

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aj Cracknell, a prisoner at HMP Rochester, on 12 May 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 Aj Cracknell was found hanged in his cell at HMP Rochester on 12 May. He was 25 years old. I offer my condolences to Mr Cracknell's family and friends.

I am concerned that, despite Mr Cracknell telling staff several times that he was in debt and being bullied and that these allegations were supported by security information, no one investigated them or considered the potential impact on his risk of suicide and self-harm. Mr Cracknell already had a number of risk factors associated with increased vulnerability, including a violent offence against his partner, relationship breakdown, substance misuse and a history of depression. In addition, he spent most of his time at Rochester in the segregation unit and missed appointments for counselling and substance misuse work. It is especially important that prisoners at risk who are already on a restricted regime have access to support services.

In our most recent previous investigation into a death at Rochester there were delays with the emergency response and this issue also arose in Mr Cracknell's case. The prison needs to address the matter as a priority.

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

April 2016

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Summary

Events

1. On 5 August 2014, Mr Aj Cracknell was charged with assault occasioning actual bodily harm against his partner and remanded to HMP High Down. He had been in prison twice before.
2. Mr Cracknell was diagnosed with depression at High Down and treated with antidepressants. He appears to have stopped taking these in November 2014, after he reported feeling better. He self-harmed twice, in August and September 2014, and was managed under ACCT suicide and self-harm prevention procedures, until October 2014.
3. In December 2014, he was sentenced to three years in prison. On 12 March 2014, he was transferred to HMP Rochester. After a sentence planning meeting with his offender supervisor and offender manager (probation officer), he was referred to the psychology department because of his depression, to a counsellor to address issues from his childhood and for substance misuse group work.
4. On 28 March and 1 April, Mr Cracknell had telephone conversations with his father about paying money into someone's bank account. Staff listened to recordings of these calls on 6 and 7 April and submitted a security information report, but nobody spoke to Mr Cracknell about them or took any other action.
5. On 7 April, Mr Cracknell and another prisoner climbed onto a roof and asked to be transferred to another prison because they were in debt. Mr Cracknell was charged with a disciplinary offence and received a punishment of 21 days cellular confinement in the segregation unit. During this time, he missed appointments for counselling and substance misuse group work.
6. On 1 May, at the end of his punishment period, Mr Cracknell refused to leave the segregation unit. On 3 May, he told an operational manager at a disciplinary hearing that he was in debt and being bullied. The operational manager authorised a further five days segregation to allow staff to agree a victim support plan with him. However, Mr Cracknell moved to C Wing the same afternoon but we do not know why. There is no record that any officers discussed a victim support plan with him.
7. On 12 May, Mr Cracknell blocked his cell observation panel and barricaded the door. When staff discovered this, they forced their way into his cell and found him hanged from the window by a sheet. Officers cut the ligature and began cardiopulmonary resuscitation quickly but did not radio an emergency code and there was a delay of four minutes before the prison called an ambulance. When paramedics arrived, they recorded that Mr Cracknell had died.

Findings

8. Mr Cracknell told staff a number of times that he was being threatened by other prisoners for debts. There was security information to support his allegations but no one investigated them as they should have done or considered whether he was at increased risk of suicide and self-harm. When he left the segregation unit,

there is no record that anyone put in place a victim support plan to protect him, as a manager had advised.

9. Mr Cracknell's location in the segregation unit meant he missed appointments for counselling and substance misuse services.
10. When officers found Mr Cracknell hanged, they did not follow the expected emergency procedures, which meant there was a delay in calling an ambulance. Although there is no evidence that this affected the outcome for Mr Cracknell, in other emergencies, such a delay could be critical.

Recommendations

- The Governor should ensure that all information and allegations of bullying or threats against prisoners are fully investigated and potential victims supported.
- The Governor should ensure that staff fully consider the impact of bullying and threats on a prisoner's risk of suicide and self-harm.
- The Governor should ensure that prisoners in the segregation unit have access to counselling, substance misuse and other relevant support services.
- The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance and that the ambulance is appropriately directed to the prison to avoid delay.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Rochester informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
12. The investigator visited Rochester on 20 May. She obtained copies of relevant extracts from Mr Cracknell's prison and medical records and copies of CCTV and the emergency radio message.
13. The investigator interviewed six members of staff and three prisoners on 18 June and 28 July, including the prisoner who responded to the notices. She spoke to another three members of staff by telephone.
14. NHS England commissioned a clinical reviewer to review Mr Cracknell's clinical care at the prison.
15. We informed HM Coroner for Mid-Kent of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Cracknell's father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Cracknell's father asked why no one had identified that his son was depressed. He said his son's actions were out of character, as he was strong-willed and had served most of his sentence. Mr Cracknell's father received a copy of the draft report. He did not make any comments.

