Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Warren Sampson a prisoner at HMP Chelmsford on 4 September 2015

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.

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 Warren Sampson was found hanged in his cell at HMP Chelmsford on 4 September 2015. He was 29 years old. I offer my condolences to Mr Sampson's family and friends.

At the time of his death, Mr Sampson had been identified as at risk of suicide and self-harm but I do not consider that his risk was well managed. Case reviews were not multidisciplinary and did not adequately identify Mr Sampson's main concerns and agree effective actions to address them. His medication for anxiety was poorly managed and stopped without a GP review. On the day he died, there were some clear signs that his anxiety and risk of suicide had increased, but little was done.

I am particularly concerned at the prison's inadequate response when Mr Sampson's mother contacted the prison on the evening of 4 September. She had been understandably anxious about telephone messages her son had left and expressed her worries about his safety. However, no one spoke to Mr Sampson about this or tried to gauge his risk. He was found hanged two hours later. The investigation also identified a need to improve emergency response procedures at Chelmsford.

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 **July 2016**

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Summary

Events

1. On 3 August 2015, Mr Warren Sampson was remanded to HMP Chelmsford. During a previous sentence in 2014, a cell mate had killed himself. Staff began Prison Service suicide and self-harm prevention procedures (known as ACCT) when he arrived, after Mr Sampson said he might kill himself, but ended monitoring a few days later, as he seemed settled. No one obtained his community GP records when he arrived.

2. On 12 August, staff began ACCT procedures again, after Mr Sampson said he had thoughts about hanging himself. He continued to be managed under ACCT procedures for the rest of his time at Chelmsford.

3. On 19 August, Mr Sampson was reported to have been verbally abusive to an officer and was put on a basic regime, which meant he was not allowed to mix with other prisoners during association periods. Because of his risk, he was allowed to keep his television. On 21 August, a psychiatrist recommended counselling. The counsellor considered Mr Sampson was a moderate risk of suicide and aimed to reduce his anxiety levels. Mr Sampson's prescription for diazepam to help relieve his anxiety had ended on 25 August, but a GP did not review this.

4. At the beginning of September, Mr Sampson was worried about his relationship with his partner and became very anxious about being able to phone his partner and his mother. At an ACCT case review on the morning of 4 September, Mr Sampson's mood appeared low. He was anxious and said he had no money to phone his family or buy tobacco. The review did not consider he was at raised risk of suicide and did not increase his observation levels, which were once every two hours. After the case review, he saw his counsellor and told her that he had made a noose a few days earlier and that his diazepam had been stopped. The counsellor told wing staff about the noose and shared her concerns about his level of anxiety with them and at a multidisciplinary healthcare meeting.

5. Later that afternoon, Mr Sampson was let out of his cell to use the telephone but was unable to get through to his partner or his mother. He left messages suggesting he intended to kill himself. He spoke to the prisoner in the next cell who told an officer he was worried that Mr Sampson intended to harm himself. That evening, Mr Sampson's mother rang the prison as she was concerned about the messages he had left. She asked that someone should let him know that everything was positive about his relationship with his partner. At 7.40pm, a supervising officer went to check Mr Sampson, but just observed him through the cell door. He did not speak to him or say that his mother had rung.

6. At 9.45pm, a night patrol officer found Mr Sampson hanged and radioed an emergency. Other staff responded quickly, unlocked the cell, cut the ligature and moved Mr Sampson to the landing outside the cell. The control room did not call an ambulance until four minutes after the emergency code. A nurse assessed Mr Sampson and then left to get oxygen while an officer gave chest compressions. A first paramedics arrived at the cell just before 10.00pm and

was joined by others shortly afterwards. The paramedics took over emergency treatment but, at 10.40pm, recorded that Mr Sampson had died.

Findings

7. Mr Sampson was managed under the ACCT procedures from 12 August 2015 until he died on 4 September. We found that ACCT procedures did not operate fully effectively. There was never any member of healthcare staff present at case reviews and none of the reviews were multidisciplinary. The caremap, which should set out agreed actions to deal with identified concerns and help reduce risk, was not reviewed and updated at each review as should have happened.

