

**Investigation into the death of a man
at HMP & YOI Chelmsford in June 2012**

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

March 2013

This is an investigation into the death of a man, who was discovered hanging in his cell at HMP & YOI Chelmsford in June 2012. Despite the efforts of staff and paramedics, he could not be resuscitated. He was 20 years old. I offer my condolences to his family.

The investigation was carried out by an investigator. The local PCT commissioned a clinical reviewer to carry out a clinical review of the man's medical care at Chelmsford.

The man had a troubled background and a history of mental health problems. Healthcare professionals and other staff at the prison worked actively with him and tried to understand his challenging behaviour. However, he was often uncooperative and gave conflicting accounts of his health and how he was feeling. He had been prescribed anti-psychotic medication for some time but decided to stop taking it, against medical advice. He was also anxious about a number of issues in his life, but was not forthcoming about most of these.

Despite having a number of apparently good and supportive relationships with staff at Chelmsford, no-one noticed anything out of the ordinary about the man on the day he died. Accordingly, the investigation concludes that it would have been difficult to predict or prevent his death.

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.

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Prisons and Probation Ombudsman

March 2013

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SUMMARY

1. The man was born in July 1991. He had served a previous custodial sentence at Chelmsford prison, and was released in December 2011.
2. In February 2012, the man was an in-patient at a Mental Health Unit, when he attacked another patient. As a result he underwent a psychiatric assessment which determined that he was fit to be arrested and he was taken to Basildon police station. He was remanded in custody at Chelmsford prison on 11 February.
3. The man was subject to ACCT procedures twice in Chelmsford. Firstly when he arrived and then again for one day in March. Both times he threatened to kill himself and later retracted the statements. We have concerns about the quality and lack of multi-disciplinary involvement at the ACCT case reviews.
4. The man gave a mixed account of his drug history. He told staff he had recently taken heroin, and had taken cocaine in the past, but refused to be referred to the prison's drug treatment team for an assessment. He subsequently provided a urine sample which tested positive for cannabis only and then said that cannabis was the only drug he had used in the past. He had been prescribed an anti-psychotic drug and a mood stabiliser in the community and these continued in Chelmsford.
5. The man was under the care of the Early Intervention in Psychosis Team and had been assigned a community psychiatric nurse. He was also assigned a key worker at the prison, who worked closely with him and arranged for him to be further assessed by a psychiatrist. He was assessed on 27 February and it was noted that he did not exhibit any signs of a psychotic illness or mood disorder. He attended an anger management group, a creative expression group and a relaxation class.
6. Throughout his time at Chelmsford, the man received a number of warnings from staff about poor behaviour. He became involved in fights which often led to him being moved to the Segregation Unit.
7. On 10 April, during an assessment with the prison's psychiatrist, the man said that he had pretended to be mentally unwell in the past and that he had never harmed himself. He apologised for lying about his illness. It was decided that he should remain on his current medication, as the psychiatrist did not consider he could carry out a drug free assessment safely in a prison environment.
8. Shortly before the man died, he became concerned that he would have nowhere to live when he was released and was also worried about his mother's health. He had received a letter from the Department of Work and Pensions informing him that he owed a substantial amount of money. In addition his solicitor told him that, as he had been assessed as not having a mental illness, this could no longer form part of his defence. From 7 June, he stopped collecting and taking his medication. This appeared to go un-noticed

by staff although there was supposed to be a system to identify this. None of these potential problems or triggers seemed to have been identified by staff.

9. In the middle of June, it was reported that the man raised no concerns to staff. He went outside during the exercise period and collected his lunch. Later that afternoon, when unlocking prisoners to collect their evening meal, an officer found him hanging by some bed linen threaded through a privacy screen in his cell.
10. Staff responded quickly and attempted to resuscitate the man. Paramedics arrived, checked him and confirmed he had died.
11. A post mortem report concluded that the man had died from hanging.
12. This report makes six recommendations. These concern SAFE procedures, access to religious services and funeral costs. Other recommendations relate to proper follow up of prisoners who do not collect medication and healthcare records. There is one recommendation to the Governor and the Head of Healthcare about the quality of ACCT procedures.

THE INVESTIGATION PROCESS

13. On 16 June, notices were issued to staff and prisoners at Chelmsford, informing them of the investigation and inviting anyone with relevant information to contact the investigator. The investigator visited Chelmsford on 20 June 2012 and met the deputy governor, a member of the Independent Monitoring Board, a member of the Prison Officers' Association and the prisons family liaison officer. She was shown around the prison and viewed the man's cell.
14. The investigator conducted interviews on 3, 4, 10, 25 July and 7 August, accompanied by the clinical reviewer for some interviews, and an Assistant Ombudsman for others. One of the man's friends, who had left the prison, gave the investigator a written statement.
15. The investigator provided verbal feedback about the early stages of the investigation to a prison manager and written feedback to the Governor on 31 July.
16. The local PCT commissioned a clinical reviewer to carry out a clinical review of the man's medical care. The clinical review was received on 16 August. The Coroner for Essex and Thurrock was informed of the investigation and will be sent a copy of this report to assist with her enquiries.
17. The investigator and one of the Ombudsman's family liaison officers visited the man's mother on 6 September. She asked exactly how her son had died and at what time, as she believed he had died some time earlier than recorded. She also wanted clarification about how he was able to take his life.
18. As part of the consultation process, the man's mother and legal representatives received a copy of the draft report. They raised concerns about the man's mental health, the medication he received and his level of supervision. We share these concerns and have covered these matters in the investigation report. We have made no amendments in light of these comments.

HMP/YOI CHELMSFORD

19. Chelmsford is a local prison accepting prisoners directly from courts in its catchment area, mainly in Essex and London. It holds up to 710 adult and young adult men. Accommodation is in four residential wings (A, B, C and D) in the older Victorian part of the prison and in three separate new units (E, F and G).

Her Majesty's Inspectorate of Prisons (HMIP)

20. The most recent inspection of Chelmsford was in May 2011. Inspectors noted about bullying and violence reduction:

“Arrangements to deal with violence had improved. There was an overarching violence reduction strategy based on analysis of the pattern of violence in the prison and informed by meaningful consultation with prisoners. The collection of data was consistent and the overarching structures to monitor the progress of the violence reduction strategy were very good. The use of prisoners as violence reduction representatives, particularly on the young adult units, was a good initiative. Although the number of violent incidents remained too high, particularly among young adults, most fights and assaults were low level and the number of serious assaults was low.”

21. With regard to suicide prevention, the report said:

“A comprehensive strategy set out procedures to minimise the risk of self-harm. Protocols were well known to staff and prisoners. The multidisciplinary suicide prevention committee met monthly to monitor and ensure consistent implementation of the policy. There were good links with the mental health in-reach team. The Listeners' scheme was well supported, their role was properly advertised and prisoner had good access to them. Despite solid structures, the quality of self-harm monitoring forms was inconsistent. Care mapping required some further development, attendance at case reviews was sometimes irregular and written entries on HMP/YOI Chelmsford observation forms were sometimes cursory. The attitude of staff to prisoners at risk was particularly good throughout the prison and the level of care was generally high.”

