

**Investigation into the circumstances surrounding the
death of a man at HMP Chelmsford
in December 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2008

The man was 19 years old when he died on 25 December 2007 (Christmas Day) in his cell at HMP Chelmsford. He had been found hanging at 7.00 in the morning. My investigators and I offer our sincere condolences to the man's family and friends for their very sad loss.

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 also asked for a clinical review to be carried out into the care and treatment the man received in custody. I am grateful to two registered nurses for their assistance.

The man was a foreign national prisoner, originally from Sudan, and was just 13 days from the end of his 12 month prison sentence when he died. On the day prior to his death, the man had been issued with a notice of intention to hold him in custody at the end of his sentence, pending deportation. He had previously believed that he was to be released back into the community. The member of staff who delivered the notice had no training in immigration matters. Although he could speak some English, the man's command of the language was not fluent and, after receiving the notice, he was apparently confused, angry and, later in the day, quiet.

The man did not want to return to Sudan for fear of being killed. There must be every likelihood that the notice led directly to his subsequent actions.

The man had evidenced some signs of self-harm on reception into prison but not during his time in custody. He had also been under some pressure from other prisoners to change his religion from Christian to Muslim.

Since taking over responsibility in April 2004 for investigating all deaths in prisons, 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. The man was one of 23 foreign national prisoners who appear to have taken their own lives in prison during 2007.

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SUMMARY

The man was a foreign national prisoner, originally from Sudan. He was found hanging in his cell at HMP Chelmsford on the morning of Christmas Day 2007. The man was serving a 12 month prison sentence that was due to expire on 7 January 2008.

Whilst in prison, the man had had a few difficulties with prisoners who had apparently attempted to pressure him to change his religion from Christianity to Islam. However, he resisted and on more than one occasion got himself into fights and arguments with those involved. The matters were investigated by prison staff and eventually the man was placed in a small wing where he appeared to settle down well.

In the meantime, and apparently unknown to the man, the Border and Immigration Agency (now UK Border Agency) were preparing to deport him to Sudan at the end of his sentence. On 24 December 2007, the man was handed a document that told him that at the end of his sentence he would be held in custody pending deportation.

I judge that when the man was given the notice of detention document, he probably did not understand what was happening to him. His English was limited and, when told that he would be deported, he presumably felt vulnerable, confused and angry. He was genuinely afraid of returning to the country of his birth and appears to have believed that he would be killed. I conclude that in the case of the man, it seems very likely that the notice of detention – both its message and the means of delivery – were the trigger for what followed.

THE INVESTIGATION PROCESS

1. Whilst already at HMP Chelmsford investigating another case, my investigator was told of the man's death and was asked to take on this further investigation. He opened the investigation by meeting the Governor and was briefed about the circumstances. The governor told my investigator that he had commissioned his own disciplinary investigation into the actions of a member of his staff. The officer had apparently signed a document to say that he had checked the landing roll where the man lived at 6.00am, but had not actually carried out the task.
2. On 21 January 2008, my investigator, along with another investigator from my office returned to the prison to begin interviewing staff and prisoners who knew the man. They were assisted by a clinical reviewer from Mid Essex Primary Care Trust (PCT). All those interviewed cooperated fully with my investigation. Unfortunately, not all those whom the investigators wanted to speak to were available at the time and so arrangements were made to return at a later date to complete the interviews. After completing the interviews, my investigator wrote to the Governor with a summary of the findings.
3. The following month, on 13 February, my investigator returned to HMP Chelmsford and was assisted on this occasion by a second clinical reviewer, also from Mid Essex PCT, as the previous clinical reviewer was unavailable. I am grateful for the second clinical reviewer's kind offer to assist with the clinical issues.
4. The second clinical reviewer told my investigator that she was concerned at the delivery of healthcare at the prison and would be recommending a referral to the Healthcare Commission for an urgent clinical review of service delivery. My investigator fed this back immediately to one of the senior managers at the prison. He also told the senior manager that there was an unacceptable delay of eight minutes in providing medical assistance to the man, in part due to the nurse not having keys and carrying heavy emergency resuscitation equipment.
5. Additionally, my investigator told the senior manager that he had been to the prison reception department to speak to a Listener, but when he got there had been told that Listeners were not available in reception. The investigator pointed out that the prison had told HM Chief Inspector of Prisons, Ms Anne Owers, that Listeners were available in reception. The senior manager confirmed that this was not the case.
6. As part of my investigation procedures, I copy the Chief Inspector into feedback correspondence. After receiving a copy of the investigator's letter, Ms Owers wrote to the Governor seeking reassurance that her report was correct. After receiving the letter, the Governor wrote to Ms Owers apologising for the failure to provide Listeners in reception, and gave an assurance that he had personally dealt with the issue.

7. My investigator also informed the senior manager that during his visit to reception he had been told that a prisoner had been held in a waiting room in reception for at least seven hours that day. My investigator told the senior manager that this was due to the Duty Governor not going to reception to authorise the prisoner's cell location, despite apparently having been asked on two occasions by reception staff to do so.
8. The following day (14 February), my investigator wrote to the Governor to make him aware of the findings and feedback given to the senior manager. The Governor has not yet replied to my investigator's letter.
9. One of my family liaison officers telephoned a representative of the man's family in England, whose contact details had been passed to her by the Coroner's officer. 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 for the man's family to contribute towards my report and ask any questions they would like me to examine. The representative told my family liaison officer that he would liaise with the man's family in Sudan regarding my investigation. He told her that the family would like to know how the man died and would be keen to see the report when it was completed. My family liaison officer offered to translate the report once it is ready.
10. Following any death in prison, I publish a notice to staff and prisoners inviting anyone with information and who wishes to contact me to make themselves known to my investigator. On this occasion, I was made aware by the prison's Governor of a letter that a prisoner at Chelmsford, had written to him. My investigator invited the prisoner to speak to him, which he agreed.
11. On 8 July, after translating the draft report, I issued it to the Prison Service and the man's family. The purpose of issuing the report was to invite comments on its content and to check for any factual inaccuracies.
12. Two months later, 29 September, I received comments from the man's family. They did not identify any factual inaccuracies, but did raise concern about the issuing of deportation documents and that he was able to hang himself in prison. They asked whether the fight with another prisoner had any relevance to his death. I have not found any evidence to suggest that it did.
13. The Prison Service did not identify any factual inaccuracies and have not commented on the recommendations.

