PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in November 2013 while in the custody of HMP & YOI Chelmsford

Our Vision

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

This is the investigation report into the death of a man. He was found hanging in his cell at HMP Chelmsford on 14 November 2013 and subsequently died in hospital. He was 18 years old. I offer my condolences to his family and friends.

A clinical investigation was conducted into the man's clinical care at the prison. The prison cooperated fully with the investigation.

On 13 November, the man was remanded to Chelmsford after allegedly assaulting his father. When he arrived at the prison, staff who saw him in reception did not consider that he was at risk of suicide or self-harm, although there was an alert on his escort record to indicate some concerns. He had previously spent some time at Chelmsford in the summer of 2013, when he was serving a short sentence after assaulting his mother. During that sentence, he had been monitored as at risk of suicide and self-harm three times, for short periods.

The man spoke to a Listener (a prisoner trained by the Samaritans to offer support to other prisoners in distress) twice on the evening of 13 November. Two prisoners said that he asked to see a Listener again the next morning, but officers refused. The officers said that they did not recall this. At lunchtime, he again asked to see a Listener. The only Listener the officer was aware of on the wing was busy, so she asked him to wait until after lunch. When prisoners were unlocked, almost an hour and a half later, he was found hanging in his cell. It was less than 24 hours after he had arrived at the prison. He was taken to hospital but subsequently died.

The investigation found that, even in the short time he was at the prison, staff missed several opportunities to identify the man's risk of suicide and relied too much on his personal presentation and assurances that he did not intend to harm himself. The reception officer did not use a local suicide and self-harm screening tool which might have highlighted his risk and the reception nurse attached too little significance to known risk factors. While staff did explore some concerns over him the next day and some appropriate referrals for support were made, no suicide and self-harm monitoring was initiated and concerns about his mental health were not shared with wing staff. His case indicates that the prison needs better local guidance about identifying and managing prisoners at risk of self-harm.

A further concern is the difficulty encountered by the man in trying to see a Listener and it appears that his requests on the morning of November 14 were not acted on. The Listener scheme is a vital part of keeping prisoners safe in custody and it is important that prisoners have no impediment to seeing one.

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 **June 2014**

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SUMMARY

1. In July 2013, the man was sentenced to 24 weeks in prison for, among other offences, assaulting his mother. He was 18 years old. He was sent to HMP Chelmsford where he was monitored briefly on three occasions as a risk of suicide and self-harm. He was released on licence from HMYOI Glen Parva on 18 October.

2. On 11 November, the man was charged with assaulting his father. He was remanded to HMP Chelmsford on 13 November. A nurse and an officer in reception did not consider he was a raised risk of suicide, despite a self-harm warning on his escort record, scars on his arms and other risk factors. The reception officer did not complete the local self-harm screening form as he was supposed to.

3. The man was allocated a single cell on the prison's induction wing and spoke to a Listener (a prisoner trained by the Samaritans to offer confidential support to other prisoners in distress) twice that evening. He mentioned that he had had recent suicidal thoughts. The Listener later offered to speak to staff on his behalf about whether he should be monitored as a risk of suicide or self-harm, but he did not want this.

4. The next morning, the wing manager spoke to the man because there was a warning about previous self-harm on his Police National Computer record. The wing manager did not consider that he needed to be monitored as a risk of suicide and self-harm. Later that morning, the daily multidisciplinary meeting discussed him because a nurse at court had contacted them with concerns about him. Staff at the meeting made a number of appropriate referrals for him but did not consider whether he needed to be monitored as at risk of suicide and self-harm. They did not share the court nurse's concerns with wing staff.

5. Two prisoners have alleged that during the morning the man asked to speak to a Listener, but the wing officer he spoke to said that she was too busy. She and the other officer present said that they did not recall this incident, but CCTV footage shows him talking to them and the two other prisoners.

6. The second officer said that the man had asked her for a Listener when she locked him up at lunchtime. She knew of only one Listener on the wing, who was busy at the time, so she asked him to wait till after lunch. During the lunch period, he passed his tobacco to the prisoner in the cell next door and asked for some writing paper. When some prisoners were unlocked at the end of the lunch period, one of his neighbours looked through his door observation panel and saw him hanging in his cell. Prison officers unlocked the cell within seconds, cut down him and began resuscitation and were joined by healthcare staff shortly afterwards. Paramedics took him to hospital, but sadly, he did not recover and subsequently died.

7. When the man arrived at Chelmsford, he had a number of known risk factors. He was only 18 and had a history of suicidal thoughts and had harmed himself by cutting. He had previously been convicted of a violent offence against a family member and was now facing a further such charge. His

alleged offence had taken place while he was on licence after being released from a previous prison sentence.

8. The investigation found that there were a number of missed opportunities when the man's risk could have been more fully considered and suicide and self-harm monitoring procedures might have been initiated. Reception staff did not identify all of his risk factors and relied too heavily on his apparent mood and what he told them. However, his mood appears to have been very changeable – he had been upset at court hours before and asked to speak to a Listener as soon as he reached the wing after the reception process. The reception officer did not complete the local suicide and self-harm screening tool as he should have done.

