Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Saunders a prisoner at HMP Chelmsford on 4 January 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

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

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

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

Mr Saunders died on 4 January 2016 at HMP Chelmsford, after electrocuting himself. He was 25 years old. I offer my condolences to Mr Saunders' family and friends.

Mr Saunders was at high risk of suicide but the investigation found a number of weaknesses in the way this risk was managed at Chelmsford. Staff relied too much on his presentation rather than his significant underlying risk factors for suicide when assessing his risk and setting his level of observations. There was then too little focus at case reviews on actions needed to help reduce his risk, such as facilitating family contact. I am also concerned that too little was done to involve Mr Saunders' family in his care or to respond to their concerns.

More generally, Mr Saunders was acutely mentally ill and all those involved in his care agreed that prison was not an appropriate place for him. Yet the systems designed to divert him from prison did not operate effectively. I am also concerned that there appears to have been some confusion at Chelmsford about the process for transferring mentally ill prisoners to hospital, which meant that an opportunity to transfer Mr Saunders in December was missed. Sadly, the Criminal Justice System did too little to protect this very vulnerable man.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

Contents

Summary

Events

1. On 17 December, in the course of an acute mental health crisis, Mr Dean Saunders stabbed a family member and, while trying to stab himself, injured another family member. The police charged Mr Saunders with two counts of attempted murder. The next day, he was remanded to HMP Chelmsford. The prison was alerted that he was at high risk of suicide and that there was a report that recommended he should be transferred to hospital under the Mental Health Act. Mr Saunders was admitted to the inpatient unit at Chelmsford and staff began Prison Service suicide and self-harm prevention procedures, known as ACCT. Initially staff agreed they would constantly supervise Mr Saunders until a psychiatrist assessed him.

2. On 21 December, before the psychiatrist had assessed Mr Saunders, staff decided to reduce his level of observations from constant supervision to twice an hour. No clinician was involved in the decision.

3. Later that day, a prison psychiatrist assessed Mr Saunders as suitable for transfer to a secure hospital. Although the transfer process could have begun then, the psychiatrist did not complete the first recommendation required for transfer under the Mental Health Act because the local hospital did not have a bed available for Mr Saunders at the time.

4. On 24 December, staff recognised that Mr Saunders was at a high risk of suicide, but continued formal monitoring at just twice an hour. On 31 December, a forensic psychiatrist completed the first recommendation required for Mr Saunders' transfer to hospital. The local secure hospital had a place for Mr Saunders at the time, but prison healthcare staff believed they needed a second recommendation from the prison psychiatrist, who was on leave until 5 January, when a signature from any other doctor would have sufficed. This meant the transfer did not go ahead.

5. Mr Saunders asked to speak to his family several times, but he could not remember their phone numbers, and staff did little to help him get them. He continued to behave in a paranoid manner and, on 3 January, he showed a mental health nurse some scratches he had made on his arms. The mental health nurse did not investigate how Mr Saunders had made these scratches, discuss this with anyone, or consider whether this indicated increased risk.

6. On the morning of 4 January, Mr Saunders asked an officer to help him write a letter. At 10.20am, a nurse checked him and noted that he was awake, lying on his mattress on the floor, which he sometimes did. Five minutes later, the officer came back to Mr Saunders' cell to help him write the letter. Mr Saunders did not respond when the officer spoke to him. The officer tried to rouse him, but realised that Mr Saunders had electrocuted himself using wires from the TV. Staff and paramedics were unable to resuscitate him and, at 11.19am, a doctor recorded that Mr Saunders had died.

Findings

7. There were a number of failings in the management of ACCT procedures. There was no clinical input into the decision to reduce the level of Mr Saunders observations from constant supervision to twice an hour, staff did not consider all of Mr Saunders' known risk factors when assessing his risk of suicide and did not set observation levels that reflected his risk. The ACCT caremap was not updated and reviewed at each case review and did not include actions designed to reduce his risk. Observations were at regular and predictable intervals and a mental health nurse took insufficient action when Mr Saunders cut his arms.

8. Mr Saunders had been identified as seriously mentally ill and needed hospital treatment. Prison healthcare staff did not properly understand the process for transferring prisoners to hospital under the Mental Health Act and did not follow this process in arranging Mr Saunders' transfer. This meant that an opportunity to transfer Mr Saunders to hospital at the end of December was not met. We are also concerned that the psychiatric cover at Chelmsford is insufficient to meet the needs of the population.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including in particular that:
    - Mental health staff attend or contribute to all ACCT reviews for prisoners in their care and are fully involved in decisions about their level of risk.
    - Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations which reflects that risk.
    - ACCT observations are at irregular, unpredictable intervals.
    - Staff review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.
    - Effective caremap objectives are set which are specific and meaningful, aimed at reducing risk and updated at each case review.

- The Governor should ensure that any concerns from a family member or friend about a prisoner's welfare and safety are appropriately recorded and followed up. ACCT case managers should consider involving the prisoner's family in the ACCT process when appropriate and record this in the ACCT plan.

- The Head of Healthcare should ensure that there is an established process, in line with national guidance, which healthcare staff understand and follow, to transfer prisoners to hospital under the Mental Health Act, within 14 days where possible.

- NHS England – East of England Area Team should ensure that psychiatric services commissioned for prisoners at HMP Chelmsford are sufficient to meet their needs and reflect community provision.

The Investigation Process

9. The investigator issued notices to staff and prisoners at Chelmsford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator and another investigator visited Chelmsford on 13 January 2016. They obtained copies of relevant extracts from Mr Saunders' prison and medical records. They interviewed two prisoners.

11. NHS England commissioned a clinical reviewer to review Mr Saunders' clinical care at the prison.

12. The investigator and an assistant ombudsman, interviewed 13 members of staff and one prisoner at Chelmsford in February and March. The clinical reviewer joined them for some interviews. Two prisoners declined to be interviewed.

