

**Investigation into the circumstances surrounding the
death of a man, a prisoner at
HMP Chelmsford in February 2008**

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

January 2010

This is a report into the circumstances surrounding the death of a man at HMP Chelmsford in February 2008. He was just 18 years old when he was found hanging in his cell early that morning. My investigators and I offer our sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of Chelmsford for making the necessary facilities and information available to my investigators, and for the assistance of his 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 the clinical reviewer, an independent mental health consultant, who provided a mental health review, and to the second clinical reviewer, of the local Primary Care Trust (PCT), who provided a general clinical review.

The man was a young foreign national prisoner, originally from Sri Lanka. He had suffered from serious mental health problems for most of his short life. He had been a 'looked-after child' in the care of the local authority, supervised by child and adolescent mental health services. His serious mental health problems continued into adulthood and, before coming into custody, he was detained in a secure psychiatric hospital under the Mental Health Act 1983.

Since I took over responsibility in April 2004 for investigating all deaths in prisons, there have been nine apparent self-inflicted deaths at Chelmsford. There was one apparently self-inflicted death at the prison during each of the months between November 2007 and March 2008.

Following my investigation of an apparent self-inflicted death on 4 May 2007, I recommended that the PCT review the role of the mental health team in HMP Chelmsford. This recommendation was accepted at draft stage of my report and the PCT said they had completed a review. I was concerned to learn that the review had not in fact been fully completed and that the initial phase of the service redesign project was not due to commence until December 2009. This is more than two years since the review was first started. However, I am pleased to record that the PCT has made some progress with their review of the mental health service at Chelmsford, and I describe this in more detail in this report.

I recognise that the man was unwilling to engage with the mental health team at Chelmsford. However, the mental health professionals had the option to adopt a more proactive approach to treating him. His history of serious mental disorder and compulsory treatment should have alerted the prison's mental health team, prompting a far more assertive response to the man's mental healthcare whilst in custody. As the clinical reviewer says, the man came into many of the groups who are at higher risk of suicide. I am concerned that Chelmsford did not recognise these risks.

I must apologise for the delay in issuing this report. This was due to staff sickness in both my team and the PCT team who provided the clinical review. There was additional delay obtaining the mental healthcare review from the PCT. These delays did not prevent my feedback to HMP Chelmsford.

I am very pleased that the Governor has introduced a number of new initiatives over the last year in response to my recommendations from other investigations of apparent self-inflicted deaths at Chelmsford. They focus on a number of areas, including early identification of prisoners with mental health difficulties and at risk of self harm and suicide, and the introduction of effective systems to manage violence reduction and bullying problems.

This report makes eight recommendations which take into account the clinical review recommendations. I am pleased to see that all the recommendations have been accepted.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2010

CONTENTS

Summary

The investigation process

HMP Chelmsford

The man's earlier years before custody

The man's time at HMP & YOI Chelmsford

The events following the man's death

Issues considered

- Mental health care
- Mental health services and risk management
- Care Programme Approach
- PCT/Prison Partnership review of mental health services
- Prevention of suicide and self harm
- Violence reduction and anti-bullying
- Assault by another prisoner
- Foreign national and young prisoners
- Access to prisoners during night period
- First on the scene and emergency response

Conclusions

Recommendations

SUMMARY

The man was a young foreign national prisoner, originally from Sri Lanka, who had spent most of his short life in England. He communicated well in English. He had been remanded into custody pending trial to face a charge involving a sexual offence. He had been in custody before as a juvenile, in secure children's accommodation, and briefly on remand at HMYOI Feltham.

He had a long history of mental health problems which started in childhood. He was diagnosed with bi-polar affective disorder (a serious mental disorder), and as a child was under the care of the local child and adolescent mental health service (CAMHS). As a young adult, he came under the care of the local adult mental health services.

When the man arrived at Chelmsford on 3 December 2007 he was well known to community mental health services and psychiatric hospitals. He had recently been discharged from a secure psychiatric hospital where he had been detained under Section 2 (an order for assessment (or assessment followed by treatment)) of the Mental Health Act 1983.

He was a vulnerable young man and there were numerous problems with other prisoners and frequent breaches of prison rules. He spent most of his time at Chelmsford being closely monitored under anti-bullying and violence reduction measures, and was subject to the Incentives and Earned Privileges (IEP) basic regime. He was both identified as a perpetrator and a victim of bullying at Chelmsford.

The man did not cope well in custody at all. He struggled to develop mature and positive relationships with other prisoners and staff. Unfortunately, the relationships with other prisoners deteriorated considerably in the short time he was at Chelmsford.

Shortly before his death, he was again in trouble, this time for going into other prisoners' cells. He was assaulted by another prisoner the day before he died. A prisoner punched him three times, knocking him to the floor in the showers, and then kicked him. It appears that he was not badly hurt because he immediately got up and left the showers. He did not report the incident which was only discovered following a security information report submitted after his death. Following an initial investigation, the perpetrator told staff that he had assaulted the man because he had told him that he had stolen from his cell. This incident was subsequently subject to both a police and prison investigation. (There is, however, no evidence to suggest that the assault was directly linked to his death.)

In February 2008 at 5.06am, the man was found hanging in his cell on C wing by an Operational Support Grade. She called for assistance over her radio and two officers quickly arrived. Prison policy and operational procedure requires sufficient prison officer supervision, usually three officers, to unlock a cell during the night period. The officers went into the cell, cut the ligature from around his neck and the window bars and lowered him to the floor. The

officers immediately began resuscitation. When the nurse arrived a few minutes later, she found that he was not breathing and there was no pulse. She took charge of the resuscitation attempt, assisted by the officers, and continued to administer oxygen and cardiac massage until paramedics arrived at 5.14am. The paramedics took over but pronounced him dead at 5.20am.

My investigators spoke to a number of staff and prisoners who expressed their shock that the man had apparently taken his own life. He had recently completed his preventative hepatitis B vaccination course and, the night before he died, had talked to his girlfriend on the telephone.

I include one recommendation for the Governor, which seeks to improve risk assessment processes for those prisoners who suffer from mental disorder and who may be a risk to themselves or to others:

I also include one recommendation for the PCT responsible for commissioning mental health services to secure much needed improvements to mental health provision at Chelmsford.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 13 February 2008. The case was allocated to one of my investigators on the same day. The investigation was formally opened on 15 February 2008 when another of my investigators went to Chelmsford. A residential operational manager acting as liaison officer at Chelmsford collated all the relevant documentation for my investigators.
2. Notices announcing the investigation to staff and prisoners were displayed on 21 February. The notices included an invitation to those staff and prisoners who wished to contribute to the investigation to make themselves known to my investigators. The investigator informed the duty governor, a residential operational manager, that she was the senior investigator.
3. The investigator visited Chelmsford on 26 February and collected the man's custodial and clinical records and other relevant documents from the liaison officer. They organised the interviews and met the Governor and other interested parties. Prison staff informed her that the man's funeral had taken place a few days earlier and around 1,000 people had attended.
4. Unfortunately, the investigator went on sick leave soon after the start of my investigation so I asked another investigator to take over the investigation. I informed Chelmsford of the new arrangements and my investigators carried out interviews to progress the investigation. Another of my investigators was later assigned to follow up my enquiries and draft the investigation report.
5. Prison officers and healthcare staff were interviewed by my investigators. They also talked to a number of prisoners and staff, and met the Chair of the Independent Monitoring Board. My investigators visited Chelmsford on a number of occasions to familiarise themselves with the establishment and to conduct the interviews.
6. As a part of my investigation, I asked the local Primary Care Trust to commission a clinical review of the quality of the man's mental health and general clinical care in custody. Although I must acknowledge that a major delay in issuing my report was caused by sickness in the PPO office, this was compounded by difficulties on the part of the PCT making arrangements for a mental health review of his care.
7. I judged it necessary therefore to ask the PCT to commission a review that took into account the crucial mental health component of the circumstances surrounding the man's death. The PCT commissioned a mental health consultant with suitable mental health expertise to undertake this additional review in May and June 2009.

8. The process the mental health reviewer followed to assess the man's mental health care was to review his clinical record and visit Chelmsford to talk to the healthcare team. He adopted a root cause analysis approach. This involved a comprehensive review of the mental health issues and an evaluation of the overall mental health care measured against the national standards contained within the National Service Framework for Mental Health and professional standards set out by the Nursing & Midwifery Council (NMC).
9. Meanwhile, the investigator wrote to Her Majesty's Coroner for Essex and Thurrock in May 2009 to provide an update on the investigation. Upon completion, this report will be sent to the Coroner to assist her enquiries into the man's death.
10. My former senior family liaison officer contacted the man's family to explain the investigation process and offer an opportunity for the family to be involved.
11. She contacted the man's mother and also met his two uncles. The uncles raised a number of issues which this report aims to address as fully as possible. Their questions concerned the following:
 - The safety of his cell
 - The level of observations maintained on prisoners generally
 - Bullying problems
 - His mental health problems and how mental healthcare was provided for him in prison
 - The "timings" of when he was found. Specifically, the reason why he was checked by night staff earlier than expected
 - Whether or not he was alone in his cell the night before he died.

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 are young offenders between the ages of 18 and 20 years.
13. The accommodation is divided between the original Victorian wings and newly built residential units. Two new house blocks were opened in 1996 and G wing in 2007. As with most local prisons, there are constant population pressures and Chelmsford is one of the most overcrowded jails in England and Wales. Chelmsford's certified normal accommodation (CNA) is 554 with an operational capacity of 695. There have been approximately 9,000 movements out of Chelmsford and 9,000 into the prison every year in the last few years. Many of these movements include prisoners attending and returning from court, but some 2,000 new prisoners are received each year.