HMP CHELMSFORD

14. HMP Chelmsford is situated close to the town centre and serves the courts of Essex and the surrounding areas. Originally built in the Victorian era, it has undergone some refurbishment with modern residential units being added to the main building. Accommodation is provided for both sentenced and unsentenced male prisoners, with about a third of the population being made up of young offenders aged between 18 and 21 years.

Code one and code two

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

First Reception Health Screen

16. 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.

Listeners

17. The Prison Service operates a Listener Scheme, under which the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling vulnerable and at risk. The 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 speaking to a member of staff who will then make arrangements for a Listener to speak to the prisoner concerned. 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.

Police investigations of deaths in custody

18. With all deaths in prison custody, the police are notified by the prison as soon as the death has been 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. It is only when the police are satisfied that the death is not suspicious that my investigators are allowed to begin their own investigations.

Prison officer grades

19. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.
20. 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.
21. Principal Officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

Roll checks at night

22. Roll checks by night staff are carried out at about 9.00pm by the night officer responsible for the area when they first come on duty. In order to check the roll, the officer opens the cell door observation panel and looks into the cell. The officer is checking to confirm that the prisoner is in the cell and that the correct numbers of prisoners are accounted for. Unless there is a specific requirement to check a prisoner or prisoners, the next roll check is not carried out until 6.00am the following morning.

Her Majesty's Chief Inspector of Prisons

23. 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.
24. 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".
25. The report acknowledged some good work taking place in race relations and support for foreign nationals. It added that staff in these areas were unable to deal effectively with the volume of work.
26. 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.

27. 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.”

FINDINGS

28. When the man was first remanded into custody on 9 July 2007, he told the member of staff interviewing him in the reception department that he had previously harmed himself. He showed the member of staff 22 cigarette burns on his forearms. The man said that the burns had happened unknowingly, after he had taken what he described as medication from a friend.
29. The clinical reviewer writes that the nurse who completed the reception screening document when the man arrived at the prison assessed his behaviour and mental state as stable, with nothing of note. As no further action was required, the nurse did not request a mental health assessment. The clinical reviewer adds that the man told the nurse he had harmed himself about one week before being imprisoned, apparently after being given an unknown substance. The nurse also noted in the first reception screening document that burn marks were on both his forearms. It is not known when the burns occurred.
30. As part of the normal screening process, the nurse asked the man a number of questions to assess his mental health. The man said that he was not taking medication for any mental health problems. He was asked if he felt like harming himself as a result of being imprisoned, and he said not. Finally, the nurse asked him if there was any reason why he might need to see a doctor. Again, he said not.
31. The wing history record notes that for the next five months the man was settled in the prison. There are a number of entries written by prison staff describing him as polite and pleasant. He had, however, been in trouble on more than one occasion for fighting with other prisoners. The main problem appears to have stemmed from a few prisoners putting pressure on him to change his religion from Christian to Muslim. The problems were identified by prison staff as bullying, with the man being the victim, and were dealt with appropriately. As part of keeping him safe, the man was moved to A wing away from those believed to have been bullying him.
32. A prisoner, described the man as a “happy go lucky” person. He told my investigators that the man moved to A wing because a few prisoners had put him under pressure due to his religious beliefs. He said that, on one occasion, the man was attacked by a prisoner whom he [the prisoner] believed was Muslim. Both the man and the prisoner were fighting and had to be separated by prison staff. The prisoner went on to say that the man had settled in well on A wing and got on well with other prisoners. He said other prisoners on A wing would let him have tobacco, or whatever else he required, as they were aware that he had no money of his own to buy goods with.
33. There are a number of entries in the man’s medical record that relate to injuries sustained as a result of fighting, but nothing to suggest that he had ever harmed himself deliberately in custody. The only other entry of note is

that the man was seen by a doctor on 4 December 2007 in relation to a skin condition. The doctor on that occasion asked for the man's own doctor to be contacted and to supply his medical notes. The reason for this was that the doctor was finding it difficult to obtain the man's previous medical history from him. However, the medical record does not make it clear whether there was any attempt to obtain the notes.

34. The night manager said he last saw the man on 20 December. He said the man was fine. The officer went on to explain how he had been in contact with the prison education department, because he was concerned that the man did not have any money which meant he was unable to buy any items from the prison shop. The officer's concern was that the man was working without any pay and he wanted to arrange for the man to receive education on the wing. In this way, the man could be paid for his work.
35. The officer said he was successful in obtaining education for the man and that the man was "quite positive" about the prospect. The night manager said he felt the man did not want to let him down, and because of the rapport they had built up. It suggested to him that the man wanted to be occupied and was not someone who would let people down. Between them, they agreed to meet after the Christmas holiday, when the man would hand his homework to the officer for him to look at. The homework given to the man was for him to copy other written work, and was aimed at improving his writing skills. The officer said that the man appeared to understand what had been said to him and was happy with the arrangements.
36. On 21 December, the Home Office Criminal Casework Directorate faxed a three page document to the prison, with the intention that it should be passed to the man. The document advised the man that authorisation had been given for him to be detained in prison custody at the end of his sentence, which was due to expire on 7 January 2008, pending his deportation. Unfortunately, the fax was received into the prison on Friday 21 December after the administration staff had left for the weekend. It was not seen by prison staff until the office reopened three days later on Monday 24 December.
37. The person who dealt with the document was a temporary employee, replacing a member of staff who had left the Prison Service some months earlier. That person had had, as part of their job title, responsibility for dealing with correspondence relating to foreign national prisoners.
38. Coincidentally, the temporary employee was working the last day of his contract and, before finally leaving the prison, was clearing up his outstanding work. One of the pieces of work he dealt with was the faxed document relating to the man. Rather than send the letter via the internal mail system, he took it to the wing where the man was housed (A wing) where he met and spoke to a prison officer. At interview, the officer confirmed with my investigator that the temporary member was clearing up his work before leaving the Prison Service.

