A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man at HMP Chelmsford in July 2013

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 in July 2013, at HMP Chelmsford. The man was found hanged in his cell. He was 63 years old. I offer my condolences to his family and friends.

An investigator was appointed. A clinical reviewer reviewed the clinical care and treatment provided to the man. The prison cooperated fully with the investigation.

The man was remanded into custody on 4 July 2013, charged with violent offences against his estranged wife. When he arrived at the prison, he was assessed as a risk of suicide and self-harm and staff monitored him under Prison Service suicide and self-harm prevention procedures until 12 July. He began an alcohol detoxification programme, but decided to stop taking medication early. The clinical reviewer notes that appropriate assessments were not completed at that stage. On 22 July, at 7.50am, an officer found the man suspended from his cell window, by a ligature made from a laundry bag and a pair of shoelaces. The officer called for urgent assistance. Healthcare staff arrived quickly, but they assessed that the man had been dead for some time so resuscitation was not possible.

I am satisfied that prison staff at Chelmsford appropriately took into account information from the man's time in police custody and began ACCT suicide and self-harm prevention procedures (ACCT) when he arrived at the prison. However, I am concerned that the actions identified to support the man as part of these procedures were inadequate and merely required referrals to services rather than ensuring that the man got the support he needed before the monitoring ended. We cannot know whether further monitoring and support would have prevented his death.

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

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SUMMARY

1. The man was remanded into custody at Chelmsford on 4 July 2013, charged with violent offences against his recently estranged wife. While he was in police custody, the man had been very low in mood and said that he wanted to die. A police doctor assessed him and concerns were passed appropriately to the escorts and the prison.

2. At his initial health screen at Chelmsford, the man said that he felt like killing himself. He was therefore monitored under Prison Service suicide and self-harm prevention procedures, known as ACCT. The man began an alcohol detoxification programme. He decided to withdraw from the programme early, but there is no indication that appropriate clinical assessments were made at that stage.

3. On 11 July, the man told staff that he wanted to move from the wing where he was living, because he found the prisoners there offensive. He said that they were pressurising him to divulge his telephone account and give them his allocated supplies for making hot drinks. This was not investigated and the information was not discussed during the ACCT review. Staff decided that the ACCT should be closed on 11 July. We consider this was premature as, although caremap objectives to refer the man to services had been achieved, he had not actually started receiving some of the support it was identified he needed.

4. On 12 July, the man moved to G wing, a wing dedicated for older prisoners where he appeared to settle. On 21 July, an officer completed an ACCT post-closure review. The man gave no cause for concern and said that he was feeling much better as he had had time to come to terms with the split from his wife.

5. On 22 July, at 7.50am, an officer found the man hanged in his cell. He called for help but did not use the appropriate emergency code. Healthcare staff arrived quickly but decided it would be inappropriate to attempt resuscitation as it was apparent from signs of rigor mortis that the man had been dead for some time. We are satisfied this was an appropriate decision. Paramedics arrived and pronounced him dead at 8.20am.

6. We make recommendations about detoxification procedures, investigating possible bullying and caremap actions in the ACCT process.

THE INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners at HMP Chelmsford inviting anyone with information to contact the investigator. No one responded.

8. The investigator visited Chelmsford on 30 July and met senior managers, the safer custody team and the prison's family liaison officer. She obtained the man's prison and clinical records, visited his cell and spoke to the prisoners who had lived on either side of him.

9. NHS England, East Anglia Team, appointed the clinical reviewer to review the clinical care the man received while he was at the prison.

10. The investigator contacted the Coroner for Chelmsford who provided a copy of the post mortem report. A copy of this report has been sent to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process and to allow them to identify any relevant matters which they wanted the investigation to consider. They had no specific issues for the investigation to take into account.

HMP CHELMSFORD

12. HMP Chelmsford is a local prison which takes prisoners directly from courts 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 part of the prison and in three separate newer units (E, F and G). Healthcare is provided by Care UK.

Her Majesty's Inspectorate of Prisons

13. The most recent inspection of Chelmsford by HM Inspectorate of Prisons was in May 2011. Inspectors found that there was a comprehensive strategy to minimise the risk of self-harm and that protocols were well-known by staff and prisoners. The Listener's scheme was well supported and a multi-disciplinary suicide prevention committee met monthly to monitor and ensure that the implementation of the policy was consistent. However, inspectors noted that the quality of self-harm (ACCT) monitoring was inconsistent and that care maps to support prisoners at risk needed some development. Attendance at ACCT reviews was irregular and written entries on observation logs were described as cursory. The attitude of staff towards prisoners at risk was good throughout the prison and the level of care was generally high.

