Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marc White a prisoner at HMP Chelmsford on 28 September 2016

A report by the Prisons and Probation Ombudsman
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To carry out independent investigations to make custody and community supervision safer and fairer.

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We are:

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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.

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

Mr Marc White was found hanged in his cell at HMP Chelmsford on 28 September 2016. He was 20 years old. I offer my condolences to Mr White's family and friends.

It is clear that Mr White had a number of risk factors for suicide and self-harm and was vulnerable to bullying. However, staff do not appear to have been sufficiently alert to the risks he presented. Nor did staff record all relevant information, review security intelligence, or put in place suitable violence reduction arrangements   In particular, they should have considered more fully Mr White's risk of suicide when he and his cellmate said that they were having suicidal thoughts.

On the day he died, Mr White was not checked as he should have been after he had been locked in his cell for the night. It is unacceptable that staff recorded that this check had been completed when it had not been carried out.

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 **June 2017**

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Summary

Events

1. On 14 July 2016, Mr Marc White arrived at HMP Chelmsford charged with theft from a motor vehicle. It was his first time in prison. Mr White did not provide contact details for his next of kin when he arrived at Chelmsford.

2. At his health screen interview, medical staff recorded that, in March 2016, Mr White had previously tried to take his life after his relationship with his girlfriend ended. Staff decided he did not need to be supported by suicide and self-harm prevention procedures (ACCT).

3. On 22 September, the C wing manager moved Mr White and his cellmate to B wing as it was suspected that they were being bullied.

4. On 25 September, Mr White handed a letter to staff asking to move wings again as he and his cellmate were being bullied and he had had suicidal thoughts. The B wing manager told them that their request would be considered. He did not, though, start ACCT procedures as Mr White subsequently denied any thoughts of suicide or self-harm.

5. On 27 September, Mr White's cellmate moved to another cell to share with a friend. Mr White found out about the move when he returned to their cell in the late afternoon. Mr White was left alone in the cell.

6. During the afternoon of 28 September, Mr White asked the B wing manager if he could talk to him. He told Mr White he would speak to him the next day as he had limited time. At around 4.15pm, Mr White was locked in his cell after he had collected his evening meal. A roll check was supposed to take place at around 5.30pm. An officer recorded that he had checked all the prisoners on the landing but he had not in fact done so.

7. During the evening of 28 September, the night patrol officer carried out a routine check of prisoners and found Mr White had obscured the observation hatch in his cell door. The night patrol officer returned with another colleague and they opened the cell door. They found Mr White hanged in his cell. Staff went into Mr White's cell and tried to resuscitate him. An ambulance was called, but, at 9.00pm, paramedics recorded that Mr White had died.

Findings

8. We found that staff did not consider starting ACCT procedures in line with policy when Mr White expressed suicidal thoughts in a letter to staff. Even though staff subsequently spoke to Mr White and he expressed no suicidal intentions, staff should have considered the full range of Mr White's risk factors and considered placing him on ACCT procedures to address his risk of suicide.

9. Mr White told staff on two occasions in September that other prisoners were bullying him and his cellmate for a debt. Although steps were taken to move him from those who posed a threat, we found that the systems designed to identify

risks of bullying were not sufficiently joined up and, as a consequence, he was not adequately supported in line with the prison's violence reduction strategy.

10. Mr White was discovered hanging in his cell at 8:27pm. A member of staff failed to carry out a roll check at 5:30pm on the day of Mr White's death.

Recommendations

- The Governor should ensure that staff:
  - Understand, consider and record all the known risk factors for suicide and self-harm.
  - Start ACCT procedures whenever a prisoner has recently self-harmed, expressed suicidal intent or has significant risk factors.
  - Should clearly record the reasons when, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors.
- The Governor should ensure that:
  - All information about bullying and intimidation is fully coordinated and investigated.
  - Those suspected of involvement are appropriately challenged and monitored.
  - Staff consider whether victims are at increased risk of suicide or self-harm.
  - Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.

The Investigation Process

11. 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.

12. The investigator visited Chelmsford on 4 October 2016. He obtained copies of relevant extracts from Mr White's prison and medical records.

13. NHS England commissioned a review of Mr White's clinical care at the prison.

14. The investigator interviewed 12 members of staff and one prisoner at Chelmsford. He wrote to four prisoners to ask if they would agree to be interviewed for the investigation. Three prisoners did not respond and one prisoner declined to be interviewed. At the initial report stage, HM Prison and Probation Service (HMPPS) responded to the recommendations.

15. 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.