Background Information

HM Prison Rochester

17. HMP Rochester is a training prison holding about 650 men over 18. Oxleas NHS Foundation Trust is responsible for delivering primary physical and mental health services in the prison.

HM Inspectorate of Prisons

18. The report of the most recent inspection of Rochester in September 2015 has yet to be published. Initial feedback was that the prison's efforts to address significant issues underlying debt and violence had been ineffective, and urgent action was needed. There had been 2,389 information reports submitted in the previous six months. Intelligence was analysed quickly and the security department was well informed about current issues around drugs, including new psychoactive substances (NPS – such as Spice and Mamba, both synthetic cannabinoids), mobile telephones and maintaining order and control. Some intelligence-led searching was not carried out quickly enough.
19. Around 40 prisoners isolated themselves in their cells and were in fear of their safety because of threats received for debt related to the use of NPS. Some had been identified as at risk of suicide and self-harm because of this. The prison was planning a 'community development unit' for such prisoners and to offer them enhanced peer-led support.
20. Inspectors found a number of staff were not aware of the prison's emergency response protocol including the use of a code system to indicate life threatening situations.

Independent Monitoring Board

21. 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 June 2015, the IMB reported serious concerns about the availability of drugs and the associated health problems, debt, violence and self-harm. Despite some significant finds by staff, the dealers had not been deterred. Staff shortages had meant a restricted regime and cutbacks to rehabilitative courses. Prisoners spent more time on the wings and in their cells, and the prison was unable to offer purposeful activity to all prisoners. Staff and prisoner morale had been affected.

Previous deaths at HMP Rochester

22. Mr Cracknell's death was the first self-inflicted death at Rochester since the Prisons and Probation Ombudsman began investigating deaths in prison in April 2004. In October 2014, a prisoner died from a drug overdose and our investigation identified concerns about drug use and intelligence gathering. We made a recommendation about the use of emergency codes, which we repeat here. Another prisoner died in the same month after being attacked by another prisoner, and initial indications are that the investigation into that death has identified similar issues.

Segregation Units

23. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

New Psychoactive Substances

24. NPS are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
25. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence and intimidation.
26. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Incentives and Earned Privileges (IEP) Scheme:

27. Each prison has an Incentives and Earned Privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

28. On 5 August 2014, Mr Aj Cracknell was charged with assaulting his partner occasioning actual bodily harm. He was remanded to HMP High Down. He had been in prison twice before.
29. At an initial health screen, Mr Cracknell told a nurse that he had suffered from depression since the age of 15, and felt like harming himself. The nurse began ACCT suicide and self-harm prevention procedures and referred Mr Cracknell to the mental health team. A prison GP subsequently diagnosed depression and Mr Cracknell began a course of citalopram (an antidepressant).
30. On 7 August, a member of the substance misuse team assessed Mr Cracknell and referred him for group work to address a problem with alcohol.
31. On 15 August, Mr Cracknell cut both his wrists but did not need hospital treatment. He said he had done it, as he was upset because his partner would not talk to him. On 20 August, a GP increased Mr Cracknell's dose of citalopram. On 27 August, staff ended ACCT monitoring, when they considered he was no longer at risk of suicide and self-harm. On 28 August, Mr Cracknell had a second assessment with a member of the prison's substance misuse team. His caseworker said he was much brighter and more positive and was working as a painter on his wing.
32. On 8 September, a nurse assessed Mr Cracknell and decided he could keep a month's supply of citalopram in his cell instead of him collecting it from nurses each day. On 16 September, he began a programme to address his substance misuse issues.
33. On 19 September, Mr Cracknell told a nurse that he did not think the citalopram was helping him. The next day, a nurse treated Mr Cracknell after he reported having a panic attack. On 23 September, Mr Cracknell told a GP that he had taken all of his citalopram tablets four days previously and had not told anyone. He said he felt suicidal. The GP began ACCT procedures and stopped Mr Cracknell's prescription. Officers searched his cell for any remaining medication and found two packets of citalopram; one was missing three strips of tablets.
34. On 26 September, a GP prescribed fluoxetine after Mr Cracknell said he would like to try a different antidepressant. On 3 October, staff ended ACCT monitoring after Mr Cracknell said he felt much better on the new medication. On 10 November, it appears that a GP stopped the fluoxetine prescription, but no reason for this was recorded.
35. On 18 December, Mr Cracknell was sentenced to three years for unlawful wounding and actual bodily harm. He was due to be released on 3 February 2016, but would be eligible for early release on Home Detention Curfew from 6 May 2015. The trial judge imposed a restraining order, preventing Mr Cracknell from contacting his partner for five years.
36. On 10 March 2015, Mr Cracknell transferred to HMP Rochester. At an initial health screen, a nurse recorded that Mr Cracknell did not report any history of any mental or physical health problems. He said he had made superficial cuts to