14. Inspectors found that arrangements to deal with violence (including bullying) had improved, with an overarching violence reduction strategy. There were betters systems than previously for identifying potential incidents of bullying.

Independent Monitoring Board

15. 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 2012-13 report, the IMB commended the safer custody and violence reduction teams for reducing conflict and helping to keep prisoners safe. However, they also noted that insufficient time and thought had been given to entries and interaction in ACCT documents. They were also concerned about the prevalence of bullying associated with tobacco.

Violence Reduction

16. The prison's violence reduction team investigates acts of antisocial behaviour by interviewing prisoners. Part of the team's work is to oversee the SAFE process (Safe and Free Environment), the purpose of which is to identify, monitor and manage prisoners who display antisocial behaviour. There is a SAFE prisoner representative on every wing.

Assessment Care in Custody and Teamwork

17. 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 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. 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 of the actions on the caremap have been completed.

Previous deaths at Chelmsford

18. In the last year, there have been three other self-inflicted deaths at Chelmsford. In two of those investigations, we were critical of the ACCT process and made related recommendations. This investigation has found that there are still some areas for improvement in ACCT procedures.

KEY EVENTS

19. The man was remanded into custody on 4 July 2013, for violent offences against his estranged wife. While he was in police custody before going to court, a social worker from the Criminal Mental Health Justice Team assessed him after he said that he had thoughts about killing himself. During the assessment, the man said that he would not act on his thoughts. The social worker wrote a care plan which indicated that the information should be shared with Serco (the prisoner escort contractor), the court and the prison doctor. The social worker also suggested that the man should attend counselling to help him come to terms with the end of his marriage. The information was included on the man's Person Escort Record (PER), alongside a marker that said that the man was suffering from undiagnosed bipolar syndrome. The PER accompanied the man to court and prison.

20. When the man arrived at Chelmsford, in the afternoon of 4 July, reception staff immediately started suicide and self-harm prevention procedures (ACCT) because of the information on the PER. The immediate action plan stated that the man should be referred for separation counselling and that a mental health assessment should take place. The man was also referred to the doctor for an alcohol detoxification programme as he said that he had been drinking an average of eight cans of beer a day since he had split up from his wife. He was told about the support available to him in prison, such as Listeners (prisoners who are trained by the Samaritans to support other prisoners), a confidential Samaritans mobile telephone, chaplaincy staff and counsellors. He said that he did not want to use these services at the time.

21. The reception manager, agreed that the man should be observed hourly until his ACCT assessment took place. A registered mental health nurse (RMN), assessed the man who said that, other than emotional difficulties related to the end of his marriage, he was fit and well and was not taking any medication. The man said that he had split up from his wife 18 months earlier and had had difficulty coming to terms with the breakdown of his marriage. He said that he had increased his use of alcohol, but had not sought any medical support in the community. He had never been to prison before.

22. The mental health nurse concluded that the man should not be allowed to keep his medication in his cell because of his risk of self-harm and noted that the man was apathetic, uninterested and angry. He referred the man to see the doctor about his alcohol use. A doctor examined the man later that afternoon and prescribed him the following medication for alcohol withdrawal: chlordiazepoxide, hyoscine butylbromide, loperamide, metoclopromide, thiamine and vitamin B and C.

23. An officer support grade (OSG) carried out an ACCT assessment the next morning, 5 July. The man told the OSG that he did not want his family to be told that he was on an ACCT and did not want them to be involved, as he did not want to burden them. He appeared very tearful and depressed and said that he was still struggling to come to terms with his marriage break up and if he could press a button to end his life he would. However, he also said that he would not end his own life because he did not "have the bottle" to do so. The man said that his daughters and grandchildren were reasons for him to live because they relied on him. The OSG told the man about the support systems in place at Chelmsford and encouraged him to talk to staff, other prisoners or use the Listener support scheme if he needed to.

24. The SO chaired an ACCT review after the assessment interview, which the OSG, a nurse and the man attended. The review panel assessed the man's risk as low as he had started an alcohol detoxification programme and had been referred to the counselling service. The man said he did not feel suicidal and that he wanted to be able to cope. He was encouraged to write to his children.