9. The next day, the wing manager made a good effort to speak to the man about his circumstances, but she did not identify a pattern of violence within the family as a risk factor. There is an allegation that he looked distressed on the morning he hanged himself but he was not given a Listener when he asked. A multidisciplinary healthcare meeting discussed concerns communicated by a nurse at court but did not share this information with other staff responsible for his care. We are also concerned that he was denied ready access to a Listener when he asked to see one at lunchtime on 14 November. This should have been identified as a sign of distress and alternative arrangements made to keep him safe if it was not possible to arrange one. We make five recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

10. Notices were issued to staff and prisoners at HMP & YOI Chelmsford about the investigation. No one responded.

11. The investigator interviewed four prisoners at Chelmsford on 21 November, visited F wing, including the man's cell, and viewed CCTV footage of the events of 14 November. He collected copies of his clinical and prison records.

12. The investigator interviewed staff at Chelmsford on 9 and 16 December and 17 January 2014. He gave verbal and written feedback to the Governor about the initial findings of the investigation.

13. The clinical reviewer assessed the man's clinical care at the prison. She joined the investigator for the interviews with healthcare staff.

14. We informed the local Coroner of our investigation and have sent her a copy of this report.

15. One of our family liaison officers contacted the man's family to explain the investigation process and discuss their concerns. They received a copy of the draft report. We received comments from the family's solicitor, and as a result the investigator conducted additional telephone interviews with a nurse and an officer. Records of these two interviews have been annexed to this final report and relevant information from these interviews has been included in the key events section. The family's other comments have been addressed in separate correspondence.

HMP CHELMSFORD

16. HMP Chelmsford is a local prison that takes prisoners directly from court. It holds nearly 600 prisoners. Young adults (aged 18-21 years) mix with older prisoners (over 21 years) on wings, but cannot share cells with them. The reception and induction process is the same for all prisoners.

Her Majesty's Inspectorate of Prisons

17. HM Inspectorate of Prisons last carried out an inspection of Chelmsford in May 2011. After a number of previous critical inspections, inspectors noted some improvements. They described Chelmsford as an essentially safe prison and said that the early days in custody were well managed. Inspectors considered that first night procedures were good and that prisoners felt safe on the induction wing. They found the Listeners' scheme was well supported, properly explained to new prisoners and that Listeners were available 24 hours a day. 80 percent of suicide and self-harm monitoring documents were opened either in reception or on the induction wing. Inspectors noted that they were impressed with staff who they witnessed taking time to deal kindly with prisoners in distress.

Independent Monitoring Board

18. 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. However, they expressed concern that there were often insufficient Listeners available for the number and type of prisoners, as trained Listeners were often released or transferred. They also commented that insufficient time and thought was devoted to making entries in suicide and self-harm monitoring documents.

Suicide and self-harm monitoring

19. 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.

Previous deaths at Chelmsford

20. There have been seven deaths at Chelmsford in the last three years. There were two self-inflicted deaths in 2011, two in 2012 and two more in 2013 before the man's. In the investigation into the death of a man in September 2012, we found that his first period of ACCT monitoring was ended too early by the case manager after the man simply said that he was no longer feeling suicidal. The man's ACCT document was also closed very quickly at the start of his first sentence in July 2013 in similar circumstances.

KEY EVENTS

21. In April 2013, the man received an eight week prison sentence, suspended for 12 months, for assault. On 27 July 2013, he was sentenced to 24 weeks in prison for burglary and assaulting his mother and went to HMP & YOI Chelmsford. This was his first time in prison. The reception nurse identified him as at risk of suicide and self-harm and began Assessment, Care in Custody and Teamwork (ACCT) procedures. She noted that he had a history of suicidal thoughts and that he appeared angry and guarded and unwilling to talk about his feelings. A Supervising Officer (SO) closed the ACCT document an hour later after an assessment interview and first case review because he had said that he was no longer having any suicidal thoughts. The review was not multidisciplinary and no care map was drawn up.

22. On 16 August, the man was one of several prisoners who made cuts to their arms while they were waiting on an escort vehicle at the prison. The intention was to prevent a transfer to HMYOI Glen Parva. He stayed at Chelmsford and was monitored under ACCT procedures. The SO ended ACCT monitoring at the second case review on 22 August and recorded that he now realised that his reason for harming himself was 'pretty feeble'.

23. On 23 August, the man deliberately cut his arms after some tobacco he had ordered from the prison shop was not delivered and he was managed under ACCT procedures again. A Supervising Officer (SO) closed the ACCT document the next day after an ACCT assessment interview and first case review (although no care map had been drawn up). She noted that he knew that he had been stupid and that he did not have any suicidal thoughts.

24. The man transferred to Glen Parva on 20 September and was released on licence on 18 October. Under the terms of his licence he was required to live at his parents' home.

