PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in August 2013, while a prisoner at HMP Chelmsford

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man at hospital in August 2013. He died as a result of burns he suffered in his cell at HMP Chelmsford 25 days before. He was 55 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the man's clinical care and treatment at Chelmsford. The prison cooperated fully with the investigation.

The man was sentenced to 13 years imprisonment in 2004. He was released to approved premises in Essex, in September 2012, but recalled to prison within a few days and taken to HMP Chelmsford. He had a long history of mental health problems and had a particular anxiety that dogs would attack him in his cell. He received monthly antipsychotic medication by injection and his mental health often deteriorated in the period before his next injection was due.

The man harmed himself on 7 July 2013, by pouring boiling water over his hand and was monitored under suicide and self-harm prevention procedures. Just after lunchtime on 9 July, an officer found him engulfed in flames in his cell, after he had apparently set alight to his clothes. Staff responded quickly and doused the flames. He was taken to hospital, where he was treated for over three weeks. He died in August from injuries sustained in the fire.

The man's mental health care at Chelmsford was very good. I also do not consider, despite his act of self-harm two days earlier, that prison staff could have anticipated his actions on 9 July. However, I am concerned that the possibility of him sharing a cell, which might have acted as a protective factor, was ruled out on the basis of an inaccurate cell sharing risk assessment which indicated that he was a high risk to other prisoners.

While fire-related prison deaths are not unheard of, previous deaths my office has investigated have been caused by the effects of smoke inhalation. It is not possible to know whether the man understood or intended the consequence of his actions when he set fire to his clothes or whether this was an accident. Little could have prepared the prison staff at Chelmsford for the situation they encountered on 9 July and I consider they responded commendably quickly and bravely to this very unusual and traumatic incident.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2014**

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SUMMARY

1. The man was sentenced to 13 years imprisonment in May 2004. In September 2012, he was released from HMP Wakefield to approved premises[1] in Essex. Within a few days, he had breached his licence conditions and was recalled to custody. He arrived at HMP Chelmsford on 28 September 2012. When he arrived he was assessed as a high risk for cell sharing based on inaccurate information.

2. The man had longstanding and severe mental health problems, including schizophrenia, and an enduring fear that a pack of dogs would attack him in his cell. He received a lot of reassurance from staff and Listeners[2] about this. He sometimes moved to the healthcare unit when he was particularly unwell, but he generally remained on D wing, the vulnerable prisoners' unit at Chelmsford. He received monthly injections of antipsychotic medication and believed that his health deteriorated in the days before his next injection was due. Staff and other prisoners noticed it too, but there is no clinical basis to support this.

3. The man was monitored under Prison Service suicide and self-harm prevention procedures for long periods: mainly because he was reassured by the support structures and periodic checks rather than due to a belief that he was at risk of suicide. However, he was not allowed to share a cell because he had been erroneously identified as a risk to other prisoners.

4. Other prisoners were aware of the man's fears about dogs and sometimes made barking noises to taunt him. These incidents were dealt with under the prison's anti-bullying policy but it was not usually possible to identify the individuals responsible.

5. The man harmed himself on the evening of 7 July by making some minor cuts to his wrist, then pouring boiling water on his hand. He told staff that he had hoped the pain would stop him worrying about dogs, but realised afterwards that it had not helped.

6. A Listener noticed that the man seemed unsettled on the morning of 9 July and he spent some time talking to him until around 12.15pm. There is evidence that some prisoners made barking noises at around this time. Just after 12.30pm, the prisoners in the cell adjoining his rang their cell bell. An officer responded and as he walked past his cell thought he could smell smoke. He looked into the cell and saw him sitting upright on a chair engulfed in flames. Officers used a towel and then wet sheets and water to douse the flames. While waiting for an ambulance, staff continued to douse his body with cold water to cool his skin. He was taken to hospital with severe burns. Despite receiving skin grafts and other treatment, he died in August as a result of organ failure arising from a severe infection. An independent investigation into the cause of the fire indicated that he had used a cigarette lighter to ignite his jacket which was made from 100% polyester.