25. A caremap was drawn up which had three objectives. These were for the man to be assessed for alcohol withdrawal, for a referral to be made for separation counselling and for a mental health assessment. At the time the caremap was agreed, the referrals had already been made and the alcohol assessment had been completed, resulting in him beginning an alcohol detoxification programme. The review panel decided that staff should have three meaningful conversations with the man, one each shift and observe him hourly during the night and other times when he was locked in his cell. A further ACCT review was arranged for 12 July.

26. The nurse later examined the man for an initial health screen and as part of his detoxification programme. The man told the nurse how difficult he had found the breakup of his marriage and about how much he had been drinking. The nurse noted that the man seemed low in mood, but he spoke freely and was aware of what was happening. At 1.27pm, the mental health team considered the man's referral and it was agreed that as he had been referred for counselling and was now on a detoxification programme he would remain in the care of a doctor and the Integrated Drug Treatment Service until he had completed his detoxification programme.

27. On 6 July, the man told a healthcare assistant that other prisoners were pressuring him for his "tea pack" (a supply for making hot drinks) and his PIN phone number. (Prisoners are issued with a personal identification number to use their telephone accounts.) The healthcare assistant noted

in the man's medical record that she had passed this information to the SO, who said that he would look into it. The SO told the investigator that he could not recollect being told about the man's disclosure. There is no evidence in Security Information Reports or in the wing observation book that the SO took any further action and the information was not incorporated in the ACCT documentation to be discussed at a review.

28. The man had attended the healthcare centre daily to collect his medication, but did not attend on 10 July and no reason was recorded. On 11 July, at the request of an officer, a doctor spoke to the man who said he had stopped taking his detoxification medication because it had made him feel unwell. The doctor agreed to stop the medication, but the clinical reviewer noted that there do not appear to have been the assessments that she would have expected to see in his clinical notes at the end of a detoxification programme. The man did not sign a disclaimer as he should have done under the prison's IDTS policy. (IDTS – is the integrated drug treatment services which provide clinical and psychosocial services for substance users.) The doctor noted that the man was fit to move to G wing, which houses prisoners over 60 years old and is a quieter, more settled wing than I wing where he had been living.

29. On 12 July, the SO chaired a second ACCT review attended by an officer, a member of the chaplaincy team and the man. The man said that he would not harm himself because it would not achieve anything and too many people relied on him. He also said that being in prison was good because it was giving him time to reflect. The objectives in the careplan had been met and all agreed to close the ACCT. A post-closure review was scheduled for 21 July. The man then moved to G wing. All cells on G wing are single cells. When he arrived on G wing, he told the officer that he was glad to be there, but the officer noted that he did not seem to want to have a conversation.

30. On 19 July, a counsellor went to see the man who told her that he no longer wanted counselling and that he had no concerns. The counsellor noted on the record that she would discuss this at the next mental health team multi-disciplinary team meeting. (The multi- disciplinary team consists of primary and secondary mental health services, the Atrium Counselling Service and the Integrated Drug Treatment Service. It meets every weekday morning to discuss referrals.)

31. On 21 July, the SO held an ACCT post-closure review when the man told him that the shock of his imprisonment and 'losing everything' had worn off. The man said that he had made some friends in prison and did not feel that he needed to ask for support. He told the SO that he played the guitar and the SO introduced him to another prisoner on the wing who had a guitar as he wanted to encourage the man to associate with other

prisoners. He told the man that he could have his guitar sent in if he wanted it. The man said that he would be supported by his daughter when he was released. He completed the prisoner part of the post-closure review. He said that he had had the best help in the circumstances and that he was coming to terms with losing his wife. He added that the care that staff had shown could not have been improved in any way.

32. The officer told the investigator that he had seen the man shortly after this post-closure interview, as he had saved his evening dinner for him. He said that he had no concerns about the man and that he seemed normal.

33. The officer was unlocking cells on G wing at around 7.50am, on 22 July. When he came to the man's cell, he opened the door and saw the man suspended by a ligature made from a laundry bag and shoe laces, attached to the top of the window. The officer noticed that the man's feet were off the floor, his head was bent forward and his legs were deep purple in colour. He said that the man appeared to be dead. He immediately called to a nearby officer for assistance. The officer took a few seconds to get to the cell and then radioed an urgent message for medical assistance at cell 58, G wing. The control room asked him to clarify whether it was a code 1 and he replied that it was. (A code 1 is an emergency code used when someone is unconscious or not breathing.) Control room staff then called an ambulance and issued a code 1 over the main prison radio system. (The officer had thought it was a code blue, the emergency code used in most prisons in these circumstances.)

