Investigation into the circumstances surrounding the death of a man at Broomfield Hospital, Essex in March 2008 whilst in the custody of HMP Chelmsford

Report by the Prisons and Probation Ombudsman for England and Wales

August 2010

This is the report of an investigation into the circumstances surrounding the death of a man, a remand prisoner at HMP Chelmsford. Staff discovered the man hanging in his cell at about 8.30pm on 29 February 2008. He was taken to Broomfield Hospital, Essex, where he died a few days later on 4 March. The man was in his early thirties.

I would like to offer my sincere condolences to his family. The man's death was a shock and the suddenness and manner of his death must be particularly difficult for them to bear. I apologise for the significant delay in issuing my report which can only have added to the family's distress.

One of my investigator's conducted the major part of the investigation. Another investigator assumed responsibility for concluding the investigation in the latter stages, following the first's investigators retirement.

I would like to thank the Governor of Chelmsford and his staff for their co-operation. In particular, I am grateful for the high standard of prison liaison. In addition the Assistant Director of Governance, NHS Mid Essex, conducted a review of the man's clinical care. I am grateful to her for her contribution to my report.

The man was a first time prisoner who had been in prison for only four days before taking the actions which led to his death. The investigation has found that there is scope for improvements in the induction process, as well as in training staff who deal with new prisoners and the standards of record keeping. In addition, the prison failed to hold a hot debrief and staff did not take steps to investigate the man's complaint that his medication had been stolen. The prison asked the police to tell the family the sad news of his death, although this is not the recommended Prison Service procedure. I make eight recommendations covering these matters.

I am pleased to recommend two commendations to staff whose efforts and skill in cardio pulmonary resuscitation enabled the man to be revived and taken to hospital. Sadly, their efforts were ultimately unsuccessful.

The National Offender Management Service has accepted my recommendations and their response, together with the family's response is documented on pages 24 and 25 of my report.

Jane Webb
Acting Prisons and Probation Ombudsman **August 2010**

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SUMMARY

The man was arrested on 24 February and taken into police custody. The following day, 25 February, he appeared at Essex Magistrates' Court and was remanded into custody at HMP Chelmsford. He was in his early thirties and this was his first time in prison.

A registered mental health nurse carried out the First Reception Health Screen when he arrived at Chelmsford. She noted his drug history and made a referral to the detoxification team and the prison doctor. The nurse also recorded a history of psychiatric treatment ten years earlier and assessed that he had no current thoughts of self-harm or suicide. The nurse had no concerns about him. She appears not to have noticed the police doctor's comment that the man had said he was depressed.

The man went through the induction process, which took place over the course of a day. On 26 February, another registered mental health nurse completed a substance misuse assessment and he recorded that the man was depressed/distressed. The nurse assumed that his distress was solely due to being in prison and considered that no further action or additional monitoring was warranted.

At around 8.30pm on 29 February, during the evening count of prisoners, an officer opened the flap to the man's cell door. He was sitting on the floor with a ligature around his neck, attached to the window, apparently having hanged himself. Discipline and healthcare staff performed cardio pulmonary resuscitation and were able to revive him. Paramedics then took him to Broomfield Hospital in Essex where he died four days later.

The investigation has found that although the man had been assessed as depressed, no action was taken to formally assess his mental state or to initiate additional monitoring. While I have made no recommendation regarding whether self-harm monitoring should have taken place in this instance, I believe that opportunities to assess his mental state and intervene were missed. I make wide ranging recommendations relating to clinical assessments, record keeping, staff training, the requirement for hot debriefs after critical incidents, the personal officer scheme, safer cells, breaking the news of the man's death to his family and the reporting of relevant incidents to security.

I am pleased to recommend the commendation of the two officers who resuscitated the man.

THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death on 4 March 2008. Notices were issued to staff and prisoners, announcing the investigation and inviting anyone who had information about his death to contact the investigator. Nobody came forward.

2. My investigator made initial contact with the prison's liaison officer on 7 March. The man's prison and medical records and other documents likely to be required for the investigation were requested at this time. The investigation was formally opened on 11 March, when the investigator met the deputy governor and the Chair of the Prison Officers' Association. The investigator held over 30 interviews on 17, 18 and 26 March. My investigator retired during the summer of 2009 and another investigator was appointed in January 2010 to complete the investigation.

3. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The investigator considered the latest Independent Monitoring Board (IMB) report and spoke to a member of the IMB with responsibility for issues relating to safer custody. HM Chief Inspector of Prisons carried out an announced inspection in July 2007, and the report of that inspection was also considered.

4. An independent clinical review of the healthcare the man received in custody was carried out by Assistant Director of Governance, NHS Mid Essex.

5. The investigator contacted HM Coroner to inform her of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of this report will be sent to the Coroner to assist her enquiries.

6. Throughout the investigation the investigator provided the deputy governor with regular updates of emerging findings. As a result, several procedural changes have already been completed.

7. Little is known of the man before he was remanded in custody. It was his first time in prison and he had been at HMP Chelmsford for a very short time before his death. However, from the few records available, it is clear that he had an entrenched drug problem and had previous involvement with mental health services while he had lived.

8. The man's family visited him in hospital before he died. One of the Ombudsman's Family Liaison Officers contacted his family to offer them the opportunity to participate in the investigation. They raised several concerns about the man's care. The man's family questioned why he was in a cell on his own and why it took over 48 hours for his medical records to be transferred to the prison. The man's family also spoke of their disappointment with the lack of ongoing contact from the prison following his death. I hope the report helps the

family to better understand the events leading up to his death.