7. The man received a great deal of support from officers and healthcare staff at Chelmsford but it is a concern that the possibility of sharing a cell which might

[1] Approved premises accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail.
[2] Listeners are prisoners trained by the Samaritans to provide confidential support to other prisoners in distress.

have helped him was ruled out on the basis of an inaccurate assessment. Although prison staff had previously taken action when they heard prisoners making barking noises, there appear to have been further isolated incidents of this behaviour, including on the day of the fire. In spite of this, we do not believe that prison staff could reasonably have foreseen his actions that day or prevented his death. When he was discovered engulfed in flames staff responded quickly and bravely.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Chelmsford, informing them of the investigation and inviting them to contact the investigator if they had relevant information. One prisoner responded.

9. On 8 August 2013, the investigator visited HMP Chelmsford. He met the acting Governor and the Chair of the Independent Monitoring Board and obtained copies of the man's prison and health care records. He subsequently interviewed 18 members of staff and five prisoners.

10. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation and a copy of this report has been sent to him.

11. NHS England (East Anglia Area) appointed a clinical reviewer to review the clinical care the man received at HMP Chelmsford.

12. One of the Ombudsman's family liaison officers contacted two of the man's children to inform them of the investigation and offer them the opportunity to identify issues for the investigation to consider. The family liaison officer and the investigator visited one of the man's sons who wanted to know what had happened on 9 July and whether measures to try to protect his father from harming himself had been put in place. He also asked what had happened to a letter that he sent to his father and why the prison had not used his contact details to inform him that his father was in hospital.

13. The man's son was sent a copy of the draft report. However he was unable to collect this from the sorting office and as a result was unable to provide comments ahead of the report being made final. He informed the family liaison officer that he would like to receive a copy of the finalised version of the report.

HMP CHELMSFORD

14. HMP Chelmsford is a local prison that takes prisoners directly from courts, mainly in Essex and London. It holds around 578 prisoners. The man lived in D wing, the vulnerable prisoners' wing (for prisoners who might be at risk from other offenders, mainly due to the nature of their crimes).

Her Majesty's Inspectorate of Prisons

15. The Inspectorate's most recent inspection report of Chelmsford was in May 2011. Inspectors found there was a comprehensive strategy to minimise the risk of self-harm with good links to the mental health in-reach team. The Listeners' scheme was well supported and prisoners had good access to them. Inspectors found that staff were caring in their approach to prisoners at risk.

16. In relation to mental health care, the Inspectorate noted that there was good caseload monitoring. At that time the in-reach team had a caseload of 35 prisoners, who were all managed through the care programme approach (CPA). The Inspectorate found that prisoners were complimentary about the quality of mental health care.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their 2012/13 annual report, the IMB noted that a shortage of staff had led to concerns about healthcare provision but there were signs these were beginning to be addressed. The IMB commended healthcare staff who looked after prisoners with severe mental health disorders.

Assessment, Care in Custody and Teamwork

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the 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. Support for prisoners includes setting a number of significant interactions with them during the day, supplemented by checks on their well-being during the times they are locked in their cell. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Previous deaths at Chelmsford prison

19. There were four other self-inflicted deaths at Chelmsford in the two years before the man's death. A further self-inflicted death occurred at Chelmsford three months after his death. There were no similarities with his death.

KEY EVENTS

20. The man was born in Dublin in May 1958. On 21 May 2004, he was convicted of a number of serious offences and sentenced to 13 years in prison, with a further 4 years on extended licence (a period in which a released prisoner can be recalled to custody if they breach their licence conditions). He spent time in several prisons before being transferred to HMP Wakefield on 23 April 2009.