25. On 11 November, the police arrested the man for allegedly assaulting his father with a spanner. On 12 November, a community psychiatric nurse from the local Criminal Justice Mental Health Team (based in Pitsea) saw him while he was on duty at a police station. The nurse found no evidence of a mental illness and identified no issues with regard to his mental health. He accepted that he might go to prison and said that he would have to 'take this on the chin'.

Wednesday 13 November

26. On 13 November, the man was taken from the police station to the Magistrates' Court. He was remanded into custody for assault until his next scheduled court appearance by video-link on 20 November. By chance, the same nurse was on duty at the court that day. He saw the man briefly in the court cells after he was remanded. He was upset but said that he would have to do his time in prison and again said that he would have to 'take it on the chin'. He mentioned that he had been to prison before. He said that he was not having any current thoughts of suicide or self-harm. The nurse found no evidence of psychosis or clinical depression. His visit to the cells was cut short by the solicitor who wanted to see him. The escort vehicle was also waiting to take him to prison.

27. After the man left the court, the nurse faxed an alert to the mental health in-reach team at HMP Chelmsford at 2.30pm to ensure that he got the support he needed. He included the following information on the alert:

- No current thoughts of suicide or self-harm
- He had lots of anger because he had been remanded into custody again
- The prison GP should see him for his history of depression
- His most recent suicide attempt was in July 2013
- Atrium should provide anger management counselling
- The prison resettlement team should see him to find a new address for him upon release

28. The man arrived at Chelmsford at 1.40pm. Police wrote on his person escort record (PER, the document which accompanies a prisoner during transfers between criminal justice agencies) that he had cut his wrist in 2012. The court warrant named his father as the victim of the alleged assault.

29. After the man arrived at Chelmsford, a mental health nurse assessed him in the reception area. He did not look at his previous clinical record beforehand. He said that he used cannabis daily, and that he had been in prison before. The nurse noted some minor self-harm by him in the previous year and serious self-harm in the past two years. He showed him scars he had on his arm. He said that he had been upset at court because he had not wanted to come back to prison again. He said that he had no current thoughts of suicide and had not had any previously. He told the nurse that he had had a fight with his father, but downplayed the seriousness of the incident.

30. The man said that he did not have any mental health problems. The nurse conducted an eight-question mini mental health exam and scored him zero which indicated no concerns. He told the investigator that the man was pleasant, bright and cheerful and he did not think that he was either low in mood or experiencing psychotic symptoms. The nurse was satisfied that he knew how to get support if he needed it and had no significant concerns about his mental health or risk of suicide. He referred him to a GP clinic for sleeplessness and to the Inside Out drug and alcohol team because of his cannabis use.

31. An officer interviewed the man during the reception process. This was the first time the officer had ever conducted reception interviews, so another officer supervised him. The officer told the investigator that the man seemed cheerful, self-assured, boisterous and cheeky. He was chatty and outgoing and answered all of the questions properly.

32. The officer was responsible for the man's first night cell sharing risk assessment (CSRA) which is used to identify prisoners who might be at risk of seriously assaulting another prisoner in a cell. Reception officers at Chelmsford do not access a list of prisoners' previous convictions from the Police National Computer (PNC) on the first night. The officer assessed him as 'interim high risk'. In line with Prison Service Instruction 09/2011, he therefore had to spend his first night in a single cell because his CSRA had not been finalised. All prisoners at Chelmsford are given a single cell on their

first night because the PNC information is not produced until the next morning, when the CSRA is then finalised.

33. The man named his mother as his next of kin and said that he was currently of no fixed abode. He told the officer that he did not have any current suicidal thoughts. He said that he had cut himself previously to avoid a transfer to Glen Parva and he showed the officer his scars. The officer did not discuss the man's current charges or family circumstances with him. He told the investigator that he had no undue concerns about him and had no inkling that he might be at risk of taking his own life, although he was aware that he had arrived with a self-harm warning.

34. 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 Person Escort Record. 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. A self-harm warning was written on the man's Person Escort Record and the officer saw the scars on his arms. However, the officer did not complete the 'Reception self-harm risk assessment form'.

35. At about 4.00pm, the man moved to F wing, the induction unit. A Listener spoke to him in a private room. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners who want to talk about their problems.) He told the Listener that he had felt like hanging himself when he first arrived in reception. However, he said that he felt fine for now and was reassured by seeing familiar faces, but that he might want to speak to him again. In line with the Listeners' guidance on confidentiality, he did not disclose the details of this conversation to prison staff.

36. The man then had a ten minute individual induction session with an officer at 4.10pm. She told the investigator that he was chatty and interacted well. He did not appear upset or distressed. She asked him the usual induction questions including about risk of suicide or self-harm. He told her he had no suicidal thoughts. She told the investigator that she had no particular concerns about him.

37. The officer understood that the man's alleged offence meant that he was subject to the restrictions of Prison Service Order 4400, which prevents certain prisoners from contacting their victims while in prison. Therefore, after he left the room, she telephoned his uncle on his behalf. She told his uncle that he was OK and afterwards let him know that she had spoken to his uncle.

