

**Investigation into the circumstances surrounding the  
death of a man at HMP& YOI Chelmsford in January 2008**

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

**August 2009**

This is the report of an investigation into the death of a prisoner at HMP&YOI Chelmsford, in January 2008. The man had a long history of mental health difficulties and had threatened to take his life many times during his periods of imprisonment. He seriously harmed himself on more than one occasion, including during his time at Chelmsford. As a result the man was subject to monitoring to ensure he did not harm himself and the procedures appear to have been carried out properly on the whole. Nevertheless, within three months of arriving at Chelmsford, he was found hanging in his cell. Despite resuscitation attempts the man was pronounced dead upon arrival at hospital.

I must apologise for the delay in publishing this report. The investigation was initially led by one investigator who has since left the Ombudsman's office and the investigation was completed by an Assistant Ombudsmen and a senior investigator. One of my family liaison officers contacted the man's next of kin and maintained contact with them throughout the investigation. A clinical reviewer, on behalf of Mid-Essex Primary Care Trust, undertook an independent clinical review into the clinical care received by the man in Chelmsford. I am grateful to her for her assistance. I am also grateful to the Governor and staff of HMP Chelmsford, who fully co-operated with the investigation.

I have found that the man received the same level of care at Chelmsford as he had at the other prisons. Healthcare and discipline staff worked hard to support the man, who clearly was suffering with his mental health. Within hours of being relocated from healthcare to a prison wing, he apparently took his own life. The man's death was the sixth such death at Chelmsford since the Ombudsman became responsible for investigating all deaths in prison in April 2004. Since the man's death there have been another three apparently self inflicted deaths. There do not appear to be any particular similarities between the other deaths at Chelmsford and that of the man.

However, I have also examined the procedures in place for discharging prisoners on ACCT documents from healthcare and considered the training needs of staff on night duty. I have raised concerns and make recommendations accordingly. I make seven recommendations.

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

**Jane Webb**  
**Deputy Prisons and Probation Ombudsman**

**August 2009**

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## SUMMARY

The man was discovered hanging in his single cell at 10.00pm on 8 January 2008 in Chelmsford. He had been sentenced to two years imprisonment in December 2005. He was released on licence, but breached the conditions of his licence, and was recalled to serve the remainder of his sentence in prison. During his sentence, the man spent time at HMP High Down, Belmarsh, Edmunds Hill, Littlehey and Bedford. He arrived at Chelmsford in October 2007.

The man had a history of mental illness. He complained of hearing voices, particularly a male voice which told him to kill himself. During his prison sentence he had been identified as someone who was at serious risk of harming himself and had made a number of previous attempts to kill himself. Staff at High Down considered that the man's "risk of death [from self-harm] was extremely high". During his sentence, the man was frequently monitored under the ACCT (Assessment, Care in Custody and Teamwork) process, which is a support system for prisoners at risk of suicide and self-harm. He was often monitored constantly by staff. The man spent much of his sentence located in the healthcare centres of the prisons where he was held.

When the man arrived at Chelmsford he was still being monitored on an ACCT document. His ACCT transfer plan from Bedford noted that he wanted to take full part in the regime at Chelmsford and could be located on the wings rather than in healthcare. However, the man spent the majority of his sentence at Chelmsford in the healthcare centre, often monitored by constant observations.

I judge that healthcare staff worked hard to support the man's needs whilst keeping him safe. They treated him with respect and kindness and made sure that he was involved in decisions being made about his care. The man asked twice to move from healthcare to a normal wing location. Both times he was moved to a wing, but then threatened to harm himself and was quickly returned to healthcare.

After consultation with a psychiatrist and a period of settled behaviour with no more episodes of self-harm, the man was moved to B wing early in January and was placed in a single cell. He remained on an ACCT with hourly observations.

At 9.25pm on the day of the move, the man rang his cell bell and was seen by an officer who had started his first ever night shift. The man told the officer that he was hearing voices that were telling him to kill himself. The officer reassured the man and then asked if he would be okay while the officer continued with his duties. The officer said he would be back to see him later. The man told the officer not to forget about him.

At about 10.00pm, the officer responded to another prisoner who had harmed himself. He radioed for medical and staff assistance before returning to the man's cell to check on him. There he saw the man hanging from the cell window. The officer immediately went into the man's cell and was quickly joined by other officers and a nurse. The man was cut down and resuscitation was started. An ambulance was called and the man was taken to hospital where he was pronounced dead on arrival.

## THE INVESTIGATION PROCESS

1. The investigation was allocated to an investigator who was assisted during the investigation by a colleague. The investigator visited Chelmsford to open the case three days after the death. The Governor and his staff provided the man's core record and a number of other documents. The investigator met members of the chaplaincy, and arrangements were made for him to meet members of the Prison Officers' Association (POA) and Independent Monitoring Board (IMB).
2. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. No one responded to these notices. The investigator was given unrestricted access to the prison, staff, prisoners, and documentation relating to the man. I am grateful to Essex police for sharing their investigation documents with the investigator.
3. The man's death was the sixth apparently self inflicted death to have occurred at Chelmsford since April 2004, when the Ombudsman became responsible for investigating all deaths in prison. Sadly, since the man's death there have been three further apparently self inflicted deaths.
4. Prison officers, members of healthcare staff, the Independent Monitoring Board and prisoners were formally interviewed by the investigator, and those interviews were tape recorded. The interviews have been transcribed and interviewees invited to sign and return copies of the transcripts.
5. The two investigators originally allocated to the case left the Ombudsman's office before the completion of the investigation and so it was concluded by an Assistant Ombudsman and a senior investigator.
6. Mid Essex Primary Care Trust (PCT) were asked to conduct a clinical review of the man's care and treatment whilst at Chelmsford. The PCT appointed a clinical reviewer to undertake the review, which was received by the Ombudsman's office in August.
7. A family liaison officer from the Ombudsman's office contacted and subsequently met the man's family with the investigator. They asked why the man was moved to HMP Chelmsford. They were concerned that he was located in a single cell so soon after being moved from healthcare. When the man's mother spoke to him on the Monday before his death, she said that he seemed happy. He spoke to his partner on the Tuesday and again sounded fine. The family asked whether it was the man's decision to move to the wing as they believe he would have preferred to stay in healthcare where his cousin was located.
8. The family had been told that, at 9.25pm, the man saw an officer on the wing and told him he was hearing voices. They believed the officer returned to the cell at around 10.00pm when the man was found hanging. They wanted the investigation to establish exactly what took place. The family wanted to know

whether the man had pressed his cell bell to alert the officer at 9.25pm, what medication he was prescribed and where he was certified as having died. They were concerned that they were not informed of his death until 4.00am. After the man had died the family saw the ligature mark on his neck and wanted the investigation to clarify exactly what was used to make the ligature, what it was attached to and who cut him down.