HM Chief Inspector of Prisons' inspection 2007

14. HM Chief Inspector of Prisons last inspected Chelmsford in July 2007. In her report she commented:

"A high percentage – around 40% - of prisoners at Chelmsford said that they felt unsafe at the time of the inspection.

"There were deficiencies, some serious, in suicide and self-harm prevention arrangements and access to Listener peer supporters.

"Significant numbers of both adults and young adults surveyed reported that they currently felt unsafe. Bullying was a particular problem on C wing, with its preponderance of young adults, and young adults also reported that their property was frequently stolen."

Mental healthcare

15. Proper mental healthcare provision is crucial to ensure prisoners receive care and attention to meet their mental health needs whilst in custody. Prisoners suffering from mental health problems are a particularly vulnerable group and may present serious risks to themselves and others. Chelmsford's mental healthcare provision, at the time of this investigation, included a primary care mental health service provided by the Governor and a mental health day care service provided by the NHS. In his report, the mental health reviewer considers mental healthcare provision at Chelmsford to be wholly inadequate.

16. In her inspection report on Chelmsford, she wrote:

“A good daycare programme was available for prisoners with mild to moderate health problems, but the mental health in-reach team did not work with the psychiatrists, and prisoners with severe mental illness were cared for by the primary care team and did not have integrated, multidisciplinary treatment.

“There had been long delays in the transfer of some severely mentally ill patients to external specialist facilities. 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 daycare. The use of strip clothing and CCTV to monitor patients at risk of self-harm was of particular concern.”

17. Separately, the Chief Inspector published a thematic review ‘The mental health of prisoners – a thematic review of the care and support of prisoners with mental health needs’ in October 2007. In the introduction to her review, she commented:

“There is a particularly urgent need for increased provision for the care of those with mental health problems, who make up a larger proportion of the prison population than they would of any other group in the community. What is more, prison can exacerbate mental health problems, which has a long-term impact on the individual concerned and the community into which he or she may be released.”

18. Included in the section ‘Diversity of mental health need’, the Chief Inspector wrote:

“Our research and the statistics on self-inflicted deaths suggest that foreign nationals may be becoming increasingly emotionally and mentally vulnerable. In practice, healthcare staff were finding considerable needs which they were unable to meet.

“The provision of both primary and secondary mental health services should be assessed for their impact on different ethnic groups and nationalities to inform the development of more culturally sensitive services.”

The Independent Monitoring Board (IMB) Annual Report 2007/08

19. The Prisons Act 1952 requires every prison to be monitored by an Independent Monitoring Board appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The Board must satisfy itself as to the humane and just treatment of those held in custody.

20. The Chelmsford Independent Monitoring Board's most recent annual report was published in August 2008. The summary says:

"There were six Deaths in Custody, (October, November, December 2007 and in January, February, March 2008), one of which was through natural causes; the others are awaiting Coroners' inquests. The Board recognises the Governor's proactive attitude after the first death in custody in calling in the national review body to assess the prison's safer custody processes. The resulting report commended the prison on its safer custody workings. The Board will continue to monitor safer custody arrangements closely."

21. Under the heading 'Issues requiring a response' the report includes:

"Prisoners with Mental Health problems are consigned to prison where the environment itself can exacerbate their mental health problems, rather than being cared for in a secure mental health institution. This has not improved - when will HMG acknowledge that Mental Health patients should not be housed in prison?"

22. Under the heading 'Areas of recognition' the report comments positively that:

"There has been significantly improved work with Foreign Nationals and Diversity and the way in which prison managers have dealt with the challenges of a number of Deaths in Custody."

23. Under the heading 'Safer custody' the IMB report says:

"Six deaths in custody occurred during this reporting year, in October, November and December 2007 and January, February and March 2008. In the first of these the Coroner's verdict was one of natural causes and the prison was praised by the Coroner for the level of care provided during the prisoner's preceding illness. The remaining five deaths appear self inflicted by ligature, though inquests have yet to be held. The prison has no indication of dates for these outstanding inquests, though reports by the Ombudsman on two deaths have been received. The Board is concerned over the delays in holding inquests and the delays in producing Ombudsman reports as this can delay the resolution of issues and cause unnecessary distress to families and to the staff involved.

"In addition to individual local investigations, this 'cluster' of deaths has been the subject of close scrutiny. The method of self harm appears the only common denominator. This was confirmed by the Safer Custody Group at both Area and National levels following their visits to review the incidents and

the processes in place and to provide support to staff. Clearly this was a difficult time for the prison, in particular for the staff directly involved and the Safer Custody Team.

“It is to the credit of all involved that events have been dealt with in a professional and sensitive manner ensuring that there was no adverse effect upon services provided by the Team to successive deaths. The Board has remained closely involved throughout and remains impressed with the quality of support provided for both prisoners and staff.

“The role of the Violence Reduction Officer has been significantly developed to include input into the monitoring of use of force and interviewing both staff and prisoners following incidents within a new anti bullying framework, designated Safe and Fearfree Environment (SAFE).”

24. Under the heading ‘Healthcare and mental health’ the report comments:

“The support of prisoners with mental health problems has long been a concern and the prison has recognised the need for modernising and implementing mental health services. The process for agreeing a new mental health care pathway has been a difficult process, taking considerable time, but is now getting towards the much needed practical implementation stage. In the past the service has been fragmented with staff skills and expertise not being used to the best effect. It is very pleasing to report the improved communication between the Mid Essex Primary Care Trust, North Essex Partnership NHS Foundation Trust and Psychiatrists with weekly multidisciplinary meetings. This is greatly improving staff relationships and prisoner referrals to appropriate services.

“In general, prisoners have good access to health care and mental health services from reception through to arrangements on release/transfer with no significant waiting times. However, it remains the view of the Board that the prison is no place to house prisoners with mental health issues.”

25. Under the heading ‘Diversity and foreign nationals’ the IMB report says:

“Fortnightly surgeries take place with a member of Criminal Casework Directorate who meets with prisoners on the wings. The Board continue to receive a number of complaints about the length of time taken to process the deportation of prisoners following the completion of their sentences.

“The Board finds that prisoners appreciate these surgeries, however complaints have been made that there is insufficient access to foreign language facilities. Wing staff are being trained in the processes of working with foreign nationals and the Board hopes that this first line of communication is given the importance it requires through ongoing training.”

Other deaths at Chelmsford

26. The number of apparent suicides at Chelmsford was raised in the House of Commons on 25 March 2008 by a Member of Parliament for West Chelmsford. He said the “most worrying problem at Chelmsford that had emerged was the number of suicides in the prison” and that there has been a “deeply disturbing increase”. He asked the then Parliamentary Under-Secretary of State for Justice, why there had been such a “dramatic and tragic increase in the number of suicides in the prison compared with the prison’s previous record”. She responded, “We are determined that, as we follow the processes, the correct lessons will be learned, and the correct actions taken. I can report that there has been progress”.
27. Following the apparently self-inflicted death of a prisoner at Chelmsford in January 2008, my investigation found that there had been a renewed focus on prison health from the local PCT but progress had been slow. I recommended that the PCT review the role of the mental health team in HMP Chelmsford. This recommendation was accepted at the draft stage of my investigation report when they reported that they had completed the review.
28. My investigator was subsequently informed that a review and service redesign of mental health services at Chelmsford had been approved by NHS Mid Essex/HMP Chelmsford Partnership Board in November 2008. However, nearly a year later, phase 1 of the implementation of the new service is still not due to commence until December 2009.
29. I acknowledge the consultation and planning work which has already been completed to lay the foundations for a redesign of the mental health service. I am concerned, however, at the length of time this review has taken without any tangible benefits yet to be realised for prisoners with mental health difficulties.

THE MAN'S EARLIER YEARS BEFORE CUSTODY

30. The man and his mother came to the United Kingdom when he was eight years old. His mother told my investigators that they left Sri Lanka because of the war and claimed asylum in this country. She already had family members living in the UK including her brothers. At first, they went to live with his maternal uncle but the man did not integrate well with his extended family. Problems were also reported about his behaviour at school.
31. When the man was 12 he began to attend college. As a consequence of behavioural problems, he was referred by his Head of Year to the Child & Family Consultation Services and Social Services. He was reported to be "exhibiting attention seeking behaviour which included obscene comments to other children and touching girls inappropriately". The school reported that his behaviour was "uncontrollable and that the other students were alarmed by the level of his uncontrolled comments and erratic behaviour".
32. The man was also reported to be "... exhibiting repetitive compulsive behaviour such as drumming his hands or tuneless humming during lessons". Eventually, he was excluded from college and went to a Tuition Centre.
33. Social Services were involved with the man's care from 2003 and worked with him and his family to help them with "... parenting, communication and interaction difficulties". Some improvement in these areas was noted, although progress was reported as very slow.
34. He was well known to local child and adolescent mental health services. He was involved with mental health and local authority services on various levels from the age of 11 upwards. He attended anger management classes and received support from the local authority's family services for a number of years.
35. The man left school at 16 years old without any qualifications. To his credit he went on to college to study for a diploma in information technology. He had a girlfriend at this time and would spend his time with her. As a teenager, he enjoyed playing on his PlayStation, watching DVDs and going to the gym.
36. In 2005, he was placed with foster parents. He was reported to be frequently agitated and aggressive. He had several arguments with neighbours and the police had to be called. Despite these problems, the foster placement was reasonably successful and he stayed there until he was 18 years old. He clearly thought a great deal of his foster parents as he maintained contact with them once he had left their home and would telephone them from time to time.

