



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP & YOI Chelmsford in March 2014**

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, who was found hanging in his cell at HMP&YOI Chelmsford in March 2014. He was 29 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was undertaken. The prison cooperated fully with this investigation.

On 19 March, the man was arrested for assaulting his ex-partner. According to the police, he was drunk, emotional and violent and banged his head against the police cell door and wall several times. He was given an anti-ligature suit in an effort to stop him hurting himself, placed in a camera cell and visited every 30 minutes. The next day he told the custody sergeant that he felt like hanging himself. He remained in an anti-ligature suit on 30 minute visits. On 21 March, he was sentenced to 12 weeks imprisonment and taken to HMP&YOI Chelmsford. The police did not complete a suicide and self-harm warning form (SASH). The box on the front of his person escort record for risk of suicide and self-harm was empty but "threats of self-harm" was written in the 'health medical' box. His police custody record travelled with him to prison, but the section recording his statement that he felt like hanging himself was not read by staff.

The man completed the reception process and was correctly identified as needing alcohol detoxification. Only one officer remembered seeing the reference to threats of self-harm on the front of the PER. She said she thought it referred to him head-butting the police cell door and walls. On 22 March, he told an integrated drug treatment service (IDTS) nurse that he felt he had no hope of reconciliation with his ex-partner, but denied any current thoughts or history of suicide or self-harm. He spoke to three prisoners during the day. One said he was tearful during exercise, but did not want to talk and said he would be alright in a few days. Prisoners in a neighbouring cell said he seemed quiet and told them he had "lost a lot", but they were not concerned for his safety. He was found hanging in his cell the next morning. Despite a prompt emergency response, he was pronounced dead by paramedics shortly after 6.00am. Police found letters in his cell that strongly suggested suicide due to the break up of his relationship.

This was the second death within the first 48 hours of custody at Chelmsford in just over four months. The investigation into the previous death raised concerns about identification of risk in reception and on the first night. The draft report into that death was issued shortly before the man's death and before the prison had had a chance to act on the recommendation. As similar concerns about staff awareness of risk factors arise in this case, I repeat the recommendation.

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

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SUMMARY

1. On 19 March, the man was arrested for assaulting his ex-partner and taken to a police station. He was drunk, emotional and violent and banged his head against the cell door and wall several times. He was given an anti-ligature suit in an effort to stop him hurting himself, placed in a camera cell and visited every 30 minutes. The next day, he told the custody sergeant that he felt like hanging himself.
2. On 21 March, the man was sentenced to 12 weeks imprisonment. The police did not complete a suicide and self-harm warning form. The box on the front of his person escort record (PER - the form that accompanies a person between police, court and prison and lists risk factors) for suicide and self-harm was left blank, but "thoughts of self-harm" was written in the 'health-medical' box.
3. The man arrived at HMP Chelmsford at about 4.15pm. He appeared unhappy to be in prison, but was otherwise calm. Only one officer remembered seeing the reference to 'threats of self-harm' on his PER, but thought these related to injuries from head-butting the wall in the police station and marks on his wrists. None of the staff in reception read his police record in its entirety.
4. The reception GP prescribed medication for alcohol detoxification and the man was allocated a single cell on the detoxification and stabilisation unit. Before being taken there, he had a first night in prison interview. The interviewing officer did not see the prisoner's PER or police custody record and was not concerned by his presentation.
5. On 22 March, the man was interviewed by a nurse for an integrated drug treatment service (IDTS) assessment. He said that he did not have any current thoughts or history of suicide or self-harm and said he had head-butted a wall in the police cell out of anger and not with any intention to hurt himself. He was pleasant and co-operative, but seemed quiet. He said he was unhappy to be in prison and felt he had no hope of reconciliation with his ex-partner.
6. The man spoke briefly to several staff and prisoners during 22 March. A prisoner remembered him looking very upset and tearful, but said he did not want to talk. Prisoners in a neighbouring cell said he seemed a bit down, but thought his behaviour was normal for a new prisoner undergoing detoxification. He was found hanging in his cell shortly after. Cardio-pulmonary resuscitation (CPR) was given promptly but paramedics pronounced him dead just after 6.00am. Police found letters in his cell that strongly suggested suicide due to the break up of his relationship.
7. We are concerned that further training is needed for staff to ensure that they are aware of the risk factors that indicate that a person is at risk of suicide or self-harm and repeat a recommendation from the investigation into a previous, recent death at Chelmsford.

