

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ben Cathorne a prisoner at HMP Chelmsford on 4 October 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 Ben Cathorne was found hanged in his cell at HMP Chelmsford on 4 October 2015. He was 28 years old. I offer my condolences to Mr Cathorne's family and friends.

I am concerned that there were weaknesses in the assessment of Mr Cathorne's risk of suicide and self-harm risk when he arrived at Chelmsford. This is something I have raised with prison before, although I recognise that in Mr Cathorne's case, this occurred some months before he died. However, when he was later identified as at risk, suicide and self-harm prevention procedures were not managed as well as they should have been. There were also deficiencies in the emergency response.

Despite the areas for improvement we have identified, Mr Cathorne's history of suicide attempts and mental health problems suggest that he was always a long-term risk, and I do not consider that prison staff could have identified that Mr Cathorne was at high or imminent risk of suicide immediately before his death.

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

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Summary

Events

1. On 5 January 2015, Mr Ben Cathorne was remanded to HMP Chelmsford, charged with burglary. He had a history of suicide attempts and self-harm. He had mental health problems and had been diagnosed with emotionally unstable personality disorder. His community GP had prescribed antipsychotic medication, but he had not taken this recently. While Mr Cathorne was at court, a community psychiatric nurse assessed him and noted that he had previously attempted suicide and had self-harmed when remanded to prison. Court custody staff completed a suicide and self-harm warning form. This warning form and the psychiatric assessment went with Mr Cathorne to Chelmsford.
2. At an initial health screen and interviews with reception staff, Mr Cathorne said he had no thoughts of suicide or self-harm. Not all the staff saw the documents from court and no one assessed him as at risk of suicide or self-harm. During his time at Chelmsford, the primary care mental health team and psychiatrists reviewed Mr Cathorne frequently and he continued to say he had no suicidal thoughts.
3. On 5 July 2015, Mr Cathorne was taken to hospital after he was found unresponsive, apparently under the influence of a new psychoactive substance (NPS). In September, a nurse suspected that he was under the influence of an illicit substance. Wing staff suspected that he used NPS Spice more often than he had admitted.
4. Prison staff monitored Mr Cathorne using Prison Service suicide and self-harm prevention procedures, known as ACCT, for three periods at Chelmsford. The first period was from 11 June to 12 June, when he was upset that his baby was unwell. The second was from 16 to 22 June, after he had tried to hang himself. The last period was from 14 July to 4 August, after he had made superficial cuts to his arm.
5. Towards the end of September, Mr Cathorne told staff he had some relationship difficulties. However, his partner continued to visit and he received visits. On 20 September, he told his personal officer that he was looking forward to his release.
6. At 5.55am, on 4 October, night patrol officers found Mr Cathorne hanged in his cell by a piece of torn bedding tied to the window bars. One of the officers radioed an emergency medical code. Other staff arrived quickly and tried to resuscitate Mr Cathorne, but he did not respond. Paramedics arrived at 6.07am and recorded that Mr Cathorne had died.

Findings

7. We are concerned that reception staff at Chelmsford did not assess Mr Cathorne as at risk of suicide and self-harm when he arrived. They either did not see or did not act on the court psychiatric report or the suicide and self-harm warning form, and did not take into account Mr Cathorne's other risk factors. We have previously found poor reception risk assessments at Chelmsford.
8. Healthcare staff attended only one initial ACCT case review of three, although healthcare staff attendance at initial reviews is a mandatory requirement of ACCT

procedures. Mr Cathorne was under the care of the primary mental health team but healthcare staff were not invited to any other reviews, although their views were sought on one occasion.

9. On 4 October, when control room staff received an emergency medical code they did not call an ambulance immediately, but waited for further confirmation, contrary to emergency instructions. We have identified this issue at Chelmsford before. This would not have altered the outcome for Mr Cathorne as it was evident from the presence of rigor mortis when he was found hanged that he was dead. Despite this, the staff attempted to resuscitate him.
10. Although there was no up to date care plan, the clinical reviewer was satisfied that Mr Cathorne received appropriate mental health support at Chelmsford and his care was equivalent to that he could have expected to receive in the community.
11. It is apparent that Mr Cathorne used NPS at Chelmsford but, as these substances were not the subject of toxicology tests, it is not possible to draw conclusions as to whether he had used NPS shortly before his death. We understand that Chelmsford has identified that the use of NPS is an escalating problem in the prison and has taken action to educate staff and prisoners about the dangers. We therefore make no recommendation about this issue.
12. While the investigation identified concerns about risk assessment in reception and ACCT procedures, we do not consider that, at the time of Mr Cathorne's death, prison staff could have identified he was at high and imminent risk of suicide or done anything to prevent his death.

Recommendations

- The Governor should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with suicide and self-harm warning forms, they should clearly record the reasons.
- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:
 - A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.
 - Case reviews assessing the risk of suicide or self-harm based on all available information and known risk factors and setting level of observations which reflect that risk.
 - Setting effective caremap objectives, which are specific and meaningful, aimed at reducing risk and that ACCTs are not closed before all caremap actions have been completed.
- The Governor should ensure that all prison staff working in the control room are fully briefed about emergency procedures and call an ambulance as soon as an emergency medical code is broadcast.

