Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ashley Ansell-Austin a prisoner at HMP Chelmsford on 16 October 2017

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 Ashley Ansell-Austin was found hanged in his cell at HMP Chelmsford on 16 October 2017. He was 36 years old. I offer my condolences to Mr Ansell-Austin's family and friends.

Mr Ansell-Austin's behaviour was challenging. He often self-harmed and was frequently subject to suicide and self-harm prevention procedures. Although he was monitored under these procedures for one week at the start of October, staff failed to identify or take appropriate actions to reduce his risk. I also found that staff missed an opportunity to restart suicide and self-harm prevention procedures when Mr Ansell-Austin's behaviour and mental health deteriorated in the days leading up to his death. Although an urgent mental health assessment was requested, it was not completed.

There were also deficiencies with the emergency response, which despite not affecting the outcome for Mr Ansell-Austin, need to be addressed.

We have identified deficiencies in the management of suicide and self-harm prevention procedures in previous investigations at Chelmsford. I am, therefore, copying this report to the relevant Prison Group Director so they can satisfy themselves that effective action is taken to address these deficiencies.

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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **June 2018**

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Summary

Events

1. On 4 July 2016, Mr Ashley Ansell-Austin was remanded to custody at HMP Winchester and subsequently sentenced to 20 months imprisonment. Mr Ansell-Austin had a history of attempted suicide and self-harm in custody and was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) on nine occasions. He was transferred to Chelmsford on 2 October 2017.

2. Mr Ansell-Austin had a long history of mental ill-health and was diagnosed with a personality disorder. He was a drug user in the community and prescribed methadone in prison. Staff started ACCT procedures on 4 October, after Mr Ansell-Austin cut off part of his ear. The ACCT was closed on 12 October.

3. The next night, and again in the early morning of 15 October, Mr Ansell-Austin smashed his cell and he was placed on report. After he had been locked in his cell for the night on 15 October, Mr Ansell-Austin was issued with adjudication papers. He pressed his cell bell around 8.30-8.45pm and asked the night patrol officer for a razor, which was denied.

4. On 16 October, at around 5.50am, the night patrol officer found Mr Ansell-Austin hanging in his cell by a bed sheet, attached to the light fitting. Staff were unable to resuscitate him and at 6.05am, paramedics recorded that Mr Ansell-Austin had died.

Findings

5. We found that, while ACCT procedures were correctly started after Mr Ansell-Austin self-harmed on 4 October, staff failed to identify appropriate actions to reduce his risk of suicide and self-harm. After the ACCT was closed on 12 October, there were clear indications that Mr Ansell-Austin's risk had increased again. However, staff failed to properly reassess his risk, and missed an opportunity to re-open the ACCT. Some staff were unaware that an ACCT had only recently been closed

6. There was a one-week delay in assessing Mr Ansell-Austin's mental health after he cut off part of his ear. Two days before he died, an urgent mental health assessment was requested when he refused his medications, but this was not carried out. We consider this was a significant oversight and a missed opportunity to protect Mr Ansell-Austin.

7. Despite a history of substance misuse problems, Mr Ansell-Austin was prescribed an opiate for pain. There was no evidence healthcare staff or the GP reviewed Mr Ansell-Austin's methadone prescription.

8. There was a delay in staff entering Mr Ansell-Austin's cell when he was found hanging. Although it made no difference in his case, this could be critical in future cases. The investigation also found that healthcare staff inappropriately tried to resuscitate Mr Ansell-Austin, when it was obvious he was dead.

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, in particular:
    - All staff should have adequate ACCT training and refresher training.
    - All staff should be reminded of their responsibility to start (or re-open) suicide and self-harm prevention measures for prisoners at risk and ensure all relevant information is recorded.
    - Staff should set actions on the immediate action plan or caremap that are specific, meaningful and tailored to the individual to reduce their risk.
    - A system should be developed so staff can easily and quickly identify when a prisoner is in post-closure.
    - A prisoner's family should be involved where it would be beneficial.

- The Governor should ensure a system is developed so staff can easily and quickly identify when a prisoner is in post-closure and that a prisoner's ACCT status should be checked before adjudication papers are issued, and wing staff should be notified accordingly.

- The Head of Healthcare should ensure urgent mental health referrals are actioned urgently, including those made at weekends and in the evenings.

- The Head of Healthcare should ensure that lead pharmacists and IDTS at Chelmsford:
    - review the prescribing of pregabalin, audit the number of prisoners on this medication and review prescriptions in discussion with GPs and/or psychiatrists;
    - review the prescribing of hyoscine (Buscopan) to ensure prescribers are aware of the clinical guidance about potential abuse;
    - remind prescribers of the risk of multiple opiate prescribing in substance misuse patients;
    - ensure IDTS discuss and document reasons for ongoing opiate prescribing for long-term prisoners.

