Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tony Legge, a prisoner at HMP Chelmsford on 3 March 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Tony Legge was found hanged in his cell at HMP Chelmsford on 25 February 2015 and died in hospital on 3 March. He was 30 years old. I offer my condolences to Mr Legge's family and friends.

I am concerned that reception staff and others who assessed Mr Legge's risk when he arrived at Chelmsford, never saw a report by a nurse at court, which contained important information about his risk of suicide and self-harm. Although Mr Legge arrived with a suicide and self-harm warning form, in the absence of the nurse's report, staff judged that Mr Legge did not need the additional support of Prison Service suicide and self-harm prevention procedures.

The sad circumstances of Mr Legge's death indicate a need for improvements in information handling at Chelmsford and I am pleased that the Governor has already taken some action. While there is no indication that bullying was a factor in Mr Legge's actions, the investigation found that too little was done to protect prisoners from known bullies. There is also a need to improve emergency procedures so that ambulances are called immediately.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2015**

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Summary

Events

1. On 24 February 2015, Mr Tony Legge was remanded to HMP Chelmsford. A nurse assessed him at court and emailed a report to the prison outlining Mr Legge's drug, alcohol and mental health history. She noted that he was likely to lose his accommodation the next day, if he did not attend an eviction hearing and that Mr Legge had indicated that he might be at risk of suicide and self-harm if he was sent to prison. Prison reception staff did not read the report. Court escort staff also completed a suicide and self-harm warning form as Mr Legge was upset about being remanded to prison. However, prison staff did not begin suicide and self-harm prevention procedures and were satisfied from the information they had, and from what Mr Legge told them, that this was not necessary.

2. Mr Legge was dependent on drugs and alcohol and a GP prescribed a methadone maintenance programme (a heroin replacement) and medication to alleviate symptoms of drug and alcohol withdrawal. He had a single cell on E Wing, the prison's substance misuse unit. The next day, a substance misuse nurse assessed Mr Legge and a multidisciplinary healthcare meeting discussed his mental health needs. The meeting saw the nurse's report from court but did not check that others had seen it.

3. Shortly after 3.30pm on 26 February, some prisoners looked into Mr Legge's cell and saw he had hanged himself. There was a delay of about one and a half minutes before they alerted staff. Other prisoners said that at first, they had been reluctant to get locked into their cells as they were hoping to get some drugs from someone after a visit.

4. Staff responded quickly and radioed an emergency medical code but the control room did not call an ambulance until five minutes later. Mr Legge had left a suicide note in his cell. A first aid trainer arrived in less than a minute and led the resuscitation effort. A GP also arrived quickly. The staff used a defibrillator, which found a heart rhythm and detected a pulse. Paramedics and air ambulance arrived and after further emergency treatment took Mr Legge to hospital. Mr Legge did not recover and died on 3 March 2015. His family were with him at the time.

Findings

5. We are concerned that the report from the nurse at court was not handled in line with Chelmsford's information sharing protocol. Reception staff who assessed his risk of suicide and self-harm did not see the report and this meant that they did not consider important information about Mr Legge's risk. We consider that there is a need to improve information sharing and understand the Governor has introduced new procedures to help ensure important documents with information about a prisoner's risk of suicide and self-harm are not missed.

6. The multidisciplinary meeting on 25 February decided not to assess whether Mr Legge needed further mental health support until he had completed a period of

detoxification and stabilisation. This appeared to be the routine practice, and was not in line with the local protocol for treating prisoners with both substance misuse problems and mental health needs. Despite reading the nurse's report from court, healthcare staff did not question why Mr Legge had not been identified as at risk of suicide and self-harm or alert wing staff that he might be at risk.

7. In the short time he was at the prison, Mr Legge had complained to other prisoners that he was being bullied for tobacco. Several prisoners told us that new prisoners arriving on the drug treatment wing were frequently bullied for tobacco. While there is no indication this was a factor in Mr Legge's death, we are concerned that too little was done to tackle the issue and an identified bully had unsupervised contact with newly arrived prisoners.

Recommendations

- The Governor should ensure that, in line with PSI 07/2015, reception staff examine all available documentation about a prisoner and that all staff in the prison have a clear understanding of the need to share all relevant information about risk of suicide and self-harm.

- The Head of Healthcare should ensure that all healthcare staff understand and follow the dual diagnosis care pathway and do not automatically prevent prisoners from accessing secondary mental health services because they are in the early stages of treatment for substance misuse.

- The Governor should ensure that all prison staff working in the control room are fully briefed about emergency procedures and call an ambulance as soon as an emergency medical code is broadcast.

- The Governor should ensure that there are effective anti-bullying procedures to protect vulnerable prisoners and that prisoners who are on the basic regime because of suspected bullying should be supervised by staff when they are unlocked on the wing.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact her. One prisoner replied and she spoke to him by telephone.