37. The man again came to the attention of Social Services in early 2005. He received a nine month referral order for criminal damage after deliberately damaging his uncle's car. He also accused a local fast food takeaway of "... putting crack cocaine in his meal", which he said was the cause of his behaviour problems.
38. He assaulted his uncle around the same time and was arrested and charged with assault. He was noted to be exhibiting "... paranoid behaviour" during this time, which led to a mental health assessment. The approved social worker recommended that he needed admission to hospital for assessment under Section 2 of the Mental Health Act 1983.
39. A second medical recommendation was sought to expedite formal admission to hospital under Section 2 of the Mental Health Act 1983. However, the doctor, a forensic medical examiner, did not agree that detention to hospital was needed.
40. When the man's case came to court, the Youth Court ordered that a mental health assessment be carried out. He was remanded to a Secure Training Centre to enable a mental health assessment. However, there was no space there and so he was remanded to HMP & YOI Feltham.
41. Regrettably, the mental health assessment was not completed within the timescale specified by the court. When the man returned to court his uncle did not attend to give evidence for the assault and damage to his car and the case was dismissed. Other family members were present in court. They told the court that they could not cope with his behaviour if he was to return to live with either his mother or with other family members.
42. The Youth Court remanded him to local authority care and referred him to Social Services. He was subsequently placed in specialist accommodation.
43. The placement went relatively well until August 2005 when the man became argumentative, disruptive and verbally abusive towards other people in the accommodation. At one point he removed a belt from his bag and threatened to hit a female member of staff with it. The police were called and the incident led to his tenancy being terminated.
44. As a result of the problems in the specialist accommodation, the Social Services emergency duty team were involved and had to put him in bed and breakfast accommodation for the night. The next morning he left and could not be found for several weeks until he eventually telephoned his social worker.

45. The man said he had been staying with friends but would not say who they were or where they lived. He was placed in accommodation by a provider of semi-independent living. Unfortunately, problems soon arose between him and the other residents and he was asked to leave. He was angry and aggressive towards the staff when they asked him to leave.
46. Because of his aggressive behaviour, the police had to be called. When the police arrived he resisted and assaulted a police officer. He was arrested and taken to the police station for a Mental Health Act assessment. The mental health assessment considered that there were insufficient grounds for admission to hospital for assessment under Section 2 of the Mental Health Act 1983 because they felt he was "... not showing any acute psychotic symptoms".
47. Following that incident the man was admitted to the psychiatric intensive care unit for Adolescent Mental Health under Section 2 of the Mental Health Act 1983 on 27 June 2006. He was accompanied by police officers and an approved social worker.
48. The man's behaviour was increasingly disturbed, with "... further reports of his bizarre behaviour". He telephoned the police claiming to have been the victim of a robbery and a stabbing. He claimed to have murdered three people and to have stabbed someone with a sword.
49. He was aggressive and verbally abusive. He was described as hyperactive with grandiose ideas about his family wealth, telling medical staff that his father owned seven petrol filling stations. There was also evidence of paranoid thoughts. He was on bail at that time until he was due to appear in court on 2 August for assaulting a police officer.
50. During his stay at the psychiatric intensive care unit, he enjoyed sports and games with staff. He played football, long tennis and badminton and also enjoyed drawing and painting. Staff described him as a well dressed young man who was interested in his own appearance and took care of his own self care needs without any prompting.
51. The report, dated 3 July 2006, from the man's primary nurse for his Mental Health Review Tribunal, listed the risks that he presented at that time:
 - sexually inappropriate behaviour
 - 'absconson' and not engaging with services
 - poor compliance with medication
 - aggression and violent behaviour and use of offensive weapons
 - antisocial behaviour
 - poor sleep pattern.

52. The man's mental illness was treated with a number of medications whilst he was at the psychiatric intensive care unit:

- Olanzapine tab 10mg at night (for mental disorder associated with schizophrenia).
- Sodium valproate 400mg twice a day (for mental disorder associated with behavioural problems).
- Diazepam 10mg three times a day (for anxiety and agitation).
- Haloperidol 5mg as required (for agitation and violent behavioural disturbances associated with mental disorder given on an as required basis).
- Lorazepam 2mg as required (as above and used in conjunction with the Haloperidol when a patient becomes acutely disturbed and/or violent).
- Procyclidine 5mg (to reduce the side effects of other medication for mental disorder).

53. The man complied well with his medication. He complained that he disliked the taste of Olanzapine velotab (a tablet form of Olanzapine that melts on the tongue), and was given the regular tablet formulation instead. Medical and nursing staff continued to be concerned about him. The nursing report recommended:

"Based on the given circumstances in this report, he appears vulnerable for a psychiatric illness due to risk factors in the form of family history of mental illness, substance misuse and conduct disorder and that he would benefit from ongoing monitoring of his mental state in a safe environment. I feel this should be dealt with in hospital and be monitored for stability in his mental state.

"There also have been concerns in the past about his lack of engagement and motivation hence he needs to be supported and given ways of engaging with and networking into appropriate social, educational, employment and other significant therapeutic supports.

"His admission to hospital will help him deal with any identified problems he might have and provide him with relevant interventions needed to help him resume life. According to relevant information gathered from his previous comprehensive reports, it was evident that some mental assessments carried out in the past before coming to the PICU [psychiatric intensive care unit] entailed inconclusive outcome and most importantly there was no substantial detailed evidence of any form of medical interventions incorporated in his care package. Once again in my professional opinion I recommend that he remains in hospital environment under compulsory detention for proper assessments and provided with quality care."

54. After his 18th birthday in 2007, the man was discharged from local authority care. Because he had been in foster care he was subject to social services 'leaving care' arrangements. He was housed at an independent adult mental health supported accommodation facility.
55. After he had been there for two months, the care team decided it was not an appropriate place for him. Staff reported that he could not get along with the other residents and there were concerns that he did not cooperate and take the medication for his mental health problems.
56. Later that summer, the man was assessed by a Section 12 approved doctor (a doctor with special training and experience in assessment and treatment of mental disorder) and an approved social worker from for admission to hospital under Section 2 of the Mental Health Act 1983. They assessed that he was unwell and needed admission to psychiatric hospital. The plan was to admit him to a psychiatric hospital. There were no beds available and so they arranged for him to move elsewhere.
57. Unfortunately, as soon as the man arrived he ran away to the home of his foster parents. Whilst there he got into a fight with another teenager and the police were called. The police took him to hospital under Section 136 of the Mental Health Act 1983 (an Order for taking a person who appears to be mentally disordered to a place of safety). He was assessed by a psychiatrist, placed under Section 2 of the Mental Health Act 1983, and transferred to a psychiatric hospital.
58. A Senior House Officer to the Consultant Psychiatrist at the psychiatric hospital, wrote in her discharge report on 16 July 2007:

"Current social situation: The man is not welcome back at accommodation so will need some form of housing to be provided for him.

"Mental state on admission: at the time of his admission he was agitated, pacing up and down and holding a metal bracelet as a weapon. His speech was increased in rate and volume. He was rhyming and singing.

"In his mood he appeared agitated and aggressive. His thoughts were all grandiose. He believed he could jump through the window. He reported that he owned four high powered motorbikes and many high performance cars.

"In perception he denied any auditory or visual hallucinations and did not appear to be responding to any either. Cognition was intact and he was well oriented in time, place and person. He had very poor insight. He said that he does not believe he has bipolar affective disorder and that he was unwilling to stay in hospital and take medication.

“When initially admitted to the ward he was quite restless and agitated, pacing up and down the corridors. He was given 5mgs of Haloperidol and 2mgs of Lorazepam orally with good effect but for the next few days he appeared restless, was suffering from very poor sleep and needed very firm boundaries to be set.

“We restarted his regular medication of Olanzapine 15mgs at night and Sodium Valproate 500mgs BD (twice daily) and since then he has calmed down a lot, is now much more compliant and presents fewer management problems on the wards.”

59. A warrant was issued by the Youth Court on 1 December 2007 for a sexual offence allegedly committed on 26 November 2007. The man was arrested and taken into custody.
60. The following day (2 December), he was examined by a forensic medical examiner in police custody. He was considered fit to be detained. The doctor noted that he was asthmatic and needed some medicine for his sore throat. Arrangements were made to take him to HMP & YOI Chelmsford.
61. This was the man's first period in custody as an adult, albeit he had briefly been in custody before as a juvenile at HMYOI Feltham. When he arrived at Chelmsford his history of being registered on the Care Programme Approach was not identified by healthcare staff during the reception process. Only scant reference was made to his psychiatric history with inadequate assessment of his mental health by the reception nurse. His asthma and flu symptoms were however noted.