38. At 4.27pm, an officer located the man in a single cell, number 44, on the second landing of F wing. Originally there was no television in the cell, so she

found one and he took it to his cell. She locked him in his cell at 4.29pm. At 4.35pm, he pressed his cell bell and CCTV footage shows that an officer went to speak to him. When the investigator interviewed her, she could not remember what this was about.

39. At 4.46pm, an officer unlocked the man for domestic time, which included the opportunity to get his evening meal and have a shower. He was locked into his cell for the night at 6.10pm.

40. The man rang his cell bell again at 6.40pm. An officer went to see him, unlocked his cell door and spoke to him for about ten seconds. He checked him again through the observation panel at 7.11pm. The officer remembered him from his previous sentence because he had had to break up an altercation between him and another prisoner when he was last at Chelmsford. On this occasion, he told the officer not to worry and that he wouldn't be causing any trouble. He mentioned that he would be released within a few weeks. The officer could not remember why he had had to respond to him pressing his cell bell or what he had wanted or said. However, he had no particular concerns about him.

41. The man pressed his cell bell again at about 7.45pm and an officer went to see him. She told the investigator that she could not recall the reason.

42. At about 8.30pm, the man pressed his cell bell and asked an officer for a Listener. The officer told the investigator that he appeared fine at the time. The officer then brought the Listener the cell and the Listener spent about 45 minutes with him. The Listener told the investigator that the man looked vacant, said that he felt very down and was withdrawn. He mentioned hanging himself again. He felt that he did not deserve to be back in prison. The Listener asked him if he could have his permission to speak to the officers about opening an ACCT document. (Conversations with Listeners are confidential and the Listener cannot disclose what the prisoner has said without their permission.) He did not give his permission and said that he would be OK because he was going to get bail the following week. By the time the Listener left the cell, he said that the man was in a good spirits and talking about the future. The Listener did not talk to the officers about opening an ACCT document for him.

Thursday 14 November

43. An officer unlocked the man at 8.04am the next morning and he went to the resettlement centre for his induction. This usually includes sessions with the chaplaincy, housing advisor and legal aid adviser. He saw the housing adviser, and then chose not to stay for the rest of the process. An officer said that when he left the resettlement centre, he thanked her and smiled and waved at her. An officer locked him back in his cell on F wing at 8.27am.

44. Early that morning, a SO (the manager overseeing E, F and G wings that morning) was advised that the man's list of previous convictions contained a warning that he had cut his wrist in June 2012. At about 8.45am, she went and spoke to him in his cell about this. She told the investigator that he was open, talkative and calm. She said that he had a good demeanour and stood up to speak to her.

45. The man showed the SO the scars on his arms but there were no obvious marks on his wrists. He described his alleged offence in detail and told her that he had been charged with assaulting his father with a spanner in the family home. He told her that he was not happy to be back in prison but accepted that he needed to wait for his court appearance. He said that he was not having any suicidal thoughts at the time.

46. The SO told the investigator that she began to tell the man how he could access support, but he interrupted her and said that he knew this already. She told him not to hesitate to speak to staff if he had any concerns. He wanted to telephone his solicitor and she said that the staff would help him to sort this out later on. She noted this conversation in his prisoner record. She did not open an ACCT document as she had no significant concerns about him at the time.

47. Because the man had not attended his induction session, the duty chaplain went to F wing to see him at about 9.00am. He explained the role of the chaplaincy and the man said that he knew how to contact them if he wanted to speak to anyone. The chaplain had no concerns about him.

48. An officer unlocked the man to go to the exercise yard at 9.30am but he came straight back and was locked in his cell again at 9.34am. The officer could not recall why he had returned to his cell so quickly.

49. At 9.43am, a nurse at the local Criminal Justice Mental Health Team faxed another copy of his alert about the man to the prison mental health in-reach team's fax machine, adding an extra comment that the in-reach team's psychiatrist should review him because of his suicide attempt within the last six months.

50. At 10.25am, the man was unlocked for an association period during which prisoners are able to mix with each other and carry out domestic tasks. He played pool and talked to other prisoners. A prisoner who was in a cell two along from the man told the investigator that they spoke during the morning. He said that the man had told him that he had taken drugs in the community and was hoping to see a drugs worker in prison. He was annoyed and upset by the argument he had had with his father and that he had ended up in prison because of it.

51. Two officers were working on the man's spur of F wing that morning. Two prisoners told the investigator that the man approached Officer A more than once during the morning and asked to see a Listener. They said that they had witnessed this as they were sitting at a table on the first landing. Officer B was sitting with them and Officer A standing next to the table. These prisoners told the investigator that Officer A had said to him that she was too busy to bring a Listener for him. Prisoner 1 said that he had looked panicky and was 'in a bit of a state' when he came back to ask for a second time.

52. At 11.14am, CCTV footage shows Officer A standing next to the table on the first landing of F wing. Officer B is seated with two prisoners, who appear to be the ones in question. The man can be seen approaching and having a brief conversation with Officer A. He walked away and then returned shortly

after. This time he spoke to her though a locked gate as she had just left the association area to go to the servery.