his wrists in the past but did not feel suicidal or like harming himself. There is no evidence that a nurse checked his medical record, which would have showed he had been treated for depression at High Down.

37. On 12 March, Mr Cracknell's offender supervisor (responsible for his sentence planning and liaising with external probation services) introduced herself and explained her role. Mr Cracknell told her he did not have a sentence plan because his OASys report (an assessment of risk and needs) was out of date. She asked his Offender Manager (probation officer) for a revised OASys report so she could refer Mr Cracknell for appropriate courses to address his offending behaviour.
38. The same day, a drug and alcohol practitioner with the Rehabilitation of Addicted Prisoners Trust (RAPt – which provides substance misuse services at Rochester) assessed Mr Cracknell. Mr Cracknell said he had started using cannabis when he was 12, and had used amphetamines, ecstasy, cocaine and crack cocaine by the age of 20. He said he had first smoked new psychoactive substances (NPS) when he was 24. Mr Cracknell scored 31 on the Alcohol Use Disorders Identification Test, meaning he had high treatment needs. The Severity of Dependence scale test applied to his use of cannabis showed he was highly dependent. Mr Cracknell said all of his offences had been committed while he was under the influence of alcohol or drugs.
39. Mr Cracknell told the drug and alcohol practitioner that he experienced paranoia and depression when using alcohol and drugs. He said he had a history of self-harm but had not been diagnosed with a mental illness or been treated by a mental health professional. He had two children but both had been adopted and he had no contact with them. Mr Cracknell agreed to work on his alcohol dependence and she applied for Mr Cracknell to attend Alcoholics Anonymous fellowship meetings, and a course on emotional self-control. (She subsequently left her job and a replacement took over as Mr Cracknell's caseworker on 16 March.)
40. On 13 March, as a result of the drug and alcohol practitioner's assessment, an Assistant Psychologist invited Mr Cracknell to a screening for IAPT (Improving Access to Psychological Therapies – a programme supporting people with depression and anxiety disorders) on 9 April.
41. On 18 March, Mr Cracknell had a sentence planning meeting with his supervising officer and his offender manager. Mr Cracknell said he had agreed to work with RAPt and attend substance misuse courses. He also agreed to be assessed for the Thinking Skills course, and receive counselling. His supervisor officer referred him to the mental health in-reach team, substance misuse team and the healthy relationships course manager.
42. On 28 March, Mr Cracknell spoke to his father on the telephone. (All telephone calls, apart from legally privileged calls, are recorded and prison staff listen to a sample. A member of staff listened to this telephone call on 6 April 2015.) Mr Cracknell asked his father if he had paid the money into "that account". Mr Cracknell's father said he would do that later. His father told him that his family and friends would not send any more money for him to buy drugs but would only pay money into his canteen spends account. Mr Cracknell called his father back

later the same day and his father told him that he had paid the money but would not pay any more. The member of staff, who monitored the call, completed a security report but no action was taken before Mr Cracknell died.