21. The man had a long history of mental health problems, including schizophrenia with auditory and visual hallucinations, for which he was prescribed risperidone (antipsychotic medication). He had also self-harmed and taken drug overdoses in the past. In March 2011, he began receiving another antipsychotic, pipotiazine, by depot injection once every three weeks. (In December 2011, the dosage was increased and given at four week intervals. This prescription continued for the rest of his life.)

22. On 21 September 2012, the man was released on licence from HMP Wakefield to approved premises in Essex (supervised residential accommodation for offenders managed by the Probation Service). The release arrangements appear to have been inadequately planned and, during the next week, there were a number of incidents: there were concerns as to whether he was likely to take his prescribed medication; he had possibly caused damage to the premises, including setting fire to a dustbin; he was thought to be at risk of being bullied by other residents and on one occasion he failed to return to the premises before the curfew time required by his licence. The manager concluded that they could not offer the level of support that he needed. As a result, he was recalled to prison on 28 September and taken to HMP Chelmsford.

23. In reception, a cell sharing risk assessment was completed which indicated that he was a high risk for cell sharing apparently because of a sexual assault against a same sex adult victim. This was not the case as the man's victims were his children. The healthcare assessment did not indicate that he was at any increased risk of harming another prisoner because of his mental health problems. (The cell sharing risk assessment was reviewed on 6 January 2013, but again the box was ticked to indicate that he had been involved in a sexual assault against a same sex adult victim. This error meant that he continued to be assessed as high risk for cell sharing as this is a mandatory requirement for prisoners in that category. There was no other evidence indicated to suggest that he was a risk to others he might share a cell with.)

24. During a healthcare reception screen at Chelmsford, the man said he felt unsafe as he believed that people wanted to send dogs to attack him. He said that he had no thoughts of self-harm or suicide, but the reception nurse started ACCT monitoring, noting that he was very paranoid. He was moved to the healthcare unit and, within 30 minutes of arriving, he had damaged the television in his cell and put the lead around his neck. He said that he had not intended to kill himself but had been frustrated about being recalled to prison. Monitoring levels were raised from one to five times each hour. Over the next few days, the level of monitoring gradually reduced. On 11 October, observations were set at hourly intervals during times when he was locked in his cell and staff were required to have and record three significant conversations with him during the day.

25. The man was discharged from the healthcare unit on 14 October and moved to D wing, which is generally used for vulnerable prisoners at risk from others because of their offences or other reasons. Within a few weeks, he had started work clearing litter from the D wing exercise yard.

26. The ACCT monitoring continued for over two months. Prison staff consistently assessed the man's level of risk as low, but at case reviews he asked for the ACCT to continue as he found it reassuring to be checked. ACCT monitoring ended on 11 December.

27. A further period of ACCT monitoring took place between 24 December and 5 February 2013, after the man threatened to stop taking his medication and said he would bang his head on the wall because he was not allowed to share a cell. At the ACCT assessment interview, he said that he would not harm himself but wanted the ACCT support to continue as he found it reassuring. Over the course of these two months, he frequently used Listeners (prisoners trained by the Samaritans to support other prisoners in distress). He was twice admitted to the healthcare unit when his mental health deteriorated. Throughout this time, he spoke frequently about his fear that dogs would come to get him and he reported hearing dogs barking. He was not allowed to share a cell because his cell sharing risk assessment had identified him as high risk.

28. After ACCT monitoring ends, a post-closure review must be held within a specified period to ensure that that there are no outstanding concerns or problems. At a post-closure interview with a Senior Officer (SO) on 16 February, the man asked for the ACCT to be re-opened as he missed being checked. They agreed that, although it would remain closed, officers would nevertheless check him hourly through the night.

29. On the evening of 25 February, one of the prisoners on the third landing told an officer that he had heard a prisoner from the second landing barking out of his window to taunt the man. There was no evidence to identify the specific prisoner responsible so all prisoners on that landing were warned about such behaviour. After a similar incident a week later, an officer warned a prisoner, who responded by threatening the officer and he was moved to a different wing.