THE MAN'S TIME AT HMP & YOI CHELMSFORD

62. The man arrived at Chelmsford on 3 December 2007. Officer A, a prison officer working in reception, completed the initial reception admission process. Nurse A completed the reception healthscreen F2169A. She considered him to be of "low risk" and wrote in the clinical record "... insufficient evidence to give opinion ticked. States has a mental illness, no acute symptoms noted".
63. The nurse noted that "... medical/psychiatric report not required" and that "... health information not received from outside source". The man told her that he had not seen a doctor in the last few months but acknowledged he had a psychiatric history and had last taken Sodium Valproate seven days ago. He told her that he suffered from "bipolar and takes Sodium Valproate but not Olanzapine as it made him tired and did not want to take any medication".
64. The man denied any feelings of self harm in response to routine questions in the reception healthscreen. The nurse referred him to the prison doctor for further medical assessment, although the reception screen document did not indicate this. She also identified that he was fit for ordinary location, which meant he was able to go to work and be located in any type of cell. She wrote an entry in his clinical record on 3 December that he should "... see the doctor the next day but that he was also in court the next day".
65. He was allocated to E wing. The F2052A wing file, which contains the history sheets for each prisoner, was opened. His wing file noted him as 'high risk'. Staff issued him with a smoker's pack and the foreign nationals in prison information pack (FNIP).
66. The man appeared at Magistrates Court on 4 December. His prisoner escort record (PER) listed the risk categories he presented as: "... violence and sex offence, medical conditions also indicated but nature not listed".
67. Following his court appearance, the following day (5 December) he spent a night at Rayleigh police station before being returned to Chelmsford E wing. The same risk indicators were noted on his prisoner escort record. He had not yet seen the prison doctor at this point.
68. In fact, he was seen by Prison Doctor A the next day (6 December) and complained of cold symptoms. The doctor examined him and prescribed cream for a mild infection of his cracked lips. He told the doctor that he had not taken Sodium Valproate on a regular basis for perhaps a year. He complained to him that he got hyperactive and that was why he was bi-polar. He also told the doctor that he did not want any medication or any further mental health assessment. Later

that day he was given his first Hepatitis B vaccination with his next vaccination due in six days time.

69. Nurse B, nurse in charge of the prison's mental health team, received a fax from the Mental Health Trust on 7 December. The fax contained information about the man's psychiatric history in the form of Nursing Report for Mental Health Tribunal (3 July 2006) from when he was an inpatient in the Centre for Adolescent Mental Health, and a Discharge Summary (16 July 2007) from when he was discharged from the psychiatric hospital. On both hospital admissions he was detained under the Mental Health Act 1983.
70. On receiving this information, Nurse B promptly briefed Senior Officer (SO) A, who was working on C wing. The nurse told my investigators that she telephoned the wing immediately to inform staff that the man suffered from mental health problems and that an appointment had been made for him to see the psychiatrist.
71. He refused to see the psychiatrist on that occasion so Nurse B sent a mental health nurse to see him on the wing. The mental health nurse saw him and reported back to the nurse that he was alright and did not feel ill. He had told the nurse that he had a "good insight" and if he became unwell would let staff know.
72. Nurse B told my investigator:

"Some people have episodes where they are unwell but they can become reasonably well and he was a young person ... I hadn't had any concerns raised by the wing staff. Had there been any concerns they would have opened up an ACCT, which would have raised an alarm. We would have admitted him into healthcare, you know there are lots of things we could have done but there were no signs or symptoms of anything being wrong at that time."
73. SO A briefed her staff team that the man had "... serious mental health difficulties" and that he presented with "... inappropriate sexual behaviour and violent behaviour" and she made the appropriate entry in the wing file. Staff were instructed "... to contact the mental health team if he presented with any of these behaviours".
74. Nurse B put the man on the list to see the consultant psychiatrist. Later that night (7 December), Operational Support Grade (OSG) A recorded an entry in the wing file that he was

"... making strange noises throughout the night and is tapping on his cell door for over an hour despite being told to stop."
75. SO A told my investigators:

“Nurse B always has interaction with me if they get anything in late. We do like it when they first come, there are usually warnings when the prisoners first come in because it’s the first night in prison centre as well and we need to be aware. But I can vaguely remember her getting in touch with me and making me aware that there could be issues with his mental health so that I could then make my staff aware and manage him appropriately.

“I’d also make the staff aware on staff briefings the fact that, so my staff are aware that he could display this behaviour and they needed to act accordingly so that they’ve got the knowledge and information to deal with him accordingly, rather than go overboard and the interaction then could escalate into violence and this is what we don’t want.”

76. On 8 December, the SO made an entry in the wing file asking staff to record their observations on a daily and nightly basis outlining the man’s behaviour on “... association, during exercise periods and time in his cell”. The SO noted in the wing file that the man had interacted well on association, had collected his tea meal and was polite towards others that day.
77. The SO completed a cell sharing risk minimisation plan for the man which recorded that he needed single cell location due to his “... mental health issues”. This was approved by the Governor the same day with a review date in three months time. The risk indicators of antisocial behaviour, drugs and alcohol abuse, and healthcare information were recorded in the risk assessment.
78. The SO told my investigators:

“Because of the information I’d received from Nurse B, most prisoners will go into shared accommodation but because he’d got mental health and inappropriate behaviour it would be unfair to put somebody else in there that could be offended by it. Which then could mean we’d have a fight, bullying or so forth and his behaviour, it’s not fair on him either having to share with somebody that doesn’t understand his behaviour and I felt that it was better for him and his safety to be in a cell on his own rather than sharing with somebody that may not accept his behaviour.”
79. The man was observed that night by staff as instructed by SO A. OSG A reported that there were “... no concerns” throughout the night.
80. The Security Department decided to withhold the man’s PIN (personal identification number) for the prison telephones on security grounds to prevent any harassment. He asked a number of times about his PIN but was told to ask the staff again the following day.

81. OSG A reported the following morning that there had been no concerns about him that night (9 December).
82. Wing staff noted on 10 December that the man was "... polite as he collected his lunch and there were no concerns". Nurse B informed wing staff that he should be considered to be "... high risk due to his mental health problems". Again, no concerns were reported by staff that night.
83. The man was given his second Hepatitis B vaccination on 12 December. His next and final vaccination was due in two weeks time on 25 December. He was moved to B wing later that day.
84. He was scheduled to be seen by a visiting consultant psychiatrist two days later on 14 December. An unsigned entry made in the clinical record noted "... informed that the man did not wish to see a psychiatrist and left the healthcare centre before the appointment". On 24 December, an entry in the clinical record again notes that he "Did not attend the psychiatrist's clinic".
85. Two days later, on 26 December, he was given his third and final Hepatitis B vaccination.
86. The man again refused to see the psychiatrist at the clinic on 31 December. The visiting consultant psychiatrist noted in the clinical record that a mental health assessment should be carried out if possible.
87. On 2 January 2008, he appeared at Magistrates Court. His PER recorded risks indicated as "No medical condition, indicators for violence, conceals weapons, plus sex offence". He returned to Chelmsford later that day.
88. Two days later, on the afternoon of 4 January, the man told staff that he was being bullied and his canteen had been stolen. He complained that four prisoners were bullying him. A security information report (SIR) was submitted and the four prisoners were placed on stage 1 of the anti-bullying system operating at Chelmsford at that time. (Stage 1 was the first stage of the anti-bullying system where a suspected bully is monitored to identify any actual bullying behaviour.)
89. Nurse B remained concerned about him and asked a nurse from the mental health team to go and see him on B wing. Nurse C saw him on 5 January to undertake a mental health assessment. He told the nurse that he felt fine and she wrote in his clinical record:

"Denies any thoughts of self harm or delusional ideas; no grandiosity expressed; rational, alert, cooperative, good rapport;

states he stopped taking sodium valproate on 26 November 2007 and did not think that he would relapse; said he was settled and stable in his mental state for two years; declined to see the psychiatrist as he stated he was well; plan was for him to see the psychiatrist if his mental state worsened.”

90. The man told Nurse C that his community mental health team was aware of this assessment and he refused to see the psychiatrist. She felt there “... was no point as he is well at present, and will inform staff when he becomes unwell”.
91. The nurse wrote, “Plan – currently settled and stable in his mental state. To be seen by psychiatrist if mental state deteriorates.” (There were no further entries made in his clinical record for the next four weeks until 7 February.)
92. The man moved from B wing to C wing on 9 January 2008. His behaviour had deteriorated and he was given a ‘red entry’ (a red entry was a negative report about an individual’s behaviour) under the IEP scheme for being late back to his cell.
93. A week later, on 16 January, he was given a second red entry under IEP for being late back to his cell again. On 19 January, he was given a formal warning under IEP for the two red entries on his history sheet on 9 and 16 January.
94. The man’s personal officer conducted his weekly review on 22 January. He noted that the man “... attends workshop 2, is generally compliant but his behaviour can be a little odd at times. One to be kept an eye on”.
95. Officer B noted in the man’s history sheet on 24 January that he “... constantly had to be told to come off the phone when unlocked for kit change and evening meal”. He was given a third IEP red entry. Later that day, SO B reviewed the IEP warnings and placed him on basic regime.
96. A bullying incident form was completed the next day (25 January) and a security information report was submitted by SO C with an entry made in the wing file. The SO reported that “... while serving his afternoon meal an argument broke out between him and fellow prisoners”.
97. SO B told my investigators:

“He was caught coming out of a cell with possessions, canteen and other possessions belonging to two of the Chinese prisoners that were on the landing.

“My understanding from the staff was that the man had been seen by the two Chinese prisoners and they had challenged him over that.

“ ... and due to language problems it was more raised voices and the staff weren’t sure what the Chinese prisoners were saying to him. However, the situation escalated to the point where the Chinese prisoners wanted to fight with him to retrieve possessions that he had taken from their cell. Staff felt it best to press an alarm bell which they did and as a result of pressing the alarm bell, he was returned to his own cell, and the two Chinese prisoners were returned to their cell, and the remaining prisoners on the landing were placed behind their cell doors and the relevant paperwork was completed.”