16. One of the Ombudsman's family liaison officers contacted Mr White's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any issues. Mr White's parents received a copy of the initial report. They did not make any comments.

Background Information

HMP Chelmsford

17. 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

18. HM Inspectorate of Prisons most recently inspected Chelmsford in April 2016. Inspectors reported that 20% of prisoners, a similar proportion to that at other local prisons and at the time of the previous inspection, said that they currently felt unsafe. Recorded levels of bullying, assaults and fights had increased sharply and were all far higher than at similar prisons. Inspectors reported that few incidents were serious and most took place on the older wings (B and C wings) with drugs and debts being cited as the main cause. A number of actions had been taken to make the prison safer but there was a lack of a coordinated and strategic approach.

Independent Monitoring Board

19. Each prison 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 latest annual report for the year to August 2016, 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 fallen by over five per cent from the previous year and that actual incidents of self-harm had also reduced.

Previous deaths at HMP Chelmsford

20. Mr White was the fifth prisoner to take his life at Chelmsford since the beginning of 2015. In other recent investigations, we were concerned about poor assessment of risk of suicide.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. On 14 July 2016, Mr Marc White was remanded to HMP Chelmsford. He was charged with theft from a motor vehicle. This was his first time in prison. Escort staff wrote on his Person Escort Record (PER, which accompanies all prisoners when they move between police stations, courts and prisons) that Mr White had a history of anxiety and depression. A nurse completed Mr White's health screen. The nurse recorded that Mr White had tried to take his life when he broke up with his girlfriend (in March 2016). The nurse recorded that Mr White was "communicative, cheerful and cooperative". He "strongly" denied any thoughts of suicide or self-harm. The nurse made a referral to the mental health team who decided that Mr White should remain under the care of the prison GP for a review of his mood and medication.

23. Mr White saw a prison GP after his health screen. The GP recorded that Mr White had a history of anxiety and depression. He prescribed an antidepressant (citalopram).

24. At around 8.15pm, an officer completed a security intelligence report about Mr White. He recorded that Mr White might have issues with two prisoners who he had known in the community. The intelligence indicated that one of the prisoners believed that Mr White gave information about him to the police. There was no further intelligence to suggest what the issues were with the other prisoner.

25. During the morning of 15 July, information drawn from the police national computer indicated that Mr White had taken an overdose in March 2016. A business administrator from the safer custody team at Chelmsford emailed this information as part of the process where supervising officers speak to new prisoners to assess their risk of suicide and self-harm. Around midday, a supervising officer (SO) responded and confirmed he had spoken to Mr White and there were no concerns to report.

26. On 18 July, Mr White saw a reducing reoffending officer. He recorded that Mr White had substance misuse problems (he had used cocaine, cannabis and alcohol). Mr White told him he had experienced a mental breakdown in early 2016 through stress caused by his court case and the break up from his girlfriend. He said he had tried to take his life and went into hospital for four days. Mr White's parents picked him up from the hospital but they had an argument in the car. He said he "lost it" and kicked their door down. Mr White said that before this his relationship with his parents had been good. They had now put in place a restraining order against him. Mr White admitted to having a short temper and being very impulsive.

27. On 22 July, an officer saw Mr White for a violence reduction interview to follow up the information recorded in a security intelligence report on 14 July that Mr White might have issues with two prisoners who he had known in the community. Mr White told the officer that another prisoner believed that he had told the police about a burglary he may have committed. The officer recommended as part of the violence reduction process that Mr White was not to associate, attend visits or work with the prisoner. This information was not recorded on Mr White's

prison record or in his security record. On the same day, Mr White refused to move to B wing. He was placed on a disciplinary charge.

28. On 23 July, Mr White attended a disciplinary hearing. Mr White saw a nurse before his hearing. The nurse recorded that he was calm and displayed appropriate behaviour. Mr White denied any thoughts, plans or intent to self-harm.

29. The adjudicator at the disciplinary hearing said that Mr White had told her he had refused to move because there was a prisoner on B wing who had a problem with him. She asked a colleague to check if the prisoner was still on B wing. Her colleague confirmed the prisoner was still on B wing. She asked Mr White whether he would agree to move to C wing which he did. She recorded this information in Mr White's prison record but did not complete a security intelligence report. She found Mr White guilty of disobeying a lawful order. His punishment was to lose his television and the opportunity to mix with other prisoners during association periods and to be confined to his cell for seven days (but this was suspended for a month).

30. On 1 August, Mr White moved to C wing where he saw a prison GP who recorded that Mr White was doing well and had no complaints. Mr White's prescription for citalopram was repeated.