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

14. One of the Ombudsman's family liaison officers contacted Mr Saunders' family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. On 29 February, the family liaison officer, the investigator and the assistant ombudsman met Mr Saunders' family and their legal representative. Mr Saunders' family had a number of questions and concerns about his care in prison. They wanted to know more about the decision to reduce the frequency of checks; how decisions about which items Mr Saunders could have in his cell were made; what was done in response to concerns they had raised about Mr Saunders' safety; and the process for transferring him to hospital. Mr Saunders' family said that there had been poor communication from prison staff before and after Mr Saunders' death.

Background Information

HMP & YOI Chelmsford

15. HMP Chelmsford is a local prison that takes prisoners directly from courts. It holds nearly 730 men aged 18 years and older. Care UK is commissioned to provide 24-hour healthcare, which includes a range of primary care and secondary mental health services. The prison has a 12 bed inpatient unit.

HM Inspectorate of Prisons

16. The most recent inspection of Chelmsford was in April 2016. The Inspectorate said that healthcare provision at Chelmsford was inadequate and had got worse since the last inspection, exacerbated by staff shortages. The inpatient unit was not a suitable therapeutic environment and there was no clinical and managerial supervision for healthcare staff. The Inspectorate recommended that clinical governance arrangements be improved to ensure that prisoners' health was not put at risk. While the quality of ACCT documents was reasonable, case reviews were often not multidisciplinary. The Inspectorate found that only half of prisoner transfers under the Mental Health Act to secure hospitals occurred within the two week national target and recommended that transfers to external hospital beds should be expedited and occur within the Department of Health transfer target timeframes.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to August 2015, the IMB had ongoing concerns about the ability of Care UK to deliver the level of service required to meet prisoners' health needs. The IMB noted that the number of prisoners managed under ACCT suicide and self-harm prevention procedures had increased by more than 20 per cent from the previous year, but was reassured that actual incidents of self-harm had reduced.

Previous deaths at Chelmsford

18. Mr Saunders' death was the fourth self-inflicted death at Chelmsford since the beginning of 2015. In other recent investigations, we were concerned about poor assessment of risk of suicide and that staff did not take action in response to family concerns about a prisoner's state of mind. Since 2004, when the PPO began investigating deaths in prisons, we have investigated only two other self-inflicted deaths by electrocution.

Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

20. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should

be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

21. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Transfers of prisoners to hospital under the Mental Health Act

22. When a prisoner has a mental illness that requires detention in a hospital for medical treatment, and the prisoner urgently needs that treatment, the prison can arrange for them to transfer to hospital under section 48 or 49 of the Mental Health Act 1983. PSI 50/2007 (Transfer of Prisoners To and From Hospital Under Sections 47 and 48 of the Mental Health Act 1983) and the NHS England 'Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act' set out the process.

23. Before the prisoner can be transferred to hospital, two doctors (one of whom must be a mental health specialist) must provide reports stating that the prisoner meets the criteria for transfer. The reports must not be more than two months old. The prison's mental health inreach team sends the reports to the Ministry of Justice, who review the request and issue a transfer warrant. The transfer warrant, which is valid for 14 days, allows the prisoner to be transferred to hospital under the direction of the Secretary of State.

24. When a prisoner is identified as suitable for transfer to hospital, the NHS England Health and Justice Commissioning Team appoints an NHS England case manager to lead on this process and quickly locate and access a hospital bed. If the local service does not immediately have a bed space for the prisoner, the NHS England case manager should identify the most clinically appropriate alternative service. The NHS England guidance recommends that all prisoners needing transfer are transferred within 14 days.

Key Events

25. On 16 December, Mr Dean Saunders rang emergency services and said he believed that his family were involved in a conspiracy against him. Police detained Mr Saunders under Mental Health Act powers because of his paranoid behaviour. A psychiatrist from Rochford Hospital assessed Mr Saunders and recommended he should be admitted to the mental health assessment unit. Mr Saunders refused voluntary admission and his family were against compulsory admission, so his parents agreed to care for him at their home with support from the Community Crisis Mental Health Team.

26. On 16 December, the police arrested Mr Saunders after he stabbed a family member and injured another family member, who said he had intervened to stop Mr Saunders from stabbing himself. While he was in police custody, Mr Saunders told a doctor that he was hearing voices and was going to kill himself by cutting his throat.

27. At 9.00am on 17 December, a Criminal Justice Liaison and Diversion Team (CJLDT) nurse assessed Mr Saunders, but recorded that he would not engage and was 'bizarre and volatile.' (The CJLDT provide services for people in police stations, the courts, prisons and the probation service who have mental health problems and other vulnerabilities). He was restrained in arm and leg restraints. Mr Saunders said that he had no current thoughts of harming himself or others, was not hearing voices and had no history of substance misuse. The police charged Mr Saunders with two counts of attempted murder, assault occasioning bodily harm and use of or threatening unlawful violence.

28. The CJLDT nurse recommended an assessment under the Mental Health Act as soon as possible, but an on-call psychiatrist said it would not be appropriate to admit Mr Saunders to a general psychiatric ward. The psychiatrist said that a forensic psychiatrist should assess Mr Saunders so they could recommend to the court that he should be admitted to a forensic mental health ward (a specialist ward for people with mental health problems who have been charged with or convicted of a criminal offence).

29. At 1.00pm, the CJLDT learnt that Rochford Hospital could not offer a bed for Mr Saunders. Later that afternoon, two psychiatrists (one of whom had assessed Mr Saunders on 16 December) came to assess Mr Saunders at the police station, but Mr Saunders said that he did not want to speak to them and was tired and wanted to sleep. The psychiatrists noted that they could not make a decision to detain him under the Mental Health Act because Mr Saunders was not willing to engage with them.

30. On 18 December, Mr Saunders went to court accompanied by a member of the Criminal Justice Liaison and Diversion Team. The CJLDT member told the court that, if Mr Saunders was remanded to prison, he would need further assessment for suitability to transfer to hospital under the Mental Health Act and they would arrange for him to be transferred to a forensic mental health facility for assessment and treatment. Mr Saunders would need to be admitted to a prison inpatient unit and be closely monitored to prevent him harming himself and others.