- The Governor should ensure that all staff understand that when life is in danger, they should enter the cell as quickly as possible, especially when there is a history of attempted suicide and self-harm.

- The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

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 visited Chelmsford on 18 October, and obtained copies of relevant extracts from Mr Ansell-Austin's prison and medical records. She spoke to a prisoner and staff on E Wing.

11. NHS England commissioned a clinical reviewer to review Mr Ansell-Austin's clinical care at the prison.

12. The investigator interviewed 22 members of staff at Chelmsford on 13 and 14 November, and 14 December. The clinical reviewer accompanied her on 13 November. In addition, the investigator interviewed three members of staff, three prisoners and Mr Ansell-Austin's brother by telephone.

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

14. One of the Ombudsman's family liaison officers contacted Mr Ansell-Austin's family to explain the investigation. Mr Ansell-Austin's family raised no specific issues for the investigation to consider. They were provided with an audio file of a telephone call Mr Ansell-Austin made on 14 October.

15. Mr Ansell-Austin's family received a copy of the initial report was available, but did not identify any factual inaccuracies.

16. The prison received a copy of the report and clarified staff roles, which have been amended. An action plan for the recommendations is annexed to the report.

Background Information

HMP Chelmsford

17. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men aged 18 years and older. Essex Partnership University Trust provide healthcare.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Chelmsford was in April 2016. Inspectors noted there had been four self-inflicted deaths since the last inspection and a considerable increase in incidents of self-harm to a level far higher than at similar prisons. Inspectors noted the prison was working to implement recommendations made following the investigation of these deaths. The quality of most assessment, care in custody and teamwork (ACCT) case management procedures for prisoners at risk of suicide or self-harm was reasonable, with generally effective care maps and mostly good ongoing monitoring and recording, although there was often a lack of multidisciplinary case reviews. The weekly complex needs meeting contributed well to the management of prisoners requiring both enhanced support and control.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year ending 31 August 2017, the Board remained concerned at the levels of violence, bullying and self-harm and noted there had been three self-inflicted deaths in the reporting year.

20. The IMB noted the number of Assessment, Care in Custody and Teamwork (ACCT) documents opened during the reporting period fell by 12% compared to the previous year, although the actual number of ACCTs remained high. The Board reflected that prisoners who are subject to an ACCT require regular monitoring and review which required significant resources. The Board was impressed by the care, professionalism and dedication demonstrated by individual officers and other members of the prison's staff, but remained extremely concerned about staffing levels and the general shortage of resources.

Previous deaths at HMP Chelmsford

21. Mr Ansell-Austin is the fourth prisoner to take his life at Chelmsford since January 2016. There has been another self-inflicted death since. Our investigations into these three deaths also identified inadequacies in the management of ACCT and in the assessment of risk.

Assessment, Care in Custody and Teamwork

22. 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.

23. 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 (a 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.

24. 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, *Safer Custody*.

Segregation Units

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

Integrated Drug Treatment Services (IDTS)

26. The Integrated Drug Treatment System aims to improve the quality of substance misuse treatment available for prisoners, with particular emphasis on those in the early days of custody and improving the integration between clinical and other drug workers.

Incentives and Earned Privileges Scheme (IEP)

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

Key Events

28. On 4 July 2016, Mr Ashley Ansell-Austin was remanded to HMP Winchester, for offences of robbery and possession of a blade. He was sentenced to 20 months imprisonment on 25 August 2016. This was not his first time in prison.

29. Mr Ansell-Austin spent time at Winchester, Coldingley, Bullingdon, Channings Wood, Ranby, Lindholme, The Mount, Rochester, Swaleside and Elmley, before transferring to Chelmsford on 2 October 2017. Mr Ansell-Austin's behaviour was often challenging, which resulted in him spending time in the prisons' segregation units. He threatened staff verbally, including hospital staff when he was taken to A&E, he used weapons to threaten staff and climbed onto the prison roof at Rochester. He was subject to disciplinary action (known as adjudication) on 36 occasions.

30. Between 4 July 2016 and 16 October 2017, staff started Prison Service suicide and self-harm prevention procedures (known as ACCT) on nine separate occasions and he was managed under these procedures for much of his time in prison. Mr Ansell-Austin frequently cut himself, was found with a ligature around his neck, set fire to his cell and on one occasion swallowed batteries.

HMP Elmley

31. Mr Ansell-Austin transferred from Rochester's segregation unit to Elmley's segregation unit on 31 July 2017. When he arrived at Elmley, Mr Ansell-Austin became aggressive, and staff restrained him to locate him into his cell. Mr Ansell-Austin had been subject to ACCT monitoring since 24 May, as he had told staff he believed they had poisoned him and he felt like self-harming.