- The Governor and Head of Healthcare should ensure that prison and healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. NHS England commissioned a clinical reviewer to review Mr Cathorne's clinical care at the prison.
15. The investigator visited Chelmsford and obtained copies of relevant extracts from Mr Cathorne's prison and medical records. He interviewed 18 members of staff and two prisoners at Chelmsford.
16. We informed HM Coroner for Chelmsford of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Cathorne's partner to explain the investigation and ask if she had any matters she wanted the investigation to consider. Mr Cathorne's partner asked:
 - What action did the prison take when staff found Mr Cathorne in possession of 'spice' and whether he had gone to hospital after apparently taking the drug around June/July?
 - How was Mr Cathorne's ADHD/personality disorder managed, and what medication was he prescribed?
 - Had Mr Cathorne been in debt or bullied in prison?
18. Mr Cathorne's partner received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Chelmsford

19. HMP Chelmsford is a local prison that takes prisoners directly from courts. It holds nearly 745 men. F Wing is the first night in prison and induction unit. New prisoners needing detoxification from drugs or alcohol go to E Wing.
20. Care UK provides primary health care, including GP input for prisoners with substance misuse problem. North Essex Partnership Foundation Trust provides substance misuse nurses.

HM Inspectorate of Prisons

21. The most recent inspection of Chelmsford was in 2014. Inspectors noted that the number of prisoners supported by suicide and self-harm prevention procedures was high, but had reduced greatly since the previous inspection. The quality of most monitoring documents was generally reasonable. The primary and secondary mental healthcare teams worked well together and delivered a good level of care, with effective support by a resident counselling service.

Independent Monitoring Board

22. 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 number of prisoners managed under suicide and self-harm prevention procedures had increased by more than 20% from the previous year, but the IMB was reassured that actual incidents of self-harm and threats to self-harm had reduced.

Previous deaths at HMP Chelmsford

23. Mr Cathorne's death was the third of four apparent self-inflicted deaths at Chelmsford since the beginning of 2015. In other recent investigations, we have been concerned about poor assessment of risk of suicide and self-harm for new arrivals and that control room staff did not call ambulances immediately in an emergency. We had similar concerns in this investigation.

Assessment, Care in Custody and Teamwork

24. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

25. 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.
26. In July 2015, we published a Learning Lesson Bulletin about the link between the use of NPS and an increased risk of death, damage to physical and mental health, bullying, debt and possibly suicide and self-harm. The bulletin identified the need for better awareness among prison 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.

Key Events

27. On 2 January 2015, Mr Ben Cathorne was arrested on suspicion of burglary. While in police custody, Mr Cathorne said that he had cut his wrists and tied a ligature around his neck in 2011. In 2013, he had been treated for attention deficit hyperactivity disorder (ADHD) and emotional unstable personality disorder. He said he was waiting for an appointment with the community mental health team.
28. On 5 January, Mr Cathorne appeared at Magistrates' Court and was remanded to prison. The person escort record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) noted his mental health problems and suicide and self-harm risk. Based on this information, court custody staff completed a suicide and self-harm warning form. A community psychiatric nurse at court assessed Mr Cathorne's mental health. Mr Cathorne said that he had negative thoughts and paranoia when he felt low. He had attempted suicide and had self-harmed during a previous period in prison. He said he had had some recent suicidal thoughts, but his protective factor was his partner, who was four months pregnant. A copy of the assessment was placed with the PER and the suicide and self-harm warning form.
29. Mr Cathorne was sent to HMP Chelmsford, where he had served previous sentences. (He had last been released from Chelmsford in February 2014.) In prison, he had previously been assessed as at risk of suicide and self-harm. Previous mental health assessments had concluded that he did not need specialist psychiatric care.
30. Reception staff at Chelmsford are expected to check for a suicide and self-harm warning form, or warnings written on the PER and complete a local form if there is such a warning. They should record on the form current and previous episodes of self-harm, whether an ACCT document has been opened and, if not, the reasons. The reception officer should then email the form to the safer custody department and pass the self-harm warning form and other relevant documents to reception healthcare staff. The next day, the safer custody team should forward to the induction or wing manager a list of the newly-arrived prisoners with self-harm indicators so that they can assess whether additional support is required
31. When Mr Cathorne arrived at Chelmsford, escort staff handed the PER and other documents to prison staff. The self-harm warning form was not signed to indicate that reception staff at Chelmsford had seen it. Neither a Custodial Manager, who was in charge of reception, nor the officer who interviewed Mr Cathorne, could recall seeing the documents and no one involved in the reception process referred to the documents completed at court.
32. An agency mental health nurse formerly employed at Chelmsford saw Mr Cathorne for an initial health screen. The nurse recorded that Mr Cathorne's GP had previously prescribed quetiapine (an antipsychotic), but he had not taken this for several months. He had attempted to overdose on prescribed medication in prison within the last five years, and had spent time in a psychiatric hospital, but had discharged himself. Mr Cathorne said that he had used cannabis in the past month.