8. On 4 September, staff missed signs that Mr Sampson's vulnerability and risk of suicide had increased. At an ACCT case review, a supervising officer noted that Mr Sampson was in a lower mood than previously. Afterwards, Mr Sampson's counsellor was concerned about his level of anxiety and learnt that he had made a noose. Although she drew this to the attention of wing staff and others, no one explored this further with Mr Sampson. That afternoon, another prisoner told an officer that he was very worried that Mr Sampson intended to harm himself. Mr Sampson's mother rang the prison that evening as he had left concerning messages that he intended to kill himself. She asked the prison to pass on a reassuring message about his relationship with his partner but no one spoke to him about this or took any other meaningful action to review his risk and consider whether he needed additional support.

9. No one had confirmed Mr Sampson's prescription for diazepam with his community GP. His prescription stopped on 25 August, without a GP review, although a psychiatrist had said four days earlier that it should continue. Mr Sampson's counsellor had raised her concern about this at a multidisciplinary healthcare meeting earlier on 4 September and we consider the team should have treated this with more urgency.

10. Although there is no evidence that this would have changed the outcome for Mr Sampson, we are concerned that the control room did not call an ambulance immediately when a medical emergency code was called. Moreover, staff did not take emergency equipment directly to the scene and resuscitation techniques were unsatisfactory.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions, including:
    - A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.
    - Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated.
    - Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves.

    - Holding ACCT reviews whenever an event occurs that could mean the prisoner is at increased risk.

- The Governor should ensure that effective action is taken when families report concerns about a prisoner's state of mind, including that an appropriate manager should speak to the prisoner about the concerns, review the level of risk, and record the information and action taken in the prisoner's record.

- The Governor should ensure that managers imposing punishments at adjudications, and taking associated decisions afterwards, fully consider the likely impact on the health and welfare of the prisoner.

- The Head of Healthcare should ensure that:
    - Community GP records are requested in accordance with PSO 3050.
    - Appropriate mental health assessments are completed and recorded, using recognised diagnostic tools.
    - Prescriptions for diazepam are not discontinued without a GP review.
    - Medication administration sheets are completed appropriately.

- The Governor should ensure that staff are fully trained and briefed about how to respond in a medical emergency and that there are sufficient competent staff on duty at all times to administer effective basic emergency treatment until qualified professionals arrive.

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 her. No one responded.

12. NHS England commissioned a clinical reviewer to review Mr Sampson's clinical care at the prison.

13. The investigator visited Chelmsford on 11 September 2015. She obtained copies of relevant extracts from Mr Sampson's prison and medical records.

14. The investigator interviewed 13 members of staff and three prisoners at Chelmsford in October. The clinical reviewer joined her for interviews with four members of staff. She interviewed three staff by telephone and one provided written answers to questions. In January 2016, she interviewed a member of staff and a prisoner at Chelmsford again.

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. The investigator and one of the Ombudsman's family liaison officers met Mr Sampson's mother and his partner, to explain the investigation. They wanted to know what had happened when Mr Sampson's mother had telephoned the prison to tell them she was worried and why staff had not monitored him more closely as a result. His mother asked why he had not been allowed to call her back that night. She wanted more information about what happened during her son's time at Chelmsford, especially the day he died and whether the emergency response was appropriate. Mr Sampson's mother was upset that someone from the prison had called her several days after Mr Sampson's death to check whether she would be prepared to take telephone calls from him.

17. We were very sorry to learn that subsequently Mr Sampson's partner apparently took her own life and offer our condolences.

18. Mr Sampson's mother received a copy of the initial report. She had no further comments or questions about the report.

Background Information

HMP Chelmsford

19. HMP Chelmsford is a local prison that takes prisoners directly from courts. It holds nearly 730 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 services. Atrium provides therapy services including counselling and group work). The Inside Out team provides health information about the misuse of drugs.

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 significantly 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 from a 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 was concerned about the ability of the healthcare provider, Care UK, to deliver the level of service required to meet prisoners' needs. The number of prisoners managed under the suicide and self-harm prevention procedures had increased by more than 20% from the previous year, but the Board was reassured that actual incidents of self-harm and threats to self-harm had reduced.