53. Officer A told the investigator that she had no recollection of the man asking her for a Listener or seeming upset that morning. She could not remember what they had spoken about at the table. Officer B told the investigator that she could remember sitting at the table but could not remember him approaching either of them.

54. At 11.30am, Officer B locked the man back in his cell.

55. A multidisciplinary meeting involving the drug treatment team, the primary care mental health team, the mental health in-reach team and the Atrium counselling service is held at 11.30am every weekday to discuss new prisoners who have been referred because of concerns about mental health or self-harm. The man was discussed at that morning's meeting. This was not prompted by his reception health screening but instead by the community psychiatric nurse's fax. (There is no copy of a fax in his prison file and nothing in the clinical record to indicate where the referral came from.) The meeting was informed that he was depressed, low in mood and angry with his parents. The nurse had asked for him to be discussed at the multidisciplinary meeting.

56. The multidisciplinary meeting agreed to refer the man to a GP to assess whether he was depressed, to the Atrium service for anger management counselling and to the psychiatrist to determine whether or not he might have a more serious mental health problem. The community psychiatric nurse's concerns about him were not relayed to the wing staff for them to consider ACCT monitoring and the multidisciplinary meeting did not consider whether an ACCT document needed to be opened.

57. Prisoners were locked in their cells for the lunch period. Officer B checked the man at about 12.10pm as part of the lunchtime roll check. She told the investigator that when she opened the observation panel in his cell door he was lying on his bed facing the wall but turned his head towards her and asked to speak to a Listener. She told the investigator that she only had a few more cells to check, so she told him that she would finish her roll count first and then get a Listener.

58. Officer B was new on F wing, so she went to the wing office to ask her colleagues who the wing Listener was and was given his name. She went to his cell but another prisoner was already speaking to him. She went back to the man's cell and told him that there was no available Listener and that she would arrange one to come and see him after the lunch break.

59. During the morning, an officer had checked the man's Police National Computer record and finalised his cell sharing risk assessment. He had assessed him as a standard risk to a potential cellmate, which meant he could share a cell, but there was no immediate plan to move him to another cell.

60. Prisoner 2 was in the cell next to the man. He told the investigator that the man had seemed in good spirits that morning, and they had discussed his arrest following what the man had described as a 'silly fight' with his father.

During the lunch period, the man passed him some tobacco through a gap in the cell wall and told him to keep it. He thought this was generous and unexpected. He said that the man had asked him for a sheet of paper to write a letter, which he gave him. He later heard a slight banging sound from the man's cell. He asked if everything was all right, but did not get a reply. He told the investigator that the man made no noise between 1.15pm and 1.40pm.

61. At 1.40pm, Officer B unlocked Prisoner 2 and another prisoner to go to afternoon activities. She did not unlock the man's cell as he was not yet allocated any work or education. Prisoner 2 was concerned about him and wanted to check on him because he had been so quiet for the previous 25 minutes. He asked the other prisoner, who was unlocked just before him, to look through the observation panel on the man's cell door. The prisoner immediately saw that he had hanged himself. At 1.41pm, both men shouted to the officer to alert her.

62. Officer B was a few metres away and was the first member of staff to reach the man's cell. She looked through the observation panel, saw him hanging and immediately radioed a code 1 emergency to the control room. (Code 1 is the emergency call at Chelmsford which indicates that a prisoner is either unconscious or not breathing.) She shouted for help from staff on the wing and then opened the cell door. A custodial manager had arrived at the cell within 20 seconds of the alarm being raised and they both went into the cell together about 30 seconds after the prisoners had raised the alarm. The control room staff requested an ambulance as soon as they received the code 1 call, in line with national and local emergency response requirements.

63. The man had hanged himself using a torn bed sheet attached to the cell window bars. The officer cut the bed sheet from the window, helped by the custodial manager, who shouted for more staff. They put him on his back on the floor of the cell and the officer removed the rest of the bed sheet from his neck while the custodial manager checked him. Two more officers arrived at the cell at exactly 1.42pm. Officer C and the custodial manager checked him for a pulse, but could not find one and began cardiopulmonary resuscitation (CPR). Officer B gave her protective mouth shield to the other officer. The custodial manager performed chest compressions while Officer C tilted his head, to begin giving rescue breaths, but was unable to do so as his tongue was swollen.

64. The SO (who was in charge of E, F and G wings that afternoon and is a qualified first aid instructor) and an officer then arrived at the cell. The custodial manager asked the SO to take over chest compressions. An officer opened the man's airway and supported his head. After an initial 30 chest compressions, the SO tried to give rescue breaths using the protective mouth shield, but did not think that any oxygen was reaching his lungs because they did not inflate and his chest did not rise.

65. A nurse was the first member of healthcare staff to reach the cell. Prison staff had already brought an emergency bag, which was kept on the wing and which contained an oxygen cylinder and defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest).

66. The nurse inserted an airway into the man's throat and attached an oxygen cylinder. The SO continued chest compressions while an officer prepared the defibrillator for use. Three more nurses helped and a GP arrived at the cell at 1.48pm. Two officers brought a second oxygen cylinder from E wing.