33. The nurse assessed Mr Cathorne's mental state as stable, and noted that he had no thoughts or current plans of suicide or self-harm or suicide. He referred Mr Cathorne to a psychiatrist for a mental health assessment and to a GP to discuss medication, as he said he wanted to resume taking quetiapine. There is no indication that the nurse saw the court documents or the suicide and self-harm warning form. The next day, a multidisciplinary team decided that Mr Cathorne should remain under the care of the GP and should be referred to the mental health team, if necessary.
34. An officer interviewed Mr Cathorne in the first night centre on F Wing. The officer said that he had not seen the self-harm warning form or any of the other documents. He did not assess Mr Cathorne as at risk of suicide or self-harm.
35. The next day, 6 January, someone from the safer custody team emailed the SO, the manager of the induction unit, to speak to Mr Cathorne as they had noticed he had arrived with a suicide and self-harm warning. The SO did not see the form or the nurse's report. Mr Cathorne told the SO that he had been angry when he had mentioned self-harm and had no current thoughts of self-harm or suicide. The SO told him of the support available if he needed it. The SO told the investigator that they would not automatically begin ACCT procedures for prisoners who arrive with a suicide and self-harm warning, but make a judgement based on their answers to questions and their presentation. He was satisfied that Mr Cathorne did not need to be monitored under ACCT procedures. Later that day, Mr Cathorne was sent to E Wing, the drug treatment wing. (It is not clear why, as he received no treatment for substance misuse problems.)
36. On 13 January, officers raised concerns about Mr Cathorne, who was anxious that he had not received his mental health medication. This was discussed at a multidisciplinary team meeting that day. It was noted he was waiting for a GP review to assess his need for mental health support and, in the meantime, staff could use the suicide and self-harm process if they had concerns that he might harm himself.
37. On 14 January, Mr Cathorne told a prison GP that he had been experiencing hallucinations, and hearing voices, which were telling him to harm himself and others. The GP referred Mr Cathorne to a psychiatrist, to consider antipsychotic medication. He did not start ACCT procedures.
38. On 19 January, a psychiatrist assessed Mr Cathorne who said that he had been hearing the voice of his dead father. He said that he had previously cut his wrists when he felt upset but had found the counselling service at Chelmsford helpful during a previous sentence. The psychiatrist diagnosed substance abuse and possible psychosis. He advised Mr Cathorne against taking illicit drugs, prescribed quetiapine, and arranged to see him again in six weeks.
39. Between 22 January and 13 April, mental health nurses reviewed Mr Cathorne three times. Each time, Mr Cathorne said he had no thoughts or intentions of self-harm. They considered him mentally stable, although on 19 February he reported hearing voices. The psychiatrist saw Mr Cathorne on 2 March and noted he was more relaxed and hearing voices less frequently.

40. On 13 April, a psychiatrist and a mental health nurse reviewed Mr Cathorne's mental health. Mr Cathorne said that his medication had not been working as well as previously; the voices had returned, and he had self-harmed by cutting himself in the last two weeks. (There is no record that he had reported this self-harm.) The nurse recorded that Mr Cathorne had no current thoughts or intent to harm himself, and there was no evidence of depression or anxiety. The psychiatrist increased his dose of quetiapine from 50mgs to 100mgs daily. The nurse said she did not inform any other staff that Mr Cathorne had reported recent self-harm, or consider beginning ACCT monitoring, as she had no concerns about how he presented at the time.
41. At four mental health reviews between 16 April and 30 May, nurses noted that Mr Cathorne's mental state was normal. He told them he had felt better since the increase in his medication and had no current thoughts of suicide or self-harm. He was attending art classes, and had a good relationship with other prisoners on the wing. In April, wing staff recorded that Mr Cathorne had made an effort to engage with his drug-testing compact, and had shown a good attitude.
42. A SO said that on 30 May, staff told Mr Cathorne that as he was not taking medication to treat substance misuse problems he needed to move wings to make space for a new prisoner with treatment needs. Mr Cathorne became argumentative about this and lunged at him. Staff restrained him and took him to the segregation wing, where a nurse later assessed him. He told the nurse that he had refused to move from E Wing, as he had problems with some prisoners on another wing. He also said that he was happy in a single cell and did not want to share. He said that he had no thoughts of suicide or self-harm, and would speak to staff if he felt stressed. The nurse recorded that Mr Cathorne was medically fit for segregation.
43. Mr Cathorne was placed on a violence reduction compact. Prisoners on such compacts are monitored for twenty-eight days, with weekly reviews to check their progress. They are placed on a basic regime (the lowest level of the prison's privileges scheme), and lose privileges, such as additional visits, extra time out of cell and a television. Where possible, prisoners on basic are located in shared cells. Mr Cathorne told an officer that he felt at risk if he moved because of a long-running feud in the community with two prisoners who were on C Wing. In view of this, staff moved him to B Wing.
44. On 4 June, a psychiatrist and a nurse assessed Mr Cathorne. He told the psychiatrist that he would prefer to be in a single cell, but had no other issues and no thoughts of suicide or self-harm. The psychiatrist noted that Mr Cathorne should continue with his current medication and he would review him in 10-12 weeks. A violence reduction review on 6 June, recorded that Mr Cathorne was polite and compliant, with no negative entries from staff. To recognise his positive behaviour, staff allowed Mr Cathorne a television in his cell, on the understanding that it would be removed if his behaviour deteriorated.
45. On 8 June, during a routine check, officers discovered a bottle of fermenting liquid (hooch) hidden in the cell occupied by Mr Cathorne and another prisoner. Mr Cathorne denied any knowledge of it and his cellmate admitted responsibility. However, staff removed the television.