Previous deaths at HMP Chelmsford

23. There have been seven other self-inflicted deaths at Chelmsford since the beginning of 2013. Five were before Mr Sampson's death and two subsequently. We have identified some concerns about the operation of ACCT procedures in other investigations and about emergency response procedures.

Assessment, Care in Custody and Teamwork

24. 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.

25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

26. 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.

Key Events

27. Mr Warren Sampson had been in prison several times before. In May 2014, at HMP Highpoint, Mr Sampson discovered his cellmate had hanged himself. During his previous sentence at Chelmsford, staff had managed him under ACCT suicide and self-harm prevention procedures six times between December 2014 and March 2015, after he cut himself and put nooses around his neck. At one point his risk was so high, he was constantly supervised. He was released on 12 June 2015. After his release, his children were taken into care.

28. On 3 August 2015, Mr Sampson was remanded to Chelmsford for assault occasioning actual bodily harm against his partner. He had a history of substance misuse, particularly amphetamines. An escort custody officer had completed a self-harm warning form because of Mr Sampson's previous self-harm, but noted that he appeared okay.

29. A community psychiatric nurse from the Criminal Justice Mental Health Team assessed Mr Sampson at court and noted that he had been diagnosed with attention deficit hyperactivity disorder as a child and had referred to a family history of bipolar disorder. Mr Sampson said he had been prescribed mirtazapine (an antidepressant) and diazepam (for anxiety) but, because he found social situations difficult, had not been to his GP to collect them. He was emotional when he talked about his partner and children. The nurse noted his history of suicide attempts in prison and Mr Sampson said he had no current plans or thoughts of suicide or self-harm. He said he intended to work with social services and probation staff to be reunited with his family. The nurse recommended that he should be referred to the mental health in-reach team or counselling services in prison.

30. When Mr Sampson arrived at Chelmsford on 3 August, he refused to go to the prison's first night centre (F Wing) as he said he had a problem with another prisoner there. Officers took him to F Wing by force and then began ACCT procedures as Mr Sampson said he would kill himself. Staff initially observed him every 15 minutes, which the night manager later reduced to every 30 minutes. At 9.00pm, a nurse recorded that he was pleasant and calm, and just wanted to ring his partner, smoke a cigarette and have a warm bed. He said he had no thoughts of suicide or self-harm. The nurse noted in his medical record (SystmOne) that Mr Sampson had previously self-harmed by making superficial cuts to his arms in 2014 and had tied a ligature in January 2015.

31. At 9.21pm, Mr Sampson saw a GP and told him that he took mirtazapine and diazepam. The GP prescribed mirtazapine and a low dose of diazepam until Mr Sampson's community GP confirmed his prescriptions. The GP recorded that he thought Mr Sampson might have bipolar disorder.

32. The next morning, because Mr Sampson said he had problems with the other prisoner, it was agreed that he should move to D Wing, the prison's vulnerable prisoner unit. An officer assessed him as part of ACCT procedures and Mr Sampson said he felt low and unsafe on F Wing. He said he had thought about cutting himself, but would be happy when he moved to the D Wing. A Supervising Officer (SO) held the first ACCT case review. No other member of

staff was present but a nurse had phoned before the review and said that the multidisciplinary healthcare team meeting would discuss Mr Sampson that morning. She noted that Mr Sampson was in good spirits about moving to D Wing and knew people there. She added the move to D Wing as a completed action on his ACCT caremap, assessed his risk of suicide and self-harm as low and reduced his observations to hourly. Mr Sampson moved to a shared cell on D Wing an hour later.

33. That morning, the multidisciplinary healthcare team meeting noted the contents of the court report and that Mr Sampson had a history of attention deficit hyperactivity disorder (ADHD) and bipolar disorder, had previously tried to hang himself in prison and that he was currently being managed under ACCT procedures as a risk of suicide and self-harm. The meeting referred Mr Sampson to the primary care psychiatrist and to the Atrium therapy service.

34. At the next ACCT review on 5 August, which a nurse attended, Mr Sampson said he was happy on D Wing, had received his medication and had no thoughts of suicide or self-harm. The review was satisfied he was no longer at risk and decided to end ACCT monitoring.