39. As it was lunchtime, all prisoners were locked in their cells and could not be unlocked. The prison officer offered to issue the document to the man once staff returned to their duty. The prison officer told my investigator that he was not given any specific instructions about the document, other than it was to be handed to the man.
40. The prison officer went to see the man and handed him the documents. At interview, the officer said he asked the man if he understood English and he replied not very well. The prison officer said he tried to explain to the man that the documents told him that he would not be released at the end of his sentence as he was to remain in custody until being deported. The officer described the man as being confused and remembered him repeating that he was going to be released from prison, and not deported. The prison officer offered the man the opportunity to make a telephone call to his solicitor, but the man said he did not know who his solicitor was. The officer said he stressed to the man the need to speak to his solicitor. The prison officer said at interview that he told the man he could appeal against any decision to deport him, but that the man did not appear to understand.
41. My investigator asked the prison officer if he had ever received any specific training in dealing with deportation or immigration matter and was told not. The prison officer also said that he had not noticed any other reaction from the man, except that other prisoners told him that the man went upstairs and talked to them about the documents.
42. An officer that normally works on A wing has been based there for about 18 months. As part of his normal duties he is required to work at night for one week in every 12. He told my investigator that he had had no specific training relating for working at night, but had done the work previously and confirmed that he understood his duties.
43. The A wing officer said he had first met the man when he had been in the segregation unit but could not recall why he had been segregated. He described the man as a polite and clean man, referring to him as a "nice lad". The A wing officer was aware of the problems the man had had on another wing and said this resulted in him being asked if he would move to A wing. The man agreed to the suggestion and was given a job as a wing cleaner. He added that the man was happy and fitted into the wing well. My investigator asked the officer about the man's understanding of English. The A wing officer told him that the man could communicate with him, adding that he did not require the assistance of an interpreter or anyone else to assist.
44. On 24 December 2007, the A wing officer arrived at the prison to start his night duty. He told my investigator he went to A wing at about 8.25pm and received a handover from the officer who was due to leave. The A wing officer said that the handover did not include anything about the man or the issue of documents from the Home Office Criminal Casework Directorate. He confirmed that there were no special watch arrangements to monitor the man that night.

45. After taking over responsibility for the wing that evening, the A wing officer carried out routine security checks. The checks include ensuring that all cell doors are closed and locked and that fire hose reels are unlocked. Additionally, the officer counted all prisoners in the wing and completed a roll check, after which he signed his night lock up report to confirm that the roll was correct. At interview the officer confirmed that the wing roll was 23 prisoners and that the man was not under any special watch arrangements. He also confirmed that, when he carried out the first roll check shortly after starting duty, the man was alive.
46. During the night, the night manager visits all areas of the prison. The purpose of the visit is to support staff and to deal with any non-urgent issues that may arise.
47. At interview, the night manager told my investigator that the staffing levels on 24 December were correct and that all staff had arrived for duty. The night manager said he and the assistant night manager were the only two members of staff on duty that night who were carrying keys. The keys are held in a sealed pouch and only opened in the event of an emergency. The night manager said that, under normal circumstances, the assistant night manager's role in an emergency is to go to healthcare and allow the night nurse access to the rest of the prison or to the gate to allow emergency vehicles into the prison.
48. The night manager told my investigator that he visited all the wings during the night and spoke to the A wing officer. He said the A wing officer did not report any problems other than alerting him to two prisoners identified as potential escapees who had been placed in adjoining cells on landing one. (This matter has no bearing on the man. I note it simply as the only issue discussed between the night manager and the officer.)
49. At about 5.20am on Christmas Day, the night manager entered A wing and collected from the A wing officer the Report of Night Patrol document, a form used to record the wing roll as it was at 9.00pm the previous evening. It is also used by the night patrol officer to record the times that the night manager visits the wing, which in this case was 11.25pm, 1.40am and 5.25am.
50. In addition to collecting the report, the night manager has a roll book used to collate the prison roll. The A wing officer said that, before leaving the wing, the night manager asked him for a signature to confirm the roll had not changed overnight. When asked by my investigator what he was signing for at 5.25am, the A wing officer said he believed that he was signing that no prisoners had been on or off the wing during the night. He confirmed that at that point he had not checked the roll, or been required to do so, but had signed the form, despite it showing that it should not be completed until at least 6.00am. My investigator asked the officer if it was normal practice for the night manager to collect the signatures at that time of the morning. He confirmed that it was.