31. The court remanded Mr Saunders to HMP Chelmsford, pending a mental health assessment. The CJLDT member told the clerk to the court and the Crown Prosecution Service that they were worried about Mr Saunders' mental health and faxed a high risk of self-harm alert to Chelmsford. Their court report was included with the Person Escort Record (which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors). Later that afternoon, Mr Saunders arrived at Chelmsford. Mr Saunders had never been in prison before.

32. Nurse A, the primary care team leader, read the CJLDT report and went to see Mr Saunders in the prison's reception area. She noted that Mr Saunders was very guarded and suspicious and was not engaging well with the reception officers. She arranged for Mr Saunders to be constantly supervised in the prison's inpatient unit.

33. A mental health nurse, Nurse B, assessed Mr Saunders in reception and began ACCT suicide and self-harm prevention procedures. The nurse recorded that Mr Saunders had tried to cut his throat in the past few days and that he had told the doctor in police custody that he would be better off ending his life by cutting his throat. The nurse wrote that Mr Saunders was very low in mood. Mr Saunders said he used cannabis and the nurse noted that he had tested positive for cannabis in police custody. The nurse noted that Brockfield House (a forensic mental health hospital in Essex) had already phoned the prison to discuss admitting Mr Saunders. He referred Mr Saunders to a doctor and for a mental health assessment.

34. Nurse B said that Mr Saunders had been calm and cooperative. However, he had been guarded and suspicious when he responded to questions about suicide and self-harm.

35. At 6.20pm, Mr Saunders was given a single cell in the inpatient unit and constantly supervised. Nurse A noted in his medical record that Mr Saunders avoided social interactions and had thoughts of suicide by hanging, strangulation or suffocation.

36. Later that evening, a locum GP, assessed Mr Saunders through the hatch in his cell door. The doctor noted that Mr Saunders was cooperative but suspicious. He asked for medication to help him manage 'pain caused by emotions'. He prescribed Mr Saunders three nights' supply of zopiclone to help him sleep. Later that night, Mr Saunders asked the night manager to help him get his family's phone numbers, but the night manager said that he would have to wait until the following morning.

37. At 8.30am on 19 December, Mr Saunders asked Officer A if he could make a phone call. The officer noted that he had asked the regular inpatient unit officers to speak to Mr Saunders about this. There is no evidence that any staff took any action to help Mr Saunders to make a call.

38. At 10.30am, Officer B assessed Mr Saunders as part of ACCT procedures. He noted that Mr Saunders would not answer any questions but said he was 'fine and happy'. The officer noted that the information accompanying Mr Saunders outlined his suicidal thoughts and that he had tried to kill himself. The officer

wrote that Mr Saunders seemed to think that staff knew everything about him. When he asked him questions about his past, Mr Saunders would not give him any further information.

39. That afternoon, Mr Saunders spoke to a mental health nurse, Nurse C, about the circumstances of his arrest. He said that he was angry with members of his family and his partner's family because they were conspiring against him. Mr Saunders told the nurse that he did not trust anyone, but had no intention of killing himself, and that his recent attempt was 'the last resort'. He said that he had intended to run away and go into hiding after dealing with the people he thought were trying to frame him. Mr Saunders said that he did not feel remorse for his actions because they were justified.

40. Shortly afterwards, Nurse D, a mental health nurse and the clinical team manager, Officer C, and a prison manager held Mr Saunders' first ACCT case review. Mr Saunders refused to answer any questions and the nurse noted that they were unable to assess him fully because of his mental state. The nurse told the investigators that Mr Saunders was agitated and too unsettled to have an in-depth conversation.

41. The review assessed Mr Saunders as at a raised risk of suicide and self-harm (from the options of low, raised and high), and decided that staff should continue to supervise him constantly. Nurse D recorded four actions on the ACCT caremap. First, that Mr Saunders would remain in healthcare under constant watch. Secondly, that inpatient unit staff would arrange for the prison psychiatrist, to assess Mr Saunders. Thirdly, that the mental health inreach team would arrange for someone else to assess Mr Saunders for transfer to forensic services. Fourthly, that he would remain "on his own regime" until he could be assessed.

42. At 2.00pm on 20 December, Nurse D, the prison manager, Officer C and Officer D held the second ACCT case review. The nurse noted that Mr Saunders had been eating, drinking and watching television and interacted well during the review. Mr Saunders had paranoid thoughts about his family and terrorism, and, when asked if he had any suicidal thoughts, he paused for some time before saying no. He said he had no thoughts of harming others but was angry with his family.

43. The review considered that Mr Saunders was still at raised risk of suicide and self-harm and that he should remain constantly supervised until the prison psychiatrist assessed him. Nurse D noted that a member of the mental health inreach team should attend the next review to update on the progress of Mr Saunders' hospital transfer.

44. Later that afternoon, Mr Saunders went to the inpatient unit courtyard for a cigarette and some time on his own. Afterwards, he played pool and went out into the courtyard with other prisoners. Around 5.45pm, Mr Saunders talked to the nurse who was constantly supervising him, about the conspiracy against him. He said that a member of his partner's family had framed him and that members of his family should be in prison instead of him. Mr Saunders said that he felt he had been labelled a mad man.

45. That evening, Officer A was constantly supervising Mr Saunders. He noted that Mr Saunders had become agitated and tearful and kept repeating 'this is a game,' and that he wanted answers. Mr Saunders said that he thought he was under surveillance, that one of the nurses had a microphone in her hair, and that another member of staff had a camera in her glasses. He threatened to pour a kettle of hot water over his head. He picked up a plastic knife and said he was going to draw blood for a paternity test for his son. He stood at the cell gate demanding answers about his son.

46. Afterwards, staff noted that Mr Saunders was eating his evening meal but was still very upset. About half an hour later, Mr Saunders had calmed down and talked to the nurse who was constantly supervising him.

47. At 9.45am on 21 December, Mr Saunders told the nurse who was supervising him that he was going to cover the camera in his cell. (Each cell in the inpatient unit and the unit corridors are fitted with CCTV cameras. However, the camera system had not been in operation for some time.) Mr Saunders moved his mattress onto the floor on the other side of his bed so that the nurse could not see him. Officer D asked him to move where the nurse could see him, but Mr Saunders did not reply or move.