35. On 6 August, Mr Sampson declined help from Atrium and said he was doing well. That day, he told a nurse that his diazepam prescription was for only 5mg twice a day, when it had been 20mg three times a day in the community. The nurse requested a GP review, but there is no record that this happened and there is no record that that the healthcare team requested his community GP records to check the prescription.

36. On 12 August, Mr Sampson told staff he had thoughts about hanging himself and he had been tearful on the phone when talking to his partner. An officer began ACCT procedures and an SO asked staff to check Mr Sampson hourly. An officer assessed Mr Sampson the next day. Mr Sampson told him that drugs were the cause of all his problems. He said that he had been in a very dark place the night before and wanted his medication reviewed as it had been reduced. The officer summarised actions to address his key issues as addressing his drug problems with Inside Out, and to have counselling with Atrium.

37. The first ACCT case review was postponed that day because Mr Sampson refused to attend after being told by staff to change out of shorts and flip flops. An SO held the review on 14 August. No member of healthcare staff was present, which is a mandatory requirement for first ACCT case reviews. The SO recorded that Mr Sampson had fleeting suicidal thoughts but said he would tell someone if he felt suicidal. Caremap actions were noted as changing his medication and seeing Atrium, with responsibilities attributed to Mr Sampson and wing staff. There is no evidence that anyone informed the healthcare team, and no one made an appointment for Mr Sampson to see the GP or the Atrium service. Mr Sampson's level of risk was assessed as low and observations were set at one every two hours.

38. On 19 August, an officer said that Mr Sampson was abusive and aggressive towards her while she was doing cell checks. He had shouted to her not to go into his cell because he was hearing voices in his head telling him to kill

someone. He was charged with a disciplinary offence for using threatening, abusive or insulting words or behaviour. Mr Sampson asked to see the mental health team because of the voices. He was given an appointment to see a GP on 27 August, and was added to the multidisciplinary healthcare team discussion list for the next day, because wing staff had raised concerns about his mental state. The multidisciplinary meeting noted that he was waiting to see the psychiatrist.

39. At a disciplinary hearing on 20 August, Mr Sampson pleaded guilty to the offence the day before and was punished with 21 days loss of association. (This meant he would not be unlocked for association periods when prisoners are able to spend time socialising with each other, have showers and make telephone calls.) An SO put Mr Sampson on "VR2" (the second stage of the prison's violence reduction programme), which meant that Mr Sampson had a restricted basic regime and lost a range of privileges including time out of cell. (The VR2 records appear to be incorrect, as they refer to a different incident, from the one involving Mr Sampson. Mr Sampson should have had a review on 2 September to see whether he could return to the standard regime but there is no record that this happened.) The SO allowed Mr Sampson to keep his television because he was on an ACCT and was waiting to see the psychiatrist. The SO held an ACCT case review and said he would try to establish when Mr Sampson was going to see the psychiatrist. There is no record that anyone from the healthcare team was invited to attend the review.

40. On 21 August, a psychiatrist and a nurse reviewed Mr Sampson, who said he misused amphetamines but wanted to stop using drugs and spend more time with his family. He said he had applied for help from the Inside Out service (which gives factual information about drugs and addiction) and was happy to start counselling. He felt stressed that his children had been taken into care, but said he did not have any thoughts of suicide and self-harm. The psychiatrist recommended that Mr Sampson should continue with his current medication of mirtazapine and diazepam (but did not discuss the dosage), have counselling and receive support from nurses. He planned to review him in 10 to 12 weeks.

41. On 25 August, an SO and an officer held an ACCT case review. No other member of staff, including from the healthcare team, attended. The SO recorded that Mr Sampson had said he had fleeting suicidal thoughts but that his medication issues were resolved. However, Mr Sampson had not yet seen a GP to review his medication. He also recorded that Mr Sampson was seeing Atrium, although he had not yet had an appointment. The SO noted that Mr Sampson still needed to see the Intensive Drug Treatment System (IDTS) team, although Mr Sampson had not been referred to them as he had not been withdrawing from alcohol or opiates when he arrived at the prison. The SO decided to continue ACCT monitoring but recorded that Mr Sampson was at low risk of suicide and self-harm. He ticked to say they had reviewed the caremap, although no changes were made to it. Observations continued at once every two hours.