51. At 6.00am, the A wing officer was due to carry out the morning roll check after which he would normally complete the Daily Security Information report. The Daily Security Information report is a wing based record of all roll checks carried out during the day, starting at 6.00am. Further entries are required at 7.15am, lunchtime, teatime, during the evening and finally by the night patrol.
52. The A wing officer said at interview that, as it was Christmas Day, he delayed the roll count and started some time around 6.35am. He explained to my investigator that to complete a roll check he has to look into the cell via the observation panel in order to see the prisoner. He said he first of all went to check the prisoners in cells on the first landing. Before he went to the second landing to continue the roll check, he used the toilet. He added that, whilst continuing to check the roll, his prison radio began to make a bleeping sound that told him the battery required changing. The A wing officer said he stopped counting the roll and returned to the wing office on the ground floor to collect a new battery. As he was doing so, he heard someone entering the wing and saw that it was a prison officer. The prison officer had arrived early for duty, so that the A wing officer might leave early. The A wing officer believes the time was somewhere between 6.45am and 6.50am. He said that he and the officer had a brief chat and then the officer said he would have a walk around. The A wing officer described how the officer ushered him out of the wing.
53. My investigator asked the A wing officer whether the officer who arrived early for his shift was aware that the roll check on the third landing had not been completed. He said not, as he had forgotten to tell him. The investigator showed the A wing officer the Daily Security Information report, which notes that he had signed the report to show that the wing roll was correct at 6.00am. The A wing officer said he signed it at the same time as the night manager asked him to sign the roll book (that is, at about 5.25am). He added that he had signed the Daily Security Information report automatically, due to the way he had been "conditioned" into signing for a completed roll check even when he had not made the check. He said that, since the man's death, the system had changed and night staff were no longer required to sign for the roll at 5.20am.
54. At interview, the night manager described the man as a polite and quiet man. He added that the man did not cause any problems for staff or other prisoners and had progressed well to be on A wing. The night manager told my investigator that the man's command of English was such that he thought the man could probably understand what was being said to him. However, because his English was not to basic skills level, he could not be engaged in paid employment. Despite this and in order to occupy him, the wing officers would allow the man to work as an unpaid cleaner, which the man appeared to enjoy.
55. My investigator asked the night manager whether the man had ever discussed with him anything to do with immigration or deportation. Although he could not say with any certainty, the night manager told my investigator that he became aware from colleagues that the man was concerned about

being deported to Sudan, and had previously had some difficulties with Muslim prisoners.

56. By about 7.00am on Christmas Day, the officer had received a handover from the A wing officer and taken over responsibility for the wing. The officer told my investigator that the wing office held the roll check document, which he said the A wing officer has signed to confirm that the wing roll was correct at 6.00am. He added that, although the document was signed, he had no reason to know and was unaware that the third landing had not been checked.
57. As the officer taking over from the A wing officer and as part of his normal duties, the night manager carried out a further roll check shortly after 7.00am. He told my investigator that he started counting the roll from the first landing, making his way to landing three. When he arrived at cell A3:11, which was the cell occupied by the man, he looked into the cell and saw a silhouette of the man's head and shoulders. The officer said he was surprised to see the man, and asked him if he was okay but received no response. Unsure about what he had seen, the officer switched on the cell light and saw the man facing the door, with his left leg in the sink basin. He said that he could see the man hanging and could tell instantly that he was hanging. The officer said the man's left leg was in the basin of his cell sink. He thought straightaway that the man was dead.
58. The officer told my investigator that he decided to enter the cell alone, but before doing so used his prison radio to request urgent assistance. He entered the cell and saw that the man had lost bladder control. When he touched the man's wrist, it was cold. Whilst waiting for assistance, the officer took the weight of the man's body, although he said he felt it was a vain attempt to do anything. The officer said the man was fully suspended off the ground.
59. My investigator asked the officer if he knew what rigor mortis was. The officer described it as stiffening of the body. He believed it was present in the man's body, as his left leg remained slightly angled, as did his knee.
60. The night manager and the assistant night manager were elsewhere in the gate area of the prison when they heard a radio message requesting assistance. The night manager said they both went directly to A wing. He added that another officer had arrived for duty. As he had collected his keys, he was sent to healthcare to collect the night nurse.
61. When the night manager and the assistant night manager arrived at the man's cell, they helped to cut the ligature which had been attached to the window bars. The night manager said that as soon as the pressure of the ligature was released from the man's neck, air was heard evacuating his chest. The officer told my investigator that he then thought, "They might be lucky, but realised it was wishful thinking." He said they laid the man on the floor and removed the ligature. He described how the man's leg would not lie flat on the floor and had no spring in it. They attempted chest compressions, but he felt it was

fruitless and believed that the man had died. He added that they were unable to perform full cardio pulmonary resuscitation (CPR) as they were unable to open the man's mouth and his tongue was protruding. He said the best they were able to do was to elevate his neck to attempt to make an airway. He told how, during the compressions, air could be heard being expelled from the man's chest.

62. The night manager also told my investigator that they were unable to get any air into the man or carry out CPR, adding that rigor mortis was present. He said after removing the ligature from around the man's neck, they began chest compressions. He described how the man's skin tone had changed to an ashen colour and was cold to touch.
63. The assistant night manager said at interview that he and the night manager continued to perform CPR until the night nurse arrived. He estimated the time taken for the nurse to arrive was anything up to eight minutes later and possibly longer.
64. The night manager said the night nurse arrived at the cell, carrying a bag containing medical emergency equipment and oxygen. He said she began chest compressions and was quickly joined by the registered mental health nurse. The SO said the nurses decided within about 30 seconds that there was nothing more they could do for the man. About ten minutes later, paramedics arrived and pronounced the man's death soon afterwards.
65. In the meantime, the officer had left the cell and did not re-enter it. My investigator asked him how the prisoners were reacting. He said they were very quiet and not causing any problems. Shortly afterwards, two members of the chaplaincy team arrived to offer support. The officer said it was the Head of Chaplaincy and a Sister.
66. At interview, the night manager said he later found out that the man had been issued with immigration papers on Christmas Eve. He thought that the man had perhaps panicked because he thought he was going to be deported on 9 January 2008. The night manager said the man was looked after well by prison staff.
67. The night nurse told my investigator she had been on duty all night, and had started her duty at about 9.00pm the previous evening. She said that, because it was Christmas, the staffing levels in healthcare had been reduced by one nurse. She was on duty with an officer and a healthcare assistant.
68. My investigator asked the nurse whether she carried keys at night, and what the system was in the event of a medical emergency. The night nurse said nurses do not carry keys at night and, if medical assistance is required, the nurse waits for the night manager to go to healthcare to unlock the gates. She added that the nurse carries a prison radio and is aware of any request for medical assistance. The nurse then goes to the entrance to healthcare to wait for the gates to be unlocked. Once the gates have been unlocked, the nurse has to carry emergency equipment to the patient, including an oxygen