9. The investigator visited Chelmsford on 6 March 2015 and obtained copies of Mr Legge's prison and medical records. She viewed CCTV footage of E Wing during the emergency response.

10. NHS England commissioned a clinical reviewer to review Mr Legge's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed five members of healthcare staff. The clinical reviewer spoke to other healthcare staff by telephone. The investigator interviewed six members of prison staff and three prisoners. One prisoner chose not to speak to the investigator and two others (who had been transferred) did not respond when we wrote to them. The investigator liaised with the coroner's officer and the police investigator.

11. We informed HM Coroner for Essex of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Legge's mother to explain the investigation. The investigator and another family liaison officer met Mr Legge's mother, father and other family members. They wanted to know why prison staff had not identified and monitored Mr Legge as at risk of suicide and self-harm, when he was detoxifying. They asked whether Mr Legge had been in a single or double cell and wanted more information about what happened to him during his time at Chelmsford.

13. Mr Legge's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Chelmsford

14. HMP Chelmsford is a local prison that takes prisoners directly from courts. It holds nearly 730 men. F Wing is the first night in prison and induction unit. New prisoners needing detoxification from drugs or alcohol go to E Wing.

15. Care UK provides primary health care, including GP input for prisoners with substance misuse problem. North Essex Partnership Foundation Trust provides substance misuse nurses.

HM Inspectorate of Prisons

16. The most recent inspection of Chelmsford was in June 2014. Inspectors reported that most prisoners felt safe and that the atmosphere in the prison was settled and calm. Although recorded levels of violence and bullying had reduced considerably since the last inspection, they were higher than at similar prisons. Inspectors commented that reception was busy at certain times, particularly in the evening, and that processes were slow and prisoners spent too long there.

17. Inspectors described the clinical management of substance misuse and alcohol dependence as good and an appropriate range of medicines were used for detoxification and maintenance. Prescribing and care were flexible and recovery focused, with reviews at appropriate intervals.

Independent Monitoring Board

18. 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 its latest annual report, for the year to August 2014, the IMB reported that a large number of prisoners were supported by suicide and self-harm prevention procedures and that officers and healthcare staff spent a substantial amount of time monitoring and supporting them.

Previous deaths at HMP Chelmsford

19. There have been four other self-inflicted deaths at Chelmsford since the beginning of 2013, three in 2013 and one in March 2014. Two of these deaths were of prisoners who had very recently arrived in prison. After the investigation into the death in March 2014, Chelmsford issued local guidance to staff, specifically to reception, nursing and first night staff setting out the need to share relevant information about a prisoner's risk.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews

involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. Mr Tony Legge started using heroin and drinking alcohol when he was 13. In 2014, he had served two short sentences in HMP Chelmsford and HMP Pentonville for shoplifting. Staff did not monitor him as at risk of suicide and self-harm during these sentences. A substance misuse worker at Chelmsford in 2014, noted that Mr Legge had made three suicide attempts in the past year, heard voices and was self-medicating with olanzapine (an antipsychotic) and zopiclone (to help him sleep). Mr Legge said he had been bullied as a child and felt worthless.

23 February 2015

22. On 23 February 2015, Mr Legge was arrested and charged with stealing meat from a petrol station. At the police station, he said he had an injury to his right elbow and was taking pain relief. He said he suffered from depression, anxiety and post-traumatic stress and took amitriptyline (an antidepressant). Mr Legge said he had never tried to self-harm. He said he was dependent on drugs, but not alcohol.

24 February 2015

23. The next morning, Mr Legge appeared at Basildon Magistrates' Court and he pleaded guilty. His Person Escort Record form (PER, which goes with prisoners when they move between police stations, courts and prisons and lists their risks) noted he was a prolific offender, used heroin and had a history of violence. Magistrates remanded Mr Legge to prison, to wait for a probation pre-sentence report before sentencing him. When he returned to the cell area at 12.52pm, a prison custody officer noted that Mr Legge was visibly upset and he told another officer that he felt bad. The custody officers completed a suicide and self-harm warning form to alert the prison to his risk. Mr Legge told them he had self-harmed years before, had no current thoughts of harming himself, but was upset about going to prison.

24. While he was at the court, a nurse from the Criminal Justice Liaison and Diversion team saw Mr Legge for 35 minutes and wrote a report for magistrates. She noted that Mr Legge had been diagnosed with post-traumatic stress disorder by a psychiatrist in 2013, as he had been bullied when he was a child. He said he was self-medicating with olanzapine and seroquel (both antipsychotics). Mr Legge was due to attend an eviction hearing the next day, and, if he missed this, he might be homeless. He told the nurse about his alcohol and drug history and described his mood as "sad/low most days". He said he had periods of paranoia and sometimes heard a male voice making derogatory comments about him. Mr Legge wanted to stop using illicit substances and regain control of his life. The nurse wrote that Mr Legge said he had begun self-harming by cutting a few years previously, but had not done so recently. He said he had taken four overdoses, the last time three weeks earlier. Mr Legge said he did not have any current thoughts or plans to end his life but said "they will have to watch me if they put me in prison". The nurse noted that, in order to be seen by Community Mental Health Services, he would need to be drug-free for eight weeks. She recommended that, if Mr Legge went to prison, he should see the mental health

in-reach team for monitoring while withdrawing from alcohol and drugs and start a methadone programme.