HMP CHELMSFORD

9. HMP Chelmsford is a category B local prison built in 1830, located within walking distance of the city centre. Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels: A, B, C and D. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

10. Originally built as a county jail with four wings, the prison has been extended twice and currently has an operational capacity of 695. The prison's function is to serve the courts. Prisoners are held on six main wings. There is a small healthcare centre that has 12 in-patient beds. More than one third of the prison population are young people under the age of 21. At Chelmsford, they are distributed throughout the prison. The prison no longer holds juvenile prisoners (those under the age of 18).

11. Until recently, the prison induction unit was located on E wing and held approximately 120 prisoners. The introduction of an Integrated Drug Treatment System (IDTS) on E wing has resulted in a gradual reduction in the number of spaces available for prisoners undergoing induction. (The IDTS programme includes maintaining prisoners on methadone instead of placing them on a detoxification programme which was the only previous option. Induction has now been moved to a new location.

12. The man's death in March 2008 was the fifth self-inflicted death in custody at Chelmsford in a five month period commencing in November 2007. In each case the method used was hanging. Since 2004, the Ombudsman has investigated 13 deaths at Chelmsford. The IMB member responsible for monitoring safer custody told the investigator that the safer custody team had considered any possible links between the recent deaths. No pattern had emerged.

13. The HM Chief Inspector of Prisons reported in July 2007 that induction appeared efficient and appropriate, although it only lasted one day. Her report goes on to say that, although the personal officer scheme had been re-launched, it had not yet become embedded. Many entries on wing history sheets focused on prisoners' compliance and did not suggest general engagement between staff and prisoners.

14. The HM Chief Inspector of Prisons also found few entries to demonstrate quality engagement with prisoners who were subject to an Assessment, Care in Custody and Teamwork (ACCT) document. (The ACCT procedure provides additional monitoring and individual support for prisoners considered to be at risk of self-harm or suicide.)

KEY FINDINGS

15. The man was arrested and detained in police custody on 24 February 2008. A Police Detained Person's Medical Form timed at 11.24am was completed by the police doctor. No visible injuries, other than old ones, were noted on the form. (Although it is recorded in the Prison First Reception Health Screen document, completed later at the prison by healthcare staff, that the man had "swollen eyes, cracked ribs" and "swollen broken knuckles".)

16. In the doctor's opinion the man had abused opiate drugs for the past 12 years. There was clear evidence that he took drugs intravenously[1]. (Documents completed the following day at the prison show that he abused heroin, crack cocaine and cannabis.) The doctor assessed the man as suffering from the early stages of drug withdrawal and that "DP [2] states feels depressed, not done self-harm for 6 years". The man was described as coherent and knew where he was. His risk of self-harm was assessed as "standard" and he was considered fit for detention at the police station.

17. The Detained Person's Medical Form says that, in accordance with the doctor's instructions the man was given two 30mg dihydrocodeine[3] tablets at six-hourly intervals, plus two five mg tablets of diazepam[4].

18. The following morning, preparations were made for the man to leave the police station to attend the Magistrates' Court. The Prisoner Escort Record (PER) Part A document, completed by a Police Sergeant, says the risk factors were violent behaviour on arrest and drugs. No concerns about self-harm were recorded. (The PER accompanies staff on all prisoner escorts. It provides a chronological record of the escort, eg meals served, times journey started etc and also serves as a communication tool about the risks a prisoner poses on escort or transfer.)

19. The man appeared before the magistrates at Essex Magistrates' Court at 11.30am. His case was sent for trial at Chelmsford Crown Court. The next hearing date was 4 March and he was remanded to Chelmsford prison.

20. Part B of the PER shows that the man arrived at Chelmsford prison at 3.56pm. The man spoke with the escort staff and to other defendants. There were no concerns or difficulties reported during the day or on the journey to the prison.

21. In their response to the report, the family have confirmed that the man's brother saw him when he appeared at court. The man's brother did not see the injuries recorded on the First Reception Healthscreen. The family question how the man could have received the injuries documented in the First Reception Healthscreen between leaving the court and arriving at the prison.

Reception at Chelmsford

[1] Intravenously means injecting directly into a vein.
[2] DP stands for Detained Person.
[3] Dihydrocodeine is a analgesic for pain relief.
[4] Diazepam is used for the relief of anxiety.

22. An officer who had worked in the reception area of the prison for two years confirmed that he had not had formal training in reception work, but had learned by working with more experienced officers. At interview the officer recalled that the reception department was busy the afternoon the man arrived. He said that the man had seemed relaxed and answered questions appropriately. He did not detect that he was distressed. He completed a Cell Sharing Risk Assessment (CSRA) document, a form used to assess the risk a prisoner poses to a cellmate if they are required to share a cell. The document noted that it was the man's first time in prison and that there were no concerns. The officer commented to the investigator that, if he had any concerns, he would have noted them on the CSRA form at the time.

23. The officer added that the man did not tell him that he wished to share a cell. There is no evidence that the officer asked this question or that the man would have known he could ask to share a cell if he wanted to. The officer explained that he made notes on the assessment form as it was the man's first time in prison. He thought it might assist other prison staff to allocate the man to a cell and give them an understanding of why he might ask more questions than other prisoners.

24. The officer confirmed that he was aware there might be issues for first time prisoners and that this was the purpose of the induction wing. He said that, depending on the nature of any concerns, there were a number of options available to him. He told the investigator that he could open an ACCT[5] or speak to healthcare and/or wing staff. He did not meet the man again after that.

25. A part-time registered mental health nurse (RMN) completed the man's First Reception Health Screen. In interview the nurse told the investigator that she takes information about where prisoners live, identifies their general practitioner (GP), notes any recent injuries and whether prisoners are taking any medication. She explained that if they bring medication with them into the prison, they generally have to wait until the next day to see the doctor, whether it is urgent or not. If the problem is not urgent, prisoners make a written application to the healthcare department and wait for an appointment. If prisoners misuse drugs in the community, they are referred to the detoxification team. Similarly, if mental health problems are identified, prisoners are referred to the mental health team.