48. Officer E went into Mr Saunders' cell and spoke to him. He did not answer, but pulled the covers over his head and pretended to be asleep. The officer tugged Mr Saunders' foot and went to pull the blanket back from him face when Mr Saunders jumped up, as if to scare him. The officer told Mr Saunders that this was not acceptable behaviour. Mr Saunders asked the officer if he could go outside for a cigarette and the officer said that he would take him in five minutes. Mr Saunders asked if he could have a lighter and the officer repeated that he would take him out for a smoke soon.

49. Shortly afterwards, the supervising nurse called Officer F back to the cell because Mr Saunders had put a plastic bag over his head. Mr Saunders held onto the bag, but the officer managed to remove it and Mr Saunders apologised for his behaviour. The officer told the investigators that he did not think Mr Saunders had put the bag over his head to harm himself but because he was frustrated about having to wait for a cigarette. The officer noted the incident in the observation book but did not record it in the ACCT document.

50. At 10.30am on 21 December, a prison manager, Officer F, Officer E and the Head of Healthcare held the third ACCT case review. No one from the mental health inreach team attended, although Nurse D had noted at the previous review that someone should attend to update on progress about transferring Mr Saunders to hospital. The Head of Healthcare said she was new at Chelmsford and this was her first ACCT case review there. She said that she met the Head of Healthcare before the case review and the Head of Healthcare told her that they would be ending the constant supervision for Mr Saunders and another prisoner that morning.

51. The Head of Healthcare told the investigators that she had attended Mr Saunders' case review as a representative of healthcare staff, but she had no clinical qualifications. She said that a member of healthcare staff should always attend ACCT case reviews, but that they did not necessarily need clinical

qualifications. She said that she had consulted members of the mental health team before attending the review, but she did not record this at the time and could not recall which staff she had spoken to when we interviewed her. None of the mental health nurses we interviewed remembered discussing Mr Saunders with the Head of Healthcare before the review.

52. The prison manager told the investigators that she relied on the input of clinical staff when making decisions about ending constant supervision. The prison manager said that she had assumed that the Head of Healthcare was clinically qualified.

53. The review team noted that Mr Saunders had engaged well during the review and spoke about the future, in particular, about getting help with reading and writing and about his 15-month-old son. Mr Saunders said that he had only made one serious attempt on his life, which was when he was younger and he had separated from his partner. He said he felt fine about being in prison and about the future. The review team assessed Mr Saunders as a low risk of suicide and self-harm, and reduced his observations from constant to twice an hour.

54. The Head of Healthcare told the investigators that the case review decided to end constant supervision based on Mr Saunders' presentation, what he had said during the review, and the fact that the inpatient unit is a supportive environment with a nurse on duty 24 hours a day, allowing for a greater frequency of informal checks. No one updated or referred to Mr Saunders' caremap or the comments from the previous review, which said that Mr Saunders should be constantly supervised until the prison psychiatrist assessed him. There was no record about whether any progress had been made about assessing Mr Saunders for a transfer to hospital.

55. At midday, Nurse E, a mental health nurse, and the acting mental health inreach team leader, attended a multidisciplinary healthcare team meeting and discussed Mr Saunders' case management. The nurse noted that the psychiatrist would assess Mr Saunders later that day and that she was waiting for a phone call from Brockfield House about his hospital transfer.

56. Later that day, a doctor from Brockfield House phoned Nurse E and said that they did not currently have a bed for Mr Saunders. The doctor advised that the prison psychiatrist should encourage Mr Saunders to take antipsychotic medication. The doctor said that, if Mr Saunders refused medication, she would arrange for him to be assessed for an out of area bed.

57. At 2.00pm, the prison psychiatrist assessed Mr Saunders, who said that he was a poly-drug user and that he had starting harming himself when he was very young, but would not say anything more about this. The prison psychiatrist found Mr Saunders to be very guarded and agitated. Mr Saunders sometimes became very emotional and left the interview room. He contradicted himself a few times, said that there was a conspiracy against him, and that he needed to sort his head out to 'place all the puzzles together.' Mr Saunders said he had felt different since he had stopped taking drugs, but could not say whether this change was good or bad. He told the prison psychiatrist that he had occasional nightmares

but felt good in prison because he was being looked after. Mr Saunders said that he was worried that Social Services might take his son into care.

58. Mr Saunders refused to take antipsychotic medication. Nurse E told investigators that Mr Saunders did not want to take medication because he thought it would cloud his judgement and because he did not think he needed it. The prison psychiatrist noted that Mr Saunders would benefit from a period of assessment and treatment in a mental health hospital and referred him to Brockfield House. He told us that this was the first step in arranging a transfer to hospital.

59. Nurse E told the investigators that normally they waited for a doctor from the receiving hospital to complete one of the recommendations for transfer under the Mental Health Act. She did not think the process would have worked if the prison psychiatrist had written the first of the two required reports under section 48 of the Mental Health Act because there was no bed for Mr Saunders at Brockfield House at the time. (This was not a correct understanding of the process under the Mental Health Act.)

60. On the afternoon of 23 December, two members of Mr Saunders' family visited him. Officer F noted that Mr Saunders seemed happy about the visit, but when he saw his family, he refused to speak to them. He became rude and abusive, and demanded that the visit end because he thought his family were part of the conspiracy against him.

61. Nurse D and a prison manager spoke to Mr Saunders' family afterwards. Nurse D said that Mr Saunders' family were distraught and very worried about him. They asked when Mr Saunders would be transferred to hospital and the nurse said that this would be done as soon as possible. In the meantime, he would be monitored under ACCT procedures. The nurse tried to reassure his family that he was doing okay in the inpatient unit. She advised them to contact the safer custody department if they wanted more information.

62. At 4.30pm, Nurse D, the prison manager, Officer G, and Officer F held another ACCT case review. The nurse told Mr Saunders that his family were worried about him, but he was dismissive about his family's concerns. He said that he wanted a blood test to determine if he was the father of his child. He said he had no thoughts of suicide or self-harm.