9. The family liaison officer and one of the investigators also met the man's partner who wanted to know whether Chelmsford had properly assessed the man's vulnerability and risk to himself. She wanted to know whether the man had been aware of, and offered support after, the death of another prisoner at Chelmsford in December.
10. The man's partner was concerned that, on the day of death, having told the officer he was hearing voices, the man was left alone in his cell and was not offered a Listener or other support. The man's partner was concerned that he had not been offered the same level of support at Chelmsford that he had received at other prisons.
11. The investigator wrote to HM Coroner to inform her of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist her enquiries into the man's death.

## HMP CHELMSFORD

12. HMP&YOI Chelmsford is a category B local prison which serves the courts of Essex and surrounding areas. It holds predominantly sentenced and unsentenced adult male prisoners but almost a third of the population is made up of young offenders aged between 18 and 20 years. The prison accommodation is split between the original Victorian wings and newly built residential units. Like most local prisons, there are constant population pressures and Chelmsford is one of the most overcrowded prisons in England and Wales.
13. Healthcare is provided in a spacious and well equipped two storey building completed in 2004. A large day-care centre has a welcoming main area with comfortable seating, displays of prisoners' poetry and art, and interview and group rooms. There is an inpatient unit with 12 large individual cells, which are fitted with safe furniture, except for two cells that have hospital type beds.
14. B wing is one of the older Victorian wings. It has three landings and holds 132 prisoners with 44 on each landing.
15. Her Majesty's Chief Inspector of Prisons inspected Chelmsford in a full announced inspection in July 2007. The inspection revealed a prison suffering from all the problems of an over-crowded prison system. The population was very fluid with prisoners staying a relatively short time and with insufficient activity to occupy them. Staff turnover was high and shortages were a constant feature.
16. The inspection found that healthcare staff worked hard to provide a decent standard of care and were committed to improvements. The inspectors found that the health centre was an excellent environment for patient care. There had been a renewed focus on prison health from the local Primary Care Trust since reorganisation, but progress had been slow. Clinical skills were not used to best effect, and some aspects of service delivery were not well organised.
17. A good day-care programme was available for prisoners with mild to moderate health problems, but the Mental Health In-Reach Team did not work with the psychiatrists. Prisoners with severe mental illness were cared for by the primary care team and did not have integrated multi disciplinary treatment. The levels of patient engagement on the inpatient unit were too low, their time out of cell was too short, and they had very poor access to therapeutic or rehabilitative day-care. The use of strip clothing (special clothing made from material that cannot be ripped and therefore suitable for patients at risk of self-harm) and CCTV to monitor patients at risk of self-harm was of particular concern to the Inspectorate.
18. The inspection identified that the availability of Listeners (prisoners trained by the Samaritans to offer confidential support to other prisoners) in Chelmsford was generally poor. Initial self-harm monitoring assessor reports were found to be lacking in detail and there were insufficient monitoring entries that

showed positive engagement by staff. There was, however, evidence of a multidisciplinary approach to the management of prisoners on open suicide and self-harm monitoring documents. Chelmsford was commended for its support group for prisoners on self-harm monitoring.

19. Every prison in England and Wales is monitored by an Independent Monitoring Board (IMB) formed of members of the local community. Board members have right of access to every prisoner and every part of the prison and also to the prisoners' records. Each IMB produces an annual report, the most recent report available for Chelmsford covers the period 1 September 2006 to 31 August 2007.
20. The IMB reported that "Prisoners have better access to Healthcare than they would 'outside' and that mental health provision was readily available". The Board praised the "excellent management and dedication in the Healthcare department" which provides an "enviable service".
21. In respect of safer custody, the IMB reported that the Safer Custody Team was enthusiastically led and staffed. The report noted the integrated and multi-disciplinary approach to addressing suicide and self-harm issues. Like the Inspectorate, the Board commented that the provision of prison-wide Listener services was problematic.

### **Suicide and self-harm monitoring**

22. As at all prisons, Assessment, Care in Custody and Teamwork (ACCT) has been introduced at HMP Chelmsford to monitor and support prisoners assessed as at risk of suicide or self-harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk. The ACCT document is reviewed on a regular basis by key people who know the prisoner at risk or are involved in their care.

### **Samaritans**

23. The Samaritans is an independent organisation which has trained volunteers that will listen to prisoners' concerns. Prisoners at Chelmsford are able to talk freely and in confidence with the Samaritans using the telephones provided on the wings.

### **Listeners**

24. Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress. They are available 24 hours every day and will meet prisoners to listen to their concerns.

### **Counselling, Assessment, Referral, Advice and Throughcare (CARAT)**

25. In common with other prisons, prisoners in Chelmsford can access the CARAT team over any concerns with regards to drugs or alcohol abuse.

## **Chaplaincy**

26. Chelmsford has a dedicated chaplaincy team who cater for all religious and spiritual needs. They are supported by a number of visiting religious leaders. Prisoners can apply to attend chaplaincy services.

## **Radio call signs**

27. At Chelmsford, staff use specific call signs when using their radios and alerting staff to medical emergencies. The call sign 'Oscar 1' is given to the Orderly Officer (the prison officer in charge of the prison, known as the Night Orderly Officer during the night). 'Oscar 2' is the call sign given to his or her deputy. A 'code 2' call sign denotes a situation requiring medical assistance which is not felt to be life threatening. A 'code 1' call sign is used when medical assistance is urgently required due to a life threatening situation.