30. The man appeared to settle for the next few months. He continued to work and had a few friends on the wing. An entry in his clinical records on 4 April, indicated that he did not have any complaints about any of the other prisoners on D wing.

31. The nurse who gave the man his pipotiazine injection on 10 April, noted that, while he engaged well, he and his cell were in a dishevelled and unkempt state and that when he was in good mental health he kept himself and his cell clean.

32. An entry by a prison officer in the man's prison record on 12 May indicated that he had no concerns at that time. However, this conflicted with entries by healthcare staff at that time, who noted that he still occasionally reported fears that dogs would be coming to get him.

33. On 19 June, an officer noted in the man's prison record:

"…. continues to do well … and is currently employed as yards orderly …[spends] much of his time out his cell reading his Bible … and talking to his friend … engages with staff really well, and will always approach an officer when he had any concerns. He had the odd moment of paranoia but just a minute or so of talking to him is usually enough to reassure him …"

34. Later the same day, at a routine consultation with a community psychiatric nurse, the man said that "things [were] going really well for him" at that time. He had received information that he might be going to another approved premises and was said to be excited about making a fresh start in his life.

35. On 30 June, a nurse noted that the man appeared to be anxious. He asked if he could have his next depot injection before it was due on 3 July. He was told that this was not advisable and he received it on the prescribed date. After this, his next injection was due on 31 July.

36. On the evening of 7 July, wing staff reported that the man was hearing dogs again. A nurse went to see him in his cell and noticed that it was clean and tidy, which was not usually the case when he was unwell. They spoke for ten minutes and he said that he was scared when he was being locked in his cell as he thought that the landing was being evacuated and he would be left on his own. She said she would inform the mental health in-reach team that he was hearing dogs again and would return later in the evening to check on him.

37. The man had earlier asked to see a Listener and an officer brought two Listeners to his cell at about 7.30pm. The Listeners almost immediately rang the cell bell to report that he had cut his wrist and poured boiling water over his hand. The Listeners went back to their cell and the officer asked him why he had harmed himself. He said he believed that the prison had been evacuated so he was the only prisoner left and the dogs would be coming to get him. The officer took him to some of the other cells on the landing to try to reassure him that the other prisoners were still there and called the nurse again. She dressed his scalded hand and also noted that the cuts were very superficial.

38. The Listeners returned to speak to the man and stayed until sometime between 8.30pm and 9.00pm. An officer opened an ACCT with hourly observations through the night until they were able to assess him the next day. Entries in the ACCT document show that he watched television for several hours before falling asleep.

39. An SO held an ACCT assessment interview at about 10.00am on 8 July. (Assessment interviews are carried out within 24 hours of an ACCT being opened to explore the prisoner's problems, his current risk of self-harm and suicide and plans for the future and what might be done to reduce his risk.) The SO told the investigator that he had had very limited conversation with the man before this and was surprised at how positively he engaged that day. He said he was looking forward to moving to approved premises, but did not know where he would be going yet. He told the SO that he had scalded his hand because he was scared that dogs were coming to get him and the only thing that took away the fear was to scald himself. However, he was sorry that he had done this as it had not helped. He said he would not harm himself again but asked for the ACCT to be kept open, as the checks made him feel safe.

40. Shortly after this, the man attended an ACCT case review with an SO and a nurse. The SO was based on D wing and knew him reasonably well. She told the investigator that he needed constant reassurance about "the dogs" but otherwise it was possible to have a reasonable conversation with him. Although his anxiety levels always rose as his next depot injection approached, she never feared that he would harm himself. She did not understand why he had scalded his hand. At the review, he said he would not do it again and asked to have his kettle back. The SO and nurse assessed his risk of further self-harm as low. His level of observations remained at one an hour when he was locked in his cell and staff were required to have three significant conversations with him during the day. The SO completed an ACCT caremap with targets to address his concerns about his medication, his fear of the dogs and uncertainty about his transfer to approved premises by discussing these. The nurse checked on him twice more that afternoon.