25. At 3.16pm, a member of staff at the court emailed the nurse's report to the custody department at Chelmsford. A minute later, the custody department sent it to an email address that all reception staff can access and to the safer custody team. At 3.22pm, a member of staff from the safer custody team sent the email to three healthcare colleagues. In her email, she said that reception staff should be aware of the report and noted the warnings that Mr Legge might harm himself.

26. At 5.05pm, staff at Chelmsford noted on Mr Legge's escort record (PER) that he had arrived in reception. The PER did not refer to this, but Mr Legge arrived with the suicide and self-harm warning form opened by the court custody staff. An officer completed the initial prison process and noted that Mr Legge had various self-harm scars on his arms.

27. The officer did not check the reception email inbox (where the report from the nurse had been sent) and told the investigator that he had never known a report like that to be sent in this way. The officer said that such reports usually arrive with the prisoner or are handed over in person by the safer custody team. He said that reception staff responsible for booking in prisoners did not usually check the reception email inbox, which was normally just used to send the list of prisoners who are leaving for court in the morning.

28. The officer said he assessed Mr Legge's risk of suicide and self-harm on his appearance and demeanour, their conversation and the contents of the suicide and self-harm warning form. He said Mr Legge was mainly concerned about medication. He told the officer that he had overdosed about a year previously because of a family issue, but that had all been resolved. The officer said Mr Legge appeared fine and was not showing any obvious symptoms of withdrawal from drugs or alcohol. The officer told him he would see the nurse and that they would refer him to see the doctor. He did not consider that Mr Legge needed to be monitored under ACCT suicide and self-harm prevention procedures.

29. Although this is not in a written local policy, reception staff at Chelmsford are expected to check for a suicide and self-harm warning form or a warning written on the PER. If there is one, they should complete a local 'Reception self-harm risk assessment' form, recording current and previous episodes of self-harm and whether an ACCT document has been opened and, if not, why not. The reception officer should then email the form to the safer custody department who, the next day, ask the relevant wing manager to speak to the prisoner. The officer followed this procedure and gave as his reasons for not opening an ACCT, that Mr Legge had not self-harmed for a long time and did not have any active thoughts of harming himself. He did not record what other risk factors for suicide and self-harm he had considered.

30. The officer completed the remaining reception processes and assessed Mr Legge as suitable to share a cell. At 5.40pm, he wrote in Mr Legge's case notes, "Seen in reception, has been in custody before. No issues or concerns raised other than his medication issues. No thoughts of self-harm at this time, support networks explained".

31. A mental health nurse then saw Mr Legge for an initial health screen. He saw the records that had arrived with Mr Legge but did not see the nurse's report. In parts, his entry in the SystmOne healthcare record appears contradictory. It includes some answers to standard questions such as, "previous mental health history: none" and "self-harm: nil in past 5 years". Later in the entry, he wrote, "Reported no physical problem but mental health issues" and "currently strongly denied any thoughts of deliberate self-harm/suicide although has history of same as indicated by warning form".

32. The mental health nurse recorded that Mr Legge had a history of benzodiazepine misuse, did not take drugs intravenously and was withdrawing. When interviewed, he said this was based on what Mr Legge had told him, although the nurse had other information, such as the police records and escort record, which showed that he used heroin and had injected the previous night. He could not specifically remember Mr Legge but noted at the time that Mr Legge was calm and interacted well. He referred Mr Legge to see a GP to discuss his substance misuse issues, and to the mental health team. He did not assess him as at risk of suicide and self-harm.

33. From reception, Mr Legge went to the first night centre on F Wing. Prisoners who need clinical intervention for substance misuse problems then go to E Wing after seeing the GP and first night officer. When prisoners arrive on F Wing, trained prisoner peer supporters help them with problems. No one raised any concerns with staff about Mr Legge.

34. At 7.04pm, a doctor assessed Mr Legge. He had a copy of the suicide and self-harm warning form from the court but did not see the nurse's report. He recorded that Mr Legge used heroin (to a value of £60 a day) and had started a methadone prescription the week before. Mr Legge said he drank 10 cans of alcohol a day and used up to 20mg of diazepam. Although he was not prescribed it, he took illicitly obtained olanzapine and seroquel (both antipsychotics) and told the doctor it helped him sleep and stopped him hearing voices. The doctor wrote that Mr Legge had been under the care of a mental health team before, but he was not sure when. He said he had previously cut his wrists and had taken an overdose two months earlier, but did not currently feel suicidal.