98. Staff believed that the man had been seen by other prisoners going into the two men’s cell. He was put in his cell for “his own protection but as the meal progressed a number of other prisoners were seen to be attempting to intimidate him through his door”.
99. The following day (26 January), SO B opened an ‘anti-bullying booklet – stage 2 compact’ for him. The entry noted, “... this has caused wing to be unsettled and is bullying”. The anti-bullying booklet notes that he would not sign the compact and action plan.
100. The SO told my investigators:

“Due to the fact that the prisoners were uneasy on the wing with the man’s actions I advised the staff to keep him behind his cell door that morning until I had time to speak to him so I could challenge his negative behaviour and offer support and see how the wing was reacting.

“But the general feeling on the wing was that were we to let him out of his cell, whether that be for exercise or a shower or a phone call or to collect his lunch, his tea or anything, he could have been at risk from serious assaults from not only the people that he had stolen from but others because there was a lot of unrest on the wing, once the prisoners had discovered that ... there was a cell thief.”
101. The man was transferred to D wing later on 26 January following this incident. SO D, a residential senior officer, noted in his anti-bullying booklet, “no evidence of bullying as he was kept behind his door”.
102. Staff noted in the man’s wing file on 28 January, “returned from workshop 2 in the afternoon, not working and upsetting other prisoners, risk to his own safety”. Staff also noted in his anti-bullying booklet:

“A demanding individual who constantly shouts from behind the door to staff – I put this down to his obvious immaturity – no evidence of bullying ... remained behind door during association. Well behaved and quiet. Quiet when collecting meals.”

103. An SIR was submitted the following morning (29 January) which reported that, “The man made comments to two prisoners on exercise yard at 10.30am. They [the prisoners] tried to confront him at end [of exercise]”. The report commented that this was because “a score might be settled”.
104. That afternoon at 12.55pm, Officer C, a residential officer, spoke to the man and noted in his anti-bullying booklet “... asked a lot of questions but no problems or issues. Seems quiet on the wing and has kept himself to himself so far”. He went on exercise later that afternoon at 1.40pm and it was noted in the anti-bullying booklet at the end that he was “making comments to other prisoners intended to belittle them. Continues to be demanding, no evidence of bullying”.
105. The anti-bullying booklet daily supervision record noted that day on 30 January, he attended the Hindu service in the afternoon. That evening he collected his meal but had no association.
106. The daily supervision record noted on 1 February that there were:

“No concerns. Did not go to exercise despite being told to do so; polite when collected lunch.

“Collected dinner. Polite. Keeping head down and getting on with basic.”
107. At 10.45am on the morning of 2 February, the daily supervision record noted that the man “... had a shower and changed cells. Very compliant and polite”. Later that afternoon it was noted “no concerns, polite, while collecting tea”.
108. At 5.30pm the next day, the daily supervision record noted that he was “given time out of cell for domestics. Chatted to staff and others. Polite throughout. At 7.30pm ok in cell, said goodnight”.
109. The following day (4 February), the daily supervision record noted that the man “conformed with all instructions throughout the day”. He moved back to C wing the next day (5 February) to single cell C3 - 021. The daily supervision record noted at 8.15pm that he was “... behind his door for association. No problems to note”.
110. The daily supervision record noted on 6 February at 11.05am that the man:

“Stayed in his cell all morning. No problems to report. Came out of his cell for his half hour first thing. At 5.30pm went on a visit in afternoon. Collected evening meal, no problems to note. 8pm no association.”

111. No entries were made in the daily supervision record on 7 February. Later that day at 3.00pm, he was seen by Nurse C on C wing after wing staff reported to healthcare that he had fallen and suffered a nosebleed. When she saw him he told her that he had had a fall. She wrote in the clinical record:

“States he is fine, nose bleed noted, no swelling evident. States he had a fall in the shower but later said he had a fight with someone but declined to name the person. Already had paracetamol to relieve pain. No further treatment given. Advised to inform healthcare if situation deteriorates. Asked wing staff if F213 [injury to inmate report] is done. Has not been completed by staff. Informed to contact healthcare when completed.”

112. The daily supervision record noted at 12.20pm on 8 February that he “... came out for domestic period, stayed in cell declined exercise. No problems”. At 7.45pm “... stayed behind door this afternoon. Collected dinner. Not a control problem”.
113. The daily supervision record on 9 February reflected the 14 day anti-bullying review. Present were SO B, Officer C and the man himself. They decided to continue with the same plan.
114. The next day (10 February) at 10.25am, the daily supervision record noted that he had come out for exercise, come back and went straight behind his door. At 2.45pm, “... came out for half hour (to wash and clean his cell). No problems”.
115. Just after 5.00am on the morning of 12 February, OSG B called over her radio to Oscar 1, SO E, who was the orderly officer in charge of the prison that night. (Oscar 1 and 2 refer to call-signs for staff radio communications.) Officer B recalled in interview:

“I was Oscar 2 who shadows Oscar 1 on duty that night. I was in reception with Officer D (Oscar 3) when I heard OSG B calling over her radio for Oscar 1’s assistance. I could tell that how she was speaking something quite serious must have happened. So, we made our way straight up to the Gate to get our keys and then went straight over to C wing.”

116. OSG B was outside the cells on the third landing of C wing when both officers arrived a couple of minutes later. Officer B described her as in a distressed state.

117. The OSG pointed to a cell on C3 landing and told Officer B that she thought she had just seen “someone hanging” and asked the officer to check the cell. He undid the cell door hatch and looked through but could see both prisoners in bed. He suggested to her that they “must be messing around with her”. She said that she had “definitely seen something” and this time pointed to the cell next door.
118. It is clear that the OSG had initially indicated the wrong cell. Officer B told my investigators:
- “She appeared to be panicking, she was shocked. She was in shock and she was very scared.
- “The shock had hit her big time, she was flapping and she was in shock.”
119. It would seem that the OSG had checked the prisoners who were subject to ACCT (Assessment, Care in Custody and Teamwork, which is the Prison Service policy and procedure to identify, assess and support those prisoners at risk of self harm and suicide) and also decided to check prisoners in the adjacent cells. When she checked C3-21 she saw someone hanging from the cell window bars. She called for assistance and opened her pouch to retrieve her fish knife (a small sharpened implement carried by frontline staff to cut a ligature).
120. The OSG’s incident report failed to mention her initial confusion about the cell where she thought that she first saw him. (My investigators were unable to interview her because she has left the Prison Service and indeed has since left the UK.)
121. After a few minutes Oscar 2 (Officer B) and Oscar 3 (Officer D) arrived at the man’s cell. Officer B undid the observation hatch of cell C3-21 and looked into the cell. The officer later said:
- “I didn’t turn the light on immediately. I don’t know why I didn’t do it but all I could see when I looked through was a silhouette and that will stay with me forever. A dark silhouette of him hanging, neck sort of slightly down at the window and that vision will stay with me forever and then obviously I turned the light on because I mean, I just stood there and stared for a couple of seconds just to see if he was moving.
- “I couldn’t detect any movements. I turned the light on and at that precise moment I still didn’t realise he was dead.
- “His feet were on the ground and he had a smirk on his face.”
122. He had radioed through to Communications and told them he was going into the cell. (During the night period the prison is in patrol state

and authority must be given before staff can enter a prisoner's cell.)
Officer D followed him into the cell. According to Officer B:

"I called out to him and I said, 'Are you okay, are you alright?' because I still did not think he was dead, which it didn't even enter my head. I thought he was just playing up because he was almost tiptoeing. He was just slightly tiptoed and he didn't answer me so I proceeded.

"I stretched out one arm and touched his arm. I felt that it was freezing cold and he felt stiff and it was at that moment it hit me that he had been hanging and he was dead."

123. In his incident report, Officer D said:

"I saw the man standing next to the back wall with a green bed sheet tied around his neck. The other end was tied around the window bars. The OSG passed me a fish knife and with Officer B's assistance I cut the ligature. We lowered him to the cell floor. I checked his pulse in both wrists and in his neck but could find no trace of a pulse."

124. The two officers supported the man's body, cut the ligature, and placed him on the cell floor. A few seconds later SO E (Oscar 1), and Nurse D arrived, after responding to their radio call. The nurse noted in the clinical record:

"I had heard, and responded to, the radio transmission to Hotel 5 [the radio call sign for Healthcare] code 1 [the code for a medical emergency] and had collected the emergency equipment and gone directly to C wing."

125. She arrived at the cell at 5.11am (five minutes after receiving the Hotel 5 call at 5.06am that there was an emergency on C wing). As noted, she was accompanied by SO E and saw that the man had been laid on the cell floor. The nurse applied a SATS monitor (a device to assess level of oxygen saturation in a patient's circulation) to his thumb to check his oxygen levels but there was no reading. She checked that he was not breathing and there was no pulse. She attached a face mask and administered oxygen and Officer B assisted while she carried out cardiac massage.

126. The nurse continued to attempt resuscitation until the paramedics arrived (Officer D had asked Control to summon the ambulance via 999). The nurse noted in her statement and clinical record:

"The man was lying on the floor on his back. His eyes and mouth were closed. I noted immediately that there were no chest movements. I opened the emergency bag; put the SATS monitor on his right thumb. I checked his temporal pulse. There

was no recording. The oxygen SATS monitor did not record any reading.

“I took out the oxygen cylinder, connected it to the Ambu bag (a hand-held device used to provide positive pressure ventilation to a patient who is not breathing or who is breathing inadequately). I placed the facial mask on his face, instructed Officer B on how to maintain a clear airway. I tried to put in the Guedal airway [used to maintain a patient’s airway].