41. An officer told the investigator that she had known the man throughout his time on D wing and they had a good relationship. (Other officers and prisoners agreed that this was the case.) She said she had spoken to the man several times during the afternoon and evening of 8 July. At 5.30pm, she noted in his ACCT document that he had said that she would not see him the next day as the dogs would be getting him that night and she had tried to reassure him. At 7.00pm, she made a much more positive entry after he had rung his cell bell to tell her that he had forgotten to show her a letter from his solicitor about a possible placement at approved premises that looked very promising. She told him that it sounded very positive as there would be a lot more support there compared to where he had been previously. He spoke to Listeners for around an hour later that evening.

42. The officer said that the man had settled well in D wing and got on with most of the other prisoners there. However, he disliked being in a cell on his own and often asked to speak to Listeners in the evening as he wanted someone to talk to. He frequently asked to share a cell as he believed that would make him feel safe. As previously, because he was assessed as high risk this was not allowed. She said that his mood always declined in the week or so before his next depot injection was due and he would talk a lot more about dogs coming to get him. On bad days, she said she would spend every spare moment reassuring him that dogs would not be coming.

43. A prisoner in the cell two doors from the man's cell said that the staff at Chelmsford were mostly very good with the man, but at about 11.00pm on the night of 8 July, he had heard an officer say to him "the dogs won't be getting you tonight but they'll be getting you tomorrow". He said that it was a male voice which he did not recognise. The investigator asked Chelmsford for the name of the officer on duty on D wing on the night of 8 July and was told that it was a female officer who has since left the prison. D wing is not covered by CCTV cameras so we were unable to check whether any other member of staff went to his cell that night. (It is possible that the prisoner could have heard another prisoner saying this from his cell and believed it was a member of staff on the landing.) The man did not mention this incident the next day to either a member of staff or any of the other prisoners.

44. A counsellor at Chelmsford saw the man for a number of one-to-one sessions between March and May 2013. On 9 July, she was asked to see him as he had

scalded his hand. He showed her his hand and said he was not feeling too good as his medication had not "kicked in". At his request, she agreed to contact a nurse. She invited him to join her Tuesday afternoon art therapy group and he agreed to attend that afternoon. She then spoke to the nurse, who said that she would go to see him in the afternoon. She reported her conversation with him to an officer on the wing.

45. A prisoner on D wing who worked with the prisoner anti-bullying team told the investigator that he had met the man in the middle of May and they got on well. He said that the man's mental health deteriorated in July when he spoke more about the lights going out and the dogs coming to get him but prison staff tried their best to try to reassure him. He said that some other prisoners occasionally barked as they walked past the man's cell and he believed it was dogs, rather than prisoners. The prisoner said he had heard more barking just before prisoners were locked up at lunchtime on 9 July, but he did not have a chance to report it to staff before he set fire to himself. An officer also said that he heard prisoners making barking noises at around this time. He called out for it to stop and it then went quiet.

46. A Listener on D wing told the investigator that he had known the man since November 2012. He had had a lot of contact with him as a Listener and also from general interaction on the wing. He said that the man had often spoken about his family and said that he missed them. One of his sons had written recently asking to meet him, but unfortunately he had not put his address on the letter. He said that although the man spoke about general matters, his conversation would always turn quickly to his fear of "the dogs". In his contact as a Listener, he tried to reassure him about this. He said that all the other prisoners knew about the man's fears and some would make barking noises at him.

47. The Listener said that staff were good at dealing with incidents of bullying and prisoners shouting out inappropriate comments but this was more difficult at night as there was only one officer on duty and it was difficult for them to identify who might be shouting or making barking noises out of their cell windows. He said that the man had seemed well for most of June and had not asked to see the Listeners. However, he became unwell in July and on the morning of 9 July was very unsettled. On that day the man had told him, "I won't be here tomorrow". He got him to promise him he would not harm himself and then went back to his cell as it was lunchtime.