26. The nurse identified drug issues from the health information received from the police station and referred the man to the detoxification team. She noted that he was prescribed dihydrocodeine and tamazepam[6] and recorded the injuries the man said he had received in the community. Contrary to the police doctor's assessment at the police station that the injuries were old, he told her he was injured during the week before coming into prison. The form specifically asked whether he received these injuries in the past few days and the man confirmed to the nurse that he had.

[5] Assessment, Care in Custody and Teamwork (ACCT) is a prison service process for monitoring and supporting prisoners at risk of self-harm.
[6] Tamazepam is used to treat insomnia.

27. The nurse recorded that the man had a previous history of contact with a psychiatrist and the community mental health team around ten years before he went into prison. She noted her impression of the man's behaviour and mental state at the time as "no thoughts of self-harm or suicide at present". On page two of the document the nurse ticked the box to confirm she had received health information from the police station. Whilst she recorded that he was withdrawing from drugs, there is no evidence that she noticed the police doctor's note that the man said he was depressed. When asked if he thought there was any reason why he should see a doctor, he said yes. He was referred to the prison doctor for his physical injuries and substance misuse.

28. The nurse told the investigator that if she had concerns about the man, she would have opened an ACCT plan. She had no formal ACCT training but did not think the lack of training significant on this occasion because her knowledge of mental health issues meant that she asked questions about mood and thoughts. She was aware that triggers such as substance misuse and drugs made prisoners more vulnerable, but the nurse did not identify any risks of self-harm. She made a referral to the doctor concerning the man's physical health and substance misuse. He was not referred for a mental health assessment at this stage.

29. A registered general nurse, worked in reception. Her duties included completing the initial healthcare assessment. She confirmed in interview that the police medical record is usually held with the papers, and if appended, she would take time to read it.

30. An untimed entry on 25 February, in the clinical record, with an illegible signature summarises the outcome of the First Reception Health Screen document. It records the man's poor physical state of health and evidences lack of sleep and leg cramps, drug misuse and drugs of choice. It describes his speech as normal with good eye contact.

31. An officer told the investigator about his role as a First Night in Prison officer. He said he meets new prisoners when they first arrive in reception and gives them information about the prison, what will happen to them and the wing they will go to. The man went to E Wing induction unit when the reception process ended.

E Wing induction unit

31. The officer continued his duties on E wing. E wing is the induction unit and it is divided into two parts or "spurs". Blue spur is where prisoners spend the first night of their imprisonment. Prisoners then move to Red spur where they remain for up to a week while awaiting a space on one of the prison's main wings. When the investigator visited the prison, he was surprised to see that there are no safer cells[7] on E wing induction unit. I consider this point later in the report.

[7] A safer cell is a cell adapted for use for prisoners who are at risk of self harm or suicide. There are no ligature points, furniture is fixed to the cell and has smooth or rounded corners to reduce risk of injury.

32. After prisoners are unlocked at around 8.00am, new prisoners go to the induction room. The induction is a full day process. They are given a powerpoint presentation which gives information about the prison and health and safety. It lasts for half an hour and is carried out by staff trained in induction policy and procedures. Probation and other agencies working in the prison meet new prisoners and explain the services they offer. The officer recalled the man as quiet with "absolutely no issues with him at the time". He did not reveal any problems and was pleasant.

33. The officer explained that staff on the induction unit go through a formal selection process to work on the wing, although he was approached to take the position. The officer works from 1.30pm until 10.00pm. He said that once the prisoners have seen the nurse he speaks to them. He tells them about the Insiders[8] and the Listeners[9]. In interview the officer described the first experience of prison, in his opinion, as an "overwhelming situation unless they've been in before". He said that prisoners are given an information pack, a bed pack, smokers or non smokers pack containing biscuits and a drink. They pay £2.50 for this at a later date, taken at 50p per week from wages or 'allowance' given to all prisoners by the prison.

34. Following this, prisoners go to the wing where they see the Insiders, who again explain what they can expect. Prisoners are allocated a cell when they arrive on the wing and, after meeting the Insiders, are sent to their cell.

35. New prisoners are allowed one telephone call, primarily to tell relatives or friends where they are. The officer gives them a £2.00 pin credit and they can use the telephone as soon as they get to the wing. (The prisoner telephone system is known as pinphone. Each prisoner is given a unique PIN to access their account, and are only able to dial authorised numbers.) The man made a telephone call to his family on 25 February.

36. The officer completed the Reception/First Night In Prison (FNIP) Information form for the man. The form said the man was offered a shower, a meal, a breakfast pack and a smokers pack. Notably, the question relating to healthcare issues/IDTS/ACCT was not completed.

Substance misuse assessment on 26 February

37. An officer on E wing. At interview, he explained that his role and responsibility is to allow prisoners out of their cells in the mornings and send them to work or to appointments around the prison.

38. An entry in the clinical record timed at 8.30am shows that the man had a substance misuse assessment. (The signature is illegible and I refer to the matter of standards in record keeping later in this report.) A later entry timed at 10.15am shows that a medical information request for a copy of his medical

[8] Insiders are a group of prisoners who are able to share their knowledge of prison and its systems with new prisoners. They only work on the induction wing at the prison.
[9] Listeners are prisoners trained by the Samaritans to offer confidential emotional support to fellow prisoners in crisis.

records was faxed to his doctor in the community. The form asked for a reply to be sent to a doctor, MO (Medical Officer), detoxification unit at the prison.

39. The substance misuse assessment was carried out by a registered mental health nurse (RMN). The nurse was employed by an agency. He worked in the prison detoxification unit around three or four times a week. In interview, he described himself as "still on probation as to the proceedings of the IDT Unit". He completed the detoxification induction assessment with the man.