“It was difficult. I stopped, placed the facial mask on his face. Officer B held it in position and I commenced cardiac massage. The oxygen was fully opened at 20 litres and cardiac massage was done until the paramedics arrived, and advised me to stop and they took over.”

127. At 5.14am, ten minutes after the initial request for a blue-light ambulance from Officer D, the paramedics arrived. They pronounced that the man was dead at 5.20am.

THE EVENTS FOLLOWING THE MAN'S DEATH

Allegation of bullying

128. On 20 February 2008, one of my investigators received an urgent telephone call from the Deputy Head of Security at Chelmsford, saying that he had received information that the man had been bullied. The main suspect was interviewed and had admitted to assaulting him in the showers on C wing the day before he died. My investigators asked for the relevant paperwork to be forwarded to my office. The suspect had been placed in segregation and the police had been informed.

Family liaison

129. The prison's family liaison officer notified the man's mother of his death. The prison arranged for social services to be there when they informed her.
130. A visit to the prison was arranged for the man's uncles. They were accompanied by a councillor and stayed at the prison for a few hours. They were shown his cell and met prison managers. They asked about the bars on the cell window and other matters which prison staff were able to clarify.
131. The uncles expressed their concern that their nephew had been on anti-bullying measures because he was "caught taking their canteen from them". They said that this behaviour was not a surprise to them because of their past experience.
132. On behalf of the prison, the family liaison officer attended the man's funeral. The liaison officer offered to pay the costs on behalf of the prison, but I understand the family have not yet responded. The man's mother attended the funeral, supported by her mental health worker. The family are Hindus and over 1,000 people attended his funeral.
133. My former senior family liaison officer maintained contact with the man's mother through her link worker from the Community Mental Health Team. He told her that the man's mother had told him that her son was "the centre of her life".
134. The senior family liaison officer contacted the man's social worker from the Social Work Office. He knew him and his family well because he had been his young person's worker and had attended his funeral.
135. He explained to her that he had been involved with the man for some time. He said that when he attended the funeral he was approached

by one of the uncles who wanted to know about the investigation and to be kept informed. He offered to act as a link to the family.

136. He said he understood that the man had:

“... only been talking to his girlfriend the day before but she must not have picked up that he was going to do what he did but that she thought he was having issues in the prison with other inmates.”

137. The social worker told the liaison officer that a court case was due the following week, which was waiting for the results of forensic tests on a jacket. These results had been due for a while but were not yet back. He said that the issue of bail would have arisen. He said he was unsure if the man's actions were related to his court case but that he was more inclined to think that there were issues with other prisoners. He said the family had asked for an investigation.

138. He met the man's mother again on 7 April 2008. She said she wanted to meet with the investigator and senior liaison officer and gave him permission to make the arrangements. The meeting went ahead on 24 April. The mother was supported by an interpreter.

139. The uncle said that he was “confident that something had happened with his nephew because he was someone who never gave up”. He said he “always had a challenging attitude, even at school with his teachers, and would challenge everyone about everything”. He said that his nephew “enjoyed pushing others to anger and that he would never give up, so the concept of him taking his life is unbelievable”.

ISSUES CONSIDERED

Mental healthcare

140. The mental health reviewer's independent mental health clinical review focused on two areas: the quality of mental healthcare that the man received whilst at Chelmsford, and a review of the mental health service operating at Chelmsford at the time.
141. The first reception healthscreen identified that he had a psychiatric history but Chelmsford's mental health team did not take the initiative to request further details from his community mental health team.
142. The reviewer writes:
- “The fact that he himself told staff that he suffered from bi-polar affective disorder, but did not think that he needed to take medication, was in itself an alarming fact.
- “It is very common for patients with this disorder to lack insight into their illness (particularly this young age group). This is often an early warning sign of deterioration in their mental health.”
143. I share the mental health reviewer's concern that no further investigation of the man's mental disorder was made and no further checks completed to ascertain if he was still subject to Care Programme Approach registration or subject to 'aftercare arrangements' under the Mental Health Act 1983. (The Care Programme Approach is for people with a mental illness who are referred to specialist psychiatric services and requires specified arrangements to be out in place for their care and treatment in the community, which includes when in prison.)
144. The man was not assessed by a psychiatrist at an early stage of his imprisonment. Nursing staff told the reviewer that he was referred to the psychiatrist but a consultation did not take place. Instead he was seen by a registered mental nurse and the prison doctor. The reviewer has found that no formal mental health assessment or clinical risk assessment was carried out by clinical staff at this time.
145. He reports:
- “It seemed that the mental health team did not act upon the information contained in the fax which was received from the man's community mental health team. The fax contained two documents with clear information that could have proved vital in alerting the prison's mental health team to his previous behaviours, symptoms and risks.”

146. The reviewer says that:

“It must be noted, however, that when his community mental health team last visited him, they did not detect any clear symptoms or signs that his mental state may have been in decline.”

147. He talked to both healthcare and wing staff. He writes:

“It did not appear that wing staff were effectively briefed about his mental health history and the risks he presented and that this likely had a bearing on wing staff’s decision to return him from D wing back to C wing.”

148. He comments that:

“If he had not been a prisoner he would have received a more assertive response from mental health services, especially given his life had become more unstable. He had lost his job, was not engaging with mental health services and had stopped taking his medication. Assertive Outreach teams have been in place for a number of years now across the UK, and their role is to actively engage patients in such cases as his.”

149. He says that:

“The man fell into many of the high risk groups for suicide because he was:

- A young male (men under 25 present a higher risk)
- Suffering from an established mental health issue; it should be noted that bi-polar affective disorder carries a significantly higher risk due to the potential for dramatic mood swings
- From an ethnic minority background
- Not actively engaging in treatment for his mental disorder
- Unhappy due to loss of liberty, his job, possibly relationship with girlfriend
- Subject to bullying issues
- Recently taken into custody.”

150. I am not sure the mental health reviewer is entirely correct in respect of the relationship between ethnicity and suicide risk, but I agree with him that these risk factors should have been considered when planning the mental health management. If they had been considered, different decisions may well have been made about his overall treatment.

151. The reviewer has also reviewed the organisation of mental health service provision at Chelmsford. He has found that services were split into two distinct teams: a day care service and a primary care team. He reports that the day service offers:

“Robust and professional service to its patients within the prison. There was evidence of formal mental health assessments, appropriate care planning, effective treatments being offered, and a clear management structure was in place. The day service mirrored mental health day services to be found in the community.”

152. However, he has found the primary care mental health team to be:

“Disjointed, lacked mental health leadership and offered a fragmented service to its patients. It is clear that this is a prison run facility which lacks the specialist knowledge and practice of an NHS-led service.

“The Care Programme Approach is not being used (the CPA was introduced to the NHS in 1991, some 18 years ago now) this is a requirement of all Mental Health Services throughout England and Scotland, including Prisons and Community Services.

“I made a request for the team to use the Day Care Services computer system to begin checks on the CPA register with immediate effect. This could be achieved very easily by contacting the Day Care Service by phone and asking for a verbal check on all new prisoners who are referred to the service. This could give the team valuable information on prisoners including mental health history and risks.”

153. He also reports:

“I saw no formalised Mental Health Assessment documentation provided by this service. The process of assessment provided by the Primary Care Team would not be adequate in a service within the local community, and is not adequate for prisoners.

“There was no evidence of a structured risk assessment process for inmates with mental health problems, which is very alarming as the Prison Team deal with some of the most vulnerable members of society who are at a higher risk of suicide than others. There appears to be little or no knowledge in strategies which may help to reduce the risk of self harm/suicide apart from an environmental control approach, which appears custodial and out of date.

“There was evidence of poor documentation within the Clinical Record. One entry was not signed for, but the author had put their first name and many signatures could not be distinguished as there was no printed surname, nor was there a signature sheet identifying authors.

“Although some specialist nurses (Registered Mental Health Nurses) are employed, they are not functioning in the specialist role for which they are trained. RMNs appear to be used to offer generic care which includes physical care, as well as some domestic duties. The staff have had no specialist updates on their skills and no training has been provided in areas such as Suicide Risk Assessment and Management.

“There is neither clear mental health clinical direction, nor professional leadership and I did not see evidence of Clinical Supervision, a tool used for many years in the mental health fields for self and professional development, stress management and workload management.”

154. The reviewer concludes his report thus:

“In conclusion, it appears that there are two, very different approaches to mental health care within HMP Chelmsford. Day Care Services are functioning well, but the service received by the man is failing in its function. The Primary Care Team is disjointed from the Day Care Service and is dysfunctional in its operation and service delivery.

“The service does not offer the expertise or the understanding of Mental Health problems for its patients and is not in line with services offered to the local population, nor of what is expected under the National Framework for Mental Health as set out by the Department of Health.”

155. I endorse the 11 recommendations the reviewer makes in his mental health clinical review:

- A formalised and recognised mental health risk assessment tool should be implemented without delay.
- The Care Programme Approach should be introduced for all prisoners with serious mental disorder at Chelmsford.
- A robust mental health assessment tool should be introduced for registered mental nurses to utilise.
- Training for prison healthcare staff in mental health risk assessment of patients with mental disorder should be introduced.
- Registered mental nurses' roles should be clearly defined to deliver mental health provision.