35. The doctor wrote in the SystmOne medical record that he thought Mr Legge was withdrawing and snuffly. His case would be discussed at a multidisciplinary meeting the next day. (At this meeting, mental health nurses, drug treatment staff and counsellors discuss patients with mental health needs.) He prescribed a diazepam detoxification of 30mg, which would also alleviate symptoms of alcohol withdrawal. He continued the prescription of methadone, starting at 20 millilitres a day, increasing to 40mls. He also prescribed a range of other medication to help ease withdrawal symptoms, such as stomach cramps, vomiting and diarrhoea. He thought Mr Legge looked uncomfortable and said that he telephoned the nurse on E Wing so that Mr Legge would get medication as soon as he arrived on the wing.

36. An officer saw Mr Legge and started an induction file. He offered him a shower, phone call and something to eat. Mr Legge also got a smoker's pack (tobacco

and papers). The officer noted in Mr Legge's prison record that he had been in Chelmsford before, had no concerns and no thoughts of suicide or self-harm. When interviewed, the officer said he did not see the report from the nurse, but he saw the records from reception, including the cell sharing risk assessment and the reception officer's comments in the case notes. He did not see the escort record or the suicide and self-harm warning form. He said that he did not have any concerns about Mr Legge.

37. Mr Legge then went to E Wing. A nurse gave him his medication just before 8.00pm, after which he was locked in a single cell for the night. An officer said he spoke briefly to Mr Legge, and remembered him from his last sentence. Mr Legge told him that he was back because of a bit of silliness and said that he might be going back to Pentonville. A further officer remembered that Mr Legge was quite upbeat and said he was glad to be in Chelmsford rather than Pentonville.

25 February 2015

38. At around 10.00am on 25 February, a nurse from the substance misuse team saw Mr Legge for an initial assessment. He noted Mr Legge had a history of heroin, crack cocaine and alcohol misuse. Mr Legge told the nurse he used olanzapine and was due to see a psychiatrist because he heard voices. The nurse noted that he had no family history of mental illness or substance misuse and that Mr Legge had deliberately overdosed three years previously but had no current thoughts of suicide or self-harm. He noted that staff should take Mr Legge's clinical observations for the next five days, before another review.

39. The nurse from the substance misuse team recorded in the medical record that he would speak to wing officers and ask them to direct Mr Legge to Listeners (prisoners trained by the Samaritans to support other prisoners in distress) the chaplaincy or the Samaritans if his mental state deteriorated. He noted Mr Legge would be discussed in the multidisciplinary meeting that morning and referred to appropriate services if necessary. He noted Mr Legge's issues in prison as his risk of being bullied, risk of bullying others, risk of using illicit substances, risk of diverting prescribed medication and risk of deterioration in his mental state. He said that Mr Legge felt peer pressure played a strong part in his drug use.

40. The nurse from the substance misuse team told the clinical reviewer he remembered Mr Legge well. He said that he thought Mr Legge should have been under the care of the mental health team because he was hearing voices and self-medicating, but this might have been missed in the community because of his criminal behaviour. He wanted Mr Legge to have a mental health assessment and asked a healthcare assistant in the substance misuse team to go to the daily mental health multidisciplinary meeting at which Mr Legge would be discussed. He did not think Mr Legge was experiencing significant withdrawal symptoms. He did not see the nurse's report, which was uploaded to SystmOne at 1.00pm that day. He described Mr Legge as "quite jovial".

41. A wing cleaner spoke to Mr Legge and said he seemed like a typical prisoner. Mr Legge did not have any particular concerns about being in prison, other prisoners or his medication.

42. That morning, the safer custody team asked a supervising officer (SO) to speak to Mr Legge to follow up the form completed in reception about his risk of suicide and self-harm. The safer custody team noted an entry in Mr Legge's prison record from a previous sentence referring to him taking an overdose in 2014. The supervising officer said he had only the information usually sent to the wing, such as the cell sharing risk assessment and the case notes in Mr Legge's record. He did not see the court warning form or the report by the nurse. He said he asked Mr Legge how he was and specifically asked him whether he had any thoughts of harming himself and told him that he had been identified as a potential risk of suicide and self-harm in reception. Mr Legge said he was "a bit down" and unhappy about being in prison. The supervising officer told him he could talk to staff or Listeners, the Samaritans and the chaplaincy. He said that Mr Legge made good eye contact and did not indicate that there was anything wrong. He did not ask about the circumstances of his previous self-harm.

43. The healthcare assistant from the substance misuse team took Mr Legge's blood pressure and pulse in the morning as a routine check. They were within the normal range.