40. The (RMN) completed the Detox Team New Reception/Transferred Patients Initial Assessment – Illicit Substances form. The man told him that he had self-harmed around four years before, due to relationship problems. The (RMN) told the investigator that he did not note any intent of self-harm at this time. More critically, he noted that the man felt "depressed/distressed" on the form but no action appears to have been taken. The (RMN) thought that the comment came as a joint assessment from himself and another nurse, who was supervising him in the interview. (The investigator identified that the other nurse was not present in the interview, but countersigned the document afterwards.)

41. The (RMN) told the investigator that he is aware of the ACCT procedure, but had not undertaken any formal training. He judged that the man was not distressed enough to be on an ACCT, but was only distressed because he was in prison. This appears to be an assumption and there is no evidence that this assessment was explored further. The assessment was sent with the man's file to be put with his medical record.

42. An entry in the clinical record, with an illegible signature, says that a substance misuse assessment was carried out on 26 February. An entry made by "the other nurse" confirmed that the man abused drugs. Mention is made of dihydrocodeine and tamazepam but the entry is unclear. The man was said to be complaining of insomnia and self harm but no specific action is noted other than for a referral to the detox programme and to write to his doctor.

43. Later the same day, a second medical information request form asking for copies of the man's health record was faxed to his general practitioner in Clacton.

44. The investigator spoke with the other nurse. In interview the nurse said he is a registered general nurse with a degree in health education. He explained that he had undergone special training in substance misuse at St George's Hospital, London and is trained to work in a secure environment. He had started working full-time at Chelmsford the previous month. He supervised the (RMN) because he was an agency nurse, did not have keys and he needed to supervise and protect him. However, he was not the nurse's line manager.

45. The nurse countersigned the assessment form but was vague in interview with the investigator and could not recall whether or not he had been present at the interview between the man and the (RMN). He said that he did not write the document. He was unable to assist the investigator to establish whether the man said he felt distressed/depressed or whether this was the nurse's opinion.

He commented that, if he had been there when this was said, he would have probed further and then referred the man to the mental health team. The nurse explained that he would have explored this further because there are signs to look for, such as fluctuations in mood. He said that a collective judgement would be made as to what action should be taken once a referral was made to the mental health team.

46. The nurse said that if he thought a person was in danger of harming themselves, he would put him on ACCT monitoring although he had not received training in how this should be done.

Missing medication

47. The (RMN) told the investigator that he remembered the man because he spoke with him on the morning of 28 February, in response to a note the man sent to the Unit. The note said that he needed some help because some of his tablets were missing. The man reported that his medication had been stolen the day before when he moved cells. The man said he received his detox medication for 28 February but his dose for the previous day had been stolen. The (RMN) explained that staff could not retrospectively give him medication for 27 February as there would have been a risk of an overdose. Two doses of the medication had been given to him, one to be taken the night before and the other in the morning.

48. The man told him that two tablets were missing. The (RMN) said this was unlikely as he would have taken one tablet which would have left him one for the morning. Therefore it was unlikely that both were missing. He did not believe that the man was telling the truth. The (RMN) told the investigator that the matter was dealt with amicably and the man understood that he would not get the medication he had missed. The (RMN) thought that he recorded this information but said he did not report the matter to the security department for investigation.

Events on 29 February

49. One of the documents relating to the man's short time at Chelmsford was a note with a number of dates. The 29 February and the date before were crossed off. It is likely that he used this as his own calendar to chart the days he was in custody until his court date on 4 March. The note was blunt and left no doubt about his feelings regarding the situation in which he found himself.

50. The officer on E Wing was on night duty. He arrived on the wing at around 8.30pm and received a brief handover from another officer. The officer explained that there is usually just one officer on the wing at night. Two officers continually patrol the prison and the wing officer has a radio if he needs assistance. He also carries a cell key in a sealed pouch which can be used to open a cell in an emergency. During the man's time on the wing the officer had not spoken to him as there is little interaction with prisoners at night.

51. After the handover the officer went on to Blue spur. He counted the prisoners on Blue landing one first and then Blue landing two. He walked across the spur to the Red spur second landing and then worked his way down to the Red one landing. The officer confirmed that this was his normal route. He started from cell 1-24 and worked his way down the numbers until he came to cell 1-16 when another officer gave him a spare battery for his radio. He said it was a matter of seconds between receiving the battery from the officer, thanking him and carrying on with his count. The other officer turned to walk off the wing.

52. Meanwhile an officer was dealing with three new reception prisoners and was waiting for another prisoner to arrive from the healthcare unit in a wheelchair. He recalled that he briefed the officer on E Wing at about 8.35pm. He was busy preparing the cell for the wheelchair prisoner and saw a Senior Officer (SO) and a Principal Officer (PO) arrive on the wing pushing the prisoner. He had just returned to the wing office to prepare paperwork when the alarm was raised and he and another officer went to the man's cell.

53. An officer said that he had finished work in reception at around 8.15pm. This was earlier than usual so he walked down to E wing. The Principal Officer (PO) who was in charge of the prison in the role of Oscar 1, was on the wing and assigned him to further duties. The officer walked on to E wing ground floor, Red spur and saw an officer counting prisoners. The officer on E Wing asked him to get him another battery for his radio, which he obtained from F wing, and then returned. On his return the officer on E Wing had just reached the stairs leading to the 2's landing. This was about two doors away from the man's cell. The officer took the battery and walked back to the door continuing his check.

54. The officer then came to the man's cell. He opened the flap in the door and saw the man sitting on the floor with his legs straight out and a ligature around his neck, attached to the window.