32. On 6 August, Mr Ansell-Austin was moved from the segregation unit to a standard residential wing. Although he had deep cuts to his arm that appeared infected, he refused to be examined by healthcare. A psychologist, met Mr Ansell-Austin on 10 August, to discuss his self-harming and the reason why he had been transferred to Elmley. Mr Ansell-Austin said he did not have any current thoughts of suicide and self-harm, but cut himself to cope with his feelings. The psychologist recorded that she had spoken to the mental health in-reach team and noted Mr Ansell-Austin wanted to be referred to a psychiatrist. His ACCT was reviewed and closed on 15 August.

33. On 21 August, Mr Ansell-Austin told prison staff that he was going to 'turn himself inside out [self-harm]' as he did not have his trainers. An officer started ACCT procedures. Three minutes later, she recorded that Mr Ansell-Austin had cut his head with a piece of porcelain from his sink. He made similar threats three days later, and staff recorded they believed there was a pattern of behaviour emerging whereby Mr Ansell-Austin harmed himself to get what he wanted. The ACCT was closed on 6 September.

34. On 22 September, Mr Ansell-Austin smashed the contents of his cell and made a weapon from a metal pipe, and staff used control and restraint to remove him from the cell. Staff recorded that Mr Ansell-Austin had attempted to cause serious harm to prison staff. He was moved to the segregation unit. The same day, Mr Ansell-Austin was also seen covering CCTV when another prisoner had

boiling water thrown over him. Mr Ansell-Austin was placed on report, but the hearing was adjourned for him to obtain legal advice. He remained in the segregation unit.

35. On 26 September, the deputy governor at Chelmsford, contacted the deputy governor at Elmley, to request a segregation to segregation exchange of prisoners, because security intelligence indicated that a member of staff at Chelmsford was at risk from a prisoner. The duty governor at Elmley agreed to the transfer request. The Head of Offender Management Unit, informed the duty governor at Elmley that there were two potential prisoners in Elmley's segregation suitable for transfer, Mr Ansell-Austin being one of them. The decision was made to transfer Mr Ansell-Austin, because he was due to be released earlier than the other prisoner.

HMP Chelmsford

36. On 2 October, Mr Ansell-Austin was transferred to Chelmsford. Nurse A, a mental health nurse, completed the initial healthscreen at 11.47am. The nurse noted Mr Ansell-Austin had epilepsy, was prescribed methadone (an opiate substitution treatment) and was thought to have a personality disorder. She also recorded Mr Ansell-Austin had a history of self-harm and attempted suicide while in custody, but that he had no current thoughts of harming himself. She referred Mr Ansell-Austin to the integrated drug treatment services (IDTS) and to the prison GP to review his medications.

37. Officer A completed the reception interview and recorded Mr Ansell-Austin was happy to have transferred, had not self-harmed in over a month and had no current thoughts of suicide and self-harm. The officer noted Mr Ansell-Austin would be assessed by the mental health nurse. Officer B completed Mr Ansell-Austin's first night interview at 2.56pm on F Wing. Officer B said he had read the prison record and was aware of the reasons for Mr Ansell-Austin's transfer from Elmley, but did not consider he was at an increased risk of suicide or self-harm.

38. Dr A examined Mr Ansell-Austin at 6.59pm. The doctor recorded Mr Ansell-Austin had previously been diagnosed by a prison psychiatrist as having post-traumatic stress disorder and a personality disorder, and he prescribed him anti-psychotic medication (quetiapine); pregabalin for pain, anxiety and epilepsy; dalteparin for the treatment of deep vein thrombosis and pulmonary embolism; hyoscine (Buscopan) for stomach cramps; dihydrocodeine for arthritic pain; omeprazole for reflux, and ibuprofen, in addition to his methadone.

39. Dr A noted Mr Ansell-Austin looked anxious, stressed and was agitated about his medications. Although the doctor told Mr Ansell-Austin hyoscine was not usually prescribed at Chelmsford as it was a banned medication (hyoscine is a highly traded drug in prison because of its euphoric effects), he listed the medication on Mr Ansell-Austin's prescription chart and recorded 'prescribed for now', although it was never dispensed. The doctor told the investigator he intended to speak to the pharmacist about prescribing Mr Ansell-Austin hyoscine if an exception could be made, but there is no evidence this conversation took place. The doctor recalled the pharmacist told him it was a banned drug at Chelmsford.

40. Prison staff located Mr Ansell-Austin on the drug treatment wing (E Wing) and he was checked throughout the night with no reported problems.

