Prison Service, the Governor and PCT should examine the difficulties faced at Chelmsford and resolve the problem.

Clinical Care

104. The clinical reviewer is satisfied that the level of care given to the man was appropriate and relevant to his needs. However she has commented on three areas requiring action.

Record Keeping

105. The clinical reviewer comments on the quality of entries made in the man's medical notes by medical staff. She says that, although signed, the surname of the person making an entry is not always legible and the record is of substandard quality. As an example, the clinical reviewer highlights an entry made on 22 November 2007. The person making the entry has simply written "Substance Misuse assessment". She points out that there is no entry detailing how the man was assessed nor is there an assessment pro forma in the record. The clinical reviewer suggests that the implementation of an electronic system would improve the quality of record keeping.

The Governor, in partnership with the PCT, should consider how best to improve the quality of medical record keeping.

Training

106. The clinical reviewer says in her clinical review that it is essential for all healthcare staff responding to emergency medical situations to be appropriately trained in the use of available emergency equipment. Additionally, she says that all healthcare staff should be given appropriate training in ACCT. (As I have already mentioned this point, I will make no further recommendation here.)

107. The second RGN told my investigator that, although a defibrillator was available, she did not take it with her as it did not work correctly. She also said she was unsure how to use it.

108. In his letter to the Governor dated 20 December 2007, my investigator raised the matter of the defibrillator. He wrote as follows:

"The defibrillator which was available on 27 November was not taken to the scene. It would appear from the nurse interviewed that it was not working correctly. However, when we tested it, it was working, albeit the battery was low in charge. The manager did not know if a replacement battery was available. Additionally and apparently contrary to PCT guidelines, it is not tested on a daily basis. The Clinical Reviewer will comment on this in her report."

I have not been made aware whether the Governor has dealt fully with this matter and therefore make the following recommendations:

The Governor, in partnership with the PCT, should ensure that healthcare staff receive appropriate training in the use of the emergency medical equipment provided.

The Governor, in partnership with the PCT, should ensure that emergency medical equipment is routinely tested and a record kept.

Emergency response

109. The second RGN said in her evidence that, when attending a medical emergency during the night, the nurse has to carry heavy medical equipment. She said taking the equipment adds to the delay in reaching the patient.

110. In her clinical review, the clinical reviewer has identified that although medical treatment rooms are available in the wings they do not contain emergency medical equipment. She recommends that in order to aid response times, the rooms should contain emergency equipment:

The Governor, in partnership with the PCT, should consider equipping the wing medical rooms with emergency medical equipment.

CONCLUSION

111. The man made it very clear to everyone that he was struggling in prison, and I judge that prison staff took his problems seriously. He was monitored under ACCT and, when appropriate, the level of observations was increased straightaway. His medical needs had been identified quickly and proper procedures put in place to support him. In fact, the man welcomed the support given and spoke about strengthening relationships with his children once released from prison.

112. The man's family have raised concerns that, although the second officer had sufficient cause to return to the man's cell to carry out a further check on him, he left him alone between 00.30am and 1.10am. I have considered this matter carefully. It seems to me that, although it was unusual that the man did not talk to the second officer, he gave no indication of his actual intentions when the officer looked into the cell. The man had demonstrated a number of mood swings over the few days he was in prison (including: being angry, talkative, hugging one member of staff and, shortly before he died, being deep in thought). An additional safeguard was that the man was in a shared cell. On balance, I do not believe that the second officer had any reason to suspect that a constant watch should be put in place and that he should have remained with the man.

113. As many of my reports have shown, it takes just a few minutes from placing a ligature around the neck for death to occur. With hindsight it would be easy to say that all those on ACCT should be monitored constantly. I do not believe that to be either practical or dignified. Nor in the case of the man would it have been warranted on the facts as they were known at the time.

RECOMMENDATIONS

1. The Governor should ensure that all new and existing staff at Chelmsford, including agency staff, receive basic training in ACCT.

   The Prison Service have accepted the recommendation

2. The Prison Service, the Governor and PCT should examine the difficulties faced at Chelmsford and resolve the problem.

3. The Governor, in partnership with the PCT, should review as a matter of urgency the policy of not allowing the night nurse to carry keys. (Repeat recommendation)

   The Prison Service have accepted the recommendation

4. The Governor, in partnership with the PCT, should consider how best to improve the quality of medical record keeping.

   The Prison Service have accepted the recommendation

5. The Governor, in partnership with the PCT, should ensure that healthcare staff receives appropriate training in the use of the emergency medical equipment provided.

   The Prison Service have accepted the recommendation

6. The Governor, in partnership with the PCT, should ensure that emergency medical equipment is routinely tested and a record kept.

   The Prison Service have accepted the recommendation

7. The Governor, in partnership with the PCT, should consider equipping the wing medical rooms with emergency medical equipment.

   The Prison Service have accepted the recommendation