55. As an officer was just about to walk off the wing, the officer on E Wing called him back to the door. The officer confirmed this and said the other officer called to him that he did not have a key to open a cell door. (This was because he was a member of the night staff.) The officer had access to a key that he carried in a sealed pouch but it was quicker to ask the other officer to help. One of the officers called to the PO and SO, saying that the officer on E Wing had asked for the key to open a cell.

56. The officer said he was carrying a piece of paper around with him plus the battery. He placed them both on the floor. An officer unlocked the door and the other officer went in. As he went in to the cell, he pulled his anti-ligature knife out of his pouch and cut the ligature, supporting the man's head at the same time. One of the officers said that the SO supported the weight of the man's lower body and he was eased to the ground. An officer described the man as looking blue in the face, feeling clammy but not breathing.

57. At the same time the SO, was on duty as Assist Orderly Officer. This is an assistant to the principal officer PO responsible for running the prison, including responding to incidents.

58. The SO said that he and the PO, the Night Orderly Officer, (also referred to as Oscar 1[10],) needed to move a prisoner from E wing to healthcare where he could be placed on constant watch. To make room to do this, they had to move a prisoner in a wheelchair from the healthcare unit to E wing. The SO reversed into cell E 17 with the wheelchair prisoner. He said they heard a commotion outside and, as he was facing outwards from the cell, he could see two members of staff running past the door. He heard a cell door open. He and the PO were aware that there must be a problem as staff do not open a cell door at night unless they ask permission from either the Orderly Officer or his assistant. They concluded there was an emergency. The SO said that he and the PO made sure the prisoner was alright. The PO locked the cell and then went straight across to the man's cell.

59. The PO thought that around 30 to 45 seconds passed between the alarm being raised and his arrival at the man's cell. He quickly assessed the situation and called a Code 1 level emergency over the radio net. The PO explained the code system to the investigator. He said that a Code 1 is a serious life threatening incident, Code 2 was fairly serious and healthcare would attend quickly and Code 3 was a minor incident and healthcare would assist when they could.

60. The SO said that as he went into the cell, he saw one of the officers standing at the far wall and a prisoner sitting on the floor with his back against the wall. He noticed the prisoner had blue lips. He saw that two other officers were also in the cell, standing near the door. They told him they had found the man hanging. The SO felt a pulse in the man's neck, but his skin was cold and clammy and he was not breathing. He immediately started cardiopulmonary resuscitation (CPR). As the SO did this, he said he asked if anyone had a face mask. An officer passed one to another officer. The SO told the officer to give two breaths and he the SO, would give 15 compressions. They continued until healthcare staff arrived. The duty governor and the PO were also there.

61. An officer confirmed that another officer and the SO started CPR immediately with 30 compressions to two breaths which is the correct ratio. He said the SO was delivering chest compressions. They carried on until a nurse arrived and an officer continued to make sure the man had oxygen. He was aware of the arrival of the paramedics and they asked him continue to give the man oxygen. He said that the paramedics and the nursing staff did not relieve him of the task of giving oxygen.

62. At this point, another officer described himself as a "spectator" to the more experienced officers. He had recent first aid training but this was his first experience of this type of incident. The officer described the SO as very cool and calm, with the ability to give instructions to the officers present without any undue fuss. The PO approached him to make sure he was alright. He said the SO and an officer were attending to the man. The PO asked him and another

[10] Oscar 1 is the discipline officer who has the operation control of the prison
Oscar 2 assists Oscar 1 in his duties, doing whatever task Oscar 1 allocates to him.

officer if they could find other cells to move prisoners who were located immediately either side of the man.

63. The SO recalled that a Registered Mental Health Nurse (RMN) came into the cell and saw them carrying out CPR. She told them to carry on. She left the cell and returned with what the SO thought was either a stethoscope or equipment to measure blood pressure. The RMN tested the man's blood pressure. She asked the SO what had happened and he described the circumstances in which the man was found. He said that she then left the cell, returning with a defibrillator machine[11]. The SO said the defibrillator instructed CPR to continue which the RMN confirmed this in interview. An agency nurse, unknown to the SO, went into the cell and took over CPR from him as he was tiring. At that moment, they heard over the radio that the ambulance had arrived.

64. A Staff Nurse arrived at the man's cell with the RMN and a healthcare officer. She saw the man on the floor with an officer holding his head with his airway open. She relieved an officer who was carrying out CPR.

65. A nurse had completed her duty that day and was on her way home. She told the investigator that she saw a healthcare officer running from E wing towards the gate. She asked him what was happening and he replied there was a Code 1 medical emergency. As a nurse, she thought she could help. She saw the Staff Nurse and a newly qualified nurse assisting with CPR. She took over CPR from the Staff Nurse and continued until the paramedics arrived around three to five minutes later. She helped a RMN to attach the defibrillator to the man. The defibrillator said to stand clear (while it gave him a shock to start his heart) and then continue CPR.

66. At interview the SO said that he was not surprised that nursing staff did not take over CPR from the officers. He said the RMN checked that he and an officer were comfortable with what they were doing. The RMN confirmed in interview that she supervised the officers because they carried out CPR effectively. She said that she knew that the man's blood was circulating round his body as he felt warm.

67. The healthcare officer collected the defibrillator and helped the RMN by passing her the oxygen and the face mask, while the SO and an officer continued CPR.

68. The paramedics arrived and took responsibility for the man's care. The Incident Log records that the ambulance left the prison at 9.30pm. The Bedwatch Log says the man arrived at the hospital at 9.47pm.

69. Prison managers did not hold a hot debrief[12]. However, staff were offered support.

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[11] A defibrillator is a machine that delivers an electric shock to try and restart the heart in the event of cardiac arrest.

[12] A hot debrief is a meeting of all staff involved in an incident. It is held so that staff are able to share their experience of events and whether there are any early lessons to be learned or good practice to be highlighted. It is an opportunity for staff to speak to members of the prison Care Team if they need support.