Independent Monitoring Board (IMB)

22. Each prison has an IMB made up of unpaid volunteers from the local community who help to ensure standards of care and decency are maintained. In their report for the period between 1 September 2011 and 31 August 2012 the IMB noted:

“The importance of Safer Custody, Violence Reduction and the ACCT process is continually apparent throughout all areas of the prison and many aspects are also included in other sections of this report.

Current Violence Reduction data indicates a downward trend between the reduction in the number of YPs and the number of violent incidents... The Safer Custody meetings reflect the team's work effectively from their strategic approach to the care of individual prisoners.

Whilst Young Prisoners (a high proportion of which are BME sent from London Courts) continue to account for the majority of disciplinary issues, current data indicates that the Prison's Violence Reduction initiative has significantly reduced the number of Adjudications resulting in fewer CC awards. Since the opening of other prisons in London, this population has declined markedly".

Violence Reduction

23. One of the purposes of the Violence Reduction Team at Chelmsford is to investigate any acts of anti-social behaviour by prisoners. A member of the team will interview the prisoner to find out what happened and why. The team are alerted to incidents by any member of staff in the prison. Part of the team's work is to oversee the SAFE process (Safe and Fear Free Environment).
24. Chelmsford devised a SAFE policy in April 2011 as part of the Violence Reduction Strategy. The purpose of SAFE is to identify, monitor and manage prisoners who display anti social behaviour. The objectives of the policy are:
 - To increase problem solving capacity of staff and prisoners
 - To improve risk management
 - To reduce violent offending and prevent victimisation
 - To contribute to safe resettlement and release.
25. There are different levels of SAFE for tackling anti-social behaviour and any forms of violence. SAFE level 1 is the first level where a prisoner's behaviour would be monitored. SAFE 2 can restrict a prisoner's regime to a basic level. SAFE documents should be reviewed every seven days by the senior officer on the wing.

Incentive and Earned Privileges Scheme (IEP)

26. The IEP scheme which runs in all prisons allows prisoners privileges for reaching and maintaining certain standards of behaviour and compliance with their sentence plan targets. If standards are not maintained then the privileges can be withdrawn. There are three levels on the scheme – basic, standard and enhanced - with a different regime and privileges attached to each level.

Self-harm monitoring

27. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened by anyone

working in the prison if they have concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and set according to the perceived risk of harm. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Previous deaths at Chelmsford prison

28. There were two deaths at Chelmsford in 2011. Although both were self inflicted, the circumstances were very different from those of the man's death. However, a criticism was made of the management of the ACCT process in one of these reports. Two prisoners have died at Chelmsford since his death. The circumstances are still being investigated.

KEY EVENTS

February 2012

29. On 10 February, while he was an inpatient at a Mental Health Unit, where he had been admitted the previous day, the man allegedly assaulted another patient. He was transferred to another Unit for a psychiatric assessment. A consultant psychiatrist concluded he was not suffering from any acute mental health problems which needed further treatment in hospital. As a result, he was arrested and taken to a police station.
30. The PER (person escort record) which accompanied the man from the police station to the magistrates court, noted he suffered from bipolar disorder and schizophrenia.
31. The man was remanded into custody to Chelmsford prison on the same day. He had previously been released from Chelmsford, on 23 December 2011. During this previous period of imprisonment he had not been subject to suicide monitoring procedures, known as Assessment, Care in Custody and Teamwork (ACCT) at any time.
32. A Cell Sharing Risk Assessment (CSRA) on 11 February judged the man as a high risk of violence to other prisoners and, therefore, unsuitable to share a cell.
33. During the first reception health screening, the man said he used drugs (heroin) which he injected into his arms and toes. He said he had done this as recently as two days before, but refused to be referred to the Integrated Drug Treatment Strategy team (IDTS) for an assessment. He also told a nurse that he had been prescribed olanzapine, an antipsychotic drug. The nurse confirmed that he received both olanzapine and epilim (a treatment for epilepsy, but also used as a mood stabiliser for people with psychiatric illness and bipolar affective disorder) in the community.
34. The man told the nurse in reception that he might harm himself because he was not getting the medication he felt he required (it is not recorded which medication he was referring to). The nurse told an officer, who in turn opened an ACCT. The officer wrote that the trigger for opening the ACCT was that the man was not getting his medication issues resolved.
35. The “concern and keep safe” part of the ACCT was completed on 11 February. It was noted that the man had harmed himself before and had been in a secure hospital in Basildon. He was recorded to be very quiet, had said that he had used heroin and cocaine occasionally and had bipolar disorder. An immediate action plan completed by a Senior Officer (SO) indicated that he would remain in a single cell until a CSRA review and ACCT assessment had been completed. He would be observed hourly until the ACCT assessment. He was informed about the role of Listeners (who are trained and supported by the Samaritans to offer confidential, emotional support to prisoners in distress) and the Samaritans.

36. The next day, 12 February, the officer assessed the man, who said he had harmed himself a week earlier by cutting his wrists, but could not explain why he had done so. He told the officer that an “act of suicide” led to him being admitted to hospital. The officer noted that he had bipolar disorder and had medication for this. He said his medication had recently been lowered which had made him feel worse and that he suffered from paranoia and anxiety, but he had no thoughts of suicide.
37. The man also told the officer that, although he had used drugs in the past, he had been “clean” for the last five months (despite saying he had recently used heroin during his reception screen). The officer wrote in the ACCT that the medication issue needed to be resolved and that the man would like to get a job in the kitchen, as he had worked in catering previously. There is no information in the ACCT to show that staff took any action about this.
38. On 12 February, a SO joined the officer and the man at the first ACCT case review, without any healthcare input. It was noted that he had come from a psychiatric unit and had been in custody at Chelmsford before. He had a long history of harming himself, but said that at that time he did not have any suicidal thoughts. It was agreed that the ACCT would remain open until the medication issues had been resolved. The next review was set for 20 February. The caremap noted the issue of medication and that he should see a doctor or psychiatrist. (The status of action was marked as ongoing with a tick beside it which indicated it had been completed.)
39. The man’s CSRA was reviewed on 12 February and he was reduced to standard risk. This meant that he was able to share a cell with another prisoner. However, he remained in his single cell.
40. On 13 February, the man provided a urine sample for drug screening and tested positive for cannabis only. He now said that he only used cannabis and no other drugs. He complained that he felt his mental health was deteriorating because he had not received the correct medication and requested to see someone from healthcare. Later that day, a prison doctor prescribed him epilim chrono tablets, one a night for seven nights, and olanzapine 10mg, one a night for seven nights.
41. On 14 February, the man appeared at magistrate’s court and was assessed in the court cells by a nurse from the Criminal Justice Mental Health Team. She noted that he was already under the care of the Early Intervention in Psychosis Service (EIP), and a community psychiatric nurse was his care coordinator. He had a long history of unpredictable and aggressive behaviour, complicated by drug use from the age of 15 years. He did not present with any acute psychosis, but was distressed by his situation. He said he had been using cocaine as well as cannabis over the previous three months. He said he had thoughts of harming himself and was on an ACCT at Chelmsford. The nurse wrote that “due to risks to himself and others he is not able to go to a low secure unit and a forensic assessment for the offences would be recommended to have a more extensive assessment of his mental

health, behaviour, and offending behaviour". He returned to Chelmsford later that same day.