## EVENTS LEADING UP TO THE MAN'S DEATH

28. The man who died was serving a two year sentence for driving related offences. He began his sentence in December 2005 and was released on licence on 1 December 2006. One of the conditions of his licence was that he must live at an address agreed with the probation service but the man failed to comply with the requirement. He was subsequently instructed to report to an approved premises (accommodation provided and managed by the probation service) in mid February, but failed to arrive. As a result, his probation licence was revoked, and he was returned to prison to serve the remainder of his sentence.
29. Whilst on licence the man committed further offences and appeared at Croydon Crown Court late March 2007, where he received an additional two years imprisonment to be served at the same time as his existing sentence. The man expected to be released from custody in May 2008.
30. The man arrived at Chelmsford in October 2007, having been in custody at HMP High Down, Belmarsh, Littlehey, Edmunds Hill and Bedford. Throughout his sentence, he was identified as at serious risk of harming himself. He would frequently attempt to hang or strangle himself and was seen to try and bite the veins in his arms. As a result he was often monitored on an ACCT plan. In 2006, staff at High Down noted that his "risk of death [from self-harm] was extremely high". Because of this risk, the man was often monitored constantly by staff. (The prisoner remains within eyesight and within a suitable distance of the member of staff at all times, such that immediate action can be taken if they attempt to self-harm.) The man complained of hearing voices that told him to kill himself. He was often placed in the healthcare centre of the prisons because of his mental health issues and risk of self-harm.
31. The suicide prevention officer at Chelmsford manages the ACCT training and implementation. She first became aware of the man when she was telephoned by staff at Bedford prison and notified of his impending arrival. She was told that the man had been in their healthcare centre with an open ACCT document and a constant watch. She was also told that the man wanted a move to Chelmsford because he felt that it would be closer to his family and easier for them to visit. The suicide prevention officer understood that Bedford thought the man would go to normal location on a wing rather than healthcare on arrival at Chelmsford. The man had apparently said that he wished to get a job at Chelmsford and take a full part in the regime. This was reflected in the ACCT transfer information provided by Bedford prison. The man attended his ACCT review on 16 October before leaving Bedford for Chelmsford. He said he had no thoughts of self-harm and was looking forward to the move as he would be nearer his family. The ACCT plan was to observe and interact with the man hourly.
32. It was highlighted on the man's Prison Escort Record (PER), which accompanied him on his transfer from Bedford to Chelmsford, that he had drug related convictions and that he was manipulative and a prolific self-

harmer. Warning markers on the Police National Computer (PNC) showed that he concealed items to self-harm, was suicidal and had previously bitten the veins in his arm.

33. When he arrived at Chelmsford, the suicide prevention officer met the man on the induction wing and subsequently in healthcare. She found him to be an engaging, likable person who was always pleased to see her. He was moved onto the induction wing (E wing).
34. It was noted on the man's Inmate Medical Record (IMR) at Chelmsford that he had transferred from Bedford and had a history of mental ill health and self-harm. He was being prescribed Chlorpromazine. It was recorded that the man had been unable to cope following his brother's recent suicide and wanted to be at Chelmsford to be nearer his family. The man said he had no thoughts of suicide or deliberate self-harm. It was recorded that he had good eye contact, and was very talkative with good, positive, forward looking conversation. An urgent referral was made to the doctor and Mental Health Team (MHT).
35. A prison officer spoke to the man the following day as part of his ACCT review. The man said he had thoughts of killing himself when he looked at his dead brother's photograph. He said staff at Bedford told him he would go straight to healthcare at Chelmsford. The man was moved to healthcare later that day, where he was to be monitored constantly. It is recorded in his medical record that he was feeling unwell because of his brother's recent suicide. The notes record that the man was not having hallucinations, and there were no physical concerns. He was referred to the Mental Health Team. It was noted in his medical records that, at 1.00am on 17 October, the man shouted "Nurse, I am hearing voices" but could not explain what the voices were telling him to do.
36. On 18 October, another prison officer observed the man as part of the constant watch. The man reiterated that he had been unable to cope following his brother's recent death and the death of his baby the previous year. He said he harmed himself because of auditory hallucinations (hearing voices), in which a male voice told him to kill himself, usually at night time. He said that Bedford prison did not understand him and did not let him see psychiatrists when he wanted.
37. The man appeared to the officer to show no signs of visual or auditory hallucinations. He had good eye contact and was happy to discuss various topics. He said he could be quite impulsive when directed by the voices and could be directed at anytime to hang himself. With his consent, the man's blankets were exchanged for non rip blankets. It was decided that the man should remain on a constant watch in healthcare and see the psychiatrist.
38. The man was seen by a psychiatrist on 19 October for his psychiatric review following his transfer to Chelmsford. The psychiatrist noted the man's history of mental health problems and previous attempts to harm himself. He

directed that the man remain on constant watch and receive the same medication.

39. The psychiatrist saw the man again on 22 October when he noted that there had been no “untoward incidents” but that the man still complained of hearing voices. The psychiatrist recorded that the man wished to go to normal location on one of the wings but that he had also admitted that he might harm himself if not on constant watch. The psychiatrist concluded that the man should remain on constant watch and that his medication should be changed from Chlorpromazine to Olanzapine (both antipsychotic drugs).
40. The man’s ACCT plan was reviewed in healthcare on 23 October, with the man, a psychiatric nurse and a different prison officer present. It was decided that the man should remain on a constant watch and under the care of the Mental Health Team. He requested the papers for a move to another prison. On 24 October, the man threatened a healthcare officer and threatened to smash up his cell. The man said he wanted to see his children but knew that he was not allowed.
41. The man was assessed by a second psychiatrist on 26 October. The second psychiatrist recorded in the man’s medical records:

“In my opinion [the man] has a long standing mental disorder in the background of mild learning disability and as a consequence as has been reported on a number of occasions, he is most likely while in HMP Chelmsford to continue to demonstrate impulsive explosive behaviour with marked propensity towards committing acts of deliberate self-harm on a very frequent basis. Therefore I recommend that [the man] remains under constant observation in a safe environment and not allowed any objects that can be used by [the man] as a weapon for self-harm or harm to others.”
42. A further ACCT review took place on 27 October with the man, the officer who had been present at the review on 23 October and another officer present. It was decided that the man should remain on a constant watch.
43. On 29 October, the man was seen by the second psychiatrist. He was moved to a cell with closed circuit television, although the reasons are not recorded, and remained under the care of the Mental Health Team. It was noted that the man remained without insight and was quite impulsive in manner. The following day the man attended another ACCT review, and it was decided that he should remain on a constant watch. At his ACCT review on 31 October, it was noted the man had declined a shower and a telephone call. When asked why, he said “I just feel tired”. It was decided that the man should remain on a constant watch under the instruction of the Mental Health Team.
44. A further ACCT review took place on 1 November and it was noted that the man had had a quiet day. He had used the telephone and remained on a constant watch. The man was desperate to be removed from safe conditions (this is when the prisoner’s bedding and clothing are replaced with items

made from material which cannot be ripped and therefore used to self-harm). The following day, the man was seen by the first psychiatrist, as part of his ACCT plan. It was decided that the man had settled and that observations should be reduced from constant to hourly. He was moved to a new room with a television. The review team were hopeful that, if he settled, he could move to C Wing.