cylinder and defibrillator. The night nurse explained that, with the exception of the defibrillator which is kept separately, the remainder of the emergency equipment is contained in a bag which is ready to be taken to the patient.

69. The night nurse said that, with the exception of seeing a few patients in the main prison who had not received their evening medication, the night had been quiet. At about 7.15am, she heard a code one radio message, and went to the healthcare entrance to wait for the night manager to unlock her. Although she had the emergency bag, she did not take the defibrillator with her. At interview, the night nurse said that, had she required a defibrillator, it would probably have taken another seven minutes to collect it. She explained that this would probably be too late.
70. In her written statement, the night nurse said she arrived onto A wing at about 7.23am. She told my investigator that the delay getting to the man was due to her waiting for the healthcare gates to be unlocked, and then having to carry heavy equipment upstairs to his cell. The nurse added that there is alternative emergency equipment available in another part of the prison, but in the man's case it would have been no quicker to have collected it from there. She further added that each wing has a medical treatment room, and it would be helpful if emergency equipment could be stored in each room to avoid having to carry heavy items from healthcare.
71. When the night nurse arrived at the man's cell, she saw him lying on the floor, with two prison officers performing CPR. At interview, the nurse said she went into the cell and assisted by checking the man's body which was cold. She added that the man's pupils were dilated and his tongue protruding. The night nurse said she was unable to find a pulse and that, when she checked the man's limbs, his left leg was rigid as was his left arm. At that point another nurse arrived (the registered mental health nurse), and between them they decided that there were no signs of life and so stopped any further attempt at resuscitation.
72. The registered mental health nurse said that, when she arrived for duty that morning at about 7.10am, a prison officer told her about the situation on A wing. She immediately ran to A wing to assist. As she arrived, prison staff were walking away from the area shaking their heads. An officer told her that someone had hanged himself and was dead.
73. When she entered the cell, the registered mental health nurse saw the night nurse kneeling by the man. The registered mental health nurse said that the night nurse was physically shaking and told her it was "too late". The registered mental health nurse said the man's right arm was bent and distended, as was his left leg. She added that the man was cold and stiff. As nothing more could be done for him, she helped the distraught night nurse out of the cell.
74. A few minutes later, paramedics arrived and placed a heart monitor onto the man's chest. They were able to quickly confirm that, sadly, the man had died.

After The man's death

75. My investigator asked a prisoner about the sort of things that he and the man would talk about. He said the man talked about his home and about the problems he would have if he went back to Sudan. He said the man could communicate reasonably well, and recalled him talking about an incident where a teacher living in Sudan had named a teddy bear with a Muslim name and encountered problems. The prisoner said the man told him he feared returning to Sudan because of religious problems. When asked if the man feared for his life, the prisoner said yes. He said the man used to watch television and would see crowds of people screaming for the teacher to be killed. The prisoner said this bothered the man, as he was a Christian and knew that this was the type of place he would be returning to.
76. The prisoner told my investigator that the man always talked about being released at the end of his sentence, and there was no conversation about deportation. The man told him that the courts had not ordered him to be deported. When the man received the immigration documents referred to earlier, he was confused at first. The prisoner said the prison officer tried to explain to the man what the documents meant. However, after receiving the documents, the man remained in his cell all day, which the prisoner said was unusual. He said that normally the man would be playing pool and talking to other prisoners, but on this occasion he remained in bed.
77. In addition, the prisoner said another prisoner had apparently been told by the man that he would kill himself. He said the reason was because of the immigration papers. My investigators spoke to the other prisoner. The other prisoner said the man was a friendly person, always joking and who got on well with people.
78. The other prisoner was also asked about the sort of things they would talk about. He said the man would talk about his sentence and told him he would be released on 7 January 2008. The other prisoner said the man was hoping to remain in England as he had been in the country for five years. He went on to confirm that the man had talked to him about the immigration documents handed to him on 24 December, and about how angry the man was at the way the information was given to him. The other prisoner said the man was also angry that no one had interpreted for him. However, the other prisoner added that the man could speak English.
79. During the interview, the other prisoner said the man told him that, if he were to return to Sudan, he would have no family there. With the exception of an uncle who apparently lives in England, the man's family were all dead. The man also told him that he would be killed if he returned to Sudan.
80. The other prisoner confirmed that the man had talked about killing himself. He said on the day the documents were handed to the man, he became more and more angry and had to be persuaded by the other prisoner to calm down and collect his lunch. The other prisoner said the man told him that it would be better for him to die in England rather than to have the Government kill him

in Sudan. The other prisoner said he did not believe the man's comments about killing himself were serious, and did not think to share them with prison staff. He added that, before finally being locked up for the night, the man had been sad. Unusually, he had not gone out of his cell to associate with other prisoners.