41. On 3 October at 11.33am, Nurse B, a mental health nurse recorded Mr Ansell-Austin had been discussed at the referrals and allocation meeting, attended by mental health and IDTS workers and managers. The nurse recorded Mr Ansell-Austin had a history of emotionally unstable personality disorder and self-harming and would remain under the care of the prison GP and IDTS. Nurse C, IDTS, recorded in Mr Ansell-Austin's medical record at 12.40pm, that he had no current thoughts to end his own life, but appeared very angry and was easily agitated. Nurse C noted that he advised Mr Ansell-Austin of the support available at Chelmsford (Samaritans, Listeners and chaplaincy) and to 'push the alarm if needed, contact wing officer and document on NOMIS [prison file] and SystmOne [medical record]'.

42. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to Mr Ansell-Austin's calls made from Chelmsford. In total he made 11 calls, a total of 47 minutes and 39 seconds. On 4 October, Mr Ansell-Austin made an eight-minute call at 3.17pm to his mother and a second call lasting around three minutes at 3.40pm. In these calls he asked his mother to visit him and said 'I've had enough… can't take no more… I'll do something bad'. His mother encouraged him to speak to Listeners (prisoners trained to support other prisoners), who he said he did not trust, or the chaplain. In the second call Mr Ansell-Austin told his mother he wanted to transfer closer to home.

43. At 9.05pm, Officer C began ACCT procedures. The officer recorded on the concern and keep safe form, that Mr Ansell-Austin had chopped off a segment of his ear in protest at the way he was being treated. Mr Ansell-Austin gave no specific details of why he self-harmed, but stated all staff were corrupt. An acting custodial manager (CM A), completed the immediate action plan and set hourly ACCT observations until Mr Ansell-Austin's ACCT assessment.

44. At 10pm, Mr Ansell-Austin was taken to Broomfield Hospital for treatment, but discharged himself from the accident and emergency department at 12.25am, as he did not want to wait. Mr Ansell-Austin was returned to E Wing and slept for the remainder of the night.

45. On 5 October, Mr Ansell-Austin called his mother at 10.25am, but he was not able to get through. At 2.50pm, Officer D carried out an ACCT assessment. Mr Ansell-Austin told the officer he cut himself to relieve his frustration. Mr Ansell-Austin said he was 'alright' and had no current thoughts of harming himself. The officer recorded Mr Ansell-Austin spoke positively about his future, reducing his IDTS medication and rebuilding relationships with his family. The officer noted Mr Ansell-Austin's main issues were his recent transfer, his treatment at Elmley and obtaining a job at Chelmsford. In his prison record, Officer E recorded that Mr Ansell-Austin wanted to transfer to Lewes to be with his brother. Supervising Officer (SO) A was assigned as Mr Ansell-Austin's ACCT case manager, after the first case review was conducted although she was not on duty.

46. SO B chaired the first ACCT review at 2.52pm with Officer E, Nurse D and Mr Ansell-Austin in attendance. SO B recorded Mr Ansell-Austin struggled to share

the reasons why he cut his ear. Mr Ansell-Austin said he had been transferred away from his family who lived in Portsmouth, remained unhappy about his treatment at Elmley and that he should be located on the ground floor. The caremap was completed with an action for induction to be completed; this was recorded as completed on 10 October. Staff considered Mr Ansell-Austin's risk of self-harm and suicide to be raised, but reduced observations to two conversations daily in the morning and afternoon, and hourly observations during patrol state (when prisoners are locked in their cells). A review was scheduled for 12 October.

47. Mr Ansell-Austin made a five-minute call to his mother at 3.19pm. He did not mention cutting his ear, but sounded distressed. Mr Ansell-Austin asked after his brother and said he wanted to get work to keep himself occupied.

48. On 6 October, before 10am, Mr Ansell-Austin made two calls totalling nearly 14 minutes to his mother. He asked her when she was going to visit and told her he was on an ACCT, but gave no details. Mr Ansell-Austin said he was 'in bits'. They spoke about his brother and Mr Ansell-Austin said 'small things in prison turn into big things' and his mother encouraged him to stay out of trouble.

49. Mr Ansell-Austin refused to attend his induction meeting, and his prison record was updated with a negative behaviour entry by Officer F.

50. On 7 October, Mr Ansell-Austin made a five-minute call to his mother at 3.35pm. He asked his mother when she would visit and asked her to visit 'before it was too late… I've had enough now'. Mr Ansell-Austin told his mother he had cut off part of his ear.

51. On 9 October, Nurse B recorded at 12.23pm that Mr Ansell-Austin's recent self-harming was discussed at the mental health referrals and allocation meeting. She recorded Mr Ansell-Austin was to be assessed by the mental health team. Nurse E recorded at 12.54pm that she examined Mr Ansell-Austin as he complained of stomach pain and told him she would review him again if the pain returned.

52. The same day, Officer G issued Mr Ansell-Austin with an IEP warning for refusing to attend a resettlement meeting. He was given a further warning the next day by Officer H for failing to attend the rescheduled resettlement meeting. There are no corresponding entries on Mr Ansell-Austin's ACCT document.