45. The man was seen again by the first psychiatrist four days later on 5 November as part of his ACCT plan. It was noted that the man remained settled. He heard no voices and had no thoughts of self-harm. He was keen to be transferred to F wing, to work and be occupied. The man mentioned a possible move to HMP Belmarsh as this was closer to his family. His observations were reduced to three conversations a day and hourly observations at night.
46. As the man appeared to settle, he was moved to F wing on 8 November. However, at his ACCT review later in the day, the man threatened to harm himself unless he went back to healthcare. At 9.00pm, he told staff that he was hearing voices telling him to harm himself. It was recorded in his on-going prisoner record that at 9.25pm he rang his cell bell, threatened to rip a sheet and self-harm. At 9.40pm, after ringing his cell bell again, he said that he would smash his television and also said he had spat his medication down the toilet. Ten minutes later, he rang his cell bell as he had cut his arms with a razor blade. The man was asked to pass the blade under the door but said he had swallowed it. He said that he was not allowed to see his children, that his brother had hanged himself and that things were getting on top of him. The Night Orderly Officer (the officer in charge of the prison overnight) attended and entered the cell at 10.17pm with staff who cut a ligature from the man's neck made from his shoe laces. The orderly officer made the decision to place the man on a constant watch in strip conditions, which meant that the man was placed in a gown designed to minimise the risk of harming himself.
47. The man had managed to hide a blade, which he used to cut his arm. He subsequently agreed to place the blade on a table where both he and the officer could see it. He returned to healthcare the following day, where he remained in strip conditions and on constant observations. He was seen again by the first psychiatrist, who recommended that the man remain in these conditions. On 10 November, the man was spoken to by a member of the Mental Health Team. She noted that the man was settled in his mood and that he had harmed himself as he wanted to move closer to his relatives. The man said that he had always been impulsive and 'did not think'. The member of the Mental Health Team discussed alternatives to self-harm, such as talking to staff when he found it difficult to cope. The man said he thought about his children's reactions should anything happen to him. It was decided that the man should remain on a constant watch on an open ACCT.
48. The man was assessed by the two psychiatrists, a doctor, the member of the Mental Health Team and the psychiatric nurse on 12 November, and they decided that he was to remain in strip conditions. The Mental Health Team arranged therapy with the man. The man was more positive at his ACCT

review on 13 November, and he said that he would like to come out of safe conditions and off constant watch. He said he would not harm himself as his brother died recently and he had more sense than to do so himself. The man was advised that a decision would not be made until he had been seen by a psychiatrist. It was noted that his eye contact and conversation were both good.

49. Whilst under constant watch on 15 November, the man told the nurse watching him that he still had razors. At the man's ACCT review the following day he was seen by a psychiatrist and it was decided that he should remain on a constant watch. At 4.45pm the man was seen by healthcare staff after he claimed he had swallowed a razor blade. He was lying on his bed attempting to be sick. When asked why he had swallowed a razor, he said he wanted to be with his little brother who was dead. The man was kept under constant observations. The following day the man told staff that he had not swallowed the razor blade and was just angry at being left in healthcare when he wanted to go to the wing.
50. On 19 November, the man was seen by the first psychiatrist and another ACCT review was completed. It was decided that the risk of self-harm remained very high and that the man should be monitored in a cell with CCTV and be allowed to have his own clothes the following day if his behaviour remained good.
51. The man was seen by the second psychiatrist on 23 November who noted in his medical records that he remained very settled and showed no signs of distress. The man denied any intention of harming himself and said that he was feeling "alright". The second psychiatrist recommended a reduction in the level of observation to hourly and that the man should be allowed his normal clothing, at the Senior Officer's discretion.
52. On 27 November, the man attended his ACCT review with the healthcare senior officer, the healthcare officer who had attended the review on 24 October and the prison officer who had attended the reviews on 23 and 27 October. He had received news that his wife was visiting him and that an aunt had passed away. It was noted that he had not recently self-harmed. The man was seen by the Samaritans. On 3 December, he was seen by the first psychiatrist who noted that he denied thoughts of self-harm, and was keen to be transferred to Belmarsh or onto a wing.
53. The man went to the next ACCT review on 4 December with the healthcare senior officer and the healthcare officer. It was noted that he was still doing well. The man asked to be moved to an ordinary wing location and hoped for a transfer to Belmarsh to be nearer his family. He had not made any further attempts to harm himself.
54. At an ACCT review on 11 December with the officer who had attended the review on 27 November and another officer, it was noted the man had settled in healthcare with no negative incidents or thoughts. He was mixing well with others. The man said he was desperate to go to a London prison but was told

that this would be difficult because of a lack of space. The man said his medication was not working.