81. The other prisoner said he first learnt of the man's death when prison staff told him and other prisoners. He said staff from the prison chaplaincy team had spoken to him and asked how he was.
82. The other prisoner told my investigators that the man had not received any visitors, letters, or made telephone calls. He said the man had an uncle in England whom he wanted to contact, but his telephone number was stored on a mobile telephone that had been taken from him when he arrived into prison. The other prisoner said the man had asked prison staff to be permitted access to his telephone to recover the number, but this had not been allowed. My investigator has been unable to establish whether this information is correct or not.

ISSUES

Deportation

83. As part of investigating the man's death, my investigator asked on two occasions for a copy of the local foreign national prisoner policy but did not receive one. I can only presume that the prison does not have such a policy. However, he was given a copy of a foreign national policy statement that had been published by the then Governor in May 2007.
84. The most recent inspection report from HM Chief Inspector of Prisons also found that policy for foreign national prisoners was undeveloped. Her report says, "There were a large number of foreign national prisoners. Some of the facilities and provision for them were good, but because there was no overarching strategy, there were inconsistencies in delivery." Ms Owers went on to say, "There was no overall strategy to underpin services for foreign nationals or describe their delivery. There was a brief mission statement." Ms Owers' report acknowledged that the prison had done work to provide information for prisoners who spoke little English, including touch screen information points. These provide information in a number of languages. However, the Inspectorate found an overall lack of awareness by staff and prisoners regarding entitlements of foreign national prisoners.
85. Additionally, the Chief Inspector noted that the prison had a foreign national coordinator who dealt with immigration issues. Her report said that the work of the coordinator had increased to such an extent that the job specification had been adapted to take into account the increased paperwork. The clerk worked almost exclusively in a liaison role with the Border and Immigration Agency (now UK Border Agency). However, as I have already said, the individual referred to had left the Prison Service by the time of the man's death and a temporary replacement had been recruited to deal with the work. At the time of my investigation, the temporary person had also left the Prison Service and there were no plans to replace the post.

In light of the findings of this report and the views of HM Chief Inspector, the Governor should consider how best to ensure the needs of foreign national prisoners are met.

Listeners

86. In the Chief Inspector's report for July 2007, Ms Owers raised concern that Listeners were not routinely available in reception to support new arrivals. Her report added that this was a specific recommendation from the previous inspection which the prison had rejected on the grounds that Listeners were available on E wing. (E wing is where all new arrivals go on their first night in custody.)
87. However, the Chief Inspector found that this was not the case and produced evidence to show that one man had been placed onto another wing, and thus bypassed some of the safety procedures. Sadly, the man referred to had

been found dead in his cell after apparently hanging himself. My office investigated the death and, like the Chief Inspector, I made a similar recommendation. That too was rejected by the prison.

88. In her most recent report, the Chief Inspector was pleased to report that, although the recommendation had not been implemented before July 2007, it was implemented during the inspection. However, when my investigator went to the prison reception on 12 February 2008 to see the procedure for himself, he was told by reception staff that Listeners are not routinely based in reception. Indeed, contrary to what the Chief Inspector had been told and had reported, they never had been.
89. My investigator brought the matter to the attention of the senior manager, Head of Residence, as the Governor was not in the establishment. The senior manager told him that plans were being discussed to offer Listeners overtime pay to work in reception during the evenings, but there remained difficulties in providing a Listener service during the day.
90. The role of Listeners is a well established and invaluable support mechanism right across the Prison Service. It has been disappointing to learn that a commitment made to the Chief Inspector was simply not implemented. Whatever the difficulties at Chelmsford, the Governor must find a way to support new prisoners on their first reception into prison at the point of entry.

The Governor should ensure that Listeners are available in reception whenever prisoners are being received.

Reception

91. At the time my investigator was in reception discussing with staff the availability of Listeners, he was told about a prisoner who had been held in a waiting room in reception for at least seven hours. The investigator was in reception at about 4.00pm and the prisoner had apparently been there since at least 9.00am that morning.
92. The investigator asked reception staff why the man had been waiting so long to be allocated a cell in the prison. He was told that in this case the Duty Governor had to agree the location of the prisoner before he could be moved to a cell. I understand from reception staff that they had asked on at least two occasions for the Duty Governor to go to reception and sign the necessary documents, but he had not done so. It is not acceptable for a prisoner to be held in a waiting room for this length of time and therefore my investigator raised the matter as an urgent issue with the senior manager who had been unaware of the problem.

The Governor should ensure that prisoners are not held in reception any longer than necessary.

Roll Check

93. At 6.00am on 25 December, the A wing officer was meant to carry out the first of the daily roll checks. Although he signed for the roll, he did not carry out the check on landing three and therefore failed to complete his duty correctly. However, in this instance I am satisfied that had he done the roll check at the correct time it would not have made any difference to the outcome, other than the man would have been discovered sooner.
94. Following the man's death, the Governor identified the failure and immediately commissioned his own internal disciplinary investigation into the actions of the officer. I am satisfied that the Governor has dealt with this issue separately.
95. I understand that the night managers' routine for collecting night time roll check documents has changed since the man's death. The change has been brought about as a direct result of another manager identifying a problem with the system. He had been asked to take over night duty on 25 December because the night manager was unable to carry on with his duties because of the impact the man's death had had on him. The other manager identified a flaw in the night procedures and felt the practice of collecting roll check documents early was inappropriate. He raised his concerns immediately with a senior manager by email. In the meantime, he made his own decision to implement straightaway a new system which has since been agreed by senior managers and is in place.
96. I understand night patrols are now required to sign the night manager's book at the point when leaving the prison, upon completion of their shift, and not at around 5.00am as before. I commend the other manager for his initiative and invite the Governor to share my comments with him.