43. On 1 April, Mr Cracknell spoke to his father on the telephone again. (A member of staff listened to this call on 7 April.) Mr Cracknell's father asked if "matey" had received forty pounds and Mr Cracknell replied, "Yes, thanks for that Dad." Again, the member of staff who listened to the call submitted a security information report, but no action was taken.
44. On 2 April, Mr Cracknell did not attend a RAPt appointment with the drug and alcohol practitioner. The practitioner wrote in his case notes that he had contacted wing officers but they did not know why Mr Cracknell had not gone to his appointment. (The practitioner made a later undated entry to say that Mr Cracknell had not attended a second appointment and that he had found out this was because he was in the segregation unit at the time.)
45. At about 2.39pm on 7 April, Mr Cracknell climbed on to the kitchen roof with his cellmate and both asked for an immediate transfer to another prison because they were in debt. Prison Service negotiators spoke to them and they came down from the roof an hour later. Both prisoners were taken to the segregation unit pending a prison disciplinary hearing. A nurse examined Mr Cracknell and concluded he was medically fit to be segregated.
46. The Head of Safer Prisons and Equality wrote a segregation care plan. Mr Cracknell was allowed education materials in his cell and to use the segregation unit exercise bicycle. He was not to have a television until 6 May, but was allowed a segregation unit radio if he did not have one of his own. The Head noted that the Offender Management Unit would investigate the possibility of Mr Cracknell transferring to another prison. There is no evidence that this happened.
47. On 9 April, Mr Cracknell did not attend his IAPT appointment with the assistant psychologist because he was in the segregation unit. There is no evidence that she considered assessing him in the segregation unit or that anyone considered taking him to the appointment. On 10 April, at a disciplinary hearing, Mr Cracknell pleaded guilty to breaching Prison Rules by being on the kitchen roof. The record of hearing does not record that his explanation for climbing on the roof was an attempt to get a transfer or that the manager at the hearing explored the underlying reasons with him. He was punished with 21 days cellular confinement and other loss of privileges.
48. Mr Cracknell's segregation record shows that he spent his time reading, writing and sleeping. The duty governor and members of the mental health in-reach team and chaplaincy visited daily as required. On 14 April, Mr Cracknell was unable to attend an appointment for counselling. Again there is no record of any consideration of him having the appointment in the segregation unit.
49. On 18 April, Mr Cracknell said he had a painful shoulder from an old injury and asked for some pain relief. A GP examined him on 22 April and prescribed ibuprofen gel. On 24 April, a GP examined Mr Cracknell, after he complained of neck pain. The GP prescribed painkillers (naproxen). On 25 April, he told a nurse during a segregation round that he had anger issues. Mr Cracknell did not

elaborate and said he did not want to see a member of the mental health in-reach team.

50. On 29 April, Mr Cracknell's supervising officer gave him a copy of his sentence plan but explained that he could not take part in courses while he was serving cellular confinement in the segregation unit. Mr Cracknell said he was happy to participate, once he returned to a wing. He told her that he was being bullied for debts of a former cellmate and hoped to transfer to another prison if this continued when he left the segregation unit. She told the investigator that Mr Cracknell did not seem upset, depressed or angry and she expected the segregation unit staff to be addressing this issue with him. She did not record this conversation, submit a security report or speak to him about a support plan. She emailed the RAPt team to ask if they could complete their assessment while Mr Cracknell was still in the segregation unit. There is no record of a response in Mr Cracknell's case notes.
51. The drug and alcohol practitioner told the investigator that it was not generally possible to see prisoners in the segregation unit because most of the RAPt appointments were in the morning and the adjudication room (the only private room in the segregation unit apart from cells and staff offices) was always busy at that time. He said he preferred not to speak to prisoners while they were in the segregation unit, because they often had to speak to the prisoner through their door and it was not a therapeutic or confidential environment. He said he usually kept a check on when the prisoner returned to their wing and re-booked their appointment for then. He had re-booked to see Mr Cracknell on 13 May.
52. On 1 May, Mr Cracknell refused to return to a standard wing when he had finished serving his sentence. An officer charged him with disobeying a lawful order under Prison Rules and he remained in the segregation unit for a disciplinary hearing on 3 May. Mr Cracknell pleaded guilty but made a written submission in mitigation. He said his original cellmate (the other prisoner involved in the roof top protest) was in debt to other prisoners for spice, a new psychoactive substance (NPS). His former cellmate told him that he had promised these prisoners that Mr Cracknell would pay half the debt. Mr Cracknell said he did not personally get into a position where he owed anyone any money but his cellmate had since been transferred to another prison and he was now expected, and being threatened, to pay the whole debt. Mr Cracknell said he did not know what to do and did not feel safe on the wings. He said that, even when he was locked in his cell, he would be vulnerable to verbal abuse.
53. An operational manager told Mr Cracknell that he could be put on a support plan to keep him safe on a wing. Anyone verbally abusing him could be identified from CCTV and dealt with. Mr Cracknell reiterated that he did not feel safe. He decided that the order for Mr Cracknell to return to his wing was lawful and found Mr Cracknell guilty. He gave him five days cellular confinement as a punishment.
54. The operational manager told the investigator that he did not remember Mr Cracknell's adjudication in great detail. A punishment of five days cellular confinement is the correct tariff for the offence of disobeying a lawful order. If a prisoner says he is worried about his safety on a standard wing, a short period of cellular confinement offers an opportunity for a support plan to be put in place