55. The man had a psychiatric review on 17 December. It was noted that there were no major concerns, and it was decided to increase the dosage of his medication and that he should remain in healthcare.
56. It was noted on the man's ACCT plan on 20 December that he continued to do well. He did not complain or request anything, but did ask about his prison move. There had been no recent acts of self-harm or suicidal threats. It was agreed that the man should remain on an ACCT for a further review. Two days later the man was again present at his ACCT review with the two officers who had attended the review on 11 December. It was noted that the man continued to do well and mix with others. He asked when he would be going back to the wings. He said he had no negative thoughts.
57. A psychiatric review was carried out on 24 December by the first psychiatrist. The man said he had no ideas of self-harm and that his medication had helped, although he was hearing voices at night. It was decided to discharge the man to the wing, and he was moved to E wing the following day, where he was to be observed by staff every hour. At an ACCT review held immediately after the move, he said he felt "okay" but would prefer to move to B wing. He had no thoughts of suicide or self-harm and said he would speak to staff and Listeners if he was feeling low.
58. The psychiatric nurse told my investigator that the man's release date was nearing and he wanted to go to a London prison to improve his contact with his family. The man had said that he had wanted to come to Chelmsford as it was nearer London and was hoping his next move would be a London prison. The man wanted to leave healthcare and be located on the wing, and this was discussed with him.
59. On Christmas Day, staff found a noose in the man's cell and, because of his history, the psychiatric nurse readmitted him to healthcare for assessment. The man said he had the ligature because he was put on E wing rather than B wing, which is where he wanted to be. The man apologised and blamed the system for not putting him on B wing.
60. Three days later, on 28 December, the man went to his next ACCT review with the officer who had carried out constant observation duties on 18 October and the healthcare officer. He was settled although he claimed to have been bullied on the wing. My investigator could find no evidence that the man's allegation of bullying had been investigated further. It was noted that the man did not cope well on ordinary location, but did manage and mix in smaller groups. It was decided that he should remain on an ACCT document until seen by the psychiatrist.
61. The man was seen by both psychiatrists on 31 December and said that he would now like to go to B wing and promised "I won't do it again". It was decided that the man should remain in healthcare.

62. On 4 January, the man attended his ACCT review with the healthcare senior officer and two prison officers. It was noted that he remained settled and well. He wanted to return to a prison wing and was told that he would be further reviewed on 7 January by the Mental Health Team. The first psychiatrist saw the man on 7 January and decided he could go to B wing as he wanted to do an Enhanced Thinking Skills course. The psychiatrist noted that the man was “determined to remain on normal location to get on with his sentence”. The man remained settled, and was not hearing voices. It was noted at the man’s ACCT review with the healthcare senior officer, an officer and the first psychiatrist that it might be prudent to place the man in a shared cell – preferably with someone he knew - as he was not a danger to others but more to himself. No member of B wing staff was present at the man’s ACCT review on 7 January.
63. The healthcare senior officer knew the man well, attending a number of his ACCT reviews. He was aware that he had been transferred from Bedford and had been on a constant watch. The senior officer said the man was well liked. Early on in his time at Chelmsford, the man talked to the senior officer about wanting a move to High Down to be closer to his mother’s home, and about the death of his brother. Some months later, the senior officer recalled a conversation with the man during which he said he wanted to go on the wing. The senior officer asked the man if he was sure about this, because he could stay in healthcare if he wanted to. The man said he had asked the doctor, who said he could go to the wing and that he wanted to go to B wing as he knew some prisoners there. Early January, the senior officer arranged for the man to go to B wing. He asked him if he still wanted to transfer to High Down, and he said that, as he was being released in May, he was happy to stay. During his interview with my investigator, the senior officer said that in the ACCT case reviews he was involved in with the man, all parties to the document were consulted and contributed but did not necessarily attend the review.
64. Another prisoner at Chelmsford knew the man from outside prison. They got on well together and had adjoining rooms in healthcare. The prisoner said in interview with my investigator that they were both on ACCT plans. He last saw the man in the late afternoon of 8 January, when he came to his cell and said that he was going to B wing. He said he was looking forward to the move and would try to get a single cell and meet up with the prisoner on B wing when he too was discharged from healthcare.
65. The man was accompanied to B wing in January by two movement officers, who knew he was on an ACCT and was to be checked every hour. During her interview with my investigators, one of the movement officers explained that, on arrival on B wing, she had looked at the man’s last ACCT review, which had been completed in healthcare. She noted that it did not specify whether the man should be placed in a single or double cell when he arrived on B wing. The man asked that he be given a single cell. The movement officer rang healthcare and spoke to the healthcare senior officer, who told her that the man could be placed in a single or double cell. In interview, the

senior officer said that he told the movement officer that the man could occupy a single cell as he had been in one in healthcare. The movement officer informed the senior officer on B wing who allocated a single cell on the third landing: B3.31. The man gave the movement officer no cause for concern or any indication that he intended to take his life.

66. It was noted in the man's B wing history folder by a B wing officer that, although the man was nervous about leaving his cell for association, he came out and associated with other prisoners. The B wing officer spent at least 15 minutes helping the man to fill out application forms for education and work. The man was later locked in his cell for the night.
67. A new officer who had been working at Chelmsford since December, commenced his first ever night duty that evening on B wing. He was the only officer on the wing and had sole responsibility for the care of the prisoners. He had had no formal instruction or specific training for night duties. As part of his core prison officer training, the officer had received comprehensive training about the ACCT document and procedures. He was familiar with the system and was comfortable working with prisoners on ACCT documents. There were 132 prisoners on the wing, four of whom were monitored under the ACCT arrangements.
68. At 9.25pm, the officer on his first night duty answered the man's cell bell. The man said he was hearing voices. The officer knew the nurses had recently left the wing and asked the man if he had taken his medication. The man said that he had been given medication to help him "deal with the voices". The officer advised him to sit down and drink some water and his medication should suppress the voices. The man said he would do this. The officer thought that the man seemed "down and sad" so he asked the man what the voices were telling him to do, and the man replied that they were telling him to kill himself. The officer told the man that he did not want him to kill himself and said that there would be other people who did not want him to kill himself either. With this, the man smiled and sat down. The officer asked the man if he would be okay whilst he carried out his duties. The man nodded and said, "don't forget me" and the officer told him he would return in a while.
69. The officer then checked on other prisoners on the wing who were on ACCT documents. He returned to the central office and responded to another cell bell which was activated. As he opened the cell flap he saw that one of the prisoners occupying the double cell had made some superficial cuts to his wrist. The officer radioed a code 2 (meaning there was a non-life threatening situation needing medical assistance) call for assistance but did not enter the cell. He advised the prisoner to press a shirt on the wounds to stop the bleeding. Whilst he was waiting for assistance to arrive he returned to check on the man.
70. The officer reached the man's cell at 10.00pm. Upon opening the observation flap he noticed that the cell light was now off, and he saw the man with a ligature made from bedding material tied from the cell window bars attached to his neck. The officer radioed his position and a code 1 (meaning there was

a medical emergency) to the control room. He broke the sealed pouch containing the cell key, unlocked the door and went inside, where he supported the weight of the man's body. Very soon afterwards, the senior officer on duty, an officer, followed by a nurse, who had arrived on the wing to deal with the previous emergency.