Staff Care

97. The night manager told my investigator he had been given the opportunity to go home, but had decided to remain on duty and work through Christmas Day. At the time of interviewing him (21 January 2008), he told my investigator that the man's death still occupied his mind almost on a daily basis and at night whilst in bed. My investigator reminded him about the prison's own care team, which he acknowledged and knew about.
98. Sadly, the man's death was not the first that the night manager had had to deal with. In fact, it was the second apparently self-inflicted death in a matter of a few weeks. He said he had been told to stay off duty from 25 December and has since been diagnosed as suffering from post traumatic stress. Since the man's death, he has stopped working nights and is now employed on daytime duties only.

Clinical Review

99. The clinical reviewer is satisfied that there were no physical signs or symptoms of medication or drug withdrawal that should have been identified during the first reception health screening. Additionally, she is content that no mental health issues were identified. The clinical reviewer also notes that the man's medical record shows no suicidal ideation or intention of deliberate self harm when first received, and that he was not displaying any behaviour that would cause concern. The clinical reviewer is satisfied that the man was assessed appropriately during further healthcare assessments and that nursing staff had documented that he had no suicidal intentions.
100. In relation to healthcare intervention after the man was found hanging, the clinical reviewer says that the nurse responded as quickly as she was able, although noting that it took eight minutes for her to get to the man. The clinical reviewer notes that the length of time was because the nurse did not have keys and had to wait for the night manager to collect her. Additionally, the clinical reviewer says the nurse did not have access to emergency medical equipment on the wings and had to carry equipment from healthcare to the patient. She goes on to say that, although a defibrillator is available, there are local issues about whether it is in good working order, tested daily and that staff are familiar with its use.
101. In addition, the clinical reviewer identifies that the nurse on duty on the night of the man's death had not received any mandatory medical training for over 14 months. She specifically identifies the need for extended life support training, which the Resuscitation Council (UK) guidelines state should be carried out at least annually.
102. The clinical reviewer finds evidence that healthcare staff were not routinely accessing clinical supervision sessions. (Clinical supervision sessions are meetings with senior colleagues, and designed to offer professional support.) However, one nurse described in-house psychological support as excellent and said she felt well supported.
103. The clinical reviewer describes the allocation of work to healthcare staff as "task orientated". She adds that nursing staff receive health status information regarding in-patients, but that the same could not be said for patients living in normal cellular location on the wings. The clinical reviewer says there does not appear to be any general sharing of information about prisoners who require, or potentially require, medical input on the wings.
104. Additionally, the clinical reviewer comments that, due to night staff being unable to attend team meetings which are held during the day, communication between night and day healthcare staff is not good. The clinical reviewer says that night staff access information via email, or during patient handover. The clinical reviewer says there appears to be no formal mechanism for reporting change in practice or policy, and suggests this point needs to be clarified by the Head of Healthcare.

105. The clinical reviewer says there is no rotation of nursing staff from the prison within the wider PCT. She suggests that to do so would give healthcare staff the opportunity of working in a broader healthcare setting, and this would aid development of clinical practice. Additionally, the clinical reviewer says it would facilitate sharing best practice and promote a better understanding of healthcare outside the prison setting which might influence the way prison healthcare is delivered.
106. The clinical reviewer says the normal night staffing level in healthcare is two registered nurses. The nurses are assisted by an officer support grade who is responsible for security. Additionally, a healthcare assistant provides patient constant watch support. However, the clinical reviewer says that, although the healthcare prisoner population and overall prison population remains constant at Bank Holidays, the registered nursing cover is reduced to one. She questions how this is possible.
107. The clinical review reports notes that urgent arrangements to audit healthcare provision at the prison is needed. It adds that the Prison Service Safer Custody Group has been invited to review processes in the prison. However, the Director of Corporate Development and Governance has confirmed that the review does not include healthcare. As a result, an independent review is to be commissioned, with the terms of reference being agreed between the PCT and prison. The Director of Corporate Development and Governance has since confirmed to my investigator that an independent review of prison healthcare will be commissioned. I welcome and support these arrangements.
108. The clinical reviewer has also reviewed the standard of medical record keeping. She says that generally the notes were of a good standard, but some entries were difficult to read and not completed correctly.

Night nurse

109. Night nursing staff do not have access to emergency medical equipment on the wings. Nor do they carry keys that would allow them to leave healthcare and attend a patient at the earliest opportunity. Instead, they are required to wait for the night manager to unlock healthcare. (In the worst case scenario, the night manager could be at the opposite end of the prison when required.) Once unlocked, the nurse has to carry heavy equipment, including an oxygen tank, in a bag from healthcare to the patient. However, due to the weight, a defibrillator is not routinely taken. In the man's case the unlocking routine meant that it was eight minutes before the nurse arrived at his cell. Although I think it is obvious that the man was already dead and the delay had no effect on the outcome, in another case it might be that eight minutes is an unacceptably lengthy delay.
110. Following his urgent feedback, my investigator wrote to the Governor on 14 February 2008 regarding this issue. In his letter my investigator said, "Once the code one message on 25 December had been made, it took the night 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.” This is a repeat finding from a previous death that my office is still investigating at Chelmsford, and something my investigator raised with the Governor at the time. Although the man was already dead, eight minutes delay will almost always be far too long for resuscitation to be effective. At the time of writing this report the Governor had not acknowledged the letter, although he may have dealt with the matter. If not, I believe the practice to be dangerous and requiring immediate action.

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

Defibrillators

111. Although a defibrillator was available, it was not taken to the man’s cell. I understand that it is a heavy piece of equipment and apparently it did not work correctly. However, when the clinical reviewer tested the equipment it was in fact working correctly. Defibrillators should be tested daily to ensure they are functioning as they should. The clinical reviewer could not find any record to show that tests were being recorded. It was also suggested by nursing staff that training in the use of defibrillator had not taken place.