Broomfield Hospital, Essex

70. At 11.20pm, doctors at the hospital told an escort officer, that the man was heavily sedated. At 11.25pm the escort officer contacted the prison. He said that the doctor advised that the man's next of kin should be contacted as his outlook was bleak. Members of the prison chaplaincy visited him.

71. The escort staff received a full update on 3 March. They were told that the man had ten per cent brain activity. He was able to breathe on his own, but had a chest infection.

72. On 4 March he was moved to a side room and some members of his family visited during the early evening. Sadly, his condition deteriorated and he died later that evening.

73. The prison asked the police to contact the man's family to tell them that he had died. His property was returned to the family by courier. The prison met the cost of the funeral.

ISSUES

Clinical care

74. The clinical review of the man's care was undertaken by Assistant Director of Governance, NHS Essex. In order to complete her review the clinical reviewer read the man's prison clinical record and spoke with the Head of Healthcare at Chelmsford. The issues she has raised relate to poor standards of record keeping. I endorse her recommendations and have incorporated them with my own.

75. In the clinical reviewer's opinion, the First Reception Health Screen document identified the man's existing drug dependency and previous treatment of mental health issues. She noted that he did not express any intentions of self-harm or suicide. The clinical reviewer concluded that the appropriate treatment plans had been implemented.

76. The man's family raised the issue of why it took a lengthy period of time for his medical records to be sent from his doctor. I am unable to answer this as it is outside the remit of the investigation. However, I am able to confirm that the prison faxed a request to the man's doctor on the morning of 26 February. The Head of Healthcare visited the man in hospital. In her entry in the clinical record, she said that she spoke with the man's family. The man's mother told her that he had been using heroin for five years and had a history of self-harm and overdoses using tablets. Whether this information would have been in his medical records in the community and would have helped is, unknown.

Reception health assessments

77. While he was in police custody, the police doctor noted on the Detained Person's Medical form that he was depressed. The nurse who conducted the First Reception Health Screen ticked the box on the document to indicate she had received health information from the police. However, despite being a registered mental health nurse, she did not probe the police doctor's assessment that the man was depressed or question the circumstances of his self-harm a few years before. She did not connect this information or question the differing information the man disclosed to her that he had a previous history of involvement with a psychiatrist around ten years before. She noted her impression of the man's behaviour and mental state at the time as "no thoughts of self-harm or suicide at present" and referred him to the detox team and the doctor for his physical injuries. This was the first missed opportunity to assess his state of mind.

78. A second opportunity was missed by an agency mental health professional, compounded by his supervisor. The nurse assessed the man as "feels distressed/depressed". There is no evidence to support that assessment or, crucially, that he explored it further. There is a suggestion that the nurse made an assumption that the man felt like that because he was in prison rather than on the basis of a sound clinical assessment. His supervisor countersigned the Detox Team assessment without questioning the judgement of the man's present mood.

79. Neither nurse considered it necessary to open ACCT monitoring on the man. This was a matter of judgement based on how he presented at the time. (It also transpired that they had not been trained to open ACCT documents, which I comment on below). Although, staff felt that such monitoring was not appropriate I judge that, given the assessment of depression, steps should have been taken to obtain a formal clinical assessment.

The Head of Healthcare should ensure that any medical information accompanying a prisoner or obtained from external sources which assesses a prisoner as depressed should be investigated by a clinician. The decision of any action or inaction should be recorded in detail in the clinical record.

The induction process

80. The Prison Service Order (PSO) for induction describes the induction of prisoners as a process. While the process at Chelmsford complied with the Prison Service Order, it is rapid and consists of a number of sessions by various agencies working in the prison who explain their purpose and the service they offer. It is completed within a 24 hour period. Prisoners are then moved on to make room for the next group to be inducted, with the result that staff rarely recall individual prisoners.

81. An officer, a reception and induction unit officer said that staff are available during the day but there is no formal interview with officers because they complete the required documents the night before. This approach suggests that officers' needs are prioritised over prisoners' needs, with the emphasis on whether officers have problems with prisoners rather than if prisoners are experiencing difficulties. The responsibility is placed upon prisoners to approach staff, but this might be difficult for some, particularly at such an early stage in their stay at the prison. It might be especially difficult for prisoners, such as the man, who are in prison for the first time and might not be comfortable about approaching staff. The officer said that officers on E wing take a more relaxed approach to prisoners' behaviour and issues. Personal officers are allocated by cells and not by individuals. Therefore, while personal officers are available, prisoners are on the wing for too short a time to have a personal officer. However, the officer told the investigator that induction staff are technically counted as personal officers and are their first port of call. In my opinion, this is not effective as most prisoners leave the unit within two days.

The Governor should ensure that confidential one to one interviews between personal officers and prisoners are a mandatory part of the induction process. This will encourage prisoners to use the opportunity to raise issues in a safe environment.

Loss of medication

82. The man told an RMN that someone had stolen his medication when he changed cells and that two tablets were missing. The RMN felt this was unlikely. He appears to have made an assumption that the man was lying and therefore took no action to investigate the matter further. He did not complete a Security Information Intelligence Report as he had not been trained to do so. He thought that he recorded it but only intended to report the matter to security on 26 March, after his interview with the investigator.

    The Governor and Head of Healthcare should ensure that reported thefts of medication are documented in a timely and appropriate manner. They should be reported immediately to the security department to enable prompt and thorough investigation.

Staff training in cardio pulmonary resuscitation

83. The SO confirmed that he had continuous first aid training in the past in the Army. However, he had not had a refresher course in the previous four years. Therefore, although experienced, his training had not been updated in accordance with current practices. It is clear that there was some confusion between himself and the officer on E Wing as to the ratio of breaths to heart compressions. European Guidelines for Resuscitation 2005 say that the ratio of compressions to ventilations is 30:2 for all adult victims of cardiac arrest. The officer said that he had not received refresher training in CPR since his original training as a prison officer.