31. On 22 August, Mr White attended court and was remanded to Chelmsford again. A nurse saw Mr White after he returned from court. The nurse recorded that Mr White looked fit and well. He denied any thoughts of suicide or self-harm.

32. On 6 September, Mr White's prescription for citalopram was repeated but there is no record that he collected his medication.

33. On 9 September, an officer recorded that Mr White had had a quiet week. He recorded that Mr White interacted positively with staff and other prisoners. The officer recorded that he had spoken to Mr White on numerous occasions and each time he was pleasant and polite. He recorded that Mr White kept to himself and was content with his small circle of friends.

34. On 13 September, Mr White moved into a cell shared with another prisoner. There was no reason recorded for the cell move.

35. On 17 September, an officer completed a security intelligence report about Mr White. He recorded that Mr White and his cellmate might have issues with two prisoners who were both located on the landing below. The intelligence indicated that the two other prisoners might be bullying Mr White and his cellmate. The investigator wrote to the two prisoners who were suspected of being the bullies. One declined to be interviewed and the other did not respond.

36. In her statement, the C wing manager (a SO), said that she was told by a member of staff that Mr White and his cellmate were in debt and they feared for their safety. She did not record any information about Mr White being in debt or being in fear for his safety in his prison record or the wing observation book. Mr

White told the SO that the debt was for tobacco but would not name the person to whom he was in debt. The SO told Mr White and his cellmate she would arrange for them to move to another wing. She arranged for staff to ensure their safety by unlocking them separately from other prisoners until they moved to another wing. The SO said that neither Mr White nor his cellmate expressed any thoughts of self-harm. On 22 September, Mr White and his cellmate moved to B wing despite Mr White having been disciplined for refusing to move to B wing previously.

25 September 2016

37. On 25 September, the B wing manager (a SO), received a joint letter from Mr White and his cellmate. They wrote that they were in fear for their lives and that they wanted to move to F wing with vulnerable prisoner status. They wrote that the matter was not being taken seriously, as they had already spoken to staff and no action had been taken. Mr White wrote that he had mental health issues and both he and his cellmate were having “serious suicidal thoughts”. They asked not to be unlocked for either association or exercise as they did not want to associate with the rest of the wing population. At interview, the SO said he did not look at the letter until the next day.

38. On the same day, an officer completed a security intelligence report about Mr White. She recorded that intelligence suggested that he was being bullied on the landing and wanted to leave the wing.

26 September 2016

39. On 26 September, the B wing manager saw Mr White and his cellmate in their cell. They told him that a debt had followed them from C to B wing and they were being threatened by unknown prisoners. In his statement, the SO recorded that neither prisoner mentioned thoughts of suicide or self-harm. The SO explained that arranging another move would be difficult and it would take time to look into the available options. He contacted the custodial manager (CM) for E, F and G wings for advice. The CM advised the SO to look into ‘own protection’ as the vulnerable prisoner spaces were limited and also used for sex offenders. The SO did not make an entry about Mr White’s possible vulnerability in his prison record and did not complete a security intelligence report. He recorded in the wing observation book that Mr White and his cellmate were having problems with unknown prisoners and had asked to move to another wing. The SO took no further action on 26 September and was not on duty on 27 September.

27 September 2016

40. During the afternoon of 27 September, Mr White’s cellmate moved out of the cell he shared with Mr White to move in with a friend located on another floor of B wing. He told the investigator he moved cells because of problems associated with Mr White’s debt. He said prisoners had taken property from their cell. He said Mr White had inherited the debt from his previous cellmate on C wing and he was being affected by it. He did not tell Mr White the real reason he moved and instead said that the officers had decided to move him. Mr White’s former

cellmate saw Mr White around the wing after he moved but he did not speak to him again before his death.

28 September 2016

41. On the morning of 28 September, an officer noted in the NOMIS prison record system that since Mr White moved to B wing, he had not brought himself to the attention of staff. This was the last record made prior to Mr White's death. (The previous entry had been made on 9 September by another officer.) She recorded that she had not recently worked on Mr White's landing but staff were keeping an eye on him as he was quiet and appeared vulnerable compared to the other prisoners located on B2 landing. The officer told the investigator she was not working on B wing when she recorded her entry in Mr White's records and did not see Mr White that day. The officer described her entry as a summary of Mr White's time on the wing. She said that neither staff nor prisoners raised any concerns with her about Mr White being at risk of suicide or self-harm. The officer told the investigator she could not remember if she was told about other prisoners bullying Mr White and his cellmate.