46. On 10 June, Mr Cathorne told a mental health nurse that his partner had recently given birth to their daughter and he was looking forward to meeting her. He said he had not thoughts of harming himself and she considered him mentally stable.
47. On 11 June, staff informed Mr Cathorne that his baby was unwell. As a precaution, staff started ACCT procedures and checked him hourly. An officer assessed him on 12 June as part of the ACCT process. Mr Cathorne spoke positively about his future. He said that he was stable on his medication and had a good support network, within and outside prison. The officer recorded that potential triggers for him harming himself were the anniversary of his father's death on 17 October, his father's birthday on 11 June, and his ill child.
48. After the assessment, a SO and an officer held the initial ACCT case review. No other staff attended, although national instructions require multidisciplinary attendance and healthcare staff to attend at least first ACCT case reviews. Mr Cathorne said that he did not intend to harm himself. He said he had been concerned about his baby, but had now spoken to his partner, and everything was all right. He was looking forward to seeing his daughter for the first time at the weekend. The SO assessed Mr Cathorne's risk as low and ended the ACCT procedures. He said that he did not know that it was mandatory for a member of healthcare to attend the initial case review, so had not invited anyone.
49. On 16 June, Mr Cathorne was sentenced to 21 months in prison. The clinical team manager spoke to him when he got back from court and he told her that he had expected to go home. Despite this, she recorded that he was in good humour and had no thoughts or intentions of suicide or self-harm.
50. Just before 8.00pm that evening, Mr Cathorne tried to hang himself by a ligature attached to his cell window. His cellmate saw him, held his body up, and called for help. Officers called a medical emergency code one (which indicates circumstances such as when a prisoner is unconscious or not breathing). There is no record of whether an ambulance was called. Healthcare staff went to Mr Cathorne's cell and saw him on his bed talking to an officer. They spoke to him for around 15 minutes and he told them he found it difficult being in a cell with no television or tobacco and nothing to focus on. Staff began ACCT procedures again and staff were required to observe him at least every half hour until he could be assessed the next day. Mr Cathorne was given a TV, to help occupy him for the remainder of the night.
51. The next day, an officer assessed Mr Cathorne and noted that he had just been sentenced and had other charges pending. Mr Cathorne said he had tried to hang himself as he was missing his daughter. He said that he had previously attempted suicide, both in and out of prison. He felt contrite and said he had not thought about the effect on his partner or baby, and needed to be more positive. He said he had no current thoughts or intent to self-harm again and the officer recorded potential triggers as Mr Cathorne's sentence, as he had a further outstanding charge.
52. A SO and an officer then held an ACCT case review. No healthcare staff attended. The SO assessed Mr Cathorne's risk as low. He noted two actions on the ACCT caremap, for Mr Cathorne to apply for a prison job and to progress from the basic regime level. Observations were set at hourly.