48. By around 12.15pm on 9 July, all the prisoners had been locked in their cells after lunch. An officer noted on the man's ACCT form that he had said he was hearing dogs, which were going to bite him.

49. Just after 12.30pm, the prisoners in cell D2-1 rang their cell bell. An officer responded and, as he walked past the man's cell, D2-2, he thought he could smell smoke. He looked through the cell observation panel and saw him sitting on his chair engulfed in flames. He ran to call for assistance from other officers on the landing below who were having their lunch break.

50. An officer told the investigator that he ran to the man's cell, followed by other officers. When he looked in the cell, he saw that he was still sitting and the flames were rising above his head. He told an SO to contact healthcare and he

then unlocked the cell and went in. The SO radioed a code 1 emergency, to indicate a life threatening incident, and asked for an ambulance to be called. The officer used a towel to try to smother the flames, but as this did not help, he pulled him out of the cell and pushed him to the floor. He then cut off his clothing and asked a colleague to bring some buckets of water. Healthcare staff attended and applied burnshields (dressings that absorb and dissipate heat) and also gave him oxygen. The officer said that while all of this was happening he remained very quiet and did not scream, but was moaning quietly while he was being treated.

51. An emergency ambulance was called within a minute of the discovery of the fire and paramedics reached the man inside 15 minutes. In the meantime, staff used wet sheets and water to cool him. The paramedics treated him at the scene for around 20 minutes and then took him to the burns unit at hospital.

52. A debrief was held to allow staff to discuss their involvement in the response and members of the prison care team attended to offer their support. Prisoners subject to ACCT monitoring were checked and Listeners were briefed.

53. One of the man's daughters was identified as his likely next-of-kin. Chelmsford contacted her community support worker, who said that she would decide the appropriate time to break the news about what had happened.

54. Nurses at Chelmsford kept in touch with the hospital. The records indicate that the man had extensive burns. Even so, his condition stabilised and he began to show some improvement and he was given a skin graft. Unfortunately, infection set in and he began to deteriorate. The hospital telephoned the prison in August to report that he had died at 5.20am. The cause of death was multi-organ failure secondary to sepsis (an overwhelming reaction to infection).

55. One of Chelmsford's family liaison officers visited the man's daughter, accompanied by her community support worker, to break the news of her father's death. Chelmsford subsequently established contact with one of his sons when they obtained his contact details and assisted with the funeral expenses in line with national guidance.

Investigation by Crown Premises Investigation Group

56. The Crown Premises Inspection Group (CPIG) is the enforcing authority for general fire precautions in government buildings, including all prisons in England and Wales. CPIG carried out an investigation into how the man had set fire to his clothing including whether he had used cigarette lighter fuel as an accelerant.

57. Five cigarette lighters and a box of matches were found in the man's cell after the fire. Two lighters found on the floor showed clear signs of heat damage and were thought to have been used as the ignition source.

58. After various tests on the remnants of the clothing, CPIG concluded that the man had not used an accelerant. However, the label on his jacket stated that the materials used for the shell, the lining and the filler were all 100% polyester. His trousers were composed of 80% cotton and 20% polyester. A flame test carried out on a jacket remnant, showed exceptionally fast burning taking

around 10 seconds for total destruction of a 10cm x 15cm piece of material. CPIG also noted that flaming molten droplets of polyester occurred readily which could in turn have ignited his trousers.

ISSUES

Clinical care

59. The clinical reviewer was concerned about some aspects of the man's physical healthcare; in particular the management of his diabetes. He concluded that his physical care was below the normal standard of care expected in the community and made several recommendations which the Head of Healthcare will need to consider. As the issues were not directly related to his death we have not repeated them here.