63. The staff continued to assess Mr Saunders' risk of suicide and self-harm as low, and kept the frequency of checks at twice an hour. Nurse D recorded that Mr Saunders did not have any sharp objects in his cell because his alleged offences involved a knife. There was no record in the ACCT documents about whether other items should be removed from his cell.

64. At 9.30am on Christmas Eve, Mr Saunders asked Officer F to help him get his family's phone numbers. The officer noted in the ACCT document that he had advised Mr Saunders how to get the numbers, but did not record what advice he had given or whether Mr Saunders had got them as a result. Later that morning, Nurse E rang Brockfield House and said that the prison was trying to arrange an urgent psychiatric assessment so that Mr Saunders could transfer to hospital.

65. That day, a member of Mr Saunders' family rang Nurse E because she was upset about her visit the previous day, and was worried that Mr Saunders would try to kill himself. The nurse did not document the phone call, but told us that the family member had asked when he would be transferred to hospital, and she had explained the process.

66. That afternoon, Nurse E held an ACCT case review with Officer F, Officer D, Nurse F and a nurse manager. Nurse E noted that Mr Saunders was incoherent and became upset when discussing his child. Mr Saunders said that he was being watched by cameras and asked Nurse E if staff planned to hold him down and gas him, because he had seen gas cylinders in the clinic. Nurse E explained that they were oxygen cylinders, but Mr Saunders remained suspicious.

67. There was no record of Mr Saunders' assessed level of risk at this case review. Nurse E told the investigators that they had assessed him as at a high risk but kept the level of observations at twice an hour, as this level of observation did not disturb him. The nurse said that they had considered constant supervision but thought this might make his paranoia worse.

68. That night, a member of staff recorded that Mr Saunders had talked about his childhood and his son, and had become very emotional. He said that he had been paranoid when he had attacked members of his family, but was not anymore. However, Mr Saunders still appeared paranoid, as he continued to speak about people out to get him, agents and surveillance.

69. There were only brief observational entries in Ms Saunders' ACCT document on Christmas Day and Boxing Day, but his healthcare records indicate he spent a lot of time talking to staff. He still did not have his family's telephone numbers. On 27 December, Officer E noted that Mr Saunders had made some bizarre comments. He had asked the officer why he was in prison and asked for 'the proof'. He said that he had been having a chat with a psychologist in his cell, which was not the case. The officer explained to Mr Saunders why he was in prison.

70. On 28 December, Nurse A chaired an ACCT case review with Nurse E and Officer E. She noted that Mr Saunders appeared anxious and had delusional ideas that cameras and recording equipment were hidden everywhere. Nurse A told the investigators that Mr Saunders had been extremely paranoid and very suspicious throughout the review. He had appeared preoccupied and talked a lot about his family. He said that he had thoughts of suicide but would not answer when the staff asked if he had a plan to kill himself. Mr Saunders said he did not understand why he was in prison because he was an innocent man. He said that he believed he would never see his family again and mentioned a traumatic event that he said had happened when he was four years old, but would not say anything more about this.

71. The case review assessed Mr Saunders' risk of suicide and self-harm as high but left the frequency of checks unchanged at twice an hour. When interviewed, Nurse A said that the team had assessed his risk as high because he said that he was thinking about suicide and because she was not comfortable with his presentation. She said that they had decided not to increase the level of observations because Mr Saunders was interacting well with the other prisoners,

had not attempted suicide since he had arrived at the prison, said that he did not have a plan to take his life, and nothing suspicious had been found in his cell. (The prison was unable to give us any records of when staff searched the cell that day.)

72. Later that afternoon, Mr Saunders went to the inpatient unit office and asked staff to search his cell. He said that there were things in his cell that were not supposed to be there and that he wanted them removed, but did not say what they were. A member of staff took him into the courtyard for some fresh air as a distraction. When Mr Saunders went back to his cell, he continued to talk about it being searched. Officer E told Mr Saunders that he did not know what he was talking about. He said that there was nobody in his cell and tried to reassure Mr Saunders by looking under the mattress. Mr Saunders eventually went back in, took his mattress off his bed, and put it on the floor.

73. That evening, Nurse C noted that Mr Saunders appeared low in mood and anxious. Mr Saunders told the nurse that he knew what people were trying to do to him and said, 'They want to physically, emotionally and psychologically scar me and then leave me'. Mr Saunders could not explain to the nurse what he meant. He appeared preoccupied and the nurse observed him pacing in his room.

74. On 29 December, Nurse G noted that Mr Saunders had asked to see his partner and would need to speak to an officer about this. That afternoon, he sat on the floor of his cell crying. He said he was missing his son and that he wanted to speak to him. A healthcare assistant told Mr Saunders that she would speak to the officers about this but there is no further record of the nurse or the healthcare assistant passed the information to officers. Although Mr Saunders had been in prison for 11 days, he had still not spoken to any of his family by phone. None of their numbers had been added to his prison phone account.

75. That evening, Mr Saunders told Officer D that he had been feeling quite down and was worried that he had lost his family. He said that he regretted how he had behaved when his family had visited. The officer offered to help Mr Saunders write a letter to his partner to tell her how he felt. Mr Saunders said he did not want to write a letter and asked to be locked in his cell early. The officer told Mr Saunders to let him know if he changed his mind.

76. At approximately 11.30am on 31 December, a forensic psychiatrist from Brockfield House assessed Mr Saunders. Mr Saunders reported using cannabis but said he had stopped a few months before. The forensic psychiatrist noted that he found it difficult to assess Mr Saunders because he was difficult to follow and gave answers that were not related to the question, or would drift off topic. The forensic psychiatrist recorded that Mr Saunders presented with symptoms that suggested an active and ongoing paranoid psychosis. The forensic psychiatrist thought that this was unlikely to resolve itself and would worsen with time. He noted that Mr Saunders had no insight into his mental health problems or the need for treatment. He recorded that Mr Saunders remained a risk of suicide and that staff should monitor his mental state closely. The forensic psychiatrist completed a section 48 recommendation that Mr Saunders should be transferred to hospital, and asked that the prison psychiatrist should complete the

second recommendation when he returned from leave on 5 January. He noted that there was now a bed for Mr Saunders at Brockfield House. (Under the Mental Health Act, any GP could have written the second recommendation for transfer, but the prison healthcare team and the forensic psychiatrist thought that another psychiatrist had to do this.)