42. The next day, 15 February, the man's solicitor wrote to Chelmsford prison and said that the Criminal Justice Mental Health Team would be seeking an assessment for a referral to a medium secure mental health unit. They said he had a long history of mental illness and had been diagnosed in the past with schizophrenia and bipolar disorder. As he was considered to be violent, and the Mental Health Unit no longer wished to treat him, they asked that he be referred to a medium secure unit, depending on the outcome of the assessment.
43. On 16 and 18 February, the man received IEP (incentive and earned privileges) warnings because he had refused to complete some documents. (what they were is not explained.) On 19 February, a SO told him he had 28 days to improve his behaviour. If he received another warning he would be referred to the IEP board for a demotion to the basic regime. That day, he received a further warning for negative behaviour.
44. The man attended an ACCT case review on 20 February, with a SO and a member of the chaplaincy. They assessed his level of risk as low. He told them he was fine and that he did not feel suicidal or at risk. He said that as long as he had his medication he was okay, but felt he would benefit from a higher dosage. It was noted that no representative from healthcare was available for the review, but it was recorded that they would be informed. (It is not clear from prison or medical records if this was done.) The ACCT was closed and a post-closure review scheduled for 27 February.
45. A nurse, spoke to a SO on 20 February about concerns she had about the man. She noted in his medical record that he claimed to be "plugged" with heroin. She said he presented as mainly incoherent, but said that the medication he had been prescribed was too low. She was concerned that he was sharing a cell (there is no evidence in the prison record to clarify when, or if, he began sharing a cell) as she believed he was a high risk of assaulting another prisoner. She noted that wing staff said they would allocate him a single cell and she would liaise with the mental health team about his current situation and his medication. She also received an application from him that day to see a doctor to discuss his medication. He was prescribed olanzapine and epilim chrono for 28 days.
46. On 21 February, the nurse who had been assigned as the man's clinical key worker at the prison, telephoned his community psychiatric nurse to check his medication and arranged for him to be seen by a prison consultant psychiatrist. Later that day, she received a telephone call arranging for him to be assessed by a consultant psychiatrist appointed by his solicitor.
47. Also on 21 February, the man's CSRA was reviewed and his risk level was raised "due to information received reference violence in custody – Arson 2008 – and mental health issues". This meant he was not regarded as

suitable to share a cell with another prisoner. Another review was scheduled for 28 days later.

48. The man was assessed by a psychiatrist on 27 February. It was noted in the medical records that the psychiatrist had said that he had not exhibited any signs of a psychotic illness or mood disorder.
49. On 28 February, a SO spoke to the man about his behaviour. She explained to him that she was issuing him with a final warning, and any further negative behaviour within the next 28 days would mean he would be placed on the basic regime. The entry in his record does not explain the reason for this warning.
50. A post-closure ACCT review was held on 29 February by a SO, two days later than scheduled. She noted that he had seen a psychiatrist and his medication issues had been resolved. She had spoken to him and he said he had no thoughts of harming himself. She also wrote that he had been encouraged to find employment in the prison, although it was still not clear if staff did anything to assist him with this. She decided that the ACCT should remain closed.
51. The man's clinical key worker visited him on F wing that day with his community nurse. The key worker noted in the medical records that he looked well kept and interacted in a coherent and appropriate manner. He said he was concerned that the psychiatrist had said he had no mental illness and he did not understand because he had been hospitalised in the past and had been prescribed medication for his mental health.
52. The man also said that he had been hearing voices. He told the key worker that the voices were not telling him to harm himself and he had no thoughts of doing so. He said he was happy to be alive and that he was looking forward to getting out of prison and not returning.
53. The man and the nurses spoke about how he needed to engage with his community nurse when he was released from prison, and she agreed to visit him again to discuss his accommodation issues.

March 2012

54. The man regularly attended Muslim prayers at Chelmsford. On 5 March, he requested his mother's contact details from a mental health nurse. She spoke to his community project worker and the Security Department and then gave him the information. Later that day he attended a relaxation and acupuncture session with a tutor in the prison's daycare centre.
55. On 8 March, the man's CSRA was reviewed again and his risk was reduced to standard. It was recorded that there were no mental health concerns and he was taking medication. He was employed in the kitchen and appeared stable and well behaved. He had asked to share his cell but the records show that he remained in a single cell.

56. Also on 8 March, the man reported sick and a nurse went to see him in his cell. He would not sit up or open his eyes. He said he had no energy. He did not have any cold or flu symptoms and she assessed him as fit for work but he refused to go. The nurse left a message for the mental health in-reach team to see him because of his fluctuating mood. There is no record that this was done.
57. On 15 March, the man made threats to kill himself and an ACCT was opened. Earlier that evening he had been reprimanded for continually pressing his cell bell to request tobacco. Later, he had been seen sitting in his cell on E wing with a ligature (it is not clear from the notes what had been used to make the ligature) tied around his neck and attached to the bars of the window. He said that he was “pissed off about not having any tobacco” and wanted to return to G wing, where he had lived during a previous sentence. He is recorded as saying that he was trying to play the system to get what he wanted and that he “tells people he self-harms when he hasn’t so when he goes to court they think he is crazy and release him early”. He said that he had a supportive mother who did not know he was in prison and that he did not want any family involvement while he was on an ACCT.
58. A nurse completed an individual care plan for a prisoner placed on constant supervision. He wrote that the man had said he had felt stressed and that he was “not getting his needs met”. He remained adamant that he intended to kill himself. The nurse also completed the ‘Concern and Keep Safe’ part of the form. He noted that the man had not said why he had attempted to take his life and he had said he should contact a mental hospital if he wanted any details about his mental health. The nurse wrote that he should be on constant supervision and should not have any shoelaces or razors in his possession and should take his medication in the presence of a member of staff. That evening, while he was constantly supervised, entries in the ACCT record were completed every 15 minutes.
59. The man attended an ACCT review at 2.00pm on 16 March with an operational manager, a senior officer and two members of healthcare staff. He said that he had been stressed due to a lack of tobacco and that he had not intended to harm himself. He said that he had been trying to manipulate the situation so he would be given tobacco. He had initially ordered tobacco on his canteen sheet, but changed this to protein drinks instead, and he regretted that decision. No mention was made about his desire to return to G wing. It was agreed that his observations would be reduced to three observations during the day and hourly during patrol state (when prisoners are locked in their cells at lunchtime and at night). There was no discussion about what the nurse had written in the Concern and Keep Safe part of the form. The next review was scheduled for 20 March.
60. A caremap completed on 16 March, noted the man’s issue with tobacco and that he wanted to stop smoking. He was advised to put in an application to attend a smoking cessation course. He also said that he wanted to go to the gym but had lost his gym card. He was advised to request a new card so he

could attend. Both actions were for him. He did not attend Muslim prayers that day, as he said he felt unwell.