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at HMP&YOI Chelmsford inviting anyone with information to contact her. One prisoner asked to speak to her.
9. The investigator visited Chelmsford on 2 April 2014 and met the Governor. She collected copies of the man's prison record and other relevant paperwork, visited the wing and cell where he had stayed and interviewed one prisoner. Chelmsford provided her with 16 disks of CCTV footage of events on E wing leading up to the incident. Unfortunately, when we attempted to view the footage at the prison with the Head of Security, only a few seconds of film had been downloaded.
10. NHS England (East of England Team) commissioned a clinical reviewer to carry out a clinical review. The investigator and clinical reviewer interviewed four members of staff. The clinical reviewer spoke to another member of staff by telephone. The investigator and an Assistant Ombudsman interviewed four members of staff and two prisoners. The investigator also spoke to the Coroner's Officer and police investigator. She was provided with a copy of the police report to the Coroner and statements taken by police at Chelmsford. We have sent a copy of this report to the local Coroner.
11. One of our family liaison officers contacted the man's mother about the investigation to invite any relevant issues she wanted the investigation to consider. She asked whether the police had told the prison that her son was at risk of suicide or self-harm. She asked about his state of mind when he arrived at Chelmsford and said he had purchased a rope with the intention of killing himself a few days before his arrest. She asked whether her son was subject to suicide and self-harm monitoring and whether he had been given anything for alcohol withdrawal.
12. The man's mother received a copy of the draft report. She said she found the report to be comprehensive and felt that her son had been let down by those responsible for his care.

HMP&YOI CHELMSFORD

13. HMP&YOI Chelmsford is a local prison that takes prisoners directly from courts. It holds nearly 600 male prisoners aged 18 and over on seven wings. F wing is the first night in prison and induction unit. New prisoners requiring detoxification from drugs or alcohol go instead to the integrated drug treatment service (IDTS) unit on E wing. Reception staff use a system of coloured trays to identify prisoners with particular needs and prioritise them. Records for prisoners thought to be at risk of suicide or self-harm are put in a red tray, records for prisoners with drug or alcohol issues go in a green tray and records for all other prisoners go in a blue tray. Prisoners identified as at risk of suicide and self-harm who also require detoxification have a red and green tray stacked together.
14. Primary health care, including GP input into first night prescribing and IDTS patients, is provided by Care UK. North Essex Partnership Foundation Trust (NEPFT) is contracted to provide IDTS nurses. The IDTS service provides a programme for alcohol detoxification and detoxification regimes for benzodiazepines. Maintenance and titration regimes for drug users using methadone or subutex are also available. Psychosocial support for IDTS patients is provided by Inside Out (a community based organization providing assessment and care planning for prisoners with class A drug problems).

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons inspected Chelmsford during this investigation in June 2014. A copy of the report was not available at the time of writing, but in their initial feedback inspectors commented that staff treated prisoners respectfully in reception but some key safety information about new arrivals was not always adequately communicated to all relevant staff. Inspectors were not assured that first night interviews were always carried out, but said staff on the induction wing knew the prisoners well. Inspectors saw evidence of some good individual support offered to prisoners with complex needs.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their 2012-2013 annual report, the IMB commended the positive atmosphere and general feeling of safety in the prison. They commented that prisoners felt well treated and that there was a good relationship between staff and prisoners. They said that concerns about nursing recruitment, loss of senior managers, staff training and communication between the various healthcare departments were starting to be addressed. These issues had not had an adverse effect on the standard of healthcare delivered to prisoners, which the IMB felt was good.

Previous deaths at Chelmsford

17. There have been eight deaths at Chelmsford in the last three years. There were two self-inflicted deaths in 2011, two in 2012 and three in 2013. In the investigation into the death of a man in November 2013, we raised a number of concerns about identifying prisoners at risk of self-harm and for managing and supporting them.

Suicide and self-harm monitoring

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 care-map to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care-map have been completed.

KEY EVENTS

19. The man had served several custodial sentences since 2003 for a variety of offences including battery, assault occasioning actual bodily harm and child neglect. He was held in Chelmsford twice for two weeks in both 2010 and 2011 and once for a week in July 2013. He was released from HMP Blundeston after serving a six month sentence in October 2013. We have seen no evidence that he was regarded as being at risk of suicide or self-harm during any of these periods in custody. In 2010, during a reception health screen, he reported suffering from depression and said that he had previously been prescribed an anti-depressant. He does not appear to have had contact with community mental health services.