77. At 4.30pm on 31 December, Nurse D, Nurse H and Officer E held an ACCT case review. Nurse D noted that Mr Saunders had asked to call his family but he did not have their phone numbers. She recorded that an officer would try to obtain Mr Saunders' family's phone numbers from staff in the visits department or the chaplaincy team, as the administrators responsible for arranging prisoners' telephone accounts would not be back at work until 4 January. She did not include this as an action for the ACCT caremap. The review assessed Mr Saunders as at a high risk of suicide and self-harm but left the frequency of observations unchanged at twice an hour. Nurse D said that the team assessed Mr Saunders' risk as high because there had been no change in his presentation since the previous review, where the team had assessed his risk as high. The review team scheduled the next case review for 5 January.

78. At 11.30am on 1 January 2016, a member of staff from the chaplaincy team, visited Mr Saunders. He told her that he wanted to speak to his family and he was trying to work things out. There is no record that anyone did anything further to help him speak to his family.

79. On 2 January, Mr Saunders gave his TV and kettle to staff and said that he did not want them in his cell, but did not say why. (There was a TV in his cell when he died, but we do not know when it was returned to him.) Nurse G recorded that Mr Saunders had asked one of the prisoners who worked in the inpatient unit to help him write a letter, but later changed his mind. He also asked to speak to the reverend, a chaplain, but he was not available until the next day. He did not want to speak to another chaplain.

80. On the morning of 3 January, Mr Saunders told Nurse B that he did not know why he was an inpatient and said that he could not sleep. The nurse said he would discuss this with a doctor. Mr Saunders showed the nurse some scratches on his arms and said that he had made them because he could not sleep. The nurse told the investigators that Mr Saunders had six or seven superficial scratches on both of his arms. He said that he had not asked Mr Saunders what he had used to make the scratches. The nurse noted the scratches in the ACCT document and told Mr Saunders that the doctor would see him the next day. The nurse did not discuss the scratches with any other staff or take any further action.

81. That day, Nurse B noted in the unit observation book and Mr Saunders' ACCT document that a member of Mr Saunders' family had given permission for Mr Saunders to call her. (Nurse B told us that Nurse D had spoken to Mr Saunders' family about this.) The nurse noted his family's phone number in the observation book, but mistakenly recorded it next to another prisoner's name. No one took any action to arrange for Mr Saunders to phone his family.

82. At 12.00pm, Mr Saunders asked to speak to the chaplain, about making a funeral plan. The chaplain said that prisoners sometimes ask to do this, so while he was

not overly concerned, he did not take the request lightly. The chaplain said that he had asked Mr Saunders why he wanted to make a funeral plan, but he had given a vague reply, saying something like it was never too early. The chaplain took Mr Saunders into a side room to talk, but Mr Saunders did not mention the funeral plan again and instead spoke about being in prison and his sense of injustice. The chaplain said that he was reassured after their conversation because Mr Saunders had focussed on the future and had asked to speak to him again later that week. The chaplain said that he discussed the conversation with Nurse D. He noted it in the ACCT document and in Mr Saunders' prison record.

83. At 12.30pm, Mr Saunders asked Nurse B if he could phone his solicitor but the nurse told him to ask again the following day. The nurse noted that Mr Saunders appeared suspicious and thought disordered. At 4.00pm, Mr Saunders asked about phone numbers for his family and the nurse told him that this would be sorted out the next day.

4 January 2016

84. At approximately 7.45am on 4 January, Mr Saunders went outside to smoke. Officer F took him back to his cell at around 9.00am. About ten minutes later, Officer D got some extra tobacco for Mr Saunders and took him back outside for another cigarette.

85. At 9.50am, Mr Saunders asked Officer D to help him write a letter to his partner. The officer said he would come back to write the letter once he had finished some other jobs.

86. At 10.20am, Nurse G checked Mr Saunders and noted that he was lying on his mattress on the floor with his hands behind his head, and that he was awake. The nurse said Mr Saunders often slept on the floor, so this was not unusual. She said that when she had looked through the hatch into his cell, Mr Saunders had looked at her and smiled. The nurse said that after checking Mr Saunders, she went to the office to make a note in his ACCT document, and then went to help an older prisoner have a shower.

87. At about 10:25am, Officer D went back to Mr Saunders' cell with some paper to help him write the letter. He was still lying on the mattress with his hands behind his head and had a blanket over him. The officer called to Mr Saunders but he did not respond. He tapped Mr Saunders on his arm and noticed that there was smoke coming from beneath the blanket and that Mr Saunders looked very yellow.

88. Officer D pulled the blanket off Mr Saunders and saw that there was a wet towel underneath the blanket across Mr Saunders' bare chest. There was a blue and a brown wire coming out from under the towel, which were still attached to the TV that was plugged into the electrical socket in the wall. The officer removed the wet towel, noticed two small burns on Mr Saunders' chest and called for help. A prisoner, who was working in the inpatient unit, went into the cell with Nurse G, who started moving furniture out of the way. (The prisoner did not want to be interviewed for the investigation.)

89. According to the control room log, at 10.32am, Officer D radioed a Code 1 (the local emergency medical code used to indicate circumstances such as when a prisoner is unconscious or having difficulty breathing). Staff in the control room called an ambulance at 10.33am. Officer F responded to the Code 1 call. He said that as he came onto the landing, he saw the nurse looking frightened and moving away from Mr Saunders' cell. Officer A also arrived at Mr Saunder's cell. Officer D told the officers that Mr Saunders was dead. Officer F agreed that he appeared dead, but said that they had to try to resuscitate him.

90. Officer F started cardiopulmonary resuscitation and Officer A ran to get the emergency bag and oxygen. Nurse A arrived shortly afterwards and checked Mr Saunders for signs of life. She noted that he did not have a pulse and his pupils were not reactive. The nurse ran to the office to check that an ambulance had been called and brought a defibrillator to Mr Saunders' cell. The defibrillator found no shockable heart rhythm and they continued to attempt resuscitation. Five other nurses arrived at Mr Saunders' cell and assisted.