71. The senior officer on duty that night said that on the evening/night of 8 January he was the Night Orderly Officer in charge of the prison with the radio call sign Oscar 1. During the evening he received a code 2 radio call telling him a prisoner on B wing had cut his wrist. He went with the nurse to B wing and, whilst they were on their way there, heard a code 1 call on his radio. He went to the man's cell and went inside, immediately behind the officer who had also responded to the code 1 call. The officer on his first night duty had taken the man's body weight and the other officer cut the ligature from his neck. The officers laid the man on his back on the cell floor. The two officers started resuscitation and were joined by the nurse, who asked the senior officer to collect some more oxygen from the wing as her cylinder was not working. When he returned to the cell, the officer who had responded to the code 1 call was carrying out chest compressions whilst the nurse was administering oxygen.
72. The nurse said in interview that she had known the man as he had been in healthcare for some months. She had a good relationship with him and they often shared a joke. She described him as a very personable young man, who had mental health problems. On the day of the man's death, the nurse started her shift in healthcare just before 9.00pm. (Nurses on night duty at Chelmsford do not routinely carry keys, as a safety and security measure against hostage taking and attack. They are therefore escorted by Oscar 1, the Night Orderly Officer, or his deputy, Oscar 2, who both carry keys to areas of the prison where prisoners may require treatment.)
73. The nurse noticed from the man's clinical records that he had been moved to B wing that day and had settled. She was not surprised that he had been moved from healthcare as she said that he was desperate to go back to the wing. He had been asking for quite some time because it was something he was working for. She said he was very positive and looking forward to being released.
74. Later that evening the nurse was asked to attend B wing as a prisoner had self-harmed by cutting himself. She was collected from healthcare by Oscar 1 and, as he was collecting her, a further message was received over her radio for a code 1 on B wing.
75. The nurse said that she arrived at the man's cell within minutes of the call, just as he was being cut down. She immediately called for an ambulance and checked him over, establishing that he had no pulse and was not breathing. She noticed he had a deep laceration around his neck. The nurse started resuscitation by putting an airway in the man's mouth and giving oxygen from a brand new bottle which she initially found difficult to turn on. She was

assisted by the two officers carrying out chest compressions until the arrival of the ambulance staff.

76. The ambulance arrived at Chelmsford at 10.15pm and the paramedics reached the man's cell at 10.19pm. The defibrillator (this is a machine that can restart the heart by giving an electric shock in some cases of cardiac arrest) was placed on the man but no heart rhythm was detected. The man was taken to hospital at 10.40pm where he was pronounced dead.
77. The suicide prevention officer said she was saddened to receive a telephone call informing her of the man's death as she had got to know him well through speaking to him and attending his ACCT reviews. The healthcare senior officer learnt of the man's death the following day and said he was absolutely devastated.

### **Post Mortem**

78. The post mortem concluded that the man died as a result of hanging. The pathologist was satisfied that there was no evidence of either third party involvement or natural disease contributing to the man's death. The toxicology report found no evidence of either alcohol or drugs (other than those prescribed to the man) in his blood.

### **Contact with the family**

79. A governor went to the man's grandmother's address in South London in the early hours of the day following his death. He arrived and liaised with the local police before breaking the news of the man's death. The prison offered to pay the man's funeral expenses and arranged for his partner to visit to Chelmsford and the cell where the man was found. The prison also arranged for other family members to attend the prison. The governing governor subsequently attended the man's funeral.

### **Prisoner and staff welfare**

80. Staff and prisoners felt generally well supported after the man's death. Members of the Care Team and Chaplaincy visited the prisoners on the wing and offered their support. The prisoner who knew the man said that the news of his death was sympathetically broken to him and he was monitored by staff and members of the chaplaincy team. The suicide prevention officer said in interview that Chelmsford's contingency plan following a death in custody was followed and all prisoners on ACCT documents in the prison were reviewed.
81. The governing governor spent time talking to affected members of staff on the day the man died. A debrief meeting was held several weeks later with members of staff who had been involved. It appears that a hot debrief (a meeting held very shortly after an incident for staff immediately involved) was not held in the hours that followed the man's death.

## ISSUES CONSIDERED IN THE INVESTIGATION

### The man's clinical care

82. A review of the clinical care the man received at Chelmsford was undertaken by a clinical reviewer. One of the issues considered by the clinical reviewer is the standard of medical record keeping at Chelmsford. The clinical record should reflect the care given to the man and so each entry should be legible, dated and timed in order to follow care over the 24 hour period. Each entry should be completed with a signature (and if the first entry in the record, the surname and title should also be printed). The clinical reviewer found the man's record to be of poor quality in this respect. Whilst all entries have been dated, not all have the time recorded and although signed, not all surnames are legible. Furthermore, on some days no entries were made and entries made by health care assistants have not been countersigned by qualified staff. The Ombudsman made a recommendation about the standard of record keeping in a report on another death in custody at Chelmsford that has just been published and this recommendation has been accepted. I do not propose to repeat that recommendation here.
83. Chelmsford currently does not have an integrated clinical record system in operation which means that treatment and action undertaken by healthcare staff and the Mental Health Team are noted on separate records. There does not appear to be a mechanism for sharing information contained in these records. The implementation of an electronic system would greatly improve the quality of the clinical record. The Head of Healthcare has told my investigators that she anticipates that an electronic system will be introduced by the end of 2009.

### Bullying

84. The man complained of being bullied when he was briefly located on E wing. Chelmsford has a comprehensive violence reduction policy. The suicide prevention officer told my investigators that all information about bullying is recorded in a Security Information Report (SIR) which is passed to the security department of the prison. The information is then passed to relevant staff to deal with. However, my investigators could find no documentary evidence that the man's claim he had been bullied had been investigated further or recorded on an SIR.