61. On 19 March, the man attended another relaxation and acupuncture session. It was noted that he engaged well.
62. On 20 March, the man attended a second ACCT case review with just a senior officer and an officer and no healthcare input. He again said that it was a lack of tobacco that had led to his actions and that he was sorry for what he had done. It was noted that his job in the kitchen was going well and he had no intention of harming himself. It was agreed that the ACCT should be closed.
63. Later that day, a nurse saw the man in his cell as he had refused to go to work that morning. He disputed that he had said he was sick and said he had not been called for work by staff. A nurse visited him twenty minutes later and he told him he had not got up for work as the medication he was taking made him feel tired. He acknowledged that the medication was helping him and said he would try to get up on time in future. He told the nurse that he had no thoughts of harming himself, was not hearing any voices and presented as being calm and settled.
64. Later that evening the man was involved in a fight on C wing which was broken up by an officer. No one sustained any injuries and both prisoners were charged with a breach of Prison Rules. An officer from the Violence Reduction Team first met with him on 20 March after the fight. He described him as a "likeable rogue" who had a keen sense of humour. He told the officer that he had had a few personal problems with the other prisoner and things had become a little heated between them, which was why they had started fighting.
65. On 21 March, the man was given a behaviour warning for shouting abuse at an officer from his cell window. The next day he attended a disciplinary hearing. He was found guilty of fighting and received a punishment of three days cellular confinement to be served in the segregation unit.
66. On 23 March, a note in the man's case history said that he was unable to attend Muslim prayers as he had only been in the segregation unit a short while and staff had not had enough time to work with him. Instead, the Imam came to see him in his cell. A nurse also saw him that day and no issues were reported. Later that day his clinical key worker visited him and noted that he presented well and was coherent and spoke to him appropriately. He said he had been taking his medication and that the fight was not related to his mental health.
67. The next day, 24 March, an entry in the case history notes said that the man had caused no problems in the segregation unit and had been fully compliant with the regime. He was seen by a nurse, who noted no problems. He was relocated to F wing.

68. A SO carried out an ACCT post closure interview on 27 March. The man told the SO that he felt fine and did not feel stressed as he was smoking again. Also on 27 March, he was due to attend prayers but did not. No reason was given, but he attended the week after. On 28 March, he was given a warning for misusing his cell bell.
69. The man complained of a painful leg on 29 March and told a nurse he had a lump on his lower leg. However, he would not get out of bed or co-operate with the nurse's examination. She assessed him as fit for work. Later that day, he attended a creative expression group (art therapy) and was reported to engage well.

April 2012

70. On 2 April, the man was given a verbal warning to improve his work effort. He had to be asked again a little later and was then given a written warning. A few minutes after that he was abusive to the officer who told him to make more of an effort, so was given a second written warning and then an IEP warning. He attended a relaxation and acupuncture session in the afternoon.
71. On 5 April, the man received a visit from his care worker in the community. He was the man's Project Worker in the Leaving and Aftercare team for Essex and was involved because he had been in local authority care, rather than because he was an offender or because of any mental illness.
72. An entry in the man's prison case notes on 8 April noted that he had displayed some poor behaviour during the previous week. An officer spoke to him about this who said he wanted to move off the wing. The officer advised him to speak to the Violence Reduction Team about this, as they would need to be consulted about which wing he could go to because of his previous fight with another prisoner.
73. On 10 April, the psychiatrist's written report of her assessment carried out on 27 February was received. There was no explanation for the delay. It said that the man "does not suffer from any acute mental health problems which need further treatment in hospital. However, he had a history of Bipolar Affective Disorder (BPAD) and was reported to be on medication in the past. Based on my assessment he is fit to be detained in custody".
74. The man was also assessed on 10 April, by a consultant psychiatrist with the prison's in-reach team. The man's care co-ordinator and clinical key worker were also present. The psychiatrist noted that he was taking olanzapine (10mg) and sodium valproate (used in the treatment of bi-polar disorder as well as other conditions) and that during the assessment he was reluctant to talk about some things. He said that he thought he would be at the prison for another two months, but was aware he could receive a longer sentence. He said he was still not happy with the medication, but that he probably did not need it. He said he believed he was "a bit manic" which is why the medication had been prescribed. He was reluctant to discuss his family and became very

upset. He said he had not spoken to his mother for four months and that he was worried about her.

75. The man said that he had pretended to be mentally unwell “as I know I will gain something”. He also told the team that he had never self-harmed as he was not that kind of person. He said he was ashamed and embarrassed about his offence which he did not commit because of mental illness but because he was angry. He said he had no plans to harm himself and that the voices he said he heard were his own thoughts. He asked the team to apologise to the people he had lied to about an illness.
76. The psychiatrist noted that the man had previously received a diagnosis of BPAD and schizophrenia and had been sectioned under the Mental Health Act. However, the doctor, care co-ordinator and clinical key worker agreed that there was no evidence of a clinical depression, elation or psychosis. They considered there was no information to support a diagnosis of schizophrenia and that, at best, a diagnosis of BPAD was questionable.
77. The psychiatrist noted that the medication the man was taking probably added to his confused state and that he should be assessed over a long period while free of medication. However, he considered that a drug free assessment could not be safely undertaken in a prison environment and that he should continue on his medication. The psychiatrist added that he displayed traits of dissocial personality (similar to anti-social personality disorder) and polysubstance misuse, and had anger management difficulties.
78. On 12 April, the man refused to attend the creative expression group. He attended Muslim prayers the next day.
79. The man’s prescription charts from 14 April were the only ones available to the investigator. The chart showed that he was prescribed Epilim chromo 200mg tablets and olanzapine 10mg, to be taken once at night.
80. On 15 April, the man was given an IEP warning for obstructing staff by refusing to move cells. It was noted in his record that “this man is due his final written warning”.
81. On 16 April, the man’s clinical key worker saw him, who said he agreed with the psychiatrist’s assessment of him a few days earlier, but was considering stopping his medication. She said he should speak to a doctor about this before taking any action and he agreed that he would.
82. In the meantime, the community project worker had discussed the man’s medication with his supervisor and a mental health professional in his team. He attempted to contact the prison’s healthcare department to ask why he was on medication. He made a note that he telephoned on 16, 18 and 23 April. He said that he left messages each time, but nobody telephoned him back.

83. On 17 April, the man's clinical key worker saw him in his cell on F wing. He said he always felt tired which he thought was because of his medication. He had missed an appointment with the doctor to discuss this as he had been asleep. She advised him to submit another application to see a doctor.
84. The man was involved in a fight with a prisoner on F wing on 19 April. A disciplinary hearing was held the next day and he was given a punishment of seven days cellular confinement suspended for three months. He also forfeited canteen (the opportunity to buy goods from the prison shop) and association for seven days. Later that day, he was issued an IEP warning for misusing his cell bell. He had asked for a shower before attending Muslim prayers. It is not recorded whether he was able to have the shower.
85. The man was prescribed a further 28 days olanzapine and epilim chrono medication, on 19 April.
86. The community project worker visited the man on 25 April for an hour. He said he was enjoying the camaraderie of the other prisoners and the absence of any responsibility. He said he was still on medication and asked for reassurance that he was not mentally ill. The project worker reminded him that every healthcare professional who had assessed him had found no mental illness. He said the man seemed relieved.
87. On his way out of the prison, the project worker asked staff how he could get in touch with a member of the mental health in-reach team, as he had tried unsuccessfully to contact them by telephone. He was directed to the main gate where he was met by the acting team leader for the in-reach team. She told him that the man had admitted that he lied about hearing voices because he thought it might help his upcoming court case. She said that his medication was being reduced gradually as a quick reduction could cause side effects.
88. On 26 April, the man transferred to B wing. No reason was noted in his prison records.