91. At 10.39am, paramedics arrived at Mr Saunders' cell and took over his emergency treatment. At 10.54am, air ambulance paramedics arrived and administered emergency medication, including five rounds of adrenalin. Sadly, Mr Saunders did not recover. At 11.19am, the air ambulance anaesthetist recorded that Mr Saunders had died.

Contact with Mr Saunders' family

92. At 12.45pm on 4 January, the prison family liaison officer, the chaplain and Officer H broke the news of Mr Saunders' death to his partner, at her parents' home. On 7 January, the prison family liaison officer and Officer H visited Mr Saunders' parents at their home and answered some of their questions. Mr Saunders' family visited the prison on 8 January. The prison offered to contribute to the cost of Mr Saunders' funeral, in line with national instructions.

93. Mr Saunders' family had some concerns about the contact they had with the prison after Mr Saunders' death. They were upset that no one from the prison attended Mr Saunders' funeral despite saying that someone would, and that the letter of condolence sent by the prison misspelled one of the family's names. They said that prison's family liaison officer was difficult to contact in the days after Mr Saunders died. We set out the family's concerns in a letter to the Governor. He accepted that there had been some deficiencies and set out some changes the prison had made to improve the experience of bereaved families.

Support for prisoners and staff

94. After Mr Saunders' death, the Head of Safer Custody, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

95. The prison posted notices informing other prisoners of Mr Saunders' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Saunders' death.

Post-mortem report

96. The post-mortem report concluded that the cause of Mr Saunders' death was electrocution.

Findings

Management of the risk of suicide

97. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and suicidal ideation, being charged with a violent offence particularly against a family member, a history of substance misuse, a history of mental health problems and recent contact with psychiatric services, early days and first time in prison. All of these factors applied to Mr Saunders.

98. Staff correctly began ACCT suicide and self-harm prevention procedures as soon as Mr Saunders arrived at Chelmsford and he was monitored under ACCT procedures throughout his time there. However, we have some concerns about the management of his risk.

Levels of observation

99. When he first arrived at Chelmsford, from 18-21 December, Mr Saunders was constantly supervised. At a case review on 20 December, the clinical team leader and mental health nurse, Nurse D, considered that Mr Saunders should remain constantly supervised at least until the prison psychiatrist, had assessed him. However, on 21 December, a case review decided to end constant supervision and reduce the level of observations to twice an hour, even though the psychiatrist had not yet assessed Mr Saunders and there had been no obvious change in his risk.

100. PSI 64/2011 states that ACCT case reviews must be multidisciplinary where possible, but it is mandatory that a nurse or a senior clinical manager attend case reviews for prisoners under constant supervision. The then Head of Healthcare, attended Mr Saunders' ACCT case review on 21 December but she was not clinically qualified and there is no record that she had sought any clinical input before attending the review. The prison manager who was new at Chelmsford, assumed that the then Head of Healthcare was clinically qualified and said that she had deferred to her judgement during the review.

101. There was a lack of understanding about the purpose of multidisciplinary case reviews, and the importance of having clinical input into ACCT case reviews for prisoners in the inpatient unit. It is particularly concerning that there was no clinical input into the decision to end constant supervision. Mr Saunders had a severe mental illness, had made a serious suicide attempt just days earlier, and had other risk factors indicating he was at high risk of suicide. We consider that Mr Saunders should have been constantly supervised at least until the prison psychiatrist had assessed him.

102. Before Mr Saunders' case review on 21 December, the then Head of Healthcare told the prison manager that they would be ending constant supervision for Mr Saunders and another inpatient that day. Decisions about the required frequency of checks should be based on the available evidence, including an assessment of the prisoner's risk at the time. They should not be made before a multidisciplinary review has taken place.

103. The case review on 21 December reduced the frequency of checks to twice an hour, a relatively low frequency and a big drop from constant supervision. The then Head of Healthcare told the investigator that they thought this was sufficient because the inpatient unit was a supportive environment with a small number of regular staff and there was a nurse on duty at all times.

104. Although not properly recorded, a case review on 24 December rightly assessed Mr Saunders as at high risk of suicide and self–harm, as did the next two case reviews. Despite this, staff were still required to check Mr Saunders only twice an hour, which remained the case for the rest of his time at Chelmsford. Staff said that they had discussed increasing the level of observations, but thought that constant supervision might increase Mr Saunders' feelings of paranoia. There is no evidence that they considered more frequent checks at a rate below constant supervision.

105. Some prisoners find constant supervision disturbing, but there is no evidence that this troubled Mr Saunders and he shared important information about his state of mind with staff when he was constantly supervised. We do not consider two checks an hour adequately reflected his level of assessed risk. We were also concerned that most observations were recorded at regular predictable intervals, contrary to instructions in PSI 64/2011. The day before Mr Saunders died, staff recorded observations every 30 minutes from 8.00am until 8.00pm.

ACCT caremap

106. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. Instructions say they should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time bound.

107. We do not consider there were appropriate caremap actions aimed at reducing Mr Saunders' risk. Mr Saunders asked to speak to his family a number of times; he said he was concerned about his son and thought that he had lost his family. However, his caremap contained no reference to helping Mr Saunders contact his family. It also contained no direct actions to help progress his transfer to hospital, the main thing that could have been done to help reduce his risk.

Response to self-harm

108. On 3 January, Mr Saunders made some scratches to his arm, which Nurse B described as superficial. He said that Mr Saunders could have made them with his fingernails. The post-mortem report noted six 'knife tip type abrasions' on Mr Saunders' right forearm, the longest of which was 16cm, and at least 16 'knife tip type abrasions' on his front and inner left forearm.