44. A mental health multidisciplinary team meeting at 11.30am each weekday discusses any new prisoners with identified mental health issues and refers them for further treatment as necessary. Present at the meeting were a nurse from the primary care nursing team, a healthcare assistant from the substance misuse team, a nurse and member of staff from the mental health in-reach team. They discussed the nurse's report. This was the first time staff at Chelmsford had considered it. The nurse from the primary care team told the clinical reviewer he remembered reading the court report and discussing it at the meeting, although he did not remember Mr Legge's comment that: "They will have to watch me if they put me in prison" being noted or discussed.

45. The nurse from court recommended that Mr Legge should be referred to the mental health in-reach team for monitoring while he withdrew from drugs, but a nurse from the mental health team said the in-reach team would not see Mr Legge at that stage as the substance misuse team would monitor the effect of withdrawal on his mental state. After Mr Legge's initial stabilisation and detoxification period, the GP would assess whether he needed further mental health support. The meeting decided to refer Mr Legge to the Atrium counselling service to discuss his childhood bullying.

46. The note of the meeting did not refer to Mr Legge's risk of suicide or self-harm. The nurse from the mental health team said they did not consider whether to open an ACCT and said they would not have been able to assess Mr Legge's level of risk because he was not at the meeting.

47. Mr Legge spoke to his mother using the wing telephones three times that day. The only concern he raised was about losing the tenancy of his council flat.

26 February 2015

48. Staff noted no concerns about Mr Legge during the night of 25/26 February. The healthcare assistant from the substance misuse team said that she had taken Mr Legge's blood pressure and pulse as part of routine clinical

observations between 9.00am and 10.00am and did not have any concerns about Mr Legge. She said he had communicated well. She did not record the observation in the SystmOne medical record until 3.09pm and said that she had not had time to record them earlier. (Later, another healthcare assistant said that she had done the checks that morning but her colleague had made the entry in the medical record. This matter is the subject of an internal investigation by Care UK.)

49. During the night of 25 February, a friend of Mr Legge's became aware he was in Chelmsford as he had heard other prisoners shouting his name. He said this was not in a threatening way, but was just prisoners' way of finding out who they knew on the wing. He and Mr Legge went to the exercise yard together for 30-45 minutes at around 10.15am and Mr Legge told him that he had given a lot of his tobacco away and now regretted it. His friend said that he thought that Mr Legge was more annoyed at himself than pressurised by others. He said that Mr Legge did not seem low but was worried about his next court appearance and the possibility that he might be sent to Pentonville, although he did not say why. He said did not have concerns about Mr Legge.

50. Chelmsford has CCTV on E Wing that records continuously but with no sound. The investigator watched the recording from the afternoon of 26 February. Just before 2.00pm, a prisoner who was unlocked and working on the wing as a cleaner, took some tobacco from Mr Legge and passed it to Mr Legge's friend. He said that his friend had shouted up and asked Mr Legge for some.

51. Shortly after, a prisoner whose cell was next door to Mr Legge, talked to him through the door hatch. He told the investigator that Mr Legge had said he was tired because he had not slept for two nights. He thought he was suffering from withdrawal symptoms and he could hear Mr Legge sneezing and coughing when they were locked up. Mr Legge told him he felt physically drained and his body and legs ached. After five minutes chatting, his neighbour said he was going to lie down.

52. At 2.31pm, the CCTV shows an officer looking through Mr Legge's cell door. According to the cell bell records, Mr Legge had pressed his cell bell at this time so it was apparently in response to that. When interviewed, the officer could not remember what Mr Legge had wanted. At 2.45pm, a supervising officer and an officer looked into cells along the landing, including Mr Legge's. This was apparently because a roll check had been incorrect and they needed to ensure that all prisoners were present.

53. Mr Legge pressed his cell bell again at about 3.05pm and an officer answered it two minutes later. The officer said Mr Legge had asked when he would be unlocked and when he would get his medication. The officer told him that they would be unlocked at 4.30pm. He said Mr Legge appeared calm.

54. At 3.29pm, several prisoners carried cans of paint onto the wing and went upstairs. At 3.31pm, a prisoner started cleaning the ground floor. At 3.32pm, several prisoners walked around the landings. One of the prisoners continued along the landing, but two looked through Mr Legge's door. This was just before 3.33pm. In his police statement, one of the prisoners said that another prisoner wanted some tobacco and as Mr Legge had recently arrived, thought he might

have some. (The wing cleaner said that prisoner had asked him earlier, who might have tobacco on the wing.) After looking into the cell, the two prisoners turned, spoke to each other, and then leaned over the railings on the landing.

55. Forty seconds later, the two prisoners beckoned to the further prisoner, who was walking back along the landing, to indicate he should look inside Mr Legge's cell. The prisoner looked in, appeared shocked and raised his hands to his face. He walked along the landing, went downstairs, and then past the wing cleaner on the ground floor, before he went out of the CCTV picture. One of the other prisoners also went downstairs.