34. The officers went into the cell and the officer lifted the man's body while the officer cut the ligature from the man's neck. They then laid the man across the bed. The officers said that it was difficult to move the man because his limbs were very stiff. They thought it was apparent that the man was dead, so neither of them started resuscitation. A nurse responded to the code 1 emergency call with another nurse. She said that they met a third nurse as they were running towards the wing and it took them a few minutes to get to the man's cell. The nurse said that emergency bags, oxygen and defibrillators were kept on each landing and when she arrived at the cell someone had already brought them. The officer thought that when the nurses arrived, one went to get the emergency bag. The nurse clarified in his incident report that he had brought the emergency bags to the cell and arrived at almost the exact time that the nurses were going into the cell.

35. The nurse found the man on his knees with his upper body lying across the bed. She said that there were obvious signs of rigor mortis. The man's limbs were stiff and she was unable to move them, his face and limbs were blue, and his body was mottled (a sign of livor mortis). His

body felt very cold and his pupils were fixed and dilated. The shoe laces were still hanging loosely around the man's neck, so she removed them. She could not find a pulse and decided that it would not be appropriate to start resuscitation because it was very clear that the man had been dead for some time and that resuscitation would be futile.

36. Paramedics arrived at the cell at 8.15am and agreed that the man had been dead for some time. At 8.20 am, they formally pronounced the man dead. The prison chaplain attended the cell and said prayers. The duty care team attended the scene and provided support to the officers.

37. An operational manager held a debrief for the staff involved in the emergency incident at 11.00am. They were offered the support of the duty care team and a member of the Independent Monitoring Board.

38. The prisoners on G wing were notified of the man's death by a letter from the Governor. They were offered support and prisoners who were on an ACCT were reviewed by the wing staff in case they had been affected by the man's death.

39. Around 11.00am, the prison family liaison officer (FLO), and the chaplain, went to the man's son's home as the man had nominated him as his next of kin. As he was out, they decided that it was best to inform him of his father's death over the telephone because they did not know when he would return. They waited for his son to return and explained what had happened and the procedures which would follow. The man's daughter later telephoned the prison to ask for information about her father's death, which she had been informed of by other family members. The family liaison officer subsequently liaised with both the man's children and the prison offered a financial contribution towards the funeral expenses in line with national guidance.

ISSUES

Clinical care

40. The clinical reviewer considered that the reception health screening process was robust and well documented, and that policies and protocols were comprehensive and clear. She found that a multi-disciplinary team meeting had considered the man's referral and offered counselling appropriately. However, the man later refused their assistance and said that he felt more settled.

41. The man started detoxification treatment but, six days later, told the doctor that he had stopped taking his medication, even though the record showed that he had signed for it. The man told the doctor that he had concealed the medication and had only pretended to take it. The clinical reviewer recommends that the IDTS team review their processes to ensure that opportunities for concealing medication are minimised. This is important for several reasons, including ensuring that prisoners take the medication that they are prescribed to progress their treatment, and to limit the opportunities for trading in illicit medication. It is also a concern that the man was on an open ACCT at the time and could have stockpiled medication to overdose. We make the following recommendation:

    The Head of Healthcare should ensure that IDTS staff observe prisoners taking their medication and limit opportunities for concealing medication.

42. The doctor agreed that the man could stop his detoxification programme on 11 July, but there is no record that appropriate clinical assessments were completed to support this decision. While it does not appear that the man was heavily dependent on alcohol, there was no assessment of his withdrawal symptoms at the time so it is not clear what the impact of the man's decision to stop taking medication to alleviate the symptoms of withdrawal would have been. Withdrawal from alcohol dependence is a risky time for people at risk of suicide and self-harm yet there is no evidence that this decision and its possible impact was discussed as part of the ACCT process. The man had the right to decline treatment but, according to IDTS policy for the clinical management of alcohol withdrawal, a disclaimer should be signed by anyone who does not want to continue with the process. There was no evidence that the man signed such a disclaimer. It is important for safety that staff follow the correct practice for drug and alcohol withdrawal and that they accurately record their actions. We make the following recommendation:

    The Head of Healthcare should ensure that clinical assessments of withdrawal symptoms and levels of dependence are completed when

prisoners decide to discontinue alcohol detoxification programmes and that that they are asked to sign a disclaimer in line with IDTS policies.

Managing the risk of self-harm

43. We are satisfied that prison staff at Chelmsford appropriately took into account information from the man's time in police custody and began ACCT suicide and self-harm prevention procedures (ACCT) when the man arrived at the prison. In addition to his reported thoughts of suicide and low mood, there were a number of other factors which would have indicated that he was at risk of suicide. He had been convicted of a violent offence against a family member, this was his first time in prison, he was in the early days of custody, he was withdrawing from a dependence on alcohol and the police doctor had identified undiagnosed mental health problems for which he had received no treatment.