before they leave segregation. He said he would expect segregation unit staff to tell wing staff on the wing the prisoner was due to return to that a support plan should be considered. He did not record this at the time.

55. Mr Cracknell's segregation history sheet shows that he remained in the segregation unit until sometime between 3.00pm and 4.00pm that day when he moved to a single cell on C Wing. His adjudication record was amended to suspend the punishment for three months. The operational manager said that the amendment was not in his handwriting. He said he thought it was possible that, later the same day, Mr Cracknell had asked to return to a standard wing and he had agreed the suspension to allow him to do so. There is no record to explain why Mr Cracknell went to C Wing that day and no evidence of a victim support plan to protect him.
56. On 4 May, a SO (Supervising Officer), one of the C Wing managers, reviewed Mr Cracknell's level under the Incentives and Earned Privileges (IEP) System. The SO told the investigator he did not remember this, but it was routine for one of the wing managers to speak to new prisoners on the wing. When prisoners have just come back from the segregation unit, he tells them that they have a fresh start, returns them to the standard level of privileges and tells them what is expected of them on the wing. The SO said he did not remember speaking to segregation unit officers or remember any of the circumstances of why Mr Cracknell had been in the segregation unit and why he had moved to the wing.
57. There are no further entries in Mr Cracknell's prison or medical record between 4 and 11 May.
58. Prisoner A told the investigator that he first met Mr Cracknell in High Down when they had completed an alcohol awareness course together. He described him as quiet and placid. He said he met Mr Cracknell again on 11 May when he moved to C Wing. They talked about their time at High Down and Mr Cracknell said he was okay. He told the prisoner that he wanted to move to another prison to be closer to his family so that it was easier for them to visit. The prisoner said Mr Cracknell did not appear any different from when he knew him at High Down. Mr Cracknell did not mention that he was being threatened or in debt.

12 May 2015

59. Prisoner B, who lived in one of the cells opposite Mr Cracknell's, said that he often played pool with Mr Cracknell, but they had not talked about anything other than the game. He said he spoke to Mr Cracknell in passing on the morning of 12 May and he seemed to be his normal self. He said Mr Cracknell seemed comfortable on the wing and had asked officers for a job because he did not like being locked in his cell. Mr Cracknell seemed to get on well with other prisoners and was friendly with a Turkish man. (This prisoner did not want to talk to the investigator.)
60. Prisoner C, who lived in the cell next to Mr Cracknell, said that he did not really speak to Mr Cracknell, but Mr Cracknell had asked him for a cigarette a couple of times. One of these was during the morning of 12 May, when they were both locked in their cells. Mr Cracknell asked him for a roll up and he passed him one through the gap in the wall, where the heating pipes ran between the cells.