53. On 20 June, a SO completed a violence reduction review with Mr Cathorne. He reinstated his access to television and association, but his access to the canteen (the prison shop) was still restricted. The officer told him that any further negative behaviour would result in a return to the basic regime.
54. A SO and a wing officer held an ACCT case review on 22 June. No healthcare staff or mental health staff were present. The SO noted that Mr Cathorne had applied for work and had moved from the landing for basic prisoners. He said he had no thoughts of suicide or self-harm and the SO closed the ACCT. A mental health review on 24 June, noted Mr Cathorne was calm and settled. On 3 July, the SO held an ACCT post-closure review and identified no further problems.
55. On 4 July, a prison GP assessed Mr Cathorne as staff were concerned about him. An officer told the doctor that Mr Cathorne had been lethargic for two days and the doctor recorded that Mr Cathorne appeared to have taken an overdose of medication. The GP reduced Mr Cathorne's medication and booked an appointment with the psychiatrist.
56. Later that afternoon, a nurse reviewed Mr Cathorne and noted he remained very vacant, although he was able to speak to her. She advised officers to notify healthcare staff if there were any changes in Mr Cathorne's presentation. At 2.00pm on 5 July, wing staff asked her to see Mr Cathorne again. She noted that he appeared 'spaced out' and there was no change when she reviewed him again at 3.00pm. Mr Cathorne denied taking any illicit substance. Nurses planned to continue monitoring him in the evening.
57. At 6.36pm, officers found Mr Cathorne unresponsive on his cell floor. Nurses monitored him until paramedics arrived and took him to hospital. Wing staff discovered a pouch of tobacco, containing what they believed to be 'Spice', a synthetic form of cannabis, or new psychoactive substance (NPS).
58. Mr Cathorne's cellmate at the time told the investigator that Mr Cathorne had smoked some Spice on 5 July and that this was not unusual, as prisoners at Chelmsford generally smoked it 'casually'. He knew that Mr Cathorne was troubled and had mental health problems. He saw no indication that anyone was bullying him.
59. Mr Cathorne remained in hospital overnight, but refused to say what he had taken. On 7 July, a nurse warned Mr Cathorne about the risks of using illicit drugs. He said that he was fully aware of the risks and would not use spice again. He told the nurse that he felt mentally fit and had no intention of harming himself. Because he was suspected of using a new psychoactive substance, Mr Cathorne was demoted to the basic regime again for 28 days.
60. On 10 July, Mr Cathorne told a mental health nurse that since the GP had reduced his medication, it was less effective. The nurse arranged a medication review. Mr Cathorne said he had no thoughts of harming himself.
61. At 7.30pm on 14 July, Mr Cathorne pressed his cell bell and told an officer that he needed to speak to a Listener (a prisoner trained by the Samaritans to offer peer support) or someone from the mental health team, as 'his head was all over the place'. An officer, a nurse and other wing staff spoke to him. He had made

superficial cuts to his arms and staff began ACCT procedures, with hourly checks. Mr Cathorne said that his relationship had broken down, as he had missed a visit from his partner and baby daughter while he was in hospital suffering the effects of using spice. Mr Cathorne said he felt better after speaking about his feelings.

62. On 15 July, an officer assessed Mr Cathorne and noted that he appeared reasonable and articulate, had plans for the future, and a supportive family. Mr Cathorne said that he suffered from paranoia and overreacted to stress, which had led to his self-harm. He said that since he had overdosed on Spice, he had felt unstable and struggled to cope when he was in crisis. The officer noted the trigger for Mr Cathorne's self-harm, was not speaking to his partner. After the assessment, he appeared calm and said he did not intend to harm himself. The officer suspected that Mr Cathorne used NPS more frequently than he had admitted.
63. A SO then held an initial ACCT case review. He noted that the officer had given a verbal handover. The SO assessed Mr Cathorne's level of risk as low and the only issue on the caremap was his need for work or education to keep active. The SO told the investigator that healthcare staff did not usually attend the first case review, and he had not invited them or sought any input from them.
64. On 20 July, Mr Cathorne asked a psychiatrist to increase his dosage of quetiapine. He said he was hearing voices, including that of his father and a female voice. He appeared slightly distressed, but said he had no thoughts of suicide or self-harm. The psychiatrist increased Mr Cathorne's dose of medication to help stabilise his mood. The psychiatrist told the investigator that Mr Cathorne had several diagnoses, including drug-induced psychosis (he had previously been a cocaine and heavy cannabis user) and emotionally unstable personality disorder, which is characterised by hearing voices, self-harm and difficulty controlling emotions.
65. At an ACCT case review on 22 July, Mr Cathorne said he had no intention of harming himself. A nurse reviewed him the next day. He said he had reflected on his use of Spice and would not use it again. He told the nurse that no one was bullying him and he was not in debt.
66. On 25 July, Mr Cathorne's new cellmate told staff that he was concerned about Mr Cathorne's mental well-being. Officers recorded that Mr Cathorne had made threats of violence towards other prisoners on another wing, connected with the breakdown of his relationship with his partner.
67. On 26 July, the clinical team manager reviewed Mr Cathorne, who said that he felt well in himself, but wanted an increase in his medication as he felt it was not working effectively. She suggested that he might benefit from admission to the prison's inpatient unit, to assess his medication level, but Mr Cathorne refused. Later that day, he changed his mind and moved to the inpatient unit at around 7.30pm. Shortly afterwards, he flooded his cell because he did not have a kettle. Staff charged him with a disciplinary offence, but he remained in the inpatient unit.
68. On 27 July, Mr Cathorne told a prison GP that he believed another prisoner was in a relationship with his partner. He felt depressed but said he was not suicidal. Later that afternoon, he told a psychiatrist that he was angry that his relationship had ended. He said he had no thoughts of harming himself, but threatened to

assault the other prisoner. He refused counselling and anger management. The psychiatrist decided that Mr Cathorne should continue with his existing medication. He considered that there was no reason for him to stay in the impatient unit and he moved back to B Wing later that afternoon.