56. At 3.34pm, a prisoner looked inside Mr Legge's cell again and then appeared to say something to the wing cleaner below. The wing cleaner came up and looked inside Mr Legge's cell 21 seconds later. He then leant over the landing and shouted to a member of staff, an SO, who was with an officer. (The prisoner told the police that he had told the SO that Mr Legge had hanged himself.) The SO said someone shouted "Gov, Gov, quick, he's hanging". The wing cleaner said he also pressed the general alarm button.

57. The officers ran upstairs and reached the cell in seconds. The SO went into the cell, followed by the officer. The SO radioed a code one emergency. (Code one is the emergency medical code used at Chelmsford to indicate that a prisoner is either unconscious or not breathing.) Control room staff logged the code one message at 3.35pm but did not call an ambulance until 3.40pm.

58. Two more officers arrived at Mr Legge's cell 30 seconds later, and others arrived shortly afterwards. Mr Legge had hanged himself using a jumper attached to the cell window bars. The SO pulled the jumper from the window, and the officer helped him to remove it from his neck. The SO said Mr Legge looked grey. They put him on his back on the floor. A further officer, a first aid trainer, had arrived and began cardiopulmonary resuscitation. He used a face shield to give rescue breaths. He said Mr Legge was blue and his body was starting to go cold.

59. A doctor was on E Wing and got to the cell at 3.35pm. He held Mr Legge's head to ensure his airway was clear and gave breaths, while the first aid trainer continued with chest compressions. Nurses arrived a minute later and the doctor inserted an airway tube and connected this to an oxygen cylinder. The nurses attached an automatic external defibrillator, which detected a heart rhythm. It did not administer any shocks and indicated that cardiopulmonary was no longer necessary. The staff felt a pulse, but Mr Legge was unable to breathe on his own and they continued to give oxygen.

60. Paramedics arrived at the prison at 3.47pm and reached Mr Legge's cell at 3.52pm. An air ambulance crew and doctor got to Mr Legge's cell at 4.06pm. They treated Mr Legge for some time before transferring him to the ambulance, which was immediately outside E Wing. The ambulance left the prison at 4.55pm and arrived at outside hospital at 5.13pm. Mr Legge was taken to the intensive care unit and remained sedated.

61. Mr Legge left a letter to his partner and a note in his cell. The note indicated that he had intended to end his life.

62. Some prisoners told us that the prisoners who had found Mr Legge hanged had hesitated before alerting staff as they had expected to obtain drugs from another prisoner who was due to come back to the wing from a visit. They said the prisoners knew that if they called staff they would be locked away in their cells and unable to get the drugs. The prisoners involved declined to be interviewed for this investigation.

Contact with Mr Legge's family

63. Shortly after Mr Legge was taken to hospital, the prison chaplain telephoned Mr Legge's mother to let her know what had happened. Mr Legge's family visited him that evening and over the following days. A prison family liaison officer met Mr Legge's family at the hospital on 27 February. Mr Legge remained in intensive care. On 2 March, after several tests, the hospital decided there was no more they could do for Mr Legge. His family remained with him until late in the evening. They returned the next morning and were with Mr Legge when he died on 3 March.

64. The family liaison officer went to see Mr Legge's family at the hospital to offer condolences. A few days later, representatives from the prison visited his family and arranged for them to visit the prison and spend some time in Mr Legge's cell. In line with national Prison Service policy, the prison contributed towards the cost of Mr Legge's funeral.

Support for prisoners and staff

65. A senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also provided support.

66. The prison posted notices informing prisoners of Mr Legge's death, and offering support. Staff reviewed prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Legge's death.

Post-mortem report

67. A post-mortem examination found that Mr Legge died as a result of hanging.

Findings

Assessment of Mr Legge's risk of suicide and self-harm on arrival

68. When Mr Legge arrived at Chelmsford in February 2015, he had a number of risk factors for suicide and self-harm, which are outlined in Prison Service Instruction PSI 64/2011 (Safer Custody). Although he had been in prison before, his first experience had been less than a year earlier for just a short period. He had a long history of drug and alcohol misuse and was experiencing withdrawal symptoms from drugs and alcohol. He had made previous suicide attempts by overdose, the last time just weeks earlier. He was self-medicating with antipsychotics because he heard voices and he was facing eviction from his home. Unfortunately, reception staff were not fully aware of all of these factors. In particular, they did not know of his reported recent suicide attempt and his possible imminent eviction.

69. In December 2014, the prison gave officers in reception additional guidance about reception processes following previous concerns identified in PPO investigations into deaths at the prison in November 2013 and March 2014. The guidance included a list of factors that might make someone at greater risk of suicide or self-harm. The categories included those with a history of attempted suicide or self-harm, mental health problems, drug and alcohol dependency.