The Governor in partnership with the PCT should ensure that there is an audit trail to show that defibrillators have been tested daily.

The Governor in partnership with the PCT should ensure healthcare staff are competent to use defibrillators.

Emergency medical equipment

112. My investigator also included the following paragraph in his letter to the Governor: “The night nurse was required to carry a heavy emergency resuscitation bag and a bottle of oxygen to the third floor of A wing, this added to the delay in getting to the patient, as she was exhausted.” The clinical reviewer suggests that emergency equipment should be placed into each wing medical office with immediate effect.

The Governor in partnership with the PCT should review the location of emergency medical equipment.

Training

113. The clinical reviewer recommends that a training needs analysis be carried out to ensure that all healthcare staff are up to date with mandatory training. The training should include extended life support.

The Governor in partnership with the PCT should undertake a training needs analysis of all prison clinical staff and ensure all mandatory training is up to date.

Clinical supervision

114. The clinical review raises the issue of healthcare staff not accessing clinical supervision sessions. The clinical reviewer found evidence that healthcare staff were not regularly participating in the sessions. However, she acknowledges that one member of staff suggested that in house psychological support was excellent.

The Governor in partnership with the PCT should undertake an audit of healthcare staff to establish who is participating in clinical supervision and encourage those who are not currently accessing the service to do so.

Clinical handover

115. The clinical reviewer says in the clinical review that healthcare staff receive handover information about those patients in healthcare, but the same cannot be said for prisoners living on normal location in the wings who might require medical intervention.

The Governor in partnership with the PCT should review the handover arrangements and establish if a wider range of information on prisoner health needs, including the medical treatment of prisoners held on the wings, should be included in nursing handovers.

Healthcare communication

116. The clinical review has identified that nursing staff who work regularly on nights are unable to attend team meetings, as they are held during the day. The clinical reviewer says the current practice is not conducive to good communication and the only way night staff are kept informed is either via email, or during patient handover.

The Governor in partnership with the PCT should consider how best to ensure all healthcare staff are able to attend team meetings.

Staffing levels

117. The current night staffing levels require two registered nurses to be on duty. The clinical reviewer has identified that during Bank Holidays the level is reduced to one, although healthcare and the prison population as a whole remains constant. She believes this to be unsafe.

The Governor in partnership with the PCT should ensure that to maintain safe practice there are two nurses on duty at night.

118. Finally, the clinical reviewer has expressed her thanks to prison staff for their help and co-operation throughout the clinical review process. She adds that it was clear from interviewing clinical staff that the man's death was a difficult experience for them. She concludes that staff acted in the best interests of

the man, but sadly were unable to resuscitate him. The clinical reviewer commends the staff trying to save the man for the compassionate way in which they dealt with the situation.

CONCLUSION

119. It seems most likely that when the man was given the notice of detention document, he did not understand fully what was happening to him. He was a young man with little understanding of the UK. His English was limited and it was not his first language. The man was told that he would be deported and presumably felt vulnerable, confused and angry. He was genuinely afraid of returning to the country of his birth and appears to have believed that he would be killed. Instead of celebrating his Christian faith on 25 December, it seems he chose to end his young life.
120. Despite the night officer's failure to correctly check the wing roll, I am satisfied that it had no bearing on the final outcome.
121. The deaths of foreign national prisoners have caused much anxiety in the past year. In particular, questions have been asked whether immigration status or the actions of the UK Border Agency (to use the up to date title) may have contributed to those deaths. In the case of the man, it seems very likely that the notice of detention – both its message and the means of delivery – were the trigger for what followed.
122. This is not to suggest that there are easy lessons to be learned. Those from abroad who break the criminal law cannot expect simply to remain in this country come what may. And information about detention and future removal has to be delivered in some way. However, in light of what this investigation has uncovered, I think it sensible if a copy of my report were to be shared with the Director General of UKBA for her consideration.

I recommend that a copy of this report is sent to the Director General of UKBA.

RECOMMENDATIONS

For the Governor

1. In light of the findings of this report and the views of HM Chief Inspector, the Governor should consider how best to ensure the needs of foreign national prisoners are met.
2. The Governor should ensure that Listeners are available in reception whenever prisoners are being received.
3. The Governor should ensure that prisoners are not held in reception any longer than necessary.

The Prison Service have not responded to the recommendations

For the Governor in partnership with the PCT

4. 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
5. The Governor in partnership with the PCT should ensure that there is an audit trail to show that defibrillators have been tested daily.
6. The Governor in partnership with the PCT should ensure healthcare staff are competent to use defibrillators.
7. The Governor in partnership with the PCT should review the location of emergency medical equipment.
8. The Governor in partnership with the PCT should undertake a training needs analysis of all prison clinical staff and ensure all mandatory training is up to date.
9. The Governor in partnership with the PCT should undertake an audit of healthcare staff to establish who is participating in clinical supervision and encourage those who are not currently accessing the service to do so.
10. The Governor in partnership with the PCT should undertake an audit of healthcare staff to establish who is participating in clinical supervision and encourage those who are not currently accessing the service to do so.
11. The Governor in partnership with the PCT should review the handover arrangements and establish if a wider range of information on prisoner health needs, including the medical treatment of prisoners held on the wings, should be included in nursing handovers.
12. The Governor in partnership with the PCT should consider how best to ensure all healthcare staff are able to attend team meetings.

13. The Governor in partnership with the PCT should ensure that to maintain safe practice there are two nurses on duty at night.

Neither the Prison Service nor the PCT have responded to the recommendations

For the Prison Service Safer Custody and Offender Policy Group

14. I recommend that a copy of this report is sent to the Director General of UKBA.

I have not received any comments from UKBA