53. On 11 October, Mr Ansell-Austin made an eight-minute call to his mother at 11.04am. He asked his mother if she had booked a visit as he was 'not feeling too well'. Mr Ansell-Austin told his mother he was losing weight and that not seeing his family was difficult. Mr Ansell-Austin's mother told him she planned to visit him on 12 November.

54. Nurse F, a mental health nurse, completed an assessment. He recorded in Mr Ansell-Austin's medical record at 2.47pm that he was suspicious about his food and believed it was tampered with and said he had drastically lost weight. The nurse recorded Mr Ansell-Austin appeared to have a good insight into his medical conditions and aware of the medications he was prescribed. The nurse recorded Mr Ansell-Austin wanted to continue on his medications, despite

identifying nightmares as a side effect. Mr Ansell-Austin disclosed he had previously been prescribed Ritalin which 'helped stop his mind running 100 miles an hour' and that he did not experience any side effects [Ritalin is also a highly traded drug in prison]. Nurse F added Mr Ansell-Austin to the psychiatrist's list for a review of his medications.

55. On 12 October, at 9.15am, SO A chaired the ACCT review with Officer I, Nurse E and Mr Ansell-Austin in attendance. The SO recorded that the caremap actions were complete and that Mr Ansell-Austin was 'sick of being checked on and that it is getting him down'. Mr Ansell-Austin said he had no thoughts of self-harm, and would speak to staff if that changed. Staff assessed Mr Ansell-Austin's risk of suicide and self-harm as low and closed the ACCT. The nurse told the investigator Mr Ansell-Austin was concerned about losing weight and pains in his stomach, and had asked to see the psychiatrist. She arranged a GP appointment for the next day and confirmed an appointment with the psychiatrist, had already been made for 9 November, which she recorded in his medical record. A post-closure review was scheduled for 19 October.

56. On 13 October, at 6.02am, an operational support grade (OSG), recorded that Mr Ansell-Austin had been rude and abusive to her when she locked his medicine hatch and observation panel as he incorrectly believed everyone else's were left open.

57. Mr Ansell-Austin made a brief call to his mother at 8.14am. His step-father answered, explained his mother was out, and told Mr Ansell-Austin she had not booked the visit for 12 November, as it was too far in advance for the prison booking system.

Saturday 14 October

58. The next night, the OSG recorded at 2.12am, that Mr Ansell-Austin had smashed the sink in his cell and had damaged the pipes, resulting in his cell flooding. The OSG contacted another acting CM B and he and SO C spoke to Mr Ansell-Austin. CM B said Mr Ansell-Austin was calmer when they spoke to him and he told them he was going to bed. The OSG placed Mr Ansell-Austin on report.

59. Mr Ansell-Austin telephoned his mother at 11.27am, but spoke to his step-father as his mother was out. Mr Ansell-Austin said he had no credit but would ask for emergency credit so he could call his mother later. This was the last call he made. SO D told the investigator he had intended to allow Mr Ansell-Austin to make a call from the wing office, but there was not sufficient time and there was a restricted regime. He explained it was not possible to credit Mr Ansell-Austin's account, so he could use a phone on the wing landing, as it was a weekend.

60. Nurse G intended to speak to Mr Ansell-Austin as he had refused his medication. However, when she went to E Wing she was told by prison officers not to go to his cell as he was 'smashing up'. The nurse recorded in Mr Ansell-Austin's medical record at 11.47am that she had been told by wing staff Mr Ansell-Austin was acting strangely and reported he was hearing voices. The nurse recorded she informed Hotel 8 [radio call sign for Nurse H] and 'wing staff' (in interview she confirmed this was SO D that Mr Ansell-Austin's mental health needed to be assessed. He was moved from cell E2-12 to E1-15 at 3.47pm. At 5.15pm,

Officer J recorded that Mr Ansell-Austin had been given a negative IEP warning for misusing his cell bell.

Sunday 15 October

61. On 15 October, at 6.12am, OSG placed Mr Ansell-Austin on report for flooding his cell and he accused her of restricting his air supply. The OSG recorded that other prisoners threatened Mr Ansell-Austin if he continued to bang and crash about his cell. This is the last entry in Mr Ansell-Austin's prison file.

62. Officer K told the investigator that prisoners were locked up in the afternoon as it was a weekend regime. He said he gave Mr Ansell-Austin a newspaper when he said he was bored, and unlocked him so he could clean his cell, but there was nothing unusual about the day. The officer said prisoners were checked and locked in their cells at around 4.45pm.

63. At 7.02pm, Officer L issued Mr Ansell-Austin with adjudication papers for smashing his sink on 13 October. He told the investigator he did not know Mr Ansell-Austin and was unaware he was in ACCT post-closure. The officer issued adjudication papers to two prisoners on E Wing, but had no specific recollection of Mr Ansell-Austin. The officer said when the papers were issued both prisoners replied 'okay gov'.