Wednesday 19 and Thursday 20 March 2014

20. On 19 March, the man was charged with assaulting his ex-partner. According to the report a Detective Inspector completed for the Coroner, he arrived at the police station at 7.30pm. The custody sergeant attempted to assess his risk. He thought the man was feigning sleep and used a pressure point on his neck to rouse him. He became "extremely violent and aggressive, shouting and wildly screaming". He was described as drunk, emotional and angry and he head-butted the cell door and walls a number of times, causing a red mark on his forehead. He was provided with anti-ligature clothing in an attempt to prevent further self-harm.
21. The next morning, 20 March, a different custody sergeant completed a risk assessment. The self-assessment section of the man's police custody record shows that he had a mark in the centre of his forehead but does not explain how he got this mark. He said he had no medical conditions or mental health problems and had not tried to harm himself before. He said he had drunk a lot of beer in the previous 24 hours, but had not taken any drugs and was not dependent on drugs. He said he consumed seven cans of beer daily and "got the shakes" if he did not drink.
22. The self-harm section of the custody officer's assessment records, "DP (detained person) denies any previous self-harm, however just stated he feels like stringing himself up". The custody officer referred the man for a medical assessment to record his injuries and because he said he was an alcoholic and felt unwell due to lack of alcohol. He was still wearing the anti-ligature suit and was put in a camera cell and checked every 30 minutes.
23. The man's detained person's medical form records that he had sustained a bump on his forehead and a grazed elbow after head-butting the police cell door the previous day. The police medical officer said he had no symptoms indicating a head injury. He told the medical officer that he had an alcohol problem that had escalated over the previous nine years. He also said he had anger problems. The medical officer noted that he had a slight tremor, but no other signs of alcohol withdrawal. He said he was not on any medication, but "dabbled" in non-prescription drugs. His clinical observations were in the normal range and he was coherent and orientated. The medical officer

recorded his risk of self-harm as “standard” and recommended that officers visited him every 30 minutes. He does not appear to have been given any medication for alcohol withdrawal.

Friday 21 March

24. On 21 March, the man was found guilty of assault at Magistrates’ Court and sentenced to 12 weeks imprisonment. He was also made subject to a restraining order preventing him from contacting his ex-partner for 12 months. He was taken to HMP&YOI Chelmsford the same day. His person escort record, which was completed by the police, noted in the medical health section, “marks in centre of forehead, bruising to both wrists, alcoholic, threats of self-harm”.
25. The man arrived at Chelmsford at about 4.15pm. The officer on duty at the desk in reception told the investigator that she tried to establish a rapport with him, but he was not talkative. She said he said he was unhappy to be back in prison and looked “pissed off”. She checked his PER for risk factors and noticed the entry in the ‘health – medical’ box. She said she thought the threats of self-harm related to the injury to his forehead and wrists and asked him about that. He told her he had banged his head against a wall and the marks on his wrists were from handcuffs. She could not remember if she asked him why he had banged his head and put his paperwork in a green tray to indicate that he had drug or alcohol issues. She did not use a red tray as well because she was satisfied with his explanation of the marks on his forehead and wrists that he was not at risk of self-harm. She did not read his police custody record.
26. An officer conducted the man’s reception interview. He said the purpose of the interview is to obtain information from the prisoner (including personal information and next of kin details), to give the prisoner information about aspects of prison life (including the incentives and earned privileges scheme and prison phone system) and an assessment of the prisoner’s risk of suicide and self-harm. The officer works down a checklist of questions and enters information on NOMIS (the electronic prison record). He said that, while he completes the checklist, he tries to gauge the person’s state of mind in order to help make a risk assessment of their risk of suicide and self-harm. The assessment is the last thing on the check list. He said he looks for a SASH form, checks NOMIS and the PER for alerts or risk indicators and asks the prisoner questions about current or past thoughts or attempts of suicide. He said he is aware that some offences and recent significant events such as relationship breakdown might indicate heightened risk. If he was concerned a prisoner is at risk of suicide or self-harm he said the he would open an ACCT.
27. The officer said he vaguely remembered the man but only because, once he knew he had died, he had tried to remember him. He had not stood out when he met him and he thought his paperwork came to him in a blue tray (the reception officer said she put paperwork in a green tray). The officer said he appeared distinctly normal. He did not appear forthcoming or withdrawn and was not very expressive. There was nothing to indicate that he was suffering

from withdrawal or had substance misuse issues. The officer did not remember the entry on the front of his PER that referred to 'threats of self-harm'. He did not complete an electronic 'reception self-harm risk assessment' form because he understood that he should only do so if he was concerned about a prisoner's risk. He did not read his police custody record.