**The Governor should remind staff that any allegation of bullying must be properly recorded, in line with the violence reduction policy.**

### Assessment, Care in Custody and Teamwork

85. I believe that the man was carefully supported and managed under his ACCT plan. The documentation was generally completed well, with detailed comments and observations recorded and clear action plans. He was monitored on ACCT for the majority of his prison sentence and at a number of other prisons. My investigator reviewed the paperwork relating to the man's

time at other prisons and found that they too generally had completed the ACCT documentation appropriately. I am satisfied that the man received the same standard of care whilst at Chelmsford as he did at other prisons. I am pleased to note that the man was treated with respect and kindness by staff at Chelmsford, who worked hard to respond to his needs and keep him safe.

86. However, the healthcare senior officer said that in the case reviews he was involved with, whilst all parties to the review would have been consulted before the ACCT document was completed, they may not have been present at the review. This is not reflected in the ACCT document.

**The Governor should remind staff that those participating in an ACCT review should, wherever possible, be present. The paperwork should clearly reflect who is present and who has been consulted or made a written contribution.**

87. The clinical review also considered the quality of the man's ACCT document. The reviewer found that on two occasions ACCT reviews did not take place on a daily basis as scheduled. In one case, there were four days between reviews and in the other case two. Whilst in this case, the man had been on ACCT for a long time and I am satisfied the timing of the ACCT reviews did not affect his care, in other cases it may be important.

**The Governor should remind staff that ACCT reviews should take place as scheduled.**

88. The last ACCT review held for the man took place early January 2008 when his discharge from healthcare to B wing was agreed. According to the document, those consulted included the man and healthcare staff. It does not appear that a member of B wing staff was asked to attend the ACCT review as part of a continuous ACCT plan.

**The Governor should remind staff that when a prisoner on an ACCT plan is to be relocated, a staff representative from the receiving wing is present for the ACCT review.**

89. The man's family asked whether he was aware of the death of another prisoner at Chelmsford on 25 December, and whether he received any support afterwards. There had, in fact, been two deaths at Chelmsford while the man was there. The suicide prevention officer said that all prisoners on ACCT documents were reviewed following deaths in custody. The man's ACCT documentation clearly indicates that he was reviewed on 27 November in line with the prison's post suicide policy. The man's ACCT was also reviewed at 10.00am on 25 December but it is not clear if this was as a result of the death of a prisoner that day. The man said he was not feeling low or suicidal but that he would speak to staff or ask for a Listener if he needed to. I am satisfied that the man continued to receive support from staff at the prison around the time the two other prisoners died. However, later on 25 December, the man was found with a ligature and moved back to healthcare. A further case review should have been held, in line with PSO 2700.

## **Discharging the man from healthcare**

90. On 8 January, the man was discharged from healthcare and transferred to B wing. The In Patient Discharge Policy for Chelmsford outlines a number of procedures which ensure that prisoners receive the continuing care they need after discharge. The policy is intended to be flexibly applied according to the individual needs of the patient. However, the policy states that “a discharge care plan shall be drawn up”. My investigator could find no evidence in the paperwork provided that a discharge care plan had been drawn up for the man.
91. The man was escorted to B wing by two movement officers. The man had spent a considerable amount of time in healthcare and on an ACCT and had previously attempted to self-harm when transferred to the wings. A written summary of care to fully inform staff on the receiving wing of the prisoner’s history would be more appropriate than a verbal handover when transferring prisoners from healthcare to the wings.

**The Head of Healthcare and the Governor should ensure that healthcare staff provide a written summary of care when any prisoner is being transferred from healthcare to the wings. A discharge care plan should also be drawn up, in line with the In Patient Discharge Policy.**

## **The decision to place the man in a single cell on B wing**

92. The first psychiatrist saw the man on 7 January and considered that he was well enough to be discharged from healthcare as he had been settled with no thoughts of suicide or self-harm for over a week. For some time, the man had been requesting a move to normal location. He particularly wished to be placed on B wing where he said he had friends. The man remained on healthcare until the following afternoon when he was transferred to B wing on an ACCT plan with hourly observations. Before leaving healthcare he was in a positive mood. He told another prisoner that he was going to B wing and was going to try and get a single cell.
93. At the man’s ACCT review on 7 January, it had been noted that he might be better placed in a double cell – preferably with another prisoner he knew. A single cell was available on B wing and the officers escorting the man telephoned the healthcare senior officer to establish if a single cell would be suitable. The senior officer said it was, and his rationale was that the man had been in a single cell in the healthcare, had been discharged and was on hourly self harm observations.
94. The suicide prevention officer said in interview that the man had always expressed a preference for a single cell and she felt that he would have found sharing a cell quite difficult. The suicide prevention officer emphasised that decisions about the best location for prisoners on ACCT forms had to take account of the prisoner’s preferences alongside recommendations made as part of their ACCT document. The man was allocated a cell on the third floor

of B wing and the wing office is located on the ground floor. The suicide prevention officer explained that each landing on the wing is patrolled throughout the night. She felt that, given the man was on hourly observations when he arrived on B wing, the allocation of the cell on the third floor was appropriate.

95. I am satisfied that staff gave proper consideration to the man's best interests. The healthcare senior officer knew the man well and, it seems, weighed up the potential risks in placing him in a single cell against the man's wishes to have a single cell and the fact that he had been discharged from a single cell in healthcare on reduced observations. I believe that healthcare staff at Chelmsford kept the man at the centre of all decisions made about him, and this is to be commended.
96. The man's family wished to know whether he had a personal officer when he was moved to B wing. Chelmsford's policy is that personal officers are allocated as soon as a prisoner arrives onto a wing and so the man would have been allocated a personal officer early January. However, given the short amount of time that the man spent on B wing before his death it is likely that he had not yet met his personal officer.