67. Staff took turns performing chest compressions. The defibrillator advised staff three times not to shock the man, so they carried on performing CPR throughout. He showed no signs of life before the paramedics arrived.

68. Two paramedics arrived on the wing at 1.54pm. They found a pulse but the man was breathing only with the assistance of oxygen. At 2.15pm, paramedics took him to the ambulance which left the prison for hospital at about 2.25pm. He was escorted by two officers but was not handcuffed.

69. Chaplaincy staff came to F wing and spoke to those prisoners who had been identified as at risk of suicide and self-harm in case they had been affected by the man's actions. Prison staff found a note in his cell, which was addressed to his father and stated that he intended to take his own life because he could not face being in prison for his birthday and at Christmas.

70. At 2.45pm, the duty governor debriefed the staff involved in the emergency response. The duty governor, the chaplaincy co-ordinator and the Listener also spoke to two prisoners to check on their welfare. The chaplaincy co-ordinator and a custodial manager (the assigned family liaison officer), telephoned the man's mother that afternoon to tell her that her son was in hospital.

71. Two family liaison officers met the man's family at the hospital the next day. The doctors confirmed that he had no brain activity. He was on a ventilator, which his family agreed could be switched off. They were with him when he died. A post-mortem examination found that he had died from hypoxia (oxygen starvation of the brain) resulting from hanging.

72. The funeral was held on 11 December. The prison contributed towards the cost in accordance with Prison Service policy.

Issues

Managing the risk of suicide and self-harm

73. Prison Service Instruction 64/2011 (Safer custody) requires that an ACCT document is closed only by a multidisciplinary case review team once the actions on a care map (which is intended to reduce the prisoner's risk to himself) have been completed. The man's three ACCT documents during his first period in custody at Chelmsford were not managed in accordance with this instruction.

74. In July 2013, the man went to prison for the first time after assaulting his mother. The reception nurse was concerned about his mood and opened an ACCT document to ensure that he was supported. A wing manager decided to end ACCT monitoring only an hour later, without holding a multidisciplinary case review or drawing up a care map. PSI 64/2011 requires a multidisciplinary approach to the management of the risk of suicide and self-harm but the wing manager ignored the concerns of a nurse. There is no evidence that the problems which had prompted the nurse to open the ACCT document had been resolved and no care map had been written to ensure that his needs were met.

75. A second period of ACCT monitoring was ended in August without the only issue on the care map (which was very ill-defined and unhelpful, requiring the man to 'face up to his issues') being fully addressed, while a third period was ended that same month without a care map being drawn up at all.

76. While these decisions from a previous sentence were clearly not related to the man's death, we are concerned that they are indicative of poor management of the ACCT process when risk has been identified. We raised similar concerns at Chelmsford in our investigation into the death of a man in September 2012, when a manager closed an ACCT document within 24 hours of it being opened. We make the following recommendation:

    The Governor should ensure that ACCT documents are not closed until an assessment has been completed, the goals on the care-map have been achieved, and a multidisciplinary team agrees that the risk has reduced.

77. When the man arrived at Chelmsford in November 2013, he had a number of the suicide risk factors outlined in PSI 74/2011 (Early Days in Custody) and also in PSI 64/2011 (Safer Custody). Although he had been to prison before, he was still just 18 years old and his first admission had been only a little over three months earlier. He had a history of previous self-harm by cutting and suicidal thoughts, his status had changed (he had just been charged with a further offence and rearrested while on licence) and he had been charged with a second violent offence against a family member in the space of a few months. He told the nurse in reception that he had been upset at court; he reported that he used cannabis daily and asked to see Listeners three or four times in the short time he was at the prison. A mental health nurse at court passed on concerns about him to the mental health in-reach team.

78. On 13 November, a mental health nurse completed the man's first night health screening in reception. He was entirely reassured by his mood and did not consider opening an ACCT document. The nurse did not look at his previous clinical record before he assessed him. Nonetheless, the clinical reviewer considers that the nurse had enough available evidence to have been able to identify his risk factors (his violent offence against a family member, his young age, evidence of previous self-harm, his earlier upset at court and his reported cannabis use) and that these should have prompted him to refer him to either the GP or the mental health team for a same-day appointment. We agree with the clinical reviewer that this screening represented a missed opportunity to properly consider ACCT monitoring.

79. The investigator discussed the man's risk factors with the nurse. He was aware that previous self-harm was an indicator of raised future risk of suicide. Although Prison Service instructions indicate that a violent offence against a family member increases the risk of suicide or self-harm, the nurse did not recognise that the man's charge of assault against his father increased his level of risk. Nor did he think it would have made a difference to his assessment if he had known about his previous assault on his mother, which suggested a pattern of violent offending against family members.

80. An officer also interviewed the man in reception. This was the first time he had carried out this role. He had received no special training about the reception process beforehand. However, he was an experienced prison officer and was mentored that day by a colleague who was experienced in working in reception. Like the nurse, the officer was reassured by the man's cheerful mood during their interview and he did not consider opening an ACCT document.