28. The officer was also responsible for the man's first night cell sharing risk assessment (CSRA) which is used to identify prisoners who might be a risk to other prisoners in a cell. All prisoners at Chelmsford are given a single cell on their first night in line with Prison Service Instruction 09/2011, because their police national computer (PNC) information is not produced until the next morning, when the CSRA is then finalised. The officer therefore assessed him as 'interim high risk'. His NOMIS record from previous sentences showed alerts for violence, domestic violence and carrying weapons. He had no previous alerts for suicide or self-harm.
29. At 5.30pm, the man was interviewed by a nurse for his reception health screen. The nurse told the investigator that he did not remember him. His entries on SystmOne (the electronic medical record) show that the man said he had been in Chelmsford in 2013, but he couldn't remember the dates. He appeared clean shaven and tidy and did not report any physical or mental health concerns. He denied any thoughts or previous attempts of suicide or self-harm and any history of involvement with mental health services. The nurse noted that he had slight bruising on his forehead. He said he had been drunk and had head-butted the police cell door.
30. The man told the nurse that he drank a lot and thought he had alcohol issues. The nurse noted that he responded appropriately, answered all the questions clearly and appeared calm and settled. He said he had a six week sentence and was pleased it was short. He did not appear to be in a low mood and showed no signs of mental ill-health or distress. The nurse made sure he was aware of the different support groups available in Chelmsford and referred him to the integrated drug treatment service (IDTS) and the GP because of his issues with alcohol.
31. The nurse told the investigator that he usually sees the prisoner's PER, police custody record and the first part of the CSRA. He said he was not aware of the exact nature of the man's offence and did not ask. He said he usually reads the front of the PER and the medical assessment page of the police custody record. The nurse was shown a copy of the man's police custody record. He said he did not remember seeing the reference on the PER to thoughts of self-harm, his comment that he felt like hanging himself or that he had been put in a camera cell in anti-ligature clothing. He said had he known that, he would probably have opened an ACCT.
32. A doctor saw the man at 6.45pm. He said he drank between five and seven cans of Tennants Super a day unless he had no money. He said he did not have fits, but got the shakes if he did not drink. He said he took crack cocaine, but was not on any prescribed medication. His urine test showed positive for cocaine only. The doctor noted that he looked well and his pulse

and blood pressure were reasonable. He diagnosed alcohol dependence syndrome and prescribed alcohol detoxification regime two (the medium range regime) consisting of chlordiazepoxide (Librium - a benzodiazepine sedative used for alcohol withdrawal), hyoscine butylbromide for cramps, metacloperamide for nausea, thiamine and vitamin B.

33. The doctor told the investigator that he did not remember the man. He said that the history he gave was moderate for an alcoholic, but as he said he was drinking a variable amount depending on money, he erred on the side of caution, treated him as an alcoholic and put him on the medium range detoxification programme. This would also have helped with any symptoms of withdrawal from crack cocaine. The doctor said he sees exactly the same paperwork as the reception nurse. He did not remember seeing the reference on the PER to thoughts of self-harm or the police custody record note that the man had said he felt like hanging himself. The doctor said since the previous death at Chelmsford (which happened in the prisoner's first two days of custody) he always asks prisoners in reception whether they have thoughts of suicide or self-harm. He noted on the man's record that he was not suicidal. He said, had he seen the information on the police custody record, he would have questioned him further.
34. An officer conducted the man's first night in prison interview (FNIP) in one of the induction rooms on F wing, the first night and induction unit. Prisoners with drug and alcohol issues have their FNIP interview on F wing and then move to the detoxification unit on E wing. The officer said he has a list of set questions, which he works through including questions about background, housing issues, whether the prisoner is a primary carer or has left any unattended pets at home. The only information he sees is what has been entered on NOMIS by reception staff and the prisoner's partially completed CSRA.
35. The officer remembered the man and said that he seemed "quite sensible". He told him that he had no contact with friends or family and lived in a shared house. He said he was hungry and wanted some tobacco. The officer did not check his offence on NOMIS, but noticed a stamp on his file indicating he came under the terms of PSO 4400H (which covers rules for prisoners whose offences involve harassment) and therefore he did not set up his PIN phone account as the numbers would have to be checked first to make sure he was not prevented from contacting them.
36. The officer said he asked the man directly if he was likely to attempt suicide or self-harm. He said all of the prisoners he interviews have already been assessed by a nurse in reception and he thought they would pick up on any issues about risk. He said he also checked his CSRA to see if he had any health issues. He said he always asks the prisoner how they are feeling and if they feel okay in themselves. He did not remember what the man said in response. He said nothing about his presentation gave him any cause for concern.