- Integrated team working between the day care service and primary care team should be facilitated.
- The mental health service should be reviewed to determine a future best delivery model.
- The mental health service should be reviewed to consider the most appropriate provider of the mental health service.
- An effective clinical supervision policy should be implemented for all clinical staff.
- A mental health in-reach model should be implemented to access the wider prison population to offer a more assertive treatment role for prisoners who do not engage in services.
- Better communication of 'alerts'/new information about vulnerable at-risk prisoners to ensure staff who take significant decisions are fully aware of potential implications in terms of risk management.

Mental health services and risk management

156. My investigators also found that the quality of mental healthcare was an area of concern. There was no proactive approach to mental healthcare. The first reception screening when the man entered prison identified that he had a history of mental disorder, but the follow up was inadequate. His mental health and the risk he presented to himself and to others were not adequately assessed. The prison's mental health service did not have sound risk management processes in place to assess and manage those prisoners with mental health needs.
157. The mental health clinical review has found that no follow-up risk assessment took place after healthcare staff received information about his psychiatric history. There was no follow-up when he did not comply with his medication and did not go to his appointments with the psychiatrist. This meant that the cell sharing risk assessment to place him in a single cell was not informed by a rigorous mental health risk assessment.

The Governor and Head of Healthcare, in collaboration with the PCT, should implement a formalised and recognised mental health risk assessment tool without delay.

The Governor and Head of Healthcare, in collaboration with the PCT, should introduce training for prison healthcare staff in mental health risk assessment of patients with mental disorder.

The Governor and Head of Healthcare, in collaboration with the PCT, should ensure better communication of 'alerts'/new information about vulnerable at-risk prisoners and ensure staff who take significant decisions are fully aware of potential implications in terms of risk management.

Care Programme Approach

158. The man was detained under the Mental Health Act 1983 before he came into prison. He was diagnosed as suffering from bipolar affective disorder. When he was taken into custody, he should have received a thorough mental health assessment and been placed on the prison's Care Programme Approach register (CPA). The CPA is a mandatory requirement of the National Service Framework for Mental Health and the Department of Health's policy for prisoners' mental healthcare, 'Changing the Outlook'.
159. The clinical review has identified that the CPA is not routinely in place for prisoners with a serious mental disorder. The problem was compounded as there was little evidence of multi-professional risk assessment and care planning in place to manage the risks the man presented in custody.

The Governor and Head of Healthcare, in collaboration with the local PCT, should introduce the Care Programme Approach for all prisoners with serious mental disorder at Chelmsford.

160. My investigators asked Nurse B, senior nurse in charge of the primary care mental health team, if either the healthcare team or wing staff had expressed concerns to her about the man. She responded:

"No, as far as I'm aware we had absolutely no concerns raised by wing staff, by anybody within the prison system or ourselves so it was a complete and utter shock."

161. She was also asked about mental healthcare arrangements at Chelmsford and about mental health inreach in particular. The nurse said that 'mental health inreach' was purely a technical term and that some prisons had both inreach and primary care provision in place. She told my investigators that at Chelmsford only primary mental healthcare services were provided.

The Governor and Head of Healthcare, in collaboration with the local PCT, should ensure registered mental health nurses' roles are clearly defined when working in the prison.

The Governor and Head of Healthcare, in collaboration with the local PCT, should implement an effective clinical supervision policy for all clinical staff.

The Governor and Head of Healthcare, in collaboration with the local PCT, should facilitate integrated team working between the day care service and primary care service with an objective to

improve professional practice and accountability until a new mental health service delivery model is in place.

The PCT/Prison Partnership review of mental health services

162. In November 2008, the PCT/Prison Partnership approved a proposal for future provision of mental health services at Chelmsford. It was intended that the new model would meet the requirements of the Prison Health Performance Indicators (the Department of Health's performance management framework for prison health).
163. The new service would also provide an integrated care pathway consisting of three key elements: a primary care mental health service, a secondary care mental health service based on a community mental health team (CMHT) model and contracted NHS psychiatry sessions.
164. I am reassured that a firm plan to improve mental healthcare at Chelmsford is in place, although I am concerned at the time this has taken. I ask the Director of Offender Management to pay particular attention to progress of this plan.
165. During a previous investigation, the PCT provided me with an update on their progress in developing a fit-for-purpose mental health service at Chelmsford. They told my investigators that progress was being made to develop mental health services at Chelmsford and that a number of actions had already been implemented. The actions taken to date are positive but the first phase of the project to implement a new mental health service delivery model needs to be taken forward.

The local PCT should expedite a new mental health service delivery model at Chelmsford without delay.

Prevention of suicide and self harm

166. In her inspection of Chelmsford in July 2007, HM Chief Inspector of Prisons identified a number of serious deficiencies in relation to both the prevention of self harm and suicide and mental healthcare at Chelmsford. Her concerns focused on access to Listeners (prisoners who are trained to act as sympathetic peer-supporters to other prisoners who are vulnerable and/or at risk of suicide and self-harm), the use of strip conditions (where a prisoner is put in special clothing and in a single cell to prevent him from self-harming), and CCTV (closed circuit television) cameras. I am pleased to learn that Listeners have now been placed in reception and there is more freedom of movement for Listeners throughout the prison generally.
167. A wing-based name board system has been put in place to identify the location, custodial status, and risks for easier identification of prisoners' concerns and risks, with prisoner SAFE representatives

from each wing. (Safe and Fearfree Environment is the violence reduction policy in place at Chelmsford.) Death in custody focus groups, with multi-disciplinary attendance from all staff grades, supported by the senior management team and with full prisoner and staff involvement, are also in place.

168. Principal Officer (PO) A told my investigator that improvements had been made to how the Observation, Classification and Allocation group (OCA) and Safer Custody team work together to identify concerns about vulnerable prisoners received into Chelmsford and those transferred out of the prison.
169. Chelmsford has also instigated a training programme that includes ongoing mental health awareness training for all prison staff.

Violence reduction and anti-bullying

170. Both the man's family and the professionals involved in his care over the years have spoken openly of the challenges in trying to care for him. He struggled to develop positive relationships generally and, as a consequence, came into frequent conflict with other people. Prison records indicate that he was bullied on a number of occasions and that he was also subject to violence reduction, anti bullying and IEP basic regime measures for much of his time in custody.
171. The Principal Officer told my investigators:

“It's an unpleasant phrase ‘anti-bullying’ and I would disagree with that terminology. Certainly the policy, the violence reduction policy as I would term it, was able to deal with prisoners that engaged with bullying. However, there was a distinction and I believe in this particular case it was more around the violence reduction side of things.

“There were three stages to the policy with stage 1 being a monitoring process, stage 2 being an actual incidence of violence or indeed bullying, and stage 3 would be where stage 2 had failed to address what I would say the offending behaviour.”
172. The focus of the violence reduction policy was on anti-bullying. Prisoners were assessed and quickly moved onto stage 2 of the anti-bullying booklet and IEP basic regime. My investigator considered the anti-bullying approach lacked sufficient investigation of the underlying root causes and was too reactive in its focus.
173. PO B was relatively new in post when she was interviewed by my investigators. Her new job included that of Violence Reduction Manager and Safer Custody Manager. She told my investigators that, if a prisoner was assaulted and staff witnessed it, the perpetrator would be immediately placed on stage 2 of the anti-bullying policy.

She felt that the assessment of the individual prisoner was not sufficiently rigorous in that staff did not fully explore a prisoner's background in terms of their custodial history. She said that staff would also tend to go on their previous knowledge of an individual and not investigate thoroughly.

174. PO B went on to tell my investigators that there is now a new system in place following the launch of the SAFE strategy which replaced the anti-bullying scheme. She said that the main difference with the SAFE policy is that all prisoners now placed on SAFE1 (early intervention stage) are spoken to and the reason identified for the problematic behaviour. The prisoner would then be placed on report and monitored for 14 days, but would retain his current IEPS level. Stage 2 (SAFE 2) would be where a basic regime and anti-bullying booklet is implemented.
175. She said that staff welcomed the new approach and that violence reduction was now under the remit of the psychology department. Prison staff told my investigators that SAFE had helped to reduce violence in Chelmsford. Violence reduction focus groups are run regularly by staff for prisoners and are well attended.

Assault by another prisoner

176. Information came to light after the man's death that he had been assaulted by another prisoner. Officer E from Security told my investigators:
- “I went over and spoke to the prisoner in his cell. I have had dealings with the prisoner before over other issues so he did know me and I asked him, did he send a letter out and could he tell me the content of the letter that he'd sent out. He, from the notes I have got here, this is what he said to me. He said 'Oh is it about that guy that died?' so I said 'Yes, it is', and he said 'Yeah, I did have a go at him, he said he robbed out of my cell so I gave him a clump.' He said 'I saw him in the shower, I punched him three times, he went to the floor and I gave him a couple of kicks. He got up, I walked out. I never saw him again.'”
177. My investigators followed up this matter and found that no further action was taken against the prisoner, either by way of an internal prison adjudication or any police charges being brought. My investigators also could not find out why the man was moved from D wing back to C wing, especially after the problems he had experienced previously on C wing.

Foreign national and young prisoners

178. The difficulties of caring for and managing young foreign national prisoners on C wing were highlighted in the Chief Inspector's report of 2007. Significant improvements have been made since then. Proactive action planning to reduce the risks associated with caring for foreign national prisoners, and closer collaboration with Bullwood Hall immigration officers is now in place at Chelmsford.
179. Arrangements to share information with Bullwood Hall started on 10 August 2009. Bullwood Hall staff now attend Chelmsford every week to support prison staff and prisoners. This has enabled Chelmsford to provide an advisory service to foreign national prisoners, which staff had previously been unable to provide because of their limited knowledge.
180. Foreign national prisoners have welcomed the new service and apply, on a regular basis, to be seen by staff from the UK Border Agency. I have been pleased to learn that one consequence of the new approach appears to have been a decline in self harming behaviour.