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89. On 2 May, the man attended an assessment for counselling. He engaged well and was put on the list for when a place became available. In the meantime he was to continue with the relaxation and acupuncture group, the creative expression group and attend an anger management course.
90. On 11 May, the man appeared before Crown Court via video link. The hearing was adjourned for reports and the date of his next court appearance was 25 May.
91. On 13 May, the man was involved in a fight on B wing exercise yard with two other prisoners. He had no injuries. He was placed on a disciplinary charge, but the hearing did not proceed. The same day he was issued a warning for misusing his cell bell to ask for a shower before Muslim prayers.

92. On 14 May, the man was placed on SAFE by a SO and on a basic regime because of the fight the day before. The SO identified his anti-social behaviour in the SAFE document and decided that staff should observe and have a conversation with him each morning and afternoon. The SO noted in the Immediate Action Plan part of the form that there were no concerns about him sharing a cell with another prisoner, that a case review had been arranged, staff on the wing had been briefed and the SAFE form had been logged centrally. The caremap part of the form was also completed by the SO. He identified goals for him to stop fighting and to engage with the Violence Reduction Team.
93. On 14 May, the man was prescribed a further 28 days of olanzapine and epilim chrono medication, at the same dosage as previously.
94. On 16 May, the man attempted to prevent an officer closing his cell door. The officer noted that he pushed him into the cell to enable him to close the door. Once he had done so, he arranged for him to see the duty nurse, who reported no injuries. A Use of Force form was completed by a SO, who reported no injuries to him or staff and that hand cuffs had not been used. He was not charged with a disciplinary offence.
95. The project worker visited the man on 16 May, and said he seemed less buoyant than previously. He told the project worker that he was attending courses and still on medication. He said that the dosages had not been reduced and that he had shared some of his medication with another prisoner who had become "like a zombie". The project worker told him that a nurse had closed his case as he did not have a mental illness. He became distressed about this and voiced concern about his housing prospects once he left prison. The project worker said he could help if he was released before his 21st birthday (4 July 2012), after which his case would be closed. He said he would do all he could to ensure he had support on his release.
96. Also on 16 May, an Operation Support Grade (OSG) noted that she had given the man an IEP warning for continued misuse of the cell bell. She noted that he kept ringing it from 8.30pm because he had not had an apple, a sandwich and some chocolate. There is no record to explain this.
97. On 17 May at 4.18pm, the man was involved in a fight on E and F wing exercise yard on his way back from an art therapy class and was restrained by staff. Neither he nor staff sustained any injuries. The next day, he was found guilty of fighting and given ten days cellular confinement in the segregation unit. He also forfeited his television, canteen and association for 21 days. The SAFE document that had been opened for him four days earlier was "frozen" until he returned to the wing. He did not attend Muslim prayers on 18 or 25 May, and there is no record that the Imam visited him.
98. A counsellor visited the man in the segregation unit on 21 May. He agreed to attend an anger management course beginning the next Wednesday. The same day his clinical key worker visited him to discuss the reasons for the

fight he had and how he felt. They spoke about his medication again and she reiterated that he should not stop taking his medication unsupervised, but should discuss this with a doctor.

99. The project worker telephoned the prison on 21 May and spoke to a member of staff in the Custody department (he did not know their name). He asked if the man would be allocated someone to support him before and after his release. He was told that he would be allocated an Offender Supervisor if he received a sentence. He advised that the man was vulnerable and was subject to multi-agency public protection arrangements. On 23 May, a member of Essex Probation Service seconded to the prison telephoned the project worker. He said that he was looking into accommodation for the man in case he was bailed at court. He said he would keep in touch, but the project worker did not hear from him again.
100. On 24 May, the man's mother visited him. He also attended an anger management class that afternoon.
101. The man appeared before Crown Court on 25 May via video link. He entered a plea of guilty and remained in custody for pre-sentence reports. His clinical key worker went to see him in the segregation unit, but was told that he was sleeping and did not want to see anyone.
102. The man left the segregation unit on 27 May and went to F wing. It was noted that he had fully complied with the segregation unit's regime and attended an anger management course (He attended three sessions of anger management in May and June and received a certificate of attendance.) There is no record that the SAFE plan was re-opened and reviewed.
103. On 28 May, the man had a fight on F wing with another prisoner and had to be restrained by three officers. Records indicate that neither he nor staff sustained injuries. His clinical key worker again discussed with him his reasons for fighting and his medication. An officer also went to see him after the fight. He said that the prisoner had been winding him up, that they had an argument and things escalated. He was found guilty of fighting and given ten days cellular confinement in the segregation unit. The segregation unit documentation noted that he was not on an open ACCT, and that he had not been on one previously, which was incorrect. He was on stage two of the anti-bullying procedures (SAFE). He was due to leave the segregation unit on 7 June.
104. On 30 May, a counsellor visited the man to begin the first counselling session. However, there were no appropriate rooms available on that day in the segregation unit so the session had to be re-arranged. He attended an anger management class later that day.
105. The segregation unit daily records noted that the man complied with the regime and posed no problems to staff. He was seen every day by the duty governor, a member of healthcare and chaplaincy. He was also visited by members of the IMB. He was not able to attend Muslim prayers on 1 June.

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106. The counsellor saw the man for a counselling session on 6 June. She said they discussed his behaviour and goals for the future. There is no record of what these goals were.
107. On 7 June, the man left the segregation unit and transferred to E wing. He was given a double cell, but was not sharing with another prisoner. E wing is the detoxification wing, although he was not there for that purpose. He had been located on E wing because he had had fights in a number of different locations and E wing was considered a fresh start. An officer recalled him as being quite chatty and pleasant when he first arrived on E wing. He attended work and the gymnasium. She said he conformed to the wing regime and had not caused any trouble.
108. The man's solicitors wrote to him on 7 June. The letter said that the psychiatric report written by the psychiatrist had not provided him with a defence in law, and could only now be used in mitigation. His sentencing was scheduled for 28 June. On 8 June, he attended Muslim prayers.
109. The man stopped collecting his medication from 7 June onwards. The prison's 'Failure to Collect Medication' policy specifies that when a prisoner fails to collect their medication, the pharmacy staff should ask wing staff to remind the prisoner they have medication to pick up and annotate the prescription chart. The prisoner's details should be entered in the 'Non Urgent Medical Incidents Book' (Black Book) located in healthcare, and a nurse might then visit the prisoner to discuss why they were not collecting their medication. Persistent failure to collect medication after a nurse had spoken to a prisoner would result in a referral to a doctor. The policy stressed that "Pharmacy staff and nurses must be aware of prisoners under the mental health team NOT collecting their medication in order to prevent any issues arising and to prevent deterioration in the prisoner's mental health". This process was not followed for him.
110. On 13 June, the man enrolled in a victims' awareness course. He agreed a plan with the tutor, and aimed to complete the course by the end of June. That morning he telephoned his mother. The call lasted one minute and 38 seconds. The conversation appeared to centre on family matters. He made no mention of feeling low in mood. That day, he had been due to have a meeting with his clinical key worker, care co-ordinator and project worker because they were concerned about him getting into fights. Because he had been assessed as not having a mental illness it meant that he would no longer be supported by the community nurse and arrangements about accommodation on his release from prison needed to be discussed. However, the meeting was cancelled as his care co-ordinator was unable to attend. The project worker was not told that the meeting had been cancelled and instead met the key worker. He told the key worker that the man had told him three weeks earlier that he had given some of his medication to other prisoners. He said he had tried to pass this information to someone from