84. One of the investigators spoke with the Governor of Chelmsford regarding staff training in CPR. The Governor confirmed that, since the man's death, the prison has a vigorous retraining programme in CPR for staff, with particular emphasis on training night staff. In the circumstances, I make no recommendation on this occasion.

85. I believe that the officer made a sterling effort to save the man's life. However, it was the knowledge and experience that the SO brought with him from his army career and previous incidents in the prison that was instrumental in the efforts to save the man's life. The reception and induction unit officer described the SO as very cool and calm, with the ability to give instructions to the officers without any undue fuss. The officer on E Wing commented that the paramedics said that it was the endeavours of the SO and himself that temporarily restored the man's breathing.

    The Director of Offender Management should write to the Senior Officer commending him for his command and direction during an incident of serious self-harm and his remarkable efforts to save a prisoner's life.

    The Director of Offender Management should write to the officer commending him for his part in attempting to save the life of a prisoner following an incident of serious self harm.

Hot Debrief

86. Prison Service Order 2710 paragraph 5.3, instructs that there must always be a hot debrief immediately after this type of incident and provision should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend.

87. A debrief did not take place on this occasion. The SO explained this was because of the time of night and the time taken dealing with the ambulance crew and paramedics. By this time, the police had arrived and they interviewed staff. He said he finally left the prison at around 2.30am so there was no time to do a hot debrief.

88. The investigator discussed this with the Deputy Governor at the time. He said he understood that the timing of the self-harm and the mandatory requirement for police interviews would have made it very difficult to hold a hot debrief. He was able to confirm from staff that they were seen by members of the Care Team. The investigator was concerned that at least one member of staff he interviewed was still distressed and needed additional support. The deputy governor agreed to act on this immediately.

    The Governor should ensure that a hot debrief is held in accordance with PSO 2710, at the first opportunity after an emergency.

89. The investigator queried whether it was possible that the man timed his actions in the expectation that he would be found in time. The officer on E Wing said that he did not think it possible that the man harmed himself knowing that somebody would be arriving at the door within a few seconds. His certainty was based upon his knowledge that the day count was completed at 8.00pm so that the prison numbers could be confirmed. He started his duties early and it was impossible for the man to have known that he would carry out his roll count at the time he did. He acknowledged that the man could have heard the flaps on the cell doors sliding open. He left them open because of the noise and because it was easier to keep track of the cells he had checked.

90. The investigator was surprised to learn that at the time of the man's death, there were no safer cells in the induction unit. They were only available on G wing where vulnerable prisoners are located.

    The Governor should consider providing safer cells on the induction unit. They will reduce the risk for prisoners identified as at risk of self-harm or suicide.

Liaison with the man's family

91. At the request of the prison, the police visited the home of the man's brother to tell the family the sad news of his death. They told the man's brother's partner and she agreed to tell his brother. This is contrary to the guidance for prison family liaison officers in "Liaison with Bereaved Families Following a Death in Custody Guidance Supplementary to Chapter 4 of PSO 2710 'Follow up to

Deaths in Custody'". Paragraph 4.9 says:

> "the family should be told face to face as soon as possible after the death. Whenever possible, this should be done by a dedicated Family Liaison Officer working alongside the Chaplain or Governor or the most senior individual available together with the Chaplain."

The investigator spoke with the deputy governor at the time, about the manner in which the news of the man's death was given to the family. The prison agreed that it was unacceptable that such news should be given in this way.

The family were disappointed that there had been no ongoing contact with the prison and that their attempts to get in touch with the family liaison officer had been unsuccessful. This meant that they had received very little information from the prison.

The Governor should ensure that prison staff, particularly those acting as family liaison officers, comply with the requirements of PSO 2710 and the supplementary guidance regarding breaking the news of a death in custody to the family of the deceased.

Record keeping

92. The clinical reviewer has highlighted the poor standard of record keeping within the clinical record and I agree with her views. Entries in the medical record are not timed and signatures are illegible. The clinical record makes no reference to the man's death. The clinical reviewer discussed these issues with the Head of Healthcare who explained that as he died at Broomfield Hospital, his medical notes were sealed for the Coroner in accordance with prison policy.

The Head of Healthcare should ensure that all healthcare staff are aware of their obligation to maintain records in accordance with the standards laid down by the Nursing and Midwifery Council.

Training

93. The investigation found that some healthcare staff working in reception and on the induction unit had not been trained to open ACCT monitoring. They were unfamiliar with prison policies and the procedures to report incidents such as the theft of the man's medication. Owing to a lack of training there were three nurses who did not know how to start the ACCT process on a prisoner who had been assessed as in crisis.

94. Although these members of staff did not consider ACCT monitoring to be necessary, it is likely that these were not informed decisions given the absence of training. Moreover, there is no evidence of active consideration of whether or not such monitoring was appropriate and the rationale for reaching their decision. Greater awareness might have led them to take account of a wider range of potential triggers for self-harm such as that it was the man's first time in prison

and his drug misuse.

The Governor and the Head of Healthcare should liaise to ensure that all new healthcare staff are trained in key prison procedures, such as the completion of Security Information Reports and the opening of ACCT documents, at the start of their employment in the prison.

The family's concerns on reading paragraph 54 of the report

95. The family have commented that they were told that the man was found hanging standing up. The investigation has documented that he was sitting down on the floor with his legs stretched out. The family are concerned to have been given misinformation about the specific details of his death. The family have asked that the governor remind staff of the importance of being clear of the facts before speaking with family.

The family's concerns on reading paragraph 91 of the report.

96. The family have commented that they were told of the man's attempt at suicide and not of his death by the police. They say the hospital told them of his death when he died some days later on 4 March.