Access to prisoners during the night

181. Access to all parts of the prison during the night period was problematic at the time of the man's death. One member of staff was deployed to each wing and they would then effectively be 'locked in' for the night. However, each member of staff carried a sealed pouch containing a key to be used in the event that emergency access to other areas of the prison was required.
182. The furthest points in the prison are G wing and A wing and it could take three to five minutes to collect staff to respond to an emergency. On the morning of 12 February 2008, the time taken to collect keys and gather staff was only a couple of minutes from the first report to reaching the cell, according to those staff who arrived first.
183. My investigators asked PO A if there could be a delay in reaching an incident when staff were locked on the wings. He said that his personal opinion was it would mean a better initial response and that staff anxiety in terms of entering a cell would be reduced because they would have immediate assistance from their colleagues.
184. He said:

"If I was on Golf wing [G wing] which for me is the furthest point of the prison and I had to attend Alpha wing [A wing] this would be the furthest two points. It would probably take somewhere in the region of three to five minutes."

185. My investigators asked Nurse E if accessing the main prison at night to attend a medical emergency was a problem. She said:

“Yes, it is and it always has been really. We don’t have keys so if there is an incident we have to wait. I have to wait for Oscar 1 [the code for the senior officer in charge of the prison during the night] to come and collect me. Which obviously can cause delays.”

186. Access to prisoners during the night in 2008 involved arrangements whereby all wing staff carried a cell key in a sealed pouch. Oscar 1 carried an open bunch of keys with all the required keys on that bunch. Oscar 2, who assisted Oscar 1, also carried a full set of keys but in a sealed pouch. If access to a prisoner’s cell in a non-emergency was required, Oscar 1 would go to the wing (accompanied by Oscar 2), ensure the double keys were left outside the wing, and use the keys in the sealed pouch to unlock the gate to enter the wing. In an emergency, Oscar 1 would assess the situation and enter the wing using his keys. At that time, all gates to the wings were locked. When Oscar 1 received a call for assistance he would direct staff accordingly and then go to collect the nurse from the healthcare centre whilst Oscar 2 attended the scene of the emergency. The nurse was able to get to the nearest door in the healthcare centre to save time with only one gate left to be unlocked by Oscar 1.
187. Night state procedures have since been reviewed and old prison class 2 locks are now left off for a more immediate staff response during the night.

First on the scene and emergency response

188. Nurse E told my investigators that the emergency bag was located in healthcare just behind the staff area. She described it as a “big green bag with oxygen, suction equipment, neck braces, and any other equipment needed for an emergency”. She said the defibrillator is “about ten inches square in a bright orange box” and located at the points of use. She said, “there are defibrillators in the treatment room but we normally take this one. If there is an emergency, called a code 1, normally we would grab the emergency bag from here and the defib from here”.
189. In my investigation report into another apparently self inflicted death at Chelmsford on 4 May 2007, I recommended that Chelmsford’s death in custody contingency plans should be amended to give the control room the responsibility of allocating a specific member of staff to collect the defibrillator and oxygen and take it to the scene of all code 1 emergencies.

190. Chelmsford accepted my recommendation and responded:

“As an alternative we intend to locate a defibrillator and oxygen in the wing manager’s office for all seven residential wings. This will ensure that staff have immediate access to life saving equipment on site. This action will be complete when all nurses are fully trained.”

191. My investigators found this to be an effective arrangement to ensure prompt access to emergency equipment. They were also told that ongoing defibrillator training for prison officers is now in place.

192. As I have noted earlier, it was not possible for my investigators to interview OSG B because she has moved abroad. My investigators concluded that she made a genuine mistake when she first indicated the wrong cell to her colleagues. She was evidently (and unsurprisingly) very shocked and upset by the experience.

193. My investigators talked to a number of prison staff who all confirmed that the emergency code call system was clear and understood. I was concerned that OSG B had not properly followed procedure when she summoned help by not using the appropriate code 1, but it may be presumed that this was a consequence of her shock when finding the man hanging in his cell.

194. I made a number of recommendations for the Governor in partnership with the PCT, in my investigation report of another apparently self inflicted death on 25 December 2007. Five recommendations concerned emergency equipment and nurses’ access to prisoners during the night state. I am pleased the Governor and PCT positively responded to my recommendations from that investigation and I have not identified any further concerns.

CONCLUSIONS

195. I recognise that the man was unwilling to engage with the mental health team at Chelmsford. However, the mental health professionals did have the opportunity of adopting a more proactive approach. They did not do so, despite his young age, and his history of serious mental disorder and compulsory detention in psychiatric hospital.
196. This investigation has found the mental health service at Chelmsford to be woefully lacking in many aspects. The lack of a proactive approach to anticipating the care needs of vulnerable prisoners with mental health difficulties, and the lack of a robust approach to mental health risk management, is of serious concern.
197. The focus of the violence reduction policy at the time of the man's death was on anti-bullying. Prisoners were assessed and quickly moved onto stage 2 of the anti-bullying booklet and IEP basic regime. I consider that the anti-bullying approach lacked sufficient investigation of the underlying root causes and was too reactive in its focus, but am pleased a new violence reduction system has now been introduced.
198. Access to prisoners during the night at this time was also problematic. However, night state procedures have since been reviewed with old prison class 2 locks now left off for a more immediate staff response during the night.
199. After the man was found hanging, the prison's response was generally timely and efficient. I judge that prison and healthcare staff responded professionally and compassionately in their efforts to save his life. Sadly, those efforts were unsuccessful.

RECOMMENDATIONS

The Governor and Director of Offender Management for East of England have accepted the first seven of these recommendations. Below each recommendation is their response contained in an action plan provided to me on 16 November. The Chief Executive of the Primary Care Trust has accepted the eighth recommendation and a response provided to me on 14 December is included under the recommendation.

1. The Governor and Head of Healthcare, in collaboration with the PCT, should implement a formalised and recognised mental health risk assessment tool without delay.

This is in the process of being implemented within the Mental Health Care Pathway re-design. The Primary Care Trust is also exploring options to enhance Registered Mental Health Nurse capacity at reception. This is due to be implemented by 1 December 2009.

2. The Governor and Head of Healthcare, in collaboration with the PCT, should introduce training for prison healthcare staff in mental health risk assessment of patients with mental disorder.

Training gaps and needs have been identified as part of the Mental Health Care Pathway re-design project. The resulting training plan is due to be implemented from 1 December 2009.

3. The Governor and Head of Healthcare, in collaboration with the PCT, should introduce the Care Programme Approach (CPA) for all prisoners with serious mental disorder at Chelmsford.

The use of CPA is integral to the new mental health model. In preparation for full implementation of the revised pathway the Mental Health Team and healthcare managers have been trained to use CPA and In Reach have already started to manage patients under CPA (currently 30 patients). Full implementation is planned from 1 December 2009.

4. The Governor and Head of Healthcare, in collaboration with the PCT, should ensure registered mental health nurses' roles are clearly defined when working in the prison.

This will be achieved in phase 1 of the Mental Health Redesign due to be implemented in December 2009. There is a skills mix review underway which will further clarify the roles of the healthcare team. This is due to be completed by the end of November 2009.

5. The Governor and Head of Healthcare, in collaboration with the PCT, should facilitate integrated team working between the day care service and primary care service with an objective to improve professional

practice and accountability until a new mental health service delivery model is in place.

This process has begun as part of the service redesign and is supported by an independent consultant. There are weekly multidisciplinary team meetings, which are well attended. These will continue within the new service delivery model. Ongoing work will include the joint development of protocols and access criteria to support the new pathway.

6. The Governor and Head of Healthcare, in collaboration with the PCT, should implement an effective clinical supervision policy for all clinical staff.

Clinical supervision is part of the capacity plan and training plan. The Primary Care Trust is working closely with prison healthcare staff to ensure that it is implemented and is ongoing. Three members of staff have completed training.

The Integrated Governance Prison Lead has developed a new policy which will run alongside the new service delivery model. The Governor and Primary Care Trust are also exploring opportunities for clinical supervision to be provided from local mental health trusts. Implementation is ongoing from 1 December 2009.

7. The Governor and Head of Healthcare, in collaboration with the PCT, should ensure better communication of 'alerts'/new information about vulnerable at-risk prisoners and ensure staff who take significant decisions are fully aware of potential implications in terms of risk management.

The PCT has finalised arrangements with the NHS Trust to second an additional registered mental nurse to the prison to enhance capacity at reception screening. This will support the liaison function with external agencies when alerts and information come through for vulnerable prisoners. Completed and in place since 1 December 2009.

The risk assessment process is also subject to redesign.

To the PCT

8. The PCT should expedite a new mental health service delivery model at Chelmsford without delay.

The PCT has been working very closely with the NHS Trust to implement a new mental health clinical pathway that responds directly to the recommendations of this investigation report and is in line with national policy guidance on prison mental healthcare.

The responses provided to recommendations 1-7 above describe core elements of the new model and these have been implemented. Additional capacity and resource has been introduced as part of the new pathway and the overarching project plan has the ongoing commitment from the PCT Chief Executive, the Governor and the Director of Operations at the NHS Trust.