42. In the late afternoon, the B wing manager saw Mr White returning from work which he felt was a positive sign since he had begun to come out of his cell again. Mr White asked the SO if he could speak to him later but the SO said that he would not have time that evening due to the time it took to feed the wing but that he would be speak to him the next day. As he had been absent from the wing, the SO did not know that Mr White's cellmate had moved out of their shared cell and that Mr White was now alone in his cell. The SO told the investigator that Mr White did not tell him that he had any thoughts of suicide or self-harm on either 26 September or 28 September.

43. At around 4.15pm, Mr White collected his evening meal and an officer then locked him in his cell. The same officer was supposed to complete a roll check on Mr White's landing at 5.30pm. CCTV footage showed that the officer did not carry out the roll check even though he recorded the number of prisoners was correct. The Prison Service subsequently investigated the officer's actions and disciplinary action was taken.

44. During the evening roll check, at around 8.20pm, the night patrol officer found that Mr White had covered his observation panel with paper and did not respond when he was asked to remove it. The night patrol officer said he heard sounds of laughter from the cell and thought Mr White was playing up so he continued with his roll check. When he finished the roll check he went to the wing office and asked Officer A for help as he had not been able to check Mr White. At 8.25pm, Officer A banged on the cell door and because Mr White was still not responding, she radioed for additional staff support so that they could open the cell door. At 8,27pm, they were joined by Officer B. They entered the cell and found Mr White hanging from a ligature, made from bed sheets, attached to the window. Officer B lifted Mr White's body while Officer A cut the ligature.

45. According to the control room log, at 8.28pm, the night patrol officer radioed a Code 1 emergency (the local emergency medical code used when a prisoner is

unconscious or having difficulty breathing). Staff in the control room called an ambulance at 8.29pm.

46. Officer B told the investigator that he thought he heard a groan when he put Mr White on the floor so he began cardiopulmonary resuscitation. They were joined by Officer C and three nurses who attached a defibrillator to Mr White. The defibrillator did not shock and advised to continue resuscitation. At 8.39pm, paramedics arrived at Mr White's cell and took over his care. The paramedics assessed Mr White and continued resuscitation efforts. At 9.00pm, the paramedics recorded that Mr White had died.

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Contact with Mr White's family

47. Chelmsford did not have contact details for Mr White's mother who was his next of kin. Mr White had not provided contact details and he was estranged from his parents who he said had taken out a restraining order against him. During the evening of 28 September, the head of safety and a SO visited the last known address for Mr White's parents but found they no longer lived there.

48. Another SO was appointed as the prison's family liaison officer. The prison gave the police the addresses of Mr White's aunt and grandmother who had visited him in Chelmsford. When there was no response at Mr White's aunt's address, the police went to the grandmother's house. Mr White's grandmother then provided the police with Mr White's mother's contact details.

49. On 29 September, the prison's family liaison officer and a CM drove to the home of Mr White's parents and told them he had died. Mr White's mother explained that they had moved address around three weeks beforehand but had not shared their new contact details. The family liaison officer continued to support the family. The prison contributed to Mr White's funeral costs, in line with national instructions.

Support for prisoners and staff

50. A prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The prison's care team offered support.

51. The Governor issued notices to staff and prisoners informing them of Mr White's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr White's death.

Information received after Mr White's death

52. On 29 September, a construction tutor at Chelmsford completed a security intelligence report about Mr White. He recorded that he had overheard a discussion with the other learners in the workshop who were upset about Mr White's death. They claimed he was being bullied on B wing. The intelligence indicated that Mr White was a vulnerable and quiet prisoner who might have been targeted by bullies on B wing.

Post-mortem report

53. A post-mortem examination found the cause of Mr White’s death was suspension. The toxicology examination found evidence of Mr White’s prescribed medication (citalopram) in his body.

Findings

Identifying Mr White's risk of suicide and self-harm

54. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Mr White had a number of risk factors for suicide and self-harm including previous self-harm, a history of anxiety and depression, relationship difficulties (he was estranged from his parents and his relationship with his girlfriend had ended) and being a victim of violence or in fear of intimidation. This was also his first time in prison. There is no record that any member of staff considered all of the risk factors that applied to him.

55. PSI 64/2011 requires staff to start ACCT monitoring if they receive information or observe behaviour which may indicate a risk of suicide or self-harm. Mr White consistently denied thoughts of suicide and self-harm and there is no evidence that he self-harmed at Chelmsford. Yet, in a letter passed to a SO on 25 September about being in fear for his safety, Mr White wrote that both he and his cellmate were having "serious suicidal thoughts". The SO said that he did not start reading the letter until the next day and then decided to speak to Mr White and his cellmate. He said they both denied thoughts of suicide and self-harm. The SO told Mr White and his cellmate he would investigate whether they could be moved to another wing. He recorded in the wing observation book that Mr White and his cellmate wanted to move as they had "issues" on the wing. The SO did not record any information in Mr White's prison record about the contents of the letter or the action he intended to take.