healthcare a number of times but had been unable to speak to anybody. The key worker submitted a Security Information report (SIR) about this.

111. On 14 June it was noted in the case note history that the man had not got out of bed to go to work, so received an IEP warning.
112. The Department of Work and Pensions wrote to the man on 14 June (it is not known whether he saw this letter before he died). The letter said that he had been overpaid by almost £700 because he had given them incorrect information, and outlined the ways in which he could repay the outstanding money. Later that day, his clinical key worker went to see him on the wing as the counsellor was concerned about him and his behaviour. He told him that he had “not been feeling too good”. He said that he had been thinking about his mother a lot and that it made him feel weird. He also said that he had stopped taking his medication. The key worker said that he could start taking his medication again, but would have to speak to a doctor first. He spoke to officers on the wing, who said they had no concerns about him and that he was interacting with other prisoners and had been playing pool.
113. The key worker went to the pharmacy to check on the man’s medication and was told that he had not taken it since 8 June. His prescription chart showed that the last time he had collected his medication was 7 June. The key worker spoke to a psychiatrist, who asked him to book him the earliest appointment available to see him. The psychiatrist also advised the key worker to let him know that he needed to be assessed before the medication would be reinstated. An appointment was arranged next morning and he was informed.
114. An entry by a SO noted in the man’s record on 14 June, that he had been on SAFE when he went to the segregation unit, and that this should have continued once he returned to a wing. This had been overlooked and no observations had been recorded or reviews held. She closed the SAFE document and informed the Violence Reduction team. She also took him off of the basic regime, although she noted that this was likely to be short lived as he had just been issued with a second IEP warning. At interview she said that it was unlikely that he had actually been on the basic regime, as staff were not aware that he was on a SAFE plan, although the SAFE document would have been in his wing file.
115. The next morning, on 15 June, a psychiatrist and clinical key worker saw the man on E wing. He was reluctant to speak but said he was doing all right and enjoyed watching television. He was not working in the kitchen anymore because of his behaviour, but he said he would like to get back to work. It is not clear from prison records when he stopped working in the kitchen. He spoke about his mother and that he would not have anywhere to live when he was released from prison. He was worried about his mother who was in poor health and that he would be discharged from the Aftercare Team once he was 21 years, on 4 July. The key worker said the prison’s resettlement team might be able to help him. He said he had not taken any medication since arriving on E wing. The psychiatrist said that, as he had not taken any medication for seven days, he could start a trial time without medication as they had

discussed in April. He was advised to discuss any side effects of withdrawal with the in-reach team. The psychiatrist noted this decision in his medical record and on the prescription chart.

116. The man told the psychiatrist and key worker that he was happy to be alive and had no thoughts of harming himself. Throughout the meeting the doctor and nurse did not observe any evidence of clinical depression or psychosis, or any other mental illness. The plan was for him to continue his work with the counsellor and to speak to her about his mother. Also, that he should visit the mental health in-reach team every week so they could monitor how he was doing without medication. The psychiatrist said he would review him in six to eight weeks. Later that day that he attended Muslim prayers.

Day of the Incident

117. The routine for prisoners on E wing on a weekend is that those who wish to attend church, religious activities or had visits booked were unlocked after 8.30am. At 9.00am the remaining prisoners are unlocked for association (free time to spend as they wish) to take a shower and receive their medication. Staff remembered seeing the man on the landing speaking to other prisoners. Association lasted until 10.30am when the prisoners were then offered the opportunity to take exercise outside until approximately 11.30am. Those who did not attend exercise returned to their cell. Staff recalled him taking exercise.
118. At lunchtime Officer A noticed that the man did not collect his meal. He did not find this unusual as there was a long queue and prisoners often wait for the queue to go down. The officer had been appointed as his personal officer a few days before and had introduced himself to him. (A personal officer is assigned to a group of prisoners as the first point of contact for any issues or problems.) When the queue had reduced, the officer suggested to him that it was a good time for him to go and get his meal. He said they shared a joke about the quality of the food and he went to pick up his lunch.
119. Between locking the prisoners in their cells after lunch and unlocking, it was quiet on the wing with no incidents. At 4.00pm, officers began unlocking the cells. Officer A unlocked a cell on the second landing and began to deal with an incident where a prisoner had harmed himself by cutting his arms. He asked an officer to call for a nurse who was already on the wing. He and the nurse attended to the incident and then continued to unlock the other prisoners.
120. The officer unlocked the man's cell at approximately 4.15pm. He saw he was suspended by green material, either a bed sheet or a pillowcase which he had threaded through the partition that screened the toilet from the cell. He shouted for assistance.
121. Two officers arrived in seconds. Officer B helped Officer A lift the man to relieve the pressure, while another officer cut through the green material.

They then laid him on his bed. Officer A said he could see that his neck was damaged. He could not detect a pulse and the man felt cold.

122. An officer radioed for urgent medical assistance (Code One). A Healthcare Assistant (HCA), who had been helping Officer A with the prisoner who had harmed himself, arrived a few seconds after the radio call. She checked for a pulse in his neck and felt the man's chest, but told the investigator that he was not breathing and appeared to be dead.
123. As soon as the Code One call was made, an officer, who was working in the communications room and heard the call over the radio, telephoned for an ambulance.
124. The SO, who was in charge of the wing that day, saw staff running towards the cell and followed them. She had not heard the call over the radio which she attributed to "patchy" areas on the wing where reception was poor. She entered the cell seconds after the HCA and brought with her the emergency bag (containing airways, saline and nasal airways among other equipment) and a defibrillator.
125. A doctor and a nurse then arrived at the cell. Two more nurses also responded to the emergency call. Nurse A told the investigator that the man felt cold to the touch, his pupils were dilated and his mouth and tongue appeared swollen. He also had a very deep indentation mark on his neck, and his neck was rigid. Nurse B advised that he be moved on to the floor and Nurse A immediately began chest compressions.
126. Due to the lack of space in the cell, the HCA and the officers left to allow healthcare staff to continue resuscitation attempts two officers began to lock up the prisoners who had already been unlocked and explained that there had been an emergency.
127. The designated orderly officer that day had been alerted to the emergency over the radio. She had also attended the emergency call. She was the only member of uniformed staff who went to the man's cell who had current first aid training, but healthcare staff were already there.
128. Nurse B attached the defibrillator to the man's chest. It advised not to administer a shock so the nurse and doctor continued with breaths and chest compressions at a ratio of two to 30. Other healthcare staff took turns carrying out chest compressions.
129. A paramedic arrived at 4.25pm. After assessment, the doctor and the paramedic agreed at 4.33pm that the man had died.
130. The SO requested additional staff from A wing to assist on the wing and then went to every cell and spoke to every prisoner individually. She explained what had happened and asked whether they felt safe or needed support. Only one prisoner was on an ACCT. He received additional support from the chaplain.