37. An Operational Support Grade (OSG) was on night duty on E wing. She said the man pressed his cell bell during the evening and asked her what time night medication was given. She told him approximately 10.00pm and said he seemed happy with the answer. He did not ask about anything else or seem like he wanted to talk.

Saturday 22 March

38. At 9.08am, the man saw a nurse for his IDTS assessment in the IDTS nurses' room on E wing. It is a one to one assessment that follows a standard template on SystemOne. She said the only information she had on him was his SystemOne record. She does not see prisoner's wing files and would therefore not have seen his PER or police custody record. She checked his NOMIS record for alerts about self-harm, but there were none.
39. The nurse told the investigator she only vaguely remembered the man. She said he was pleasant, open, participated well in his assessment and answered all of her questions. He told her he drank five to seven cans of super strength lager a day usually alone in his room and smoked crack cocaine about four times a week. He occasionally used heroin and reported last using it about a week and a half previously. She noted he had some fine tremors, appeared slightly flushed and reported some stomach cramping. He said he had no physical health problems. He told her he had previous convictions for burglary, domestic violence, grievous bodily harm, actual bodily harm and neglect of his daughter. He had no contact with his daughter, but did not want to talk about it as he saw no point in "bringing up the past".
40. Part of the IDTS assessment includes a psychological assessment. The man told the nurse that he had been taken to a mental health hospital a couple of times in the last few years after being found drunk in public places. He said he stayed there until he was sober. He was supposed to engage with community mental health services but had not. He said he had no history of depression, suicidal thoughts, attempted suicide or self-harm. He said he had recently head-butted a wall in a police station out of anger and not with the intention of hurting himself. She noted he seemed quiet and low in mood, mostly because he thought his relationship with his ex-partner was beyond repair but he was also unhappy about returning to prison.
41. The last part of the IDTS assessment is a risk assessment consisting of three pages. The first section lists eight risk indicators for suicide:
- Consider planned intent
 - Major psychiatric diagnosis
 - Recent significant life events (bereavement/loss of job)
 - Misuse of drugs and/or alcohol
 - Helplessness or hopelessness
 - Believe no control over their life
 - Expressing suicidal ideas/high levels of distress
 - Previous suicide attempt

The nurse ticked the boxes for recent significant life event, misuse of drugs/alcohol and helplessness or hopelessness. In the box below she wrote that the man did not appear hopeless, but when asked to describe how he felt he told her that he felt sad about losing his ex-partner and did not think that they would reconcile. She said current thoughts of suicide or a recent attempt and past history of attempts would prompt her to open an ACCT regardless of the person's presentation. She said opening an ACCT document is always on her mind when making an assessment and she had opened ACCTs during assessments before. She said he had not struck her as someone who was at risk and she had not felt it was necessary to open an ACCT. She was very shocked when she found out that he had died.

42. The nurse referred the man to Inside Out (a voluntary organisation working with prisoners with substance misuse issues) for psychosocial support and to the genito-urinary clinic for blood borne virus screening. She also made him aware of the support networks available in Chelmsford such as the Chaplaincy, Listeners and Samaritans. She said she told him about the support available because it was her standard practice to do so and not because she was concerned about him. She also advised him to speak to Nacro (a charity dealing with the reduction of crime) about his housing because he was not sure whether he would be able to go back to the room he rented when he was released. She said that his case would have been discussed at the Monday morning multi-disciplinary team meeting and she would have looked on the Remedy database (the national mental health service database) for information about his hospital assessments.
43. An officer said the man asked him some questions about the regime and unlock times when he opened his cell at about 9.10am that morning. He said the man appeared calm and not in any distress. He remembered locking and unlocking his cell at various times during the day but they did not speak. After he unlocked him for exercise at 3.00pm, he heard him ask another prisoner if he had seen him in Southend. The other prisoner told the man he must have the wrong man and that was the end of the conversation. The officer locked him in his cell for the night at 5.20pm. He said goodnight and the man said he would see him in the morning. The officer said there was no indication that he was upset or wanted to talk and he was shocked to hear of his death.
44. A prisoner said he had spoken to the man in the exercise yard on 22 March. He said the man was sitting at the side of the yard rocking backwards and forwards. He said he tried to start a conversation with him, but he did not seem to want to talk and started crying. He tried different topics to prompt conversation including talking about the weather. He told him that he was on the same wing and he could talk to him if he needed someone to talk to. The man said, "I'll be alright in a couple of days, but thanks". The prisoner asked him if he was on any medication and he said only for alcohol. The prisoner suggested that he ask for something for depression. As he got up to walk away, the man asked him for a roll up. The prisoner gave him one and he said he would give it back to him the next Friday when they got their canteen.