61. An officer locked the prisoners on C Wing in their cells for lunch. CCTV shows the officer checked all the doors and looked through the observation panels. He checked Mr Cracknell's cell at 12.17pm.
62. Officer A unlocked cells on C Wing after lunch and noticed Mr Cracknell's observation panel was blocked with newspaper. She said she called to Mr Cracknell several times to remove the paper but he did not respond. She then went downstairs to the wing office to tell other staff. (This is in line with the local protocol for responding to blocked observation panels, which is to ask prisoners to remove them and then report the issue to the wing manager.) CCTV shows her at Mr Cracknell's door at 2.00pm. After she left, at 2.01pm, a small group of prisoners gathered at Mr Cracknell's door.
63. Prisoner B said when he left his cell after lunch he saw a female officer shouting through Mr Cracknell's door asking him to remove some newspaper from his observation panel. She then went downstairs. He said he called out to Mr Cracknell to take the newspaper down. Another prisoner kicked the door and managed to move the newspaper a little bit. He looked through the gap and saw Mr Cracknell almost sitting on the floor of the cell hanging by a sheet from the window. CCTV shows the prisoner ran down the landing at 2.01pm and a SO and Officer B opened Mr Cracknell's door at 2.03pm.
64. Officer B said he and the SO initially had trouble opening the door because it was obstructed by a chair. (CCTV shows they went into the cell at 2.04pm.) Mr Cracknell had hanged himself by a sheet tied to the window frame. Officer B removed the sheet from Mr Cracknell's neck, and he and the SO moved him on to the landing. A custodial manager began cardiopulmonary resuscitation. Another custodial manager brought a bag of emergency equipment from the wing office and the officers attached a defibrillator (a life saving device that gives the heart an electric shock in some cases of cardiac arrest) which showed that Mr Cracknell had no shockable heart rhythm. Staff took turns to perform chest compressions.
65. A SO followed a custodial manager to C Wing and arrived as staff were doing cardiopulmonary resuscitation. She locked the other prisoners in their cells and then spoke to the ambulance service on the telephone in the wing office to give them Mr Cracknell's basic details.
66. A recording of the emergency radio message shows the following. The times (taken from the control room log) are different to those on the CCTV. It appears that the CCTV times were about four minutes ahead of the radio times.

Time	Name and Radio call sign	Message
2.00pm	(Charlie 2)	Require Oscar 1 (the orderly officer) C Wing
	(Oscar 1)	Received
	(Charlie 2)	Healthcare to C Wing

	Control Room	Charlie 2 have you got a code?
	Control Room	(few seconds later) Charlie 2 have you got a code?
	Control Room	(few seconds later) Charlie 2 have you got a code?
	Control Room	Say again?
	(Oscar 4)	Code blue
2.02pm	Control Room	Hotel 2 and 3 to C Wing code blue (no response)
	Control Room	Hotel 2 and 3 make your way to C Wing code blue (no response)
	Control Room	Hotel 2 and 3 make your way to C Wing code blue (no response)
	Control Room	Charlie 2 do you require an ambulance?
	Control Room	Charlie 2 do you require an ambulance? (repeated quickly)
	Unknown (Sierra 3)	Yes
	Control Room	Keep the line clear I will put them through
	Unknown (Sierra 3)	Put them through to the main office
2.05pm	Control room	Calls ambulance
2.07pm	Control Room	Cease movement – freeze all offender movement to Charlie Wing and call routes when clear

67. Nurse A was the designated emergency response nurse on 12 May. She said she was talking on the telephone when the control room called her to C Wing. Nurse B, the other response nurse, was in the room with her and neither of them heard the radio message, but an officer in the healthcare department told them about it as soon as he heard. Nurse A said she immediately picked up the resuscitation equipment bag, Nurse B picked up some oxygen and they went to C Wing. On the way, she realised that she had accidentally switched from the main radio net to the works department radio net and switched back in time to hear that an ambulance had been called.
68. When Nurse A arrived on C Wing, staff were doing chest compressions and rescue breaths. CCTV shows she arrived at 2.09pm. She said the defibrillator was correctly attached and advised the staff to continue cardiopulmonary resuscitation. Nurse B gave Mr Cracknell oxygen. Nurse A tried to use a manual

suction pump to clear Mr Cracknell's airway but it did not work, so she cleared it manually. Mr Cracknell was unresponsive.