131. All the staff involved were given the opportunity to speak to a member of the prison's care team and to go home (after giving a statement to the police) if they felt they needed to. Members of the senior management team also checked on the welfare of staff and conducted a "hot debrief".

Informing the man's mother

132. The prison's family liaison officer (FLO) visited the man's mother at 7.30pm that evening at the nursing home where she lived. He was accompanied by a prison manager and the Imam, and they informed her of her son's death. The prison manager left his contact details with the home's manager and said he would visit again the next day.
133. The next day the FLO visited the man's mother again, accompanied by another member of the chaplaincy. They spoke at length and she prayed with the chaplain. She said that she wanted to see her son in the chapel of rest. The FLO agreed to get the details and return the next morning.
134. At 11.00am on 18 June, the FLO telephoned the home's manager. She told him that the man's mother would visit the chapel of rest with her church pastor. On 19 June, the man's mother said she would like the FLO to visit her again and meet her pastor and friends. She confirmed that she would like her son to have a Christian funeral. The FLO agreed to visit the next day.
135. At 2.00pm on 20 June, the FLO visited again with another chaplain. The man's mother had friends and her pastor in attendance. They said that she would like her son's body repatriated to Zimbabwe. The FLO returned her son's property, and gave his mother a letter of condolence from the Governor and a sympathy card signed by a number of prisoners, along with a poem written by one of them. He did not mention assisting with funeral expenses at that stage, as she was very distressed. She was informed that the prison would contribute to funeral expenses at his next visit. The prison paid towards the cost of the repatriation but not towards funeral costs. His body was repatriated to Zimbabwe on 25 July.

Post-Mortem

136. A post-mortem examination was carried out on 21 June. The pathologist conducting the examination concluded that the man died from 'suspension', by which a person causes death by applying pressure across the neck. This presses on the nerves that control the heart, the blood supply to the brain and the airway.
137. The pathologist added that:
- "The majority of suspension cases have some part of the body in contact with the ground, such as feet, knees, bottom and occasionally the whole trunk.

Following application of the weight of the body....across the neck....unconsciousness can develop almost immediately i.e. within a second or so but with a suggested average time of ten to 15 seconds.

Following the loss of consciousness the heart will stop....it is not possible to determine the time of death from the post-mortem.

There are no marks to indicate third party involvement in his death.”

Statement from another prisoner

138. A prisoner, who had been in a neighbouring cell to the man's for five or six days, spoke to an officer on 25 June. He said he and the man did not speak to each other very much and he got the impression that he wanted to be left alone. However, on the day that he died, the prisoner recalled that some things had seemed unusual, although he had not thought much of it at the time. He said he had seemed in a buoyant mood and had greeted him in the morning.
139. The prisoner said that in the time he had known the man he had not seen him shower. However, that morning he followed him into the showers and asked to use some of his shower gel. The prisoner said the way he had washed himself had seemed strange. He concentrated on small areas at a time and seemed to clean himself meticulously.
140. At lunchtime, the prisoner asked the man whether he was going to collect his lunch. He said he was. He still appeared to be in a good mood and was talking to other prisoners on the landing. The prisoner was unsure whether he did collect his lunch. However, as they were returning to their cells he showed the prisoner his tobacco tin which contained two rolled up cigarettes. He said the prisoner could have one. The prisoner protested and said he could not leave him with just one cigarette. He replied that he should not worry as that was all he needed.
141. Later that afternoon, the man spoke to the prisoner through the cell wall and asked for a Rizla paper. He counted out a few for him and was going to pass them through to him (the prisoner said he could pass these through a gap in the pipe between their cells) but he said he only needed one. The prisoner also passed him a sachet of sugar.
142. The prisoner said that he heard nothing more from the man for 20 to 30 minutes when he thought he heard the toilet seat slamming down. He thought nothing of it at the time. He was still distressed by what had happened to the man, but said he had received help and guidance from staff which had helped him a lot.

ISSUES

Clinical care

143. During his time at Chelmsford, the man had access to primary health care services (including health screening) health promotion and vaccination.
144. The man was seen in reception by a registered nurse who assessed both his physical and mental health needs. During the assessment, it was determined that, although he had no chronic physical health issues, he was receiving medication for mental health problems.
145. The man saw members of the healthcare team regularly for physical problems and to review his mental health. He was assigned a nurse as his clinical key worker, who monitored him closely. His community care worker and nurse were also involved in his care. An independent mental health assessment arranged by his solicitor determined that he did not have a mental illness. It appeared that he had displayed or reported certain behaviours in an attempt to be seen as ill. He admitted that he had pretended to be unwell in order to get what he wanted.
146. The man decided to stop taking his medication on 7 June despite being advised against doing this. This appeared to go unnoticed by staff in healthcare, the pharmacy or the wing. Some information suggested that he gave his medication to another prisoner. The prison had a procedure for alerting staff when a prisoner stops collecting his medication, but this did not work. The 'Black Book' which was supposed to record when prisoners did not collect their medication was missing.
147. Olanzapine is psychotropic medication and it is a concern that a prisoner can stop such mood-altering medication without this being discussed with them. Although a prisoner has the right to decide whether to take medication, the risks and benefits should be fully assessed and made clear to them. It is important that systems to identify when prisoners stop collecting their medication are established and operate effectively.

The Head of Healthcare should ensure that there is an auditable system to identify when prisoners do not collect their medication and ensures appropriate action is taken.

148. As well as the 'Black Book', to record non-urgent medical incidents one of the man's pharmacy records could not be located. Healthcare need to ensure that all records are kept safely and in accordance with the General Medical Council and Nursing and Midwifery Council guidelines.

The Head of Healthcare should ensure that all healthcare records are kept safely and are accessible.

149. While in the segregation unit, the man was assessed daily by either a doctor or nurse to ensure he was fit to stay in the unit and also visited by his clinical key worker and a counsellor.
150. The man was encouraged to become involved in therapy groups run by the counsellor and he appeared to engage well. However, the clinical reviewer notes that he attended a number of sessions for anger management, relaxation and creative expression, there was little information about the aims and objectives of the interventions and how they fitted into the overall management of his care.