81. As part of Chelmsford's uncodified local safer custody procedures, reception officers are supposed to complete the local 'Reception self-harm risk assessment' form if they identify concerns about suicide or self-harm. There was a self-harm warning on the man's Person Escort Record and he also disclosed that he had self-harmed before. The 'Reception self-harm risk assessment' form requires the reception officer to state whether an ACCT document has been opened and, if not, to explain why not. The document must be approved by a manager and forwarded to the safer custody department. The officer did not follow this process so another opportunity was missed to consider ACCT monitoring. However, with no written local safer custody guidance or training from the safer custody department to assist the officer, we have some sympathy that he did not know he was expected to complete this process during his first ever reception interview.

82. A SO discussed suicide and self-harm with the man the next morning after she had been alerted to his police national computer record, which contained a self-harm warning. We are pleased to see that the wing manager took prompt action after receiving this information. The SO had a detailed conversation with him but ultimately, like the reception staff, was reassured by his mood and presentation and did not give enough weight to his risk factors. She had no serious concerns about him when she left him and did not believe that ACCT monitoring was necessary. .

83. The SO considered the man to be mature for his age. However, he was only 18 years old and her perception did not alter the associated risk and his underlying vulnerability. She discussed his previous self-harm with him and looked at his scars. She said he was keen to stress that he had only made these cuts in protest at a proposed prison transfer, an incident she recalled. She accepted this explanation. However, previous episodes of cutting and other self-harm, whatever the apparent reason, are indicators of future raised risk and should never be normalised or minimised. The previous incidents should have indicated that he might be at risk of harming himself in situations of stress, even if they did not indicate a risk of suicide.

84. The man described to the SO in detail the alleged violent confrontation with his father that had brought him back to prison. As already discussed, a violent offence against a family member is recognised by the Prison Service to raise the risk of suicide. She did not think that this increased his risk because he told her that he had not had a good relationship with his parents for some time and had fought with them before. She did not consider that his alleged offence was an exceptional life event for him. Another interpretation would have been that such a violent confrontation with his father and an apparent pattern of violence towards family members would indicate risk that should have prompted further action.

85. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied so heavily on the man's presentation, when he had a number of known risk factors when he arrived at Chelmsford. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to his presentation. His mood appeared fine to the staff who saw him, which emphasises the need not to rely solely on a prisoner's presentation at a particular moment. His mood had been noted to be low at court earlier on the day he arrived and we now know that he mentioned having suicidal thoughts when he spoke to a Listener. We make the following 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.**

86. The clinical reviewer believes that the man's previous self-harm and behaviour would normally have prompted the intervention of the community crisis intervention service after he assaulted his father, had he not been imprisoned. She does not think it was foreseeable that he would have tried to take his own life, but she believes that it was certainly likely given his past behaviour that he would try to harm himself again. We agree with the clinical reviewer that, while it is impossible to say that his death could have been prevented, both prison and healthcare staff missed opportunities to consider and begin ACCT suicide and self-harm monitoring. There was enough evidence available to suggest that he needed some structured support.

87. A nurse who assessed the man at court on 13 November was sufficiently concerned about him to contact the mental health team at Chelmsford. This resulted in discussion of his case at a multidisciplinary meeting on the morning after he arrived and three subsequent referrals to address the issues the court nurse had raised.

88. We are encouraged by the contact made by the court nurse and the prompt discussion of the man's case at the multidisciplinary team meeting. The meeting made appropriate referrals. However, the entry in the clinical record about the multidisciplinary meeting did not give details about the discussion or the rationale for decisions taken. It did not explain how he came to be referred to the meeting in the first place when no concerns had been identified in reception. A nurse told the investigator that the court nurse contacted her, but she could not remember exactly when or how. She did not record this contact in his clinical record at the time and there is no evidence of an email or a fax in his prison file. We make the following recommendation:

The Head of Healthcare should ensure that entries about multidisciplinary meetings record the source of the referral, the outcome and the rationale for decisions taken.

89. Although the appropriate referrals were made, we have found no evidence either that the staff at multidisciplinary meeting considered ACCT monitoring for the man, or that the court nurse's concerns were communicated to F wing staff who were responsible for his ongoing welfare by the meeting or by the nurse when she received them. We make the following recommendations:

The Governor and the Head of Healthcare should ensure that any risk information received about a prisoner is promptly shared with the wing staff responsible for managing him.

Listeners

90. The man was not permitted to use the telephone during his first 24 hours in prison. He sought out another source of support and asked to speak to a Listener three or four times. This in itself was an indicator of raised risk which staff did not appear to notice. He saw a Listener twice on his first night in prison.

91. The next morning, two prisoners have alleged that Officer A refused the man's requests to see a Listener. CCTV footage confirms that these prisoners did

witness a conversation between them in the place and at the time described. Officer B also witnessed this conversation. When interviewed, both officers said that they did not recall him asking for a Listener at that time. Officer A said she could not remember what he had asked her and Officer B said she had no recollection of him coming up to the table where they were sitting.