64. The OSG told the investigator that Mr Ansell-Austin pressed his cell bell at around 8.30-8.45pm and asked for a razor. She said she told him one would not be issued and that he accepted her response. She said there was nothing about Mr Ansell-Austin's behaviour that concerned her. She said she was unaware Officer L had issued adjudication papers to Mr Ansell-Austin.

Monday 16 October

65. The OGS started her roll check (a count of all prisoners) and arrived at Mr Ansell-Austin's cell around 5.50am. She opened the observation panel and immediately saw Mr Ansell-Austin and checked to see if he was standing on anything as he was so high off the ground. She radioed a code blue medical emergency (indicating a life-threatening situation). A recording of the radio traffic confirmed Officer M requested an ambulance immediately. He asked the OSG for further information so he could update the ambulance service and she replied, 'non-responsive, no signs of life'. Officer M sounded the alarm to alert staff to a serious incident.

66. Closed circuit television (CCTV) provided to the investigator starts at 5.50.47am and shows the OSG outside Mr Ansell-Austin's cell door. Nurse I ran onto the wing carrying the emergency response bag. CCTV shows they both looked into the cell through the observation panel, but remained outside. The nurse removed the emergency medical bag and ran back towards the wing office. At 5.52.44am, the nurse returned carrying protective equipment (an apron and gloves). At the same time as the nurse returned, CCTV shows the OSG opened the cell door as Officers N and O responded to the code blue and arrived on the wing. Officer N was wearing a body-worn video camera (BWVC) but despite activating the camera, it did not record as the battery went flat.

67. They entered the cell and Officer N supported Mr Ansell-Austin, cut the ligature, and with Officer O lowered Mr Ansell-Austin onto the bed. The OSG and Officer N told the investigator Mr Ansell-Austin's body was very stiff (a sign of rigor mortis).

68. CCTV shows at 5.53.45am, Nurse I left Mr Ansell-Austin's cell and leant up against the wall. CM C was wearing a BWVC and the investigator viewed the footage. He arrived on the wing at 5.54am with Nurse J. BWVC footage shows the staff in the cell and Mr Ansell-Austin can be seen lying on the bed, on his back at an angle. Nobody had started cardiopulmonary resuscitation (CPR) as they believed he was already dead.

69. When Nurse J went into the cell, BWVC footage shows she is told by prison staff there were no signs of life. However, the nurse can clearly be heard saying 'we still need to do CPR' and makes a chest compression sign with her hands; CM C said, 'yes yes'. At 5.54.46am officers moved Mr Ansell-Austin out of his cell, laid him on the floor, and at 5.54.59am the nurse started CPR. An automatic external defibrillator (AED) was attached to Mr Ansell-Austin, which indicated there was no shockable heart rhythm. CPR continued until paramedics arrived. Screens were put in place to protect Mr Ansell-Austin's decency.

70. East of England Ambulance Service records show they received a request for an emergency ambulance at 5.50am. Paramedics arrived at the prison at 5.56am and were with Mr Ansell-Austin at 6.01am. They assessed Mr Ansell-Austin and recorded he had died at 6.05am.

71. Mr Ansell-Austin had started to write a letter, which was found in his cell after he died. Mr Ansell-Austin wrote that he had been sprayed with a substance, that staff had something to hide and the SO would not give him credit to contact his mother by telephone. Mr Ansell-Austin wrote 'I will go by hanging if any - so you know there is no corruption yeah'.

Contact with Mr Ansell-Austin's family

72. The prison appointed two members of staff as the family liaison officers. They visited Mr Ansell-Austin's family at their home address to break the news of his death. The family liaison officers offered condolences and ongoing support to all family members. The prison contributed towards the costs of Mr Ansell-Austin's funeral, in line with national policy.

Support for prisoners and staff

73. A duty governor, held a debrief for all staff involved in the emergency response.

74. The prison posted notices informing other prisoners of Mr Ansell-Austin's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Ansell-Austin's death. The prison held a memorial service for Mr Ansell-Austin on 19 October.

Post-mortem report

75. A pathologist concluded that Mr Ansell-Austin had died from hanging. A toxicology report confirmed there were no substances in Mr Ansell-Austin's blood at the time of his death, other than those prescribed.

Findings

Assessment and management of Mr Ansell-Austin's risk

76. Prison Service Instruction (PSI) 64/2011 - *Safer Custody*, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Ansell-Austin had several risk factors: history of self-harm and suicide attempts, mental health illness and substance misuse issues.

77. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in assessing risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.