45. An officer told the police that he had spoken to the man on the exercise yard, but could not remember what about. The officer said he appeared to be fine and had given him no cause for concern.
46. A prisoner, who lived in cell E1-7 next door to the man, said that he first spoke to him at lunchtime. The man was standing in his doorway smoking and looked like he was keeping himself to himself and getting his bearings on the wing. The prisoner said he asked him what he was in for and he said "something stupid" but that he had "lost a lot" as a result. The prisoner said he assumed he was in for some type of domestic offence. The prisoner said he saw his lunch uneaten on his table and asked him if he was going to eat it. He replied, "No I'm alright". At teatime, the prisoner saw him sitting at the bottom of the stairs. He said he looked a bit miserable but when he asked him if he was okay, he said he was fine and seemed alright. The prisoner said he did not notice anything to suggest he was suffering from symptoms of withdrawal. He said that heavy drinkers often go quiet for the first few days. They did not talk once they were locked in their cells for the night, but the prisoner heard banging noises from the man's cell at about 3.00am.
47. The prisoner's cellmate did not want to speak to the investigator. He asked to speak to the police after the man had died. He told the police he had spoken to the man on the landing and once in his cell, mainly about his sentence. He said he thought he seemed "down in the dumps". He asked him if he could get some Subutex for him. He said he had heard banging from the man's cell at about 1.00am.
48. The two prisoners in E1-5 said they had not spoken to the man. One, a servery orderly, remembered giving him a menu card at teatime and described him as looking "dazed and confused".
49. All prisoners on alcohol detoxification have their pulse rate and blood pressure taken daily for the first five days. The man's observations were taken at 6.08pm and found to be normal.
50. A nurse was the IDTS nurse working the night shift on E wing that night. He said the man complained of a headache when he saw him during the evening medication round about 10.00pm. The nurse said he gave him paracetamol. He insisted on seeing the contents of the sachet because he was allergic to co-codamol. The nurse said that, other than being quite insistent and complaining of headache, he appeared to be perfectly fine.

Events of the incident

51. At about 5.08am, a custodial manager and an officer were walking down the path alongside E wing when the custodial manager noticed through the window of the man's cell that he was hanging from the light fitting. (The police report noted that the TV in the cell was on.) She radioed the night OSG on E wing to tell her someone was hanging in one of the cells. She also asked for a nurse, an ambulance and all night orderly staff to attend E wing. (The radio

system was on talk through so all staff with radios could hear.) She and the officer ran to E wing.

52. The OSG, the night patrol officer on E wing, said she had just finished checking prisoners on open ACCT documents when the custodial manager and the officer ran on to the wing and began looking into the cells on the left hand side of red spur. She did not hear the custodial manager's radio message because she was on the telephone to a colleague in the wing office. She joined them, looked into the cell and saw him hanging from the light by a green sheet. The custodial manager radioed a code one emergency (to indicate that there was someone with breathing difficulties) and asked again for an ambulance as the officer and OSG went into the cell. The officer and OSG supported the man while the custodial manager used a cut down tool to release the sheet from the light. The OSG, who had recently received first aid training, checked to see if he was breathing and began chest compressions (cardio pulmonary resuscitation – CPR), rotating in cycles of 30 compressions with the officer. The OSG said his body was floppy and he was still warm. He had a deep ligature mark around his neck, but his face was a normal colour. His tongue was swollen and his eyes were open.
53. The custodial manager collected a nurse (who did not have a radio) from the E wing IDTS office. He was not carrying a radio and was unaware of the emergency. The nurse collected the emergency bag from the E wing senior officer's room. He attached the defibrillator to the man. It advised to continue CPR. The emergency response nurse and other officers also arrived. The emergency response nurse gave him oxygen using an ambu-bag. She said he was still warm to the touch, but there were no signs of life and his pupils were fixed and dilated. Both nurses and the officers continued CPR until paramedics arrived. The paramedics asked for him to be moved on to the landing where there was more room to work on him. A privacy screen was placed around him.
54. The custodial manager asked an officer to check the other prisoners on the wing and another officer to check all prisoners on open ACCTs.
55. The East of England Ambulance Service patient care record logs the emergency call at 5.09am. The ambulance arrived at the prison at 5.14am and the paramedics said they reached the man at 5.30am. Prison logs and reports record the paramedics arriving on E wing at 5.20am. The OSG said she thought the paramedics arrived quickly. The paramedics noted that he had no pulse, fixed and dilated pupils, there were no signs of life and no rigor mortis. They administered adrenaline and advanced life support, but pronounced him dead at 6.02am.
56. A hot debrief took place at 9.28am led by the Deputy Governor and attended by all staff involved in the incident and members of the staff care team and IMB. All prisoners on open ACCTs were checked and reviewed. The prisoners in the cells either side of the man's cell were asked if they would like to move to other cells but declined.