92. In view of the fact that the man had asked for a Listener before and did so again at the start of the lunch period, the prisoners' accounts of what happened seem credible. We note that the officers were unable to offer another explanation for what he might have been asking in the association area. With the supporting evidence of CCTV footage, we believe that it is likely that he did ask Officer A for a Listener during the morning association period.

93. The man asked Officer B for a Listener at the start of the lunch patrol period on 14 November. She had only just started working on F wing at the time and was unaware of where the Listeners were located. She checked with colleagues and was told about only one Listener. He was busy with another prisoner, so she told him that she would arrange a Listener after lunch, over an hour later.

94. PSI 64/2011 states that prisoners should be given timely access to a Listener if they request one. A Listener could have been put in the man's cell for support during the patrol state, just as the Listener had been the night before. We believe that he should not have been left without a source of support for the whole lunch period after he had requested to see a Listener. The officer does not appear to have sought advice from the wing manager or the safer custody team and a number of alternative courses of action could have been taken, such as offering him the use of a Samaritans telephone while she arranged for a Listener. (Although it appears that the F wing Samaritans telephone was not working at the time.) A Listener from another wing could have been brought to sit with him. The lunch patrol staff could have been asked to get him a Listener rather than waiting until after lunch. There is no indication that his requests to see a Listener prompted Officer B to consider if he was in any distress and whether an ACCT needed to be opened. We make the following recommendation:

The Governor should ensure that prisoners are able to see Listeners promptly. If a Listener is not immediately available, alternative sources of support should be provided in the interim.

Emergency response

95. The clinical reviewer considers that the emergency response when the man was found hanging was of a good standard. A large number of officers and nurses reached the cell very quickly and performed CPR promptly until paramedics arrived.

RECOMMENDATIONS

1. The Governor should ensure that ACCT documents are not closed until an assessment has been completed, the goals on the care-map have been achieved, and a multidisciplinary team agrees that the risk has reduced.

2. 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.

3. The Head of Healthcare should ensure that entries about multidisciplinary meetings record the source of the referral, the outcome and the rationale for decisions taken.

4. The Governor and the Head of Healthcare should ensure that any risk information received about a prisoner is promptly shared with the wing staff responsible for managing him.

5. The Governor should ensure that prisoners are able to see Listeners promptly. If a Listener is not immediately available, alternative sources of support should be provided in the interim.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that ACCT documents are not closed until an assessment has been completed, the goals on the care-map have been achieved, and a multidisciplinary team agrees that the risk has reduced.	Accepted	We now ensure ACCT plans are not closed without a full multi-disciplinary team being in attendance. All caremaps are updated at each review and no ACCT plan will be should be closed without all issues having been dealt with satisfactorily and signed accordingly. Supervising Officers have been reminded of their responsibility concerning the above. This learning point has been added to all ACCT training. Daily compliance checks are completed	April 30th 2014	
2	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: a)Have a clear understanding of responsibilities and the	Accepted	There is clear guidance in Reception and on the First Night Centre on the procedures for identifying those at risk. Reception staff have access to the PER and any other documentation that will highlight any self-harm considerations. In addition: All prisoners are asked about self-harm in Reception & FNIP There is a Listener present in Reception for those who are identified as at risk. Reception staff have guidance in the interview room that details the steps to be taken for those with self-harm warnings and these are passed to the Safer Custody functional mailbox	April 30th 2104	

	need to share all relevant information about risk. b)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. c)Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent		and to the First Night staff. Information from the PNC check will also be made available to Safer Custody Reception staff have clear guidance on how to look at historical data from previous sentences in custody. CNOMIS case notes updated and self- harm alert opened. ACCTs are opened in consultation with the Supervising Officer on duty to ensure those who need support are placed on an ACCT immediately.		
3	The Head of Healthcare should ensure that entries about multidisciplinary meetings record the source of the referral, the outcome and the rationale for decisions taken.	Accepted	The Mental Health Multi-Disciplinary Meeting is held on a daily basis, and involves members of staff from IDTS, In Reach services, Atrium Counselling Services and Primary Care Mental Health. An improved mechanism for documenting referrals has been put in place, to ensure that the source of the referral is documented on SystmOne, if the record does not contain the original referral. The meeting is minuted for audit purposes, and a review of the quality of entries will be undertaken on a quarterly basis.	April 30th 2014	

4	The Governor and the Head of Healthcare should ensure that any risk information received about a prisoner is promptly shared with the wing staff responsible for managing him.	Accepted	Information will be shared with the wings as appropriate and within the guidelines of the medical in confidence laws and Data Protection Act. Any prisoner that is at serious risk of suicide and self-harm will be managed by the ACCT process, which will allow for the sharing of at risk information.	April 30th 2014	
5	The Governor should ensure that prisoners are able to see Listeners promptly. If a Listener is not immediately available, alternative sources of support should be provided in the interim.	Accepted	Listeners are available 24 hours a day and depending on the outcome of the Listener risk assessment, a Listener will be placed with a prisoner at the earliest opportunity. If there is a delay to this process or the use of a Listener is inappropriate, the Samaritans phone will be offered.	April 30th 2014	