78. Prison staff started ACCT procedures on 4 October when Mr Ansell-Austin cut off part of his ear, and they considered him to be at a raised risk of suicide and self-harm. The only action recorded on the caremap was to complete induction, which was completed on 10 October. The ACCT was closed at the next case review on 12 October. The caremap did not reflect the issues identified during the ACCT assessment or first review, although SO B noted a number of issues Mr Ansell-Austin had raised. The caremap had no specific action about ensuring the mental health team assessed him, no target to obtain work, something Mr Ansell-Austin had requested to keep himself occupied, and no detail about his perceived poor treatment at Elmley which continued to frustrate him. There is no evidence anyone considered inviting his family to be part of the ACCT process, despite Mr Ansell-Austin saying he missed them.

79. SO B, who chaired the first case review, explained he did not know at the time of the review how to access information from Mr Ansell-Austin's time in previous establishments and was unaware of previous triggers and his significant self-harm history. All staff who had contact with Mr Ansell-Austin during the ACCT review on 12 October, considered him to be at low risk of suicide and self-harm, because he said he did not intend to kill himself and was fed up at being monitored.

80. When Mr Ansell-Austin's behaviour changed in the days before he died, the ACCT should have been reviewed. Mr Ansell-Austin received a number of behaviour warnings and damaged his cell twice, including being placed on report, during this post-closure period. This decline in his behaviour, as well as signs of increased paranoia when he believed his air was being restricted and staff had sprayed him with a substance, caused sufficient concern for both healthcare and prison staff to refer Mr Ansell-Austin for an urgent mental health assessment, but nobody considered reopening the ACCT. PSI 64/2011 clearly states that an ACCT can be re-opened at any point following closure if the risk posed by the prisoner is deemed to have been increased*. 'The Case Manager must determine*

whether or not the circumstances for re-opening are different from that of the original plan and whether or not a new assessment needs to be undertaken.'

81. Officer L gave Mr Ansell-Austin his adjudication papers for his hearing scheduled for the morning he died. The officer said that he did not interact with Mr Ansell-Austin, and was unaware that he was in ACCT post-closure. The OSG, the night patrol officer, was unaware Mr Ansell-Austin had been given adjudication documents. It was evident from interviews with various staff of all grades that there is no system in place for identifying those in ACCT post-closure, which needs to be rectified urgently.

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

- **All staff should have adequate ACCT training and refresher training.**
- **All staff should be reminded of their responsibility to start (or reopen) suicide and self-harm prevention measures for prisoners at risk and ensure all relevant information is recorded.**
- **Staff should set actions on the immediate action plan or caremap that are specific, meaningful and tailored to the individual to reduce their risk.**
- **A prisoner's family should be involved where it would be beneficial.**

The Governor should ensure a system is developed so staff can easily and quickly identify when a prisoner is in post-closure and that a prisoner's ACCT status should be checked before adjudication papers are issued, and wing staff should be notified accordingly.

Management of Mr Ansell-Austin's clinical care

Mental health assessment

82. The clinical reviewer, concluded that the overall care Mr Ansell-Austin received from the mental health team was not equivalent to the service he would have received in the community. There were several delays in him being assessed by the mental health team, including the weekend before he died.

83. Mr Ansell-Austin had a diagnosis of emotionally unstable personality disorder and a history of self-harm. He was prescribed medication for his mental health, as well as for epilepsy. When he arrived at Chelmsford on 2 October, healthcare assessed his risk of self-harm as low but, because of his history, referred him for a mental health assessment. However, at the mental health referral and allocation meeting the next day, the decision was made for IDTS and the prison GP to review Mr Ansell-Austin's needs, rather than anyone from the mental health team.

84. Mr Ansell-Austin was referred to the mental health team after he cut off part of his ear on 4 October, but he was not assessed until 11 October. This is a considerable delay for someone who required hospital treatment after self-

harming. The psychiatrist discussed Mr Ansell-Austin's case on 12 October, and scheduled another appointment on 9 November, four weeks after Mr Ansell-Austin presented with paranoia, which could indicate psychosis. The clinical reviewer concluded this delay in seeing the psychiatrist was too long.

85. On 14 October, Nurse G, informed Nurse H that Mr Ansell-Austin was acting strangely and hearing voices. Nurse G told the investigator she was initially told he had only recently been seen by Nurse F on 11 October, but that she explained his behaviour had changed.

86. Nurse H did not assess Mr Ansell-Austin after Nurse G spoke to her. She told the investigator she believed Mr Ansell-Austin's main issue was his medication and she was unable to alter any prescriptions. She arranged for him to be seen by a psychiatrist on Monday 16 October, but she did not tell Mr Ansell-Austin he had an appointment.