60. The clinical reviewer found that, overall, the man's mental healthcare at Chelmsford was better than he might have received in the community and that there was no reason to suggest that he should have been transferred to a mental health unit. Although his mental health had deteriorated in the week leading up to the fire, he typically had periods of increased anxiety usually coinciding with the time his antipsychotic depot injection was due and which continued for a few days afterwards until the medication took effect (the clinical reviewer has explained that his anxiety about reduced efficacy of depot injections in the period just before and just after an injection is a well known phenomenon, although there is no pharmacological basis for there to be any such effect). The clinical reviewer also notes that when a nurse went to see him during the evening of 7 July, she found that his cell was clean and tidy, as was he. Ordinarily, when he was ill, his cell would be untidy and chaotic so she had not considered him seriously ill that evening.

61. While the clinical reviewer noted the very detailed entries by the community psychiatric nurses (CPNs), he has pointed out an omission arising from the different recording systems used by each of the healthcare teams. The mental health in-reach team use a system called CareBase, while the prison's primary care team use SystmOne. Although records of consultations between the man and the CPNs had been copied from CareBase to SystmOne, his care programme and his risk assessment were not. This meant that primary care staff could not access these records at night when in-reach staff were not on duty, for example, when the nurse responded to his self-harm in the evening of 7 July.

62. The clinical reviewer concluded that, overall, the man's mental health care was better than he would have received in the community in that he had very prompt access to the mental health in-reach team and mental health staff in the primary care team.

Management of the man's risk of self-harm

63. The man was managed, periodically, under the ACCT procedures. His final period of ACCT monitoring began on 7 July, after he poured boiling water on his hand. He had also cut his wrist, although the cuts were noted to be very superficial. He explained that he did this because of his fear that dogs would be coming for him. He attended an ACCT assessment interview and an ACCT case review the next day, when he said that he would not harm himself again as the pain from the scald had not helped his fear of the dogs. His risk of further self-harm was rated as low.

64. The man was checked once per hour during lock-up periods, regardless of whether he was subject to ACCT measures. This was primarily because he welcomed the reassurance of these checks.

65. Apart from when he scalded and scratched himself, there appears to have been nothing significantly different in the man's demeanour in the days leading up to his significant self-harm than the many other times when his mental health and fear of dogs was at its worst. We believe there was no reason for staff to have anticipated that he was on the point of committing such a serious act and no reason for his ACCT observations to have been set at a high level. Nor can we know whether he understood or intended the consequences. We therefore agree with the clinical reviewer that his death was neither foreseeable nor preventable.

66. However, we are concerned that the man repeatedly asked to share a cell but this was not allowed because he had been assessed as a high risk of violence towards a cell mate on his cell sharing risk assessment completed when he first arrived at Chelmsford and when it was reviewed in January 2013. Both assessments erroneously concluded that he fell into the mandatory high risk category because he had been convicted of a sexual assault against a same sex victim. This was not the case and we would have expected the review in January 2013 to have identified this. There is no evidence that he was a risk of violence to others in a shared cell. Even if he had been appropriately assessed as high risk, guidance to prisons indicates that this does not mean that the possibility of sharing a cell is automatically ruled out. High risk prisoners can share cells in some circumstances, subject to a satisfactory risk assessment. Sharing a cell can be an important protective factor for a prisoner at risk of suicide and self-harm. While we accept that there might have been other factors which would have made it difficult to find a suitable cell mate for him, the possibility should have been considered. We make the following recommendation.

The Governor should ensure that cell sharing risk assessments are based on evidence which is checked for accuracy and that prisoners assessed as high risk for cell sharing who are also identified as a risk of suicide and self-harm are not automatically prevented from sharing a cell without a further consideration of whether this could be done safely.

Prisoners taunting the man

67. It was clearly common knowledge throughout D wing that the man had a great fear that he would be attacked by dogs, including when he was locked in his cell. While staff and some prisoners tried to reassure him, it seems that other prisoners enjoyed playing on his fears by making barking noises. The evidence from both staff and prisoners indicates that this was an intermittent problem. Several incidents were recorded in late February and early March 2013. On the earlier occasion, staff had not been able to identify the culprits, so all the prisoners on a particular landing had been warned. On the second occasion, the person responsible was identified and when he failed to respond positively to a reprimand, he was moved to a different wing.