#### **Staff contact with the man on the night of a day in January**

97. The officer on duty overnight on 8 January, a newly qualified officer, commenced his ever first night shift on B wing that night. Although he had undergone prison officer training he had not had any specific training for night duties. He was responsible for the care and custody of 132 prisoners on B wing, four of whom were on open ACCT forms. He spoke with the man at 9.25pm when he responded to his cell bell. The man told him he was hearing voices telling him to kill himself. The officer reassured him and told the man that he would be back to see him in a while.
98. The officer was asked, in a follow up interview with an investigator, if he had considered contacting either the Night Orderly Officer or healthcare staff for advice following his conversation with the man. He explained that whilst 25 to 30 minutes had passed between the man ringing his cell bell at 9.25pm and the other prisoner self-harming in a nearby cell, he had been busy checking other ACCT prisoners and answering cell bells and so he had not had time to think about contacting the Orderly Officer or healthcare staff. He said that he would have felt confident in doing so had he needed to.
99. The officer said that he did not offer the man a Listener or the opportunity to use the Samaritans phone that night. Although the man had seemed down and sad, the officer thought he seemed quite calm and not "at the end of his tether" and so he had not thought it necessary. Despite not having received specific training for night duty, the officer told my investigator that he felt confident about accessing Listeners during the night. He said that he thought prisoners were made aware of the availability of both Listeners and the Samaritans phone during their induction at the prison and so he might have expected the man to ask for one or other service if he felt in need. Whilst this

may sometimes be the case, staff should not assume that a prisoner will know how to or feel confident in asking for access to such services.

100. With the benefit of hindsight, the officer might have taken additional action after his conversation with the man. He explained how he made his decisions on the basis that the man was not outwardly displaying very concerning behaviour. He felt that the ACCT procedures under which the man was being monitored would be sufficient to support him through the night. In this case, I believe the officer could have offered the man the opportunity to speak to a Listener or use the Samaritans phone. While I make no formal recommendation, the Governor may wish to remind staff that prisoners should be offered the services of Listeners and the Samaritans as appropriate.

**The Governor should ensure that staff undertaking night duties receive appropriate training covering the specific responsibilities and duties involved. The Governor may also wish to consider adopting a mentoring scheme for new officers commencing night duty for the first time.**

#### **Staff response to finding the man hanging**

101. The officer checked the man at about 10.00pm after having radioed for assistance for the prisoner who had self harmed in a cell nearby. On looking through the observation panel of the man's cell, he discovered him hanging. The officer again radioed for urgent assistance before entering the man's cell using the cell key contained in his sealed pouch, shortly followed by other staff.
102. Upon discovering the man, staff acted quickly and efficiently in entering the cell, cutting him down, radioing for an ambulance and commencing resuscitation. Sadly the man was pronounced dead upon his arrival at hospital.

#### **Night nurses' access to keys**

103. A clinical reviewer noted that healthcare staff do not carry keys for the establishment at night, and in the event of an emergency must await the Night Orderly Officer who escorts them to the scene of the emergency. In the man's case, the orderly officer and nurse were already on their way to B wing to respond to an earlier code 2 alert made by the officer. I am satisfied that, in this case, there was no delay to the man receiving medical attention. I have previously recommended to the Governor that healthcare staff should be given emergency access keys during the night and so do not intend to repeat the recommendation here. I am aware that this matter is still under consideration.

### **Breaking the news of the man's death to his family**

104. The man's family were informed of his death by a governor, who visited the man's grandmother's address in South London at 4.00am on 9 January. The family felt that the prison should have contacted them sooner.
105. Prison Service Order (PSO) 2710 sets out the procedure for informing next of kin following a prisoner's death, and this has been adopted by Chelmsford. Following a death at the prison, the governing governor or deputy governor appoints an operational manager to act as the Family Liaison Officer and break the news of the death to family members. This can result in delays (particularly when the death occurs during the night) as the appointed manager will have to travel in to the prison, make sure they have as much information as possible about what has happened and then liaise with local police before travelling to the family member's home. Where the death has occurred during the night, the Family Liaison Officer will also consider whether it is appropriate to visit the family in the early hours of the morning when they may not have access to support.
106. Wherever possible, Chelmsford send the Family Liaison Officer and a member of the chaplaincy team to visit the next of kin's home to break the news in person, and this is considered to be good practice. However, it can, as illustrated above, lead to delays in the family being notified of the death. It is my view, therefore, that the five hour delay between the man being pronounced dead in hospital and the governor breaking the news to his family was not unreasonable.

### **Contacting the Independent Monitoring Board**

107. My investigators interviewed a member of the IMB and who was also the duty member for the night of the day of the man's death. PSO 2710 requires that the prison notify the IMB of a death in custody. The IMB member interviewed said that a colleague (not the duty member) was telephoned by the prison at about 10.00pm on the day of the man's death and was told that a prisoner was being resuscitated but that the IMB did not need to attend. The IMB member received another call at about 10.45pm to say that the prisoner was being transferred to the hospital. The prison did not make contact with the IMB to let them know that the man had subsequently died. In fact, the IMB only became aware of the man's death when another member arrived at the prison on the day following the day of the man's death and saw the notice to staff at the gatehouse. Subsequent investigation by the IMB revealed that there had been some confusion in the prison about whether the IMB had been contacted and which member should have been contacted.

**The Governor should remind staff that the IMB must be contacted when there is a death in custody.**

## RECOMMENDATIONS

1. The Governor should remind staff that any allegation of bullying must be properly recorded, in line with the violence reduction policy.

The Prison Service has accepted this recommendation.

2. The Governor should remind staff that those persons participating in an ACCT case review should, where possible, be present for the review. The paperwork should clearly reflect who is present at the review and who has been consulted or made a written contribution.

The Prison Service has accepted this recommendation.

3. The Governor should remind staff that ACCT reviews should take place as scheduled.

The Prison Service has accepted this recommendation.

4. The Governor should remind staff that where a prisoner on an ACCT form is to be relocated, a staff representative from the receiving wing is present for the ACCT review.

The Prison Service has accepted this recommendation.

5. The Head of Healthcare and the Governor should ensure that healthcare staff provide a written summary of care when any prisoner is being transferred from healthcare to the wings. A discharge care plan should also be drawn up, in line with the In Patient Discharge Policy.

This recommendation has been accepted.

6. The Governor should ensure that staff undertaking night duties receive appropriate training covering the specific responsibilities and duties involved. The Governor may also wish to consider adopting a mentoring scheme for new officers commencing night duty for the first time.

The Prison Service has not yet responded to this recommendation.

7. The Governor should remind staff that the IMB must be contacted when there is a death in custody.

The Prison Service has accepted this recommendation.