109. Nurse B noted in the ACCT document that Mr Saunders had scratched his arms, but he did not speak to anyone about this or record it in Mr Saunders' medical record. The nurse did not ask Mr Saunders what he had used to cut himself or search his cell for sharp implements, although Nurse D had previously noted that Mr Saunders should not have access to sharp items. This was the first time Mr

Saunders had actually harmed himself at Chelmsford, and staff should have considered whether they needed to hold a case review in response to reassess his risk. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including in particular that:

- **Mental health staff attend or contribute to all ACCT reviews for prisoners in their care and are fully involved in decisions about their level of risk.**
- **Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations which reflects that risk.**
- **ACCT observations are at irregular, unpredictable intervals.**
- **Staff review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.**
- **Effective caremap objectives are set which are specific and meaningful, aimed at reducing risk and updated at each case review.**

Family contact

110. PSI 64/2011 says that prisoners who pose a risk of harm to themselves must be encouraged to communicate with their families, and that consideration must be given to inviting the prisoner's family to ACCT case reviews where this is thought to be beneficial. Contact with family can provide an important source of support to a prisoner in crisis and staff should facilitate this wherever possible and appropriate. Mr Saunders' family were supportive and wanted to be involved in his care. However, there is no evidence that any of Mr Saunders' ACCT case managers considered inviting his family to case reviews, or otherwise involving them in the process.

111. Prisoners' families, the people who know them best, can provide vital insight and information about their risk of suicide. PSI 64/2011 contains an instruction that all staff who receive information, including from concerned family members, which indicates a change in the risk prisoners pose to themselves, must communicate the concerns immediately to a manager and make a record in an appropriate source, such as observation books, the prisoner's record or the ACCT document.

112. On 24 December, a member of Mr Saunders' family spoke to Nurse E, as she was concerned that Mr Saunders intended to kill himself. The nurse did not note this phone call in Mr Saunders' ACCT document, medical records or anywhere else. PSI 64/2011, says that a case review should be held when concerns and information are received from families or friends of a prisoner at risk. Although there was a scheduled case review that afternoon, there is no record that the nurse mentioned the family member's concerns about his risk. Mr Saunders' family phoned the prison over twenty times. We do not know the

substance of all the calls, but they said some were to raise concerns about him. None of these calls was documented.

113. When Mr Saunders first arrived at Chelmsford, he did not have any of his family's phone numbers. Staff told him a number of times that they would help him find phone numbers for his family but this did not happen. Mr Saunders' family told us that they had given their contact details to different members of staff a number of times, so they should have been readily available. Although he wanted to, Mr Saunders did not speak to his family during his time in prison, apart from when he saw his family at a visit on 23 December. Written entries in his ACCT document noted that he had asked to see or speak to his family on seven occasions. By 4 January, staff had noted the correct phone number for Mr Saunders' family in the unit observation book (but against another prisoner's name) but had not helped him call them.

114. We are concerned that staff did not appear to recognise that not being able to speak to or see his family, including his young son, caused Mr Saunders increasing distress and increased his risk. As noted above, they did not include this as an action in his ACCT caremap as we would have expected. We consider that staff should have made efforts to involve Mr Saunders' family in his care. We make the following recommendation:

The Governor should ensure that any concerns from a family member or friend about a prisoner's welfare and safety are appropriately recorded and followed up. ACCT case managers should consider involving the prisoner's family in the ACCT process when appropriate and record this in the ACCT plan.

Mental health services and transfer to hospital

115. PSI 50/2007 (Transfer of Prisoners To and From Hospital Under Sections 47 and 48 of the Mental Health Act 1983) and NHS England's 'Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act' outline the process for transferring a prisoner to hospital under the Mental Health Act. The NHS guidance recommends that all prisoners requiring transfer are transferred within 14 days of the first doctor's assessment that finds the prisoner meets the criteria for transfer to hospital.

116. In January 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths in prisons, where mental health issues were involved. In the report, we noted that where a secure hospital has been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect all possible steps to be taken by the prison and the hospital to ensure this takes place within the 14 day target. We also noted that prisons need to be extra vigilant about the care of prisoners who are being considered for, or are awaiting transfer to a secure hospital.

117. Mr Saunders was identified as needing a transfer to hospital on 18 December, when he was first remanded to prison. We are concerned that healthcare staff at Chelmsford did not fully understand the correct process for transferring prisoners under the Mental Health Act. This led to a delay in Mr Saunders' transfer to hospital.

118. No one at Chelmsford notified NHS England (who then identify the Responsible Commissioner and allocate a case manager) or the Ministry of Justice (who can also help to identify appropriate alternative inpatient facilities) that Mr Saunders needed to transfer, as should have happened. As a result, the processes for identifying an available bed in a secure mental health facility were not triggered.

119. The prison psychiatrist assessed Mr Saunders three days after he arrived at Chelmsford but did not complete the first medical recommendation for transfer required under s48, because he incorrectly believed he should not do this until Brockfield House had a bed available for Mr Saunders. The forensic psychiatrist from Brockfield House completed the first recommendation for transfer on 31 December, when he assessed Mr Saunders. This was 13 days after Mr Saunders had arrived at Chelmsford. The forensic psychiatrist thought that the prison psychiatrist would complete the recommendation that day. However, the prison psychiatrist was on leave until 5 January, and prison healthcare thought that they needed to wait for him. In fact, any doctor, including a GP could have completed the second recommendation. The delay at this stage of the process was particularly tragic, as Brockfield House had identified a bed available for Mr Saunders that day - 31 December. We make the following recommendation:

The Head of Healthcare should ensure that there is an established process, in line with national guidance, which healthcare staff understand and follow, to transfer prisoners to hospital under the Mental Health Act, within 14 days where possible.

120. The prison psychiatrist is the only psychiatrist at Chelmsford and runs five clinics a week at the prison. He also provides psychiatric services at HMP Highpoint, HMP Hollesley Bay and HMP Warren Hill. Nurse D and Nurse E told the investigators there was no psychiatrist available when the prison psychiatrist was on leave over the Christmas period or to cover periods of sick leave. The clinical reviewer considered that the reliance on one psychiatrist, with no cover, was inappropriate for a local prison. We make the following recommendation:

NHS England - East of England Area Team should ensure that psychiatric services commissioned for prisoners at HMP Chelmsford are sufficient to meet their needs and reflect community provision.

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