68. After this, the barking noises appear to have stopped for some time but reoccurred in the few days before and on the day the man set fire to himself. The perpetrators were not identified.

69. Chelmsford has a policy for dealing with bullying and other forms of anti-social behaviour that makes clear how staff should deal with inappropriate behaviour. The policy also sets out the behaviour expected of prisoners and the actions that will be taken if they fail to behave appropriately.

70. While it is very regrettable that some prisoners should have chosen to taunt a mentally ill man in this way, there is evidence that staff intervened in earlier episodes of inappropriate behaviour, regardless of whether a perpetrator could be identified. However, one of the difficulties which both staff and prisoners mentioned was identifying the cell from which the shouts and calls came. Nevertheless, we are satisfied that staff took action when they could to prevent prisoners taunting the man.

Possession of a cigarette lighter

71. The investigator spoke to Chelmsford's Head of Residence and Safety about cigarette lighters and whether the man should have been permitted to have one. The Head said that, apart from the healthcare unit, where smoking is prohibited, prisoners were able to purchase matches and lighters. The only restrictions would be if there were grounds to believe that a prisoner might be liable to commit arson and in this case, there was no intelligence to suggest this. Neither would he expect matches or lighters to be taken from a prisoner on ACCT as a matter of course, as removing their autonomy to smoke when they wanted to might make them more suicidal. Again, there would have to be some intelligence about possible risk of fire setting before matches or lighters would be removed. Although there is a suggestion that he may have started a fire in a bin at his approved premises, we are satisfied that Chelmsford's approach was reasonable and there was no grounds to suggest that he would harm himself in this way.

Emergency response

72. In the course of their careers prison staff can expect to handle incidents of self-harm and sometimes death through self-harm. The majority of self-harm incidents involve cutting, while most self-inflicted deaths occur through hanging. It is not uncommon for prisoners to set fire to bed-clothing and other materials in their cells but self-immolation is extremely rare. In the ten years that this office has investigated deaths in prison custody only four deaths have been due to smoke inhalation arising from a cell fire and the man's is the only death caused by a prisoner setting fire to his clothing. The staff who responded acted commendably quickly to an extremely traumatic incident, ensured that an ambulance was called very quickly and administered what first aid they could until paramedics arrived.

The letter the man's son sent to his father

73. The man's son told the Ombudsman's family liaison officer that he had sent his father a letter and he asked why the prison had not informed him that his father was in hospital. The prison did not have any record of this letter or any other

record of the son's contact details. One of the other prisoners, the Listener, told the investigator that the man did receive a letter from his son but his son forgot to put his address on the letter.

RECOMMENDATION

The Governor should ensure that cell sharing risk assessments are based on evidence which is checked for accuracy and that prisoners assessed as high risk for cell sharing who are also identified as a risk of suicide and self-harm are not automatically prevented from sharing a cell without a further consideration of whether this could be done safely.

ACTION PLAN: The Man - **August 2013 - HMP Chelmsford**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that cell sharing risk assessments are based on evidence which is checked for accuracy and that prisoners assessed as high risk for cell sharing who are also identified as a risk of suicide and self-harm are not automatically prevented from sharing a cell without a further consideration of whether this could be done safely.	Accepted	All new prisoners into our custody will be assessed as high risk for the first 24 hours until such times all relevant factors have been checked and risk assessed. Prisoner PER, Warrant, PNC and any medical concerns raised at first medical screening will be taken into account for the final Cell Sharing Risk Assessments (CSRA) recommendation. CSRAs are reviewed after an incident occurs or where concern is raised over the prisoners Mental Health.	07/02/14	This will remain open and ongoing due to the turn over of new prisoners daily. Night staff take forward all the relevant checks utilising the PER, Warrant, PNC and any medical warnings.