42. According to Mr Sampson's medical record, his last prescription for diazepam was on 18 August, for a seven days' supply. He was not prescribed diazepam again, despite the psychiatrist writing that Mr Sampson's current prescription

should continue when he saw him four days earlier. No one had ever checked the dose with his community GP.

43. On 26 August, Mr Sampson was convicted of actual bodily harm and sentencing was postponed until 14 September. When he got back from court, a nurse wrote in his medical record that he appeared calm and settled and said he had no intentions of suicide or self-harm. When Mr Sampson got back to D Wing, he called his mother and partner and became very tearful and upset. An officer wrote in the ACCT record that Mr Sampson was angry that he had thrown his life away to drugs.

44. The next day, 27 August, Mr Sampson saw a counsellor and therapist the clinical lead for Atrium. Mr Sampson said that his attempt to hang himself in January 2015 had been an impulsive cry for help because he was very anxious at the time. He said he was relieved still to be alive and did not have any current thoughts of suicide or self-harm, but his feelings changed through the day. She considered that Mr Sampson was at moderate risk of suicide due to his anxiety, and that his restricted regime did not help. She offered him distraction work, breathing exercises and mindfulness to help ease his anxiety. Mr Sampson appeared keen to work with her. She documented the meeting in the ACCT record.

45. On 27 August, Mr Sampson missed a GP appointment. The Head of Healthcare said he had he declined to attend but there is no record of this in his medical record and no one had written anything in his ACCT record to say he had not wanted to go to a GP appointment.

46. On the afternoon of 28 August, Mr Sampson asked if he could telephone his mother and officers unlocked him about an hour later to use the phone. Staff recorded in his ACCT document that he seemed very upset and tearful. An SO and an officer held an ACCT case review at 6.00pm and noted that Mr Sampson would not engage and was complaining about his restricted regime. (As he had lost association as a punishment and was on the basic regime, he was locked in his cell for most of the day.) They kept his observations, as previously, at one every two hours and one quality conversation each day. His assessed level of risk was unchanged at low, but there is no record that they reviewed his caremap. Mr Sampson was still upset when he was locked back in his cell. Later, the night officer wrote that Mr Sampson was watching television, said he was okay and seemed in good spirits.

47. At 2.47pm on 29 August, Mr Sampson called his partner. He left a message telling her he loved her, wanted to hear her voice and asked whether she cared about him. At 3.01pm, he called her again and left a message saying he loved her and was sorry he had made her angry. He asked her to answer when he called later, as he needed some reassurance. At 4.01pm, Mr Sampson called again and left a message asking her not to divert his calls.

48. At 4.15pm, Mr Sampson telephoned his mother, who told him he should leave his partner alone. She said his partner could not keep speaking to him, as social services had told her she had to keep him out of her life if she wanted the children.

49. At 11.03am on 30 August, Mr Sampson spoke to his partner. He asked if she loved him, and she said that he knew she did. Mr Sampson asked if she had been seeing someone else and if there was a chance for them to be together in the future. She said they would be, if she saw an improvement in his behaviour.

50. Between 28 August and 2 September, Mr Sampson had shared a cell with another prisoner. On 2 September, this prisoner appeared at court and was sent to another prison, leaving Mr Sampson alone in his cell.

51. At 4.40pm on 2 September, an officer unlocked Mr Sampson for tea and wrote in the ACCT record that he had said he felt very stressed and wanted to "string up". She told us that Mr Sampson wanted tobacco and was very anxious as he wanted to make a telephone call before being locked up again. She did not think he intended to harm himself and said that his mood often went up and down.

52. After tea, Mr Sampson was unlocked from his cell and spoke to his partner at 5.45pm, but the line was bad and he had difficulty hearing what she was saying. Mr Sampson cried and said he had not spoken to her all week. He said he was going to do something that night. He asked why she did not send him cards, money or letters and said that she must be seeing someone else. He said he would ring his mother the next day and needed to know she loved him.

53. At 9.00am on 3 September, a probation officer interviewed Mr Sampson by video link for about an hour to prepare for his pre-sentence report. Mr Sampson told her he wanted help to change and she thought he appeared positive about the future. He said he had thought about ending his life but was now doing well and having counselling. She told us that she did not have any concerns about his safety after speaking to him.