69. At 12.15pm on 29 July, the cellmate told staff that Mr Cathorne had tried to set fire to his trousers with a cigarette lighter. He had been on the top bunk at the time and had jumped down, grabbed the lighter out of his hand and banged on his leg to stop his trousers burning. He said that although there was a big age difference between them, they got on well initially and Mr Cathorne had seemed reasonably level headed, but over a period of days he changed and appeared very angry and aggressive, which is why he had reported his concerns to staff about his mental health. He thought that this was related to his relationship breakdown. He said that other prisoners had told him that Mr Cathorne used Spice heavily but he had never seen him smoke it in the few days they shared a cell.
70. Staff moved the cellmate, who said he could no longer share with Mr Cathorne and moved Mr Cathorne to a single cell. He gave no reason for setting alight his trousers and staff concluded he was a high risk for sharing a cell. A nurse assessed Mr Cathorne, and attended an ACCT case review, where the review panel assessed his risk of suicide and self-harm as high and increased the frequency of observations from two conversations a day and hourly observations during patrol state (when prisoners are locked in their cells), to every 30 minutes.
71. The next day, a SO and a wing officer held an ACCT case review. No member of healthcare staff attended. Mr Cathorne said that family issues had got the better of him the previous day. He said that he was finding life hard, but felt better than the previous day and he would talk to wing staff if he was stressed. The SO recorded his risk of suicide and self-harm as low and reduced the frequency of observations from two to one an hour.
72. On 3 August, staff reinstated Mr Cathorne to the standard regime, so he had a television, was able to mix with other prisoners during association periods and have more visits. A SO held an ACCT case review the next day with another SO. No healthcare staff were present and he did not recall seeking their advice. He recorded that Mr Cathorne was much happier, his issues had been resolved, and he was looking forward to a visit from his partner later that week. He said he had no thoughts of suicide or self-harm, and the staff ended the ACCT monitoring.
73. At mental health reviews on 13 August and 1 September, Mr Cathorne said he had no thoughts of harming himself. Officers noted in his prison record that he mostly kept to himself, associated with only a few other prisoners and spoke to staff about any problems.
74. On 8 September, a nurse reviewed Mr Cathorne's mental health and noted that he appeared to be under the influence of an illicit substance. His speech was slurred, his eyes were red, and he laughed continuously. The nurse asked him whether he had taken anything, but he just said that he was fine. The nurse told wing staff and reported it to the security department. There is no evidence that any one took any action in response.

75. On 20 September, an officer recorded that he was always polite and compliant. He had showed her letters he had written to his partner and said that he wanted to work things out with her after he was released. She told the investigator that Mr Cathorne was sometimes quite withdrawn and selective about who he would speak to. She said that some of his visits with his partner did not go too well. She knew that he had previously used Spice, but had not personally noticed any obvious signs of illicit drug use.
76. On 30 September, Mr Cathorne told a mental health nurse that things were going well. On 1 October, after a visit from his partner, staff searched Mr Cathorne as he was leaving the visits hall and found two greeting cards. Officers told him that, for security reasons, they would have to check the cards before he could take them onto the wing. He became aggressive and abusive, destroyed the cards, and threw them in a bin.
77. On 3 October, an officer saw Mr Cathorne speaking to other prisoners. She thought he appeared all right. At around 7.30pm, as she was walking past his cell, he asked her for some writing paper. She got some from the office, and passed it under Mr Cathorne's cell door. She said that Mr Cathorne did not appear upset and she had no concerns about him.
78. At 5.45am, on 4 October, two operational support grades (OSG), who were the night patrol officers on B Wing, began the early morning check of prisoners. OSG A said that at around 5.50am, she looked through Mr Cathorne's observation panel, and thought that she saw him standing at the back of his cell. He did not respond to her and she could not see him moving, so she asked her colleague to check with his torch. OSG B then saw that Mr Cathorne was hanging and immediately radioed a medical emergency code one.
79. OSG B said that within 10 to 15 seconds, two other operational support staff arrived. He said he did not feel comfortable going into the cell, as neither he nor the other three staff present had been in that situation before. Although they could have cut the ligature, none of them were first aid trained. They decided to wait for the night manager to arrive.
80. The night manager told the investigator that, at approximately 5.55am, he heard a code one call on B Wing. He and an officer responded immediately, while another officer went to bring a nurse from the healthcare centre. He estimated that it took less than a minute to get to B Wing, where he saw the operational support staff standing outside Mr Cathorne's cell. He and the officer immediately went into Mr Cathorne's cell.
81. Mr Cathorne had hanged himself from a ligature made from torn bedding, tied to the window bars. The officer cut the ligature and he and the night manager lifted him onto the landing, where there was more room. The night manager described Mr Cathorne as rigid. He could detect no breathing or a pulse so he started cardiopulmonary resuscitation and contacted the communications room to ask for an ambulance.