70. An officer and a mental health nurse interviewed Mr Legge in reception. Neither had seen the report written by the nurse at court. However, they had seen the suicide and self-harm warning form from the court custody staff and they were aware of some of Mr Legge's risk factors (although the information about his possible eviction and recent self-harm was in the nurse's report). Despite the risk factors, they were reassured by Mr Legge's calm mood. It is not clear what weight they attached to his known risk factors and why they discounted them and the suicide and self-harm warning form, in favour of his presentation.

71. As part of Chelmsford's local safer custody procedures, reception officers complete a reception self-harm risk assessment form if there are possible concerns about suicide or self-harm raised at the reception stage. An officer completed this form because of the suicide and self-harm warning from court and emailed it to the safer custody team. He did not refer to Mr Legge's other risk factors in explaining why he had not opened an ACCT.

72. A supervising officer spoke to Mr Legge the next morning because of the reception self-harm risk assessment form. He also had not seen the nurse's report so did not ask him about the issues raised, such as his potential eviction and his more recent overdose. He did not have all the information needed to assess Mr Legge's risk of suicide and self-harm.

73. Even without the information in the nurse's report, it might have been prudent to open to have opened an ACCT when Mr Legge arrived at the prison. However, we acknowledge that staff judgement is fundamental to the ACCT system. It relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. Without the additional information, we accept that the staff who assessed Mr Legge when he arrived exercised their professional judgment as to whether to open an ACCT and concluded on

balance that Mr Legge was not such a risk that he needed to be monitored at the time. While we would have preferred a fuller written account of the reasons, setting out the risk factors considered, we accept that without the further information, the decision not to open an ACCT was not unreasonable.

Information sharing

74. All the staff we interviewed agreed that they would have begun ACCT procedures had they seen the nurse's report. Chelmsford has an information sharing protocol covering circumstances when information about prisoners' risks is received from external sources. The protocol states the duty manager must be given the information, and they should ensure that the prisoner's potential risk is appropriately assessed. During the normal working day, the safer custody department should also be informed.

75. The nurse's report was emailed to Chelmsford before he arrived and then emailed to safer custody staff and a general reception inbox. A member from the safer custody team read the report, noted the concerns and forwarded it to healthcare staff. She did not contact the duty manager, as the protocol requires. There was a further missed opportunity to share the report the next day, when the member from the safer custody team emailed the supervising officer and asked him to speak to Mr Legge but did not inform him of the information in the nurse's report.

76. After Mr Legge's death, Chelmsford investigated what had gone wrong with sharing the information and recommended that:

- Safer custody will read through all reports sent to them, highlight relevant information and disseminate to appropriate staff, including wing SOs who receive self-harm warnings the following day.
- Hard copies of the reports will be taken to reception and given to the interviewing officer.
- Safer custody will agree a protocol should information be received when no safer custody staff are available such as at the weekend.
- Staff should be reminded of the information sharing protocol via a Notice to Staff. (This was done in NTS 025.15.)

77. The safer custody team told us they now contact the duty governor by phone and email whenever they receive reports like that from this nurse with information about a prisoner's risk.

78. We are concerned that this important information about Mr Legge's risk was not considered by the staff responsible for assessing him. Prison Service Instruction (PSI) 07/2015, about early days in custody, sets out mandatory reception procedures and requires reception staff to examine the 'Person Escort Record (PER) form that must accompany each new prisoner, *and any other available documentation* (our emphasis) *,*…to identify any immediate needs and risks already recorded'. As no one in reception saw or read the nurse's report, we do not consider that the prison complied with this instruction.

79. Staff at the multidisciplinary health team meeting on 24 February, the day after he arrived, considered the nurse's report. However, the purpose of the meeting

was to identify what mental health support was needed for new arrivals who might require it, not to assess individual risk of suicide and self-harm. The meeting would have been unaware that those responsible for assessing Mr Legge's risk had not seen the report and would reasonably have assumed that they had taken it into account. A nurse from the mental health team said they did not consider whether to open an ACCT and that they would not have been able to assess Mr Legge's level of risk because he was not at the meeting.

80. We accept that it was not the primary purpose of the meeting to identify who might need ACCT support, but this was a further missed opportunity to pass on the concerns. The meeting was aware that Mr Legge had not been identified as at risk of suicide and self-harm and, given the contents of the report, we are surprised that they did not question this or at least check that wing staff and others responsible for Mr Legge's welfare were aware of its contents. All staff who receive information, which indicates a change in a prisoner's risk, have a responsibility to communicate this, or to open an ACCT.

81. We recognise that the prison has already taken some action to address what went wrong with the information handling in this case. However, we note that the actions identified still leave some gap when safer custody staff are not present. There is also a need for all staff, including healthcare staff to consider the need to share information about risk. We make the following recommendation:

The Governor should ensure that, in line with PSI 07/2015, reception staff examine all available documentation about a prisoner and that all staff in the prison have a clear understanding of the need to share all relevant information about risk of suicide and self-harm.