CONCLUSION

96. The man was in his early thirties when he attempted to take his life at Chelmsford prison on 29 February 2008. He died on four days later on 4 March 2008 at Broomfield Hospital, Essex.

97. The man had not been in prison before and was a prolific and long term drug abuser. These two factors alone should have raised staff awareness and although reflected in the risk assessments by discipline staff, were not acknowledged by healthcare staff. At the time of his death, the reception and induction of prisoners at Chelmsford appears to have been a process which served to prioritise the practical aspects of induction. It did not give prisoners the opportunity to discuss their concerns in a private interview with a personal officer on the induction unit. Induction appears to have been a collective process with little focus on individual prisoners' needs.

98. I judge that there were two missed opportunities to assess the man's mental state. The first was missed by the reception nurse who did not appear to notice that the police doctor had assessed the man as "depressed". Nevertheless, she acknowledged that he misused substances and had physical injuries and accordingly, referred him to the detoxification unit and the doctor. The second opportunity, and the more critical instance, is that the nurse who conducted the substance misuse assessment noted the man as "distressed/depressed" but neither he nor his supervisor took any action. Thus, there was no exploration to discover the root of his mental state. It appears that an assumption was made that the man felt low because it was his first time in prison. That might have been the case, however, it was not fully explored as it should have been. It is possible that the man's death could have been avoided by an early intervention and with the support and monitoring of the ACCT document.

99. I am very impressed with the efforts of the SO and officer. It is clear from the statements and interviews by various staff that without their intervention, the man would not have been revived at all. The SO is to be particularly commended for taking command of the situation in a manner which was clearly appreciated by his colleagues and is in accordance with the highest standards of the National Offender Management Service.

RECOMMENDATIONS

1. **The Head of Healthcare should ensure that any medical information accompanying a prisoner or obtained from external sources which assesses a prisoner as depressed should be investigated by a clinician. The decision of any action or inaction should be recorded in detail in the clinical record.**

   Accepted. Information received on initial reception is viewed by a competent practitioner. The Duty Doctor is available for treatment, advice and guidance. Further information received via fax, care base or other sources is reviewed and discussed during health care meetings. A medical in confidence form is completed and signed by prisoners during the reception screening process in order for Health Care professionals to access on medical information from GP's and other agencies should it be deemed necessary.

2. **The Governor should ensure that confidential one to one interviews between personal officers and prisoners are a mandatory part of the induction process. This will encourage prisoners to use the opportunity to raise issues in a safe environment.**

   Accepted. Following the induction process all prisoners are interviewed by staff to ensure their needs have been met. The prisoners sign a disclosure to confirm this fact and they have no-ongoing issues.

3. **The Governor and Head of Healthcare should ensure that reported thefts of medication are documented in a timely and appropriate manner. They should be reported immediately to the security department to enable prompt and thorough investigation.**

   Accepted. All staff are aware of SIR's the Head of Healthcare has reminded everyone of this process via e-mail. This action point has been circulated to all healthcare staff for their information.

4. **The Governor should ensure that a hot debrief is held in accordance with PSO 2710, at the first opportunity after an emergency.**

   Accepted. There has been a review of the contingency plans. Any similar event will be appropriately de-briefed in accordance with Prison Service Orders.

5. **The Governor should consider providing safer cells on the induction unit. They will reduce the risk for prisoners identified as at risk of self-harm or suicide.**

   Accepted. A safer cell is now available on F wing, induction unit. This can also be used as a constant supervision cell to support prisoners who are deemed to be high risk of suicide or self harm.

6. **The Governor should ensure that prison staff, particularly those acting as family liaison officers, comply with the requirements of PSO 2710 and the**

supplementary guidance regarding breaking the news of a death in custody to the family of the deceased.

Accepted. There has been a review of instructions for staff involved in the management of an incident such as this. Any similar incidents will be appropriately managed in accordance with PSO 2710.

7. **The Head of Healthcare should ensure that all healthcare staff are aware of their obligation to maintain records in accordance with the standards laid down by the Nursing and Midwifery Council.**

   Accepted. Head of Healthcare has reminded staff of the importance of this. A compliance check system will be put in place.

8. **The Governor and the Head of Healthcare should liaise to ensure that all new healthcare staff are trained in key prison procedures, such as the completion of Security Information Reports and the opening of ACCT documents, at the start of their employment in the prison.**

   All directly employed staff undertake[n] an induction set by the Learning and development training manager, this includes key prison procedures and is delivered by the Security Manager. HCC staff then spend a period of time shadowing experienced members of the HCC team to ensure competence and confidence in procedures and policies. The safer custody manager proves training dates for ACCT to the Operation Team Leader for HCC training. Agency staff undertake the security talk on completion of vetting/security paperwork, they also complete a period of shadowing with an experienced member of nursing staff and also complete ACCT training.

The Family's response

The man's family have said that they are very concerned at the missed opportunities by healthcare staff to assess his mental health, particularly given his increased vulnerability as this was his first time in custody. They agree with the Ombudsman's recommendation regarding this matter as well as other recommendations relating to improvements in procedure. In particular the family agree with those recommendations relating to liaison with the bereaved family and the training of healthcare staff. The man's family believe he was viewed as just another addict and that his needs were not properly assessed as a result. They feel that prisons, such as Chelmsford, should have processes already in place to assess, protect and support a prison population that, by nature, is more likely to have substance misuse and/or mental health issues.

COMMENDATIONS

1. **The Director of Offender Management should write to Senior Officer commending him for his command and direction during an incident of serious self-harm and his remarkable efforts to save a prisoner's life.**

2. **The Director of Offender Management should write to the officer commending him for his part in attempting to save the life of a prisoner following an incident of serious self harm.**