82. Nurses arrived shortly after the code one call, with emergency medical equipment. They were unable to insert an airway as Mr Cathorne's jaw was locked, due to rigor mortis. A nurse attached the defibrillator, which found no shockable heart rhythm.
83. The ambulance log indicates that they received the call from Chelmsford at 5.58am, and arrived at the prison at 6.02am. The paramedics arrived at the cell at 6.07am and found that Mr Cathorne had no pulse, his pupils were dilated, his skin discoloured and rigor mortis was present. Almost immediately, at 6.08am, they recorded that Mr Cathorne had died.
84. Mr Cathorne left several letters addressed to his partner and others. He wrote about his hurt from problems in his relationship and his love for his family and gave some instructions about his funeral.

Contact with Mr Cathorne's family

85. A SO acted as Chelmsford's family liaison officer. He and a prison manager went to see Mr Cathorne's partner at 9.00am on 4 October, informed her of his death and offered condolences and support. They agreed to inform Mr Cathorne's brother and bring him back to her home for support. The SO went to see them again the next day and returned Mr Cathorne's property. Mr Cathorne's partner and other family members visited the prison on 6 October. In line with national policy, the prison contributed towards funeral costs.

Support for prisoners and staff

86. After Mr Cathorne's death, a prison manager debriefed the staff involved in the emergency and offered his support and that of the staff care team. The chaplaincy team supported the other prisoners on B Wing. Staff reviewed all prisoners assessed as at risk of suicide and self-harm and offered additional support where required.

Post-mortem report

87. The coroner confirmed that the cause of death was hanging. Toxicology tests revealed no illicit drugs or medication. Tests for NPS were not initially completed, although we understand that the Coroner has now requested these.

Findings

Assessment of risk of suicide and self-harm in reception.

88. When Mr Cathorne arrived at Chelmsford in January 2015, he had a number of risk factors for suicide and self-harm, which are outlined in Prison Service Instruction PSI 64/2011 (Safer Custody). He had a long history of mental health problems and drug misuse, he had previously attempted suicide by overdose, cutting and hanging, and he had arrived at the prison with a suicide and self-harm warning form and an assessment from a psychiatric nurse.
89. In December 2014, Chelmsford gave reception officers additional guidance arising from PPO concerns that previous investigations had found that reception staff were not identifying risk factors when new prisoners arrived. Our recent Learning Lessons Bulletin, published in February 2016, also drew attention to the need for better risk assessment in prison receptions.
90. Despite his risk factors, staff said that they were reassured by Mr Cathorne's calm mood and his responses to questions. It is not clear how they balanced his risk factors against his presentation and we are concerned that they did not take into account all the available information, as none of the reception or first night staff appear to have seen the community psychiatric report or the suicide and self-harm warning form. Although the information seems to have bypassed reception, it reached the safer custody team as a SO, the manager of the induction unit, was asked to speak to Mr Cathorne the next day. He had not seen the nurses' report or the suicide and self-harm warning form, so he did not have the full information to assess his risk of suicide and self-harm and did not ask Mr Cathorne about the issues raised.
91. Irrespective of the community psychiatric nurse's court report and the suicide and self-harm warning, it might have been prudent for staff to have opened an ACCT when Mr Cathorne arrived at the prison, based on his existing risk factors. We accept that staff used their judgement based on their experience and skills, but there is no record why they discounted his risk factors in favour of his presentation.
92. Prison Service Instruction (PSI) 07/2015, about early days in custody, sets out mandatory reception procedures and requires reception staff to examine the PER that must accompany each new prisoner, and any other available documentation to identify any immediate needs and risks already recorded. As no one in reception saw or read the community psychiatric nurse's report or the suicide and self-harm warning, we do not consider that the prison complied with this instruction. We make the following recommendation:

The Governor should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with suicide and self-harm warning forms, they should clearly record the reasons.

Subsequent assessment of risk

93. While it is a concern that staff in reception did not consider all the information about Mr Cathorne's risk, we recognise that he died some months later and better assessment of his risk in reception would not have prevented his death. He was subsequently identified as at risk of suicide and self-harm on three separate occasions and managed under ACCT procedures. We have some concerns about the procedural management of the ACCT process, which we set out below, but we consider that at the time of his death, there was little to indicate to staff that Mr Cathorne was at high or imminent risk of suicide.
94. The clinical reviewer noted that risk assessment and management of patients with emotionally unstable personality disorder can be problematic. (Mr Cathorne had been diagnosed with this disorder, which is also sometimes known as borderline personality disorder.) Although the risk of suicide in the short term is often correctly assessed as being low, the long-term risk is much higher.
95. We consider that Mr Cathorne's history of suicide attempts and mental health problems would suggest that he was always a long-term risk. However, we do not consider that prison staff could have identified that Mr Cathorne was at high or imminent risk of suicide immediately before his death and we do not consider they could have been expected to foresee or prevent his actions on 4 October.