56. Staff interviewed during the investigation consistently said they did not think Mr White was at risk of suicide or self-harm. Nevertheless, we consider that staff should have considered more thoroughly whether ACCT procedures should have been opened after Mr White informed them by letter that he was having suicidal thoughts due to being bullied and being in fear for his safety. It is also of concern that no one appears to have assessed the risk of leaving Mr White alone in his cell after his cellmate decided to move to a different cell.

57. The PPO has published a range of publications identifying the links between bullying and suicide, and we are concerned that prison staff did not seem to have recognised or considered that the bullying and intimidation Mr White experienced might have increased his risk of suicide and self-harm. In a Learning Lessons Bulletin about the self-inflicted deaths of young adult prisoners, published in July 2014, we found that 20% of 18-24 year olds who killed themselves had experienced bullying in the previous month, compared to 13% of other prisoners.

58. We recognise that it would have been very difficult to have anticipated Mr White's actions or to have identified that he was at imminent risk of suicide, but as we have found before at Chelmsford, we are not convinced that staff were sufficiently vigilant about identifying, recording and managing Mr White's risk of suicide and self-harm. We make the following recommendation:

The Governor should ensure that staff:

- **Understand, consider and record all the known risk factors for suicide and self-harm.**

- **Start ACCT procedures whenever a prisoner has recently self-harmed, expressed suicidal intent or has significant risk factors.**
- **Should clearly record the reasons when, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors.**

Bullying and use of intelligence

59. Chelmsford's violence reduction policy sets out the action staff should take if a prisoner is victimised or bullied. This policy includes:

    - Encouraging prisoners to tell staff what care and support they need and developing a care plan to implement this.
    - Keeping the prisoner up to date with the progress of enquiries and what action staff are taking.
    - Checking the prisoner's welfare at the time of the incident and in the following days and weeks.
    - Being vigilant as to the impact such issues can have to heighten the man's risk of self-harm, and providing support where required, and starting ACCT monitoring if necessary.

60. In September, Mr White told staff on two occasions that he did not feel safe in the prison and was under threat from a group of prisoners. He told the wing managers on C and B wing that he wanted to move to another wing because of fears for his safety. Mr White moved from C to B wing on 22 September and asked to move again on 25 September. Staff completed security intelligence reports but did not record information in either Mr White's prison record or the wing observation records about the alleged bullying. Mr White did not identify the prisoners who were bullying him.

61. While one of the wing managers interviewed Mr White on 26 September, little was done to help support him afterwards and there was no monitoring or investigation to establish whether his fears were genuine or whether there were other underlying issues. After Mr White's cellmate moved out of their shared cell there appeared to be no recognition that Mr White was now alone and therefore more vulnerable to being bullied. No additional checks were carried out by wing staff to ensure Mr White did not feel vulnerable or unsafe. When he asked to speak to the wing manager he was unable to talk to him due to time constraints but he did not make arrangements for another member of wing staff to talk to Mr White.

62. In our Learning Lessons report, 'Violence reduction, bullying and safety', published in October 2011, we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying.

63. We would expect that, where possible, the prison should investigate all incidents of violence and antisocial behaviour. The prison should use all relevant information including security intelligence reports to clarify recent events of note. We are concerned that prison staff did not put additional victim support measures in place while Mr White's bullying allegations were investigated. We make the following recommendation:

The Governor should ensure that:

- **All information about bullying and intimidation is fully coordinated and investigated.**
- **Those suspected of involvement are appropriately challenged and monitored.**
- **Staff consider whether victims are at increased risk of suicide or self-harm.**
- **Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.**

Roll check

64. Mr White was found hanged in his cell at 8:27pm. A roll check should have been completed at 5:30pm to confirm that all prisoners were safely in their cells. This was not done in spite of an officer having recorded that the correct number of prisoners were in their cells. While it is unclear when Mr White took his life, Mr White might have been discovered sooner if the roll check had been completed. It is very concerning that an officer recorded that the roll check had been completed when it had not been carried out. However, we are satisfied that the prison took disciplinary action against the officer concerned and make no further recommendation.

Clinical care

65. The clinical reviewer concluded in his report that Mr White's care was equivalent to what he could have expected to receive in the community.

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