57. The police removed several pieces of paper from the man's cell, including a letter to his mother and a letter to his ex-partner that had been torn up and put in the waste bin. According to the police report for the Coroner, both letters strongly suggested that his suicide was due to the break up of his relationship. His time in police custody on 19 and 20 March is the subject of an ongoing investigation by the Independent Police Complaints Commission (IPCC).

Family liaison

58. An officer was appointed prison family liaison officer. The man gave no details of next of kin when he arrived at Chelmsford on 21 March. After his death staff found a note in his cell naming his ex-partner as his next of kin. The officer and one of the prison's co-ordinating chaplains travelled to her address arriving at 9.30am on the morning of her ex-partner's death. When they received no response they telephoned the prison. By this time, the prison had realised that she was the victim of his offence and the subject of a harassment order preventing him from contacting her. The police gave the name and address of his mother. The officer and chaplain drove immediately to her house where they broke the news of her son's death. The prison returned the man's property and offered financial assistance with the funeral costs in line with national guidelines. The family were offered an opportunity to visit the prison, but did not wish to.

Post Mortem

59. The post-mortem and toxicology reports were not available at the time of writing.

ISSUES

Assessing the risk of suicide and self-harm

60. When the man arrived at Chelmsford on 21 March, he had some of the suicide risk factors outlined in PSI 74/2011 (Early Days in Custody) and also in PSI 64/2011 (Safer Custody). He had an alcohol dependency, had committed a violent offence against a partner and was subject to harassment measures. The front of his PER recorded “threats to self-harm”. The information about his alcohol dependency and threats of self-harm were written on the PER. His offence was recorded on the PER as “assault by beating”. He arrived with a restraining order imposed on his conviction for common assault preventing him from having contact with a named female. His main prison record cover was stamped with “PSO 4400 H” showing that he was subject to a harassment order.
61. One officer was the only member of staff who remembered seeing the entry “threats to self harm” on the man’s PER. At interview she said she believed this to refer to the preceding part of the entry which said he had injuries to his forehead and wrists. She asked him about this and was satisfied with his explanation that the mark on his forehead was from head-butting a wall in the police cell and the marks on his wrists were from handcuffs. She could not recall asking him why he had head-butted the wall. She did not put his record in a red tray or put an alert on NOMIS to highlight the entry on the PER about thoughts of self-harm to other reception staff. She did write “threats of self-harm” on the front of his F2050A (information of special importance).
62. Part of the duties of the reception desk officer is to perform an initial triage of the prisoner’s issues and use the coloured trays to identify their main issues and prioritise the order in which they are processed. It is not an in-depth conversation or risk assessment. We do not think it presents a sufficient opportunity for the officer to properly assess risk. Any reference on the PER to suicide or self-harm should prompt the use of a red tray and an alert on NOMIS to allow other officers to explore the issues further during the reception interview, the reception health screen and the FNIP interview.
63. Neither an officer nor a nurse remembered seeing the reference to threats to self-harm on the PER. The nurse said it was his custom to look at the page of the police custody record completed by the police medical officer and would only read the whole document if he had concerns about a person’s risk. Two officers did not read the police custody record, although one said she reads them since the death. All of the staff were reassured by his presentation.
64. It is unfortunate that the police did not complete a suicide and self-harm warning form after the man said he felt like hanging himself. The information about this was buried in the middle of the police custody record and the reference to it on the PER was not in the box staff would have expected to see it. The police medical officer who assessed him after he said that he felt like hanging himself rated his risk of suicide and self-harm as “standard”. Staff did not know that he had been put in anti-ligature clothing in a camera

cell and visited every 30 minutes. Nevertheless, we consider the entry on the front of the PER should have prompted further exploration and should have been examined in conjunction with the information that he was an alcoholic and was subject to harassment measures.