69. CCTV shows the first ambulance crew arrived on the landing at 2.19pm. They examined Mr Cracknell and attached their own defibrillator, while officers and nurses continued cardiopulmonary resuscitation. At 2.56pm, the senior paramedic ended attempts at resuscitation and recorded that Mr Cracknell had died.
70. The paramedics reported that they had initially had difficulty finding the prison entrance but the gates were open when they got there and the staff were prepared for them. They commented that the prison staff's standard of cardiopulmonary resuscitation was good

Contact with the family

71. At 3.15pm, an officer was asked to act as the prison's family liaison officer. She and a prison chaplain drove to Mr Cracknell's father's home, but his stepson told them that he was abroad on holiday. The officer telephoned Mr Cracknell's father and broke the news to him. Mr Cracknell's father asked her to drive to Mr Cracknell's mother's house nearby and break the news to her too, which she did. The next day she and the chaplain met Mr Cracknell's father and stepmother at the airport and drove them home after telling them what they knew about Mr Cracknell's death. A few days later, they drove Mr Cracknell's father and stepmother to view Mr Cracknell's body.
72. The prison contributed towards the costs of Mr Cracknell's funeral in line with national guidance.

Support for prisoners and staff

73. After Mr Cracknell's death, the Deputy Governor debriefed the staff involved in the emergency response to discuss any issues arising, and to offer support. The staff care team and two prison chaplains also offered support.
74. The prison posted notices informing other prisoners of Mr Cracknell's death, and offering support. Staff reviewed all prisoners assessed as a risk of suicide and self-harm, in case they had been adversely affected by Mr Cracknell's death.

Post-mortem report

75. The post-mortem examination concluded that Mr Cracknell died as a result of suspension. Toxicology tests for drugs and alcohol were negative.

Findings

Debt and bullying

76. Mr Cracknell told staff a number of times that he was being threatened for money. He said that he had not incurred the debts. Three of his telephone calls to his father, on 28 March and 1 April, lend credence to his claim that he was being threatened. All three conversations refer to money paid by Mr Cracknell's father into another person's account. A member of staff listened to recordings of these telephone calls on 6 and 7 April. Two security reports were completed but no one appears to have investigated the matter further.
77. On 7 April, Mr Cracknell and his cellmate climbed on to a roof and asked for a transfer to another prison. Staff reports of the incident say Mr Cracknell asked for a transfer because he was in debt. On 7 April, the then Head of Safer Prisons and Equality wrote in the segregation unit care plan that the Offender Management Unit would explore a transfer for Mr Cracknell. There is no evidence that anyone investigated either Mr Cracknell's allegations or the possibility of a transfer.
78. On 29 April, Mr Cracknell told his supervising officer that he was in the segregation unit because he was being bullied for his cellmate's debts. She told the investigator that she assumed the segregation unit staff were addressing the issue and took no further action.
79. Mr Cracknell raised the issue again on 3 May at a disciplinary hearing for refusing to return to a standard wing. He said he was being bullied for drug debts and was worried he would not be safe on a standard wing. Mr Cracknell appears to have moved to a single cell on C Wing the same afternoon but the prison has no record of why and can find no evidence that there was a handover between segregation unit and C Wing officers. There is no record that anyone discussed a support plan with Mr Cracknell.
80. Rochester's Violence Reduction Policy instructs all staff to investigate and challenge allegations of bullying and unacceptable behaviour. We are concerned that no one investigated Mr Cracknell's allegations further at the time, or took any action, despite the existence of security information to support them. Initial feedback from HM Inspectorate of Prisons noted the prison's overall action to address the significant issues underlying debt and violence had been ineffective, and urgent action was required to tackle this considerable problem. We make the following recommendation:

The Governor should ensure that all information and allegations of bullying or threats against prisoners are fully investigated and potential victims supported.

Assessment of risk of suicide and self-harm

81. Prison Service Instruction (PSI) 64/2011, (Safer Custody) lists a number of risk factors and potential triggers for suicide and self-harm. Mr Cracknell had some factors that increased his risk including previous self-harm, substance misuse, history of depression, relationship difficulties and a violent offence against his partner.
82. When he arrived at Rochester in March 2015, Mr Cracknell said he did not feel suicidal or like harming himself at his initial health screen but he disclosed his previous self-harm. He also told staff about his history of depression, relationship problems and asked for help with substance misuse.
83. None of the staff or other prisoners considered that he was at risk of suicide and self-harm. We do not consider that the weight of risk factors was sufficient to outweigh staff perceptions of Mr Cracknell's mood and demeanour and it was reasonable for staff to conclude when he first arrived at Rochester, that he was not at risk of suicide or self-harm.
84. However, from April, Mr Cracknell repeatedly told staff that he felt at risk from other prisoners and there was security information that suggested that he was being bullied. Yet, no one appears to have considered the potential impact of bullying on Mr Cracknell's risk. In our Learning Lessons thematic report into self-inflicted deaths of prisoners 2013-2014, we found that staff too rarely considered that bullying, debt and drug issues made prisoners more vulnerable and could increase their risk of suicide. We make the following recommendation:

The Governor should ensure that staff fully consider the impact of bullying and threats on a prisoner's risk of suicide and self-harm.

Access to counselling and support services on the segregation unit

85. Mr Cracknell had a history of depression and substance misuse. He self-harmed twice at High Down in August and September 2014. He said he felt depressed and suicidal and was managed under ACCT procedures until November 2014. He was treated with antidepressants and worked with RAPt to address his substance misuse problems. He appears to have stopped taking antidepressants in November 2014 but the reasons were not recorded.
86. Mr Cracknell did not say he felt depressed or suicidal at Rochester. He gave a history of depression and self-harm at his RAPt assessment on 12 March. On 18 March, he told his supervising officer that he had issues from his childhood that still affected him. As a result, of both conversations he was referred to the psychology department, for substance misuse group work and for counselling. Mr Cracknell's location in the segregation unit meant that he missed his appointments with the psychologist and the counsellor and was unable to attend substance misuse work.
87. While we recognise that the segregation unit is not an ideal location for confidential assessment or therapeutic intervention, we do not believe that

prisoners held there should have no access to appropriate support services. Many prisoners held in segregation units are vulnerable and there is evidence that the cumulative impact of restrictions due to segregation can further increase vulnerability and risk. It therefore seems all the more important that segregated prisoners have access to such services. In Mr Cracknell's case, counselling sessions and one to one sessions with his substance misuse worker would have provided an opportunity to uncover and explore the pressure he was under to repay debts.

88. Since Mr Cracknell's death, the mental health team and substance misuse service hold joint weekly triage sessions on the segregation unit to try to identify prisoners in crisis. This is a step in the right direction but we consider that all prisoners, regardless of whether they are identified as in crisis, should have confidential access to counselling, mental health intervention and substance misuse services during periods of segregation, where a need has been identified. We make the following recommendation:

The Governor should ensure that prisoners in the segregation unit have access to counselling, substance misuse and other relevant support services.

Emergency response

89. Prison Service Instruction (PSI) 03/2013 requires that the Governor must have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives 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. Governors are required to have a two code medical emergency response system based on the instruction. As is usual, Rochester use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.
90. The officer who discovered Mr Cracknell hanging did not call a code blue but even after the control room established that it was a code blue emergency they did not call an ambulance immediately. They asked further questions about whether an ambulance was needed. This resulted in a further delay of five minutes. Neither of the emergency response nurses heard the initial call for healthcare staff to attend C Wing, but the officers who found Mr Cracknell began cardiopulmonary resuscitation immediately and emergency equipment was brought promptly to the scene.
91. Although it is unlikely that the delay in calling an ambulance made a difference to the outcome in this case, such a delay could be critical for other prisoners in life-threatening situations. We are concerned that we found a similar delay in another investigation into a death at Rochester in October 2014. After Mr Cracknell's death the Governor re-issued a notice to staff reminding them about the emergency code system. However, Her Majesty's Inspectorate of Prisons

found a number of staff were unaware of the code system during their inspection in September 2015. It is evident that the Governor needs to take more active steps to ensure that staff understand what they are required to do.

92. The record of the hot and cold debriefs held after Mr Cracknell died show paramedics had a problem identifying the correct prison gate. This was also a problem in one of the deaths in October 2014 and does not appear to have been rectified. In this case staff were ready for the ambulances, gates were open and there were staff to direct the paramedics to C Wing. There is a need to ensure that the local ambulance service is fully briefed about how to get to the prison, that the entrance is clearly signposted and the control room staff direct ambulances clearly to the main gate to help minimise delays. We repeat the recommendation from our previous report:

The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance and that the ambulance is appropriately directed to the prison to avoid delay.

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