Mental health care

82. Mr Legge was withdrawing from drugs and alcohol, and told staff that he was self-medicating with antipsychotics because he heard voices and had seen mental health services in the community. The doctor thought he had good insight into his mental health problems. He did not think it appropriate to prescribe any medication for his mental health on his first night at the prison because he knew the mental health team meeting would discuss Mr Legge the next day.

83. A nurse from the mental health team said the substance misuse team initially monitor the effects of the first period of withdrawal on prisoners' mental health because this period might not be the best time to assess underlying mental health issues that need secondary mental health care or the involvement of a psychiatrist. The doctor considered that, in line with the dual diagnosis policy, (for patients with both substance misuse and mental health problems) the in-reach team should not discount someone's mental health issues. The doctor considered he should have had help from both teams. A nurse from the substance misuse team said that he expected Mr Legge to have had a mental health assessment, as a result of the multidisciplinary meeting on 25 February.

84. The North Essex Partnership Foundation Trust Dual Diagnosis Care Pathway Liaison & Referral protocol states "people whose primary issue is drug or alcohol misuse must not be automatically excluded from access to mental health

services, their access or referral to another agency must be based upon the assessment of need". We are concerned that there appeared to be an assumption among some of the healthcare staff at least, that until Mr Legge's substance use issues were stabilised and he had got through an initial withdrawal period, he would not be referred to the mental health in-reach team for assessment or support.

85. We consider that Mr Legge should have been offered a mental health assessment after the multidisciplinary team meeting on 25 February. However, we recognise that even an urgent assessment would not have affected the outcome for Mr Legge, as this was unlikely to have taken place before he hanged himself the next day. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff understand and follow the dual diagnosis care pathway and do not automatically prevent prisoners from accessing secondary mental health services because they are in the early stages of treatment for substance misuse.

Clinical care

86. The clinical reviewer said the care provided to Mr Legge was of a generally acceptable standard, other than the failure to communicate the nurse's report. She said that there was an appropriate pathway in place for his substance misuse issues and that he received appropriate medication.

Emergency response

87. Prison Service Instruction (PSI) 03/2013 requires governors to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.

88. Code one is the emergency medical code at Chelmsford, which indicates a prisoner is either unconscious or not breathing. According to the control room incident log, the SO called the code one message at 3.35pm but the 999 call was not made until 3.40pm. A code one radio message should mean that a 999 call is made immediately. Chelmsford's instruction about medical emergency response codes was issued in May 2013 and included this requirement. After our initial visit for this investigation in March 2015, the prison re-issued that instruction. We consider there is a need to target the instruction specifically to control room staff. We make the following recommendation:

The Governor should ensure that all prison staff working in the control room are fully briefed about emergency procedures and call an ambulance as soon as an emergency medical code is broadcast.

Bullying on E Wing

89. There is little to indicate that Mr Legge's actions were caused by bullying but we were concerned that newly arrived prisoners on E wing were vulnerable to bullying, particularly for tobacco, and this was not well managed. New prisoners arriving in Chelmsford who smoke, receive a pack containing tobacco to roll their own cigarettes – a 'smoker's pack.'

90. The prisoner in the cell next to Mr Legge's told the investigator that prisoners on the wing are often bullied for tobacco. He said that he had heard prisoners hassling Mr Legge for the tobacco he had received in reception and he had advised Mr Legge to split his tobacco and hide some of it. The prisoner who worked as the wing cleaner said that when new prisoners arrive on the wing, other prisoners know they will have been given a smoker's pack in reception and try to get some from them. He said that officers challenged prisoners when they saw this happening, but usually prisoners just wait until staff are not watching. Prisoners who have their tobacco taken do not tell staff because no one wants to be seen as a 'grass'.

91. Officers told us that they were confident about challenging prisoners if they saw any overt bullying. However, the SO said that it was not possible to observe prisoners at all times and a further officer said he had not personally seen any bullying on the wing.

92. We asked to see intelligence in the previous three months about the prisoners who were near Mr Legge's cell around the time he was found hanged. There was a significant amount of intelligence about one of the prisoners bullying others for drugs and tobacco. Staff had submitted nine intelligence reports about him in the previous two months and he was on the basic level of the incentives and earned privileges scheme as a result. We were surprised that with this level of intelligence, the prisoner was allowed on the wing unsupervised, when there were a number of newly arrived prisoners vulnerable to bullying for tobacco.

93. In the most recent inspection report, inspectors noted that the levels of recorded bullying was higher at Chelmsford than at comparator prisons. Several prisoners told us Mr Legge was being pressured to share his tobacco. While it does not appear that bullying was a factor in Mr Legge's death, we are concerned that not enough was done on E Wing to monitor known bullies. We make the following recommendation:

The Governor should ensure that there are effective anti-bullying procedures to protect vulnerable prisoners and that prisoners who are on the basic regime because of suspected bullying should be supervised by staff when they are unlocked on the wing

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