87. SO D told the investigator that he had also asked Nurse F to assess Mr Ansell-Austin on 15 October, as he was aware that nobody from the mental health team had assessed him. The SO told the investigator when he made this request, Nurse F (who no longer works at Chelmsford and has subsequently been suspended from work for an unrelated matter at another prison) 'flat refused' to see Mr Ansell-Austin. The mental health lead, said he would have expected an urgent mental health assessment to have been completed when it was requested. We therefore make the following recommendation:

The Head of Healthcare should ensure that urgent mental health referrals are actioned urgently, including those made at weekends and in the evenings.

Medication and management of Mr Ansell-Austin's substance misuse

88. Mr Ansell-Austin was prescribed medication for multiple medical problems. The combination of these medications could have affected his mental state if taken or used incorrectly. Despite a history of substance misuse, he was prescribed an opiate for pain which, as outlined in *Safer Prescribing in Prisons, A Guide for Clinicians*, should have been avoided.

89. Mr Ansell-Austin's medication for epilepsy, psoriatic arthritis, pain and anxiety, are all mood-altering medications and some are misused for euphoric effects. When Mr Ansell-Austin arrived at Chelmsford on 2 October, there is no evidence that the healthcare team or GP sought to access and verify Mr Ansell-Austin's records from his community GP, despite him clearly having several ongoing conditions.

90. Prisoners who are prescribed methadone need to engage with psychosocial support and groups in prisons. A plan to reduce opiate prescribing once stable should be made and discussed with prisoners, especially those who will be in prison for long periods of time. There was no discussion or documentation of methadone reduction/detox and Mr Ansell-Austin's usual 45mls dose of methadone was continued without review when he arrived at Chelmsford. Further, although he was never actually given hyoscine, Dr A still entered this on

his prescription chart, despite it being a banned medication. We therefore make the following recommendation:

The Head of Healthcare should ensure that lead pharmacists and IDTS at Chelmsford:

- **review the prescribing of pregabalin, audit the number of prisoners on this medication and review prescriptions in discussion with GPs and/or psychiatrists;**
- **review the prescribing of hyoscine (Buscopan) to ensure prescribers are aware of the clinical guidance about potential abuse;**
- **remind prescribers of the risk of multiple opiate prescribing in substance misuse patients;**
- **ensure IDTS discuss and document reasons for ongoing opiate prescribing for long term prisoners.**

Emergency Response

Delay entering Mr Ansell-Austin's cell

91. Chelmsford's local instructions (2.77) for unlocking a prisoner during the night state:

> "Under normal circumstances, no cell will be opened unless a minimum of three members of staff are present one of whom should be the Orderly Officer … Where there is, or appears to be, immediate danger to life, cells maybe unlocked without the authority of the Night Orderly Officer… Where there is, or appears to be immediate danger to life, cells may be unlocked with one member of staff."

The instruction continues:

> "You should use your judgement to decide if it is safe to open a cell in an emergency… However preservation of life supersedes security and it is down to the individual on patrol to make the assessment and decision… Staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence."

92. The OSG looked into Mr Ansell-Austin's cell around 5.50am, but did not enter the cell until around three minutes later. The OSG told the investigator she did not think she was authorised to enter the cell on her own and Nurse I was not trained in control and restraint (C&R) and she needed to have prison staff in attendance. While we understand the need to dynamically risk assess situations to ensure staff do not put themselves in danger, or risk the security of the prison, the OSG could see Mr Ansell-Austin was suspended with his feet off the floor, and believed he was already dead. The nurse did not hold a cell key and he said the OSG would not open the cell until more staff arrived for safety reasons, so he went and obtained gloves and an apron while he waited. The nurse was clear he would not have done so if the cell door had been opened.

93. Although earlier intervention would not have made a difference in Mr Ansell-Austin's case, it is critical that staff act quickly in situations such as this. We make the following recommendation:

The Governor should ensure that all staff understand that when life is in danger, they should enter the cell as quickly as possible, especially when there is a history of attempted suicide and self-harm.

Resuscitation

94. CM C told the investigator that he believed Mr Ansell-Austin was beyond the point of resuscitation when he entered his cell as he appeared stiff and in an unnatural position, had blood pooling in his hands and dark, swollen lips and tongue. Officer N told the investigator Mr Ansell-Austin was very cold, his body was stiff and he did not believe CPR was appropriate.

95. Paramedics recorded there were obvious signs of death: pooling of blood, cold to the touch and signs of rigor mortis in Mr Ansell-Austin's jaw, hands and feet, all indicators that he had been dead for some time. In interview, both Nurse I and Nurse J both said they believed that, regardless of the circumstances, they had to perform cardiopulmonary resuscitation (CPR) until paramedics arrived.

96. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons and Immigration Removal Centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The Governor had issued a notice (121.16) on 18 October 2016, alerting staff to these guidelines. However, it was clear from all staff that were interviewed, that they believed CPR must always be started.

97. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The clinical reviewer concluded the emergency response was inappropriately managed and not in line with national guidance. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

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