ACCT

151. The man's ACCTs were not of a good standard. The ACCT opened on 11 February did not indicate whether any of the actions identified in the immediate action plan were completed. Actions were not allocated to particular staff (for example wing or healthcare staff). The review did not include anyone from healthcare, just the officer who opened the ACCT and a senior officer, so was not multi-disciplinary. The status of actions recorded on the caremap is recorded as 'ongoing' with a tick beside it, rather than information about what has been done, although the actions had been completed. The second case review included an officer and a member of chaplaincy, but again there was no representative from healthcare despite his involvement with mental health. At this review the ACCT was closed.
152. The ACCT dated 20 March, failed to identify any triggers or warning signs when the document was opened. The first case review reflected the seriousness of the man's attempt to harm himself and was attended by two healthcare staff, an officer and an operational manager. The second review was attended by just a senior officer and an officer. There was no record of any checks as to whether he had applied to attend a smoking cessation course or obtained a replacement card for the gym, which were identified goals on his caremap. His ACCT was closed without checking these had been achieved.
153. These omissions show that the ACCT procedures were not carried out as required. We understand that a member of healthcare is not always available to attend a review but, as the man's mental health situation was a major issue and he had considerable involvement with the mental health team, we consider there should have been a healthcare representative familiar with his case at each of the ACCT reviews.

The Governor and the Head of Healthcare should ensure that all staff are familiar with and follow ACCT guidance. In particular case reviews should be multi disciplinary, ACCTs should not be closed unless all the goals of caremaps have been achieved and the document should be completed correctly.

SAFE process

154. The prison runs a SAFE system to identify, monitor and address bullying and disruptive behaviour. In this case, a number of processes in the system appear to have been overlooked.
155. There were times when the man was spoken to about his behaviour by a member of the Violence Reduction Team, but no action was taken and no record appears to have been made. There was also a lack of continuity in monitoring. When he returned to E wing on 7 June from the segregation unit, nobody checked his records so the staff were unaware he was subject to the process. By this stage so much time had elapsed that the SAFE document was closed.

The Governor should ensure that, as part of the SAFE process, staff are aware who is being monitored; interactions between staff and prisoners, and subsequent actions, are appropriately recorded; and paperwork is checked when prisoners move location.

Other issues affecting the man and his risk

156. The clinical reviewer noted that it was the opinion of two psychiatrists involved in assessing the man that there were no signs of mood disorder or mental illness and it was more likely that he had some form of personality disorder. There were also a number of events in his life which were likely to have an effect on his risk.
157. The community project worker was involved with the man because he had spent some time in care and was therefore entitled to an 'after care' service, which is mainly guidance and support. He told him at a meeting on 16 May that he had been discharged from the Early Intervention Psychosis Team because he had not been assessed as being mentally ill. During that meeting he became distressed about his housing situation. He knew that once he reached the age of 21 he would not receive any help finding accommodation from the project worker's team. As a result, the project worker contacted the prison to ask that he be supported before and after his release. He was told that he would be allocated an Offender Supervisor if and when he was sentenced.
158. Also, on 7 June the man received a letter from his solicitor. It said that as the assessment they had arranged for him to determine his mental health had concluded that he had no mental health issues that he could not rely on that for a defence. On the same day, without discussion or advice from healthcare, he appears to have stopped taking his prescribed medication, which was likely to have had an effect on his mood.
159. Further, a letter dated 14 June (although it is unclear if or when the man received it) from the Department of Work and Pensions informed him that he had been overpaid by a large amount of money and suggested ways he could repay them.

160. Finally, it is documented that the man was worried about his mother's health.
161. It is possible that these issues, or a combination of them, played on the man's mind and might have contributed to his actions on 16 June. However, it is impossible to know exactly what he was thinking or feeling. The clinical reviewer concludes that in the absence of signs of psychosis or mood disorder and, given his assurances that he had no intention of harming himself, his death could neither be prevented nor foreseen.

Religious observance

162. On occasion the man pressed his cell bell to request a shower before Muslim prayers. The records do not indicate whether he was able to take the showers or not. There were also times when he was in the segregation unit and not allowed to attend Muslim prayers. Prisoners have a right to practice their religion and Prison Service Instruction 51-2011 makes it clear that prisoners should have the opportunity to attend the main religious service of the week for their faith. There have to be exceptional reasons to exclude someone which must be authorised by the Governor. The PSI makes it clear that this also applies to prisoners in segregation units, unless there are exceptional reasons based on an individual risk assessment. There is no evidence that this applied in his case.

The Governor should ensure all prisoners have access to religious services wherever they are located in the prison in line with Prison Service Instructions.

Funeral and repatriation expenses

163. The prison paid towards the cost of the man to be repatriated to Zimbabwe in line with Prison Service Instruction (PSI) 64/2011. However, they did not contribute towards his funeral, which is also a requirement of the PSI and is a separate requirement to repatriation costs.

The Governor should ensure that in line with Prison Service Guidance an appropriate contribution is made to the man's family to cover the reasonable costs of his funeral.

CONCLUSION

164. The man was a complex young man who presented a number of management challenges to staff. He was released from Chelmsford in December 2011, but returned in February 2012, after a stay in a psychiatric hospital.
165. Healthcare staff engaged well with the man to identify his mental health needs and address them appropriately. He often gave conflicting and confusing accounts of how he was feeling and, at one point, told staff that he had not been truthful about his health. He admitted to being manipulative to try to get what he wanted, such as tying a ligature around his neck because he had run out of tobacco.
166. The man also presented behavioural challenges. He received numerous warnings for poor conduct from staff and became involved in a number of altercations and fights with other prisoners. As a result, he spent periods of time in the segregation unit serving punishments.
167. The man appeared to have had to deal with a number of worrying issues shortly before he died. It seemed that he did not discuss these problems with prison staff or other prisoners, although his worries about his potential homelessness were raised with the prison by his community key worker.
168. Staff had not noticed anything out of the ordinary about the man on the day that he died and it would have been difficult to predict or prevent his death.

RECOMMENDATIONS

To the Governor

1. The Governor should ensure that, as part of the SAFE process, staff are aware who is being monitored; interactions between staff and prisoners, and subsequent actions, are appropriately recorded; and paperwork is checked when prisoners move location.

The Governor accepted this recommendation and a new system is now in place.

2. The Governor should ensure all prisoners have access to religious services wherever they are located in the prison in line with Prison Service Instructions.

The Governor accepted this recommendation.

3. The Governor should ensure that in line with Prison Service Guidance an appropriate contribution is made to the man's family to cover the reasonable costs of his funeral.

The Governor accepted this recommendation.

To the Governor and Head of Healthcare

4. The Governor and the Head of Healthcare should ensure that all staff are familiar with and follow ACCT guidance. In particular case reviews should be multi disciplinary, ACCTs should not be closed unless all the goals of caremaps have been achieved and the document should be completed correctly.

The Governor accepted this recommendation. One to one sessions with Senior Officers and Custodial Managers have been introduced. Also, there is a daily ACCT check by a member of the Senior Management Team.

To the Head of Healthcare

5. The Head of Healthcare should ensure that there is an auditable system to identify when prisoners do not collect their medication and ensures appropriate action is taken.

The Head of Healthcare accepted this recommendation.

6. The Head of Healthcare should ensure that all healthcare records are kept safely and are accessible.

The Head of Healthcare accepted this recommendation.