44. The caremap objectives in the ACCT plan were completed before the ACCT was closed on 12 July. In fact, they had all been achieved by the time of his initial ACCT review on 5 July as they amounted to no more than referrals to services. These actions were insufficient in themselves to ensure that the man's risk of self-harm had abated and that he received the support he needed. One of the actions, a referral for alcohol detoxification, led to an assessment being completed and treatment being offered which the man did not comply with. The other two actions – a referral for separation counselling and a referral to the mental health team – did not lead to any meaningful action before the ACCT was closed. Although a multi-disciplinary mental health team had discussed the man's case, they had decided to leave his care to the doctor's team until he completed his alcohol detoxification programme. He never had a mental health assessment as originally envisaged and there was no member of the mental health team at the second ACCT review meeting when the ACCT was closed. When he was offered counselling he declined it. We consider that in the circumstances the ACCT was closed prematurely.

45. Prison Service Instruction 64/2011, which sets out the Prison Service's framework for delivering safer custody procedures and practices, states that caremap actions should be aimed at reducing the risk the prisoner poses to themselves. While an essential first step, it is difficult to see how a caremap action simply to refer someone for an assessment will reduce their risk. In our view, the caremap should have had more specific actions clearly aimed in themselves at reducing the man's risk and the ACCT should not have been closed until the outcomes of the referrals were known and discussed fully at an ACCT case review.

46. We note that HM Inspectorate of Prisons highlighted the need for improvements in caremap actions at their last inspection of Chelmsford. We make the following recommendation:

The Governor should ensure that ACCT caremaps have specific meaningful actions aimed at reducing prisoners' risks to themselves, that progress against caremaps is considered at each review and that caremaps are updated if additional needs are identified.

47. There was no mention in the ACCT documents about the man's complaint about prisoners on F wing pressurising him. The SO said that he cannot remember being informed of the man's concerns on 6 July. There is no evidence of any security information reports about this incident and nothing in the man's case notes and no entry in the wing observation book.

48. It is likely that such concerns would have a negative impact on a prisoner's state of mind, especially one such as the man who was experiencing his first time in custody. Such concerns should have been considered during the ACCT process. Nor is there any evidence that the allegation of bullying was followed up and investigated. The man moved to G wing shortly afterwards and it was approximately two weeks later that he died, so it does not appear that this was a factor in his actions. However, this office has investigated a number of self-inflicted deaths in prisons where bullying has been involved and it is important that all such incidents are investigated and discussed with the alleged victims as part of the ACCT process to ensure they are effectively supported and to decide whether additional caremap actions are needed. We make the following recommendation:

The Governor should ensure that all information indicating potential bullying is fully investigated and that, when the information concerns a prisoner identified as at risk of suicide and self-harm, this is highlighted in the ACCT document and discussed at ACCT case reviews to check that the prisoner is receiving effective support.

Emergency response

49. Chelmsford operates an emergency radio call code protocol, issued as a Governor's information notice, 032/13. A code one emergency should be called when a prisoner is found hanging or not breathing. The officer radioed an urgent call over the radio shortly after responding to Officer Stirling's call for help. The control room staff quickly clarified that it was a code one and called an ambulance immediately. It is unfortunate that in the urgency, the officer did not remember to call the agreed emergency code, but we are satisfied that this did not lead to any significant delay.

50. When the two officers found the man, they quickly realised that he had been dead for some time. The nurse also thought this when she arrived at the cell. There were clear signs that the man was dead and we are satisfied that the decision not to attempt resuscitation was appropriate.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that IDTS staff observe prisoners taking their medication and limit opportunities for concealing medication.

2. The Head of Healthcare should ensure that clinical assessments of withdrawal symptoms and levels of dependence are completed when prisoners decide to discontinue alcohol detoxification programmes and that that they are asked to sign a disclaimer in line with IDTS policies.

3. The Governor should ensure that ACCT caremaps have specific meaningful actions aimed at reducing prisoners' risks to themselves, that progress against caremaps is considered at each review and that caremaps are updated if additional needs are identified.

4. The Governor should ensure that all information indicating potential bullying is fully investigated and that, when the information concerns a prisoner identified as at risk of suicide and self-harm, this is highlighted in the ACCT document and discussed at ACCT case reviews to check that the prisoner is receiving effective support.