65. Chelmsford's safer custody department follows the guidance in national Prison Service Instruction 64/2011 (Safer Custody). They do not have a current local safer custody policy. There are some local processes which are not encapsulated in any local safer custody guidance, but are simply accepted practice. One procedure requires reception staff to check for an existing ACCT document, a suicide and self-harm warning form or a suicide and self-harm warning written on the PER. If any of these are found, the reception officer is expected to complete a local 'Reception self-harm risk assessment' form. This electronic form requires the officer to record current and previous episodes of self-harm and to state if an ACCT document has been opened and, if not, why not. The form has to be approved by a manager and emailed to the safer custody department, who then forward any concerns to wing managers for them to speak to the prisoner about. The entry on the front of the man's PER should have prompted completion of this form.
66. In our report into the previous death at Chelmsford in November 2013, we recommended that the Governor produce clear local guidance about identifying prisoners at risk of self-harm and ensure that reception staff consider all known risk factors and share relevant information about risk. We recommended that an ACCT is opened whenever a prisoner has recently self-harmed or expressed suicidal intent. Our draft report was issued some ten days before the man's death and before the prison had a reasonable chance to act on the recommendation and embed it. However, the prison's response to that recommendation does not appear to have resulted in any meaningful change to policy or procedures. This investigation indicates that there is still a need for a greater awareness of risk factors among staff. He had expressed thoughts of self-harm, but this was not registered or explored fully by any of the staff who spoke to him and an ACCT was not opened. The reception process is the best opportunity for identifying risk in the early days of custody because it is the only place where the prisoner's PER and police record is examined.
67. We cannot know whether management under ACCT procedures would have changed the outcome, as this procedure cannot guarantee a prisoner's safety if he is determined to take his own life. However, it allows appropriate supportive mechanisms to be put in place to help identify and address causes of distress. The ACCT process would have given staff the opportunity to make a fuller assessment of the man's risk at multidisciplinary reviews and might have offered an opportunity to discover the extent of his feelings about the breakdown of his relationship with his ex-partner and for him to be checked regularly. We therefore repeat our recommendation.

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and

supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

General clinical care

68. The clinical reviewer concluded that that the clinical care given to the man in Chelmsford was equivalent to that available in the community.

Emergency response

69. When she noticed the man hanging, the custodial manager radioed for an ambulance, the emergency response nurse and all available staff to go to E wing immediately. She did not call a code 1 emergency until she arrived at his cell, but her original call set out all the help indicated by a code 1 and we are satisfied that this did not cause a delay. She reiterated the need for an ambulance when she arrived at his cell. We consider that the emergency response when he was found hanging was of a good standard. Several officers and nurses reached the cell very quickly and performed CPR promptly until paramedics arrived.

RECOMMENDATION

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:
 - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:</p> <ul style="list-style-type: none"> • Have a clear understanding of responsibilities and the need to share all relevant information about risk. • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. 	Accepted	<p>Clear local guidance is now in place and available for all staff, about procedures for identifying prisoners at risk of self-harm and managing and supporting them through the Assessment Care in Custody and Teamwork (ACCT) process. This local guidance was issued on 3/10/14, via the e- mail system and by staff briefing.</p> <p>The local guidance clearly sets out the need to share relevant information about risk. The Guidance is specifically targeted at Reception staff, First Night In Prison (FNIP) staff, Nursing staff and managers receiving prisoners into custody.</p> <p>The local guidance also reminds reception staff of the need to consider all available documentation on the arrival of a new prisoner, including the Prisoner Escort Records, suicide and self-harm warning forms for risk-related information and record any concerns, known risks or</p>	<p>Completed</p> <p>Governor/Head of Safer Custody</p>	

	<ul style="list-style-type: none"> • Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent. 		<p>triggers on NOMIS. Advice can be sought from the reception Supervising Officer when considering a prisoner's risk. The Guidance identifies known risks and triggers.</p> <p>The local guidance reminds staff that any prisoner stating suicidal intent or whenever a prisoner has recently self-harmed or expressed suicidal intent will have an ACCT opened and given appropriate support.</p>		
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