Assessment, care in custody and teamwork (ACCT)

96. Mr Cathorne was monitored under ACCT suicide and self-harm prevention procedures three times between June and August 2015. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible, involving staff from relevant departments and services. It is mandatory that a member of healthcare staff attends the initial case review, but this did not happen in any of Mr Cathorne's initial reviews. Only one of the other case reviews were multidisciplinary. Although Mr Cathorne was under the care of the primary care mental health team, staff who conducted his case reviews did not invite them to attend, or seek their views about his risk.
97. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. Caremaps 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 must be tailored to meet the individual needs of the prisoner, be aimed at reducing risk and be time bound.
98. Particularly after Mr Cathorne tried to hang himself on 16 June, we are concerned that staff did not assess his risk correctly and set appropriate caremap actions aimed at reducing his risk. Less than 24 hours after he had tried to hang himself, he was assessed as at low risk of suicide and self-harm and there is no evidence that case reviews considered his other risk factors. Mr Cathorne had said that his main concern was missing his baby daughter, yet the only caremap actions were about his getting a prison job and his incentives and earned privileges level in the

prison. Even then there is no evidence that staff followed these up and ensured that the caremap actions were complete before they ended ACCT procedures.

99. In July, staff began ACCT procedures again when Mr Cathorne cut himself. He said he was having relationship difficulties and had felt unstable since he had overdosed on spice. Again, staff assessed his risk of suicide and self-harm as low, just a day after he cut himself. The only caremap action was about getting activity in the prison. There was nothing about how to deal with his relationship problems or his substance misuse or mental health problems. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

- **A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.**
- **Case reviews assessing the risk of suicide or self-harm based on all available information and known risk factors and setting level of observations which reflect that risk.**
- **Setting effective caremap objectives, which are specific and meaningful, aimed at reducing risk and that ACCTs are not closed before all caremap actions have been completed.**

Emergency response

100. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The PSI makes it clear that the control room should call an ambulance immediately an emergency medical code is received and should not wait to be instructed to call one by a manager or member of healthcare staff at the scene. It notes that an ambulance can be cancelled if it is later assessed that it is not required.
101. Chelmsford issued an instruction about medical emergency response codes in May 2013, which included this requirement. After a PPO investigation into a death in March 2015, highlighting the need for control room staff to call ambulances immediately, the prison reissued it. According to the control room log, OSG B called the code one at 5.55am but the control room did not call an ambulance until four minutes later, at 5.58am.
102. One of the control room staff on 4 October told the investigator that the process at Chelmsford had previously been to call an ambulance as soon as control room received a code one call. However, due to unnecessary calls, this had changed and control room staff had to confirm the circumstances and the name of the prisoner before they make the call.
103. We are concerned that the practice at Chelmsford is still not in line with national instructions for emergency procedures, although we have drawn this to the prison's attention a number of times before. While in this case the delay made

no difference as it was evident that Mr Cathorne was already dead, in other cases such a delay could be critical. We repeat the following recommendation:

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

Resuscitation

104. The night manager said that when he carried Mr Cathorne out of the cell he was stiff. He did not consider it was his role to decide not to resuscitate him, so he began cardiopulmonary resuscitation. Despite the presence of rigor mortis, which indicated that Mr Cathorne had been dead for some time, nurses continued to attempt resuscitation when they arrived.
105. We consider that it was not necessary to attempt to resuscitate Mr Cathorne. European Resuscitation Council Guidelines 2010 state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...” The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be based on a careful assessment of each individual’s situation. Decisions should never be dictated by ‘blanket’ policies.
106. We understand that the natural inclination of prison and healthcare staff is to begin emergency first aid by giving life support, but attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison and healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

New Psychoactive Substances

107. Mr Cathorne admitted using Spice, a new psychoactive substance (NPS), and was taken to hospital on 5 July 2015, after suffering an adverse reaction. A psychiatrist told the investigator that any use of NPS, would potentially undo the benefits of anti-psychotic medication, which had been prescribed to stabilise Mr Cathorne’s mood. We do not know the extent of Mr Cathorne’s use of NPS, and they were not the subject of toxicology tests. No other illicit drugs were found in his system at the time of death.
108. During the investigation, prison and healthcare staff told us that the use of NPS at the prison had led to a number of hospital admissions and violent incidents. At a full staff briefing on 22 December 2014, the then Governor gave staff information about NPS and, on 8 July 2015, she shared our learning lessons bulletin. She published two notices to prisoners in July and August 2015, highlighting the dangers of using NPS and information relating to a bad batch of

NPS. We are satisfied that Chelmsford has identified the scale of the problem, and is taking steps to deal with it. We therefore make no recommendation about this issue.

Clinical care

109. The clinical reviewer noted that Mr Cathorne had been diagnosed with emotionally unstable personality disorder, which has no cure and is difficult to treat. It has to be managed as a long-term condition. He was satisfied that the care Mr Cathorne received from the mental health team at Chelmsford was essentially in line with National Institute for Health and Care Excellence (NICE) guidelines for managing such long term conditions, but noted that Mr Cathorne did not have an up to date care or risk management plan. He had made a recommendation about this, which the Head of Healthcare will need to address. Overall, he considered that Mr Cathorne's care was equivalent to that he could have expected to receive in the community.

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