54. At 2.18pm, Mr Sampson left a message for his partner saying he loved her and needed to talk to her. At 6.08pm, he called again and left another message, saying he needed to speak to her to calm him down. He said he would ring the next day between 3.00pm and 4.00pm.

Friday 4 September 2015

55. At 9.00am on 4 September, an SO and an officer held an ACCT case review at 9.00am. As previously, there was no member of the healthcare team present or from any other prison department. The SO recorded that Mr Sampson's mood was lower than previously. He said that he had thought about harming himself but did not want to do it. Mr Sampson said he had panic attacks and asked for a cellmate, as he was frustrated at not having anyone to talk to. He said he had no phone credit or tobacco but the SO told him that he had to buy tobacco and phone credit from the prison canteen (shop).

56. The SO told the investigator that, although Mr Sampson had appeared very low at the time of the case review, he had been feeling better generally. He assessed Mr Sampson as low risk as he had said he had no thoughts of suicide or self-harm and that if he did, he would be comfortable talking to staff about it. The officer said Mr Sampson wanted a smoker's pack as he did not have enough money to buy tobacco. (A smoker's pack is a quantity of tobacco, usually issued in advance to newly arrived prisoners, who pay for it out of subsequent prison

wages.) On 1 September, Mr Sampson had only £2.50 in his prison account to spend on items from the canteen. He bought £2 phone credit and some cigarette papers. He had more money which had not yet been credited to his account.) The officer did not notice any particular change in Mr Sampson during the review. The frequency of observations remained the same and his risk was still assessed as low. The SO did not update the caremap with the new issues about tobacco, getting a cell mate or anything to help with his panic attacks.

57. The counsellor and therapist from the Atrium service saw Mr Sampson about an hour after the ACCT review. She told us this second consultation was very different from the first and Mr Sampson appeared more agitated and unfocussed. He was resistant to considering coping strategies for anxiety. He said he wanted to call his partner that afternoon, which would help reduce his anxiety. He said that he had fleeting thoughts of suicide and self-harm but had no current plans to carry them out. He was tearful, said he was having panic attacks and wanted a cellmate. Mr Sampson told her that he had made a noose a few days earlier because he had been very agitated but had thrown the noose away after he had spoken to his partner. He was also concerned that his diazepam had been stopped. She talked to him about support networks such as Listeners (prisoners trained by the Samaritans to support other prisoners) and the Samaritans. She thought he was dependent on his partner and mother for support. By the end of the session she thought he was calmer and less anxious. He said he would be fine after he made his phone call and agreed to work on distraction techniques when they met the next week.

58. She said that she told officers on Mr Sampson's wing that Mr Sampson was expecting to be able to call his partner at 3.30pm and was very anxious about it. She told them about the noose, and asked them to search his cell to check he had thrown it away. (There is no record in the ACCT document to indicate that officers checked his cell.) The officers told her that they were trying to find a cellmate for Mr Sampson but this was difficult as most of the other prisoners did not want to share. She told Mr Sampson this. An officer told us they had intended to place a new prisoner to share with Mr Sampson the next day. The counsellor submitted an intelligence report about the noose.

59. The counsellor and therapist discussed Mr Sampson's diazepam at the multidisciplinary healthcare meeting at lunchtime. The team decided to refer him to the GP for a medication review.

60. The investigator watched CCTV of D Wing on 4 September (there is no sound on the footage). Around 3.10pm, Officer A unlocked Mr Sampson's cell and Mr Sampson used the phone near his cell for several minutes. She was a few metres away. Mr Sampson went back to his cell for about a minute and then went back to the phone. The phone records show that between 3.09pm and 3.14pm Mr Sampson called his partner or mother several times, but got no answer. The last time he called, he left a message for his partner. He was crying and asked whether she did not want to be with him anymore. Mr Sampson said if he was going to do it, it would be that day.

61. Around 3.25pm, Mr Sampson went to see a prisoner in the cell next door. After a few minutes, they went to the phone, and the prisoner put his hand on Mr

Sampson's shoulder. The prisoner told us that Mr Sampson was very upset because he could not get through to his family, and the thought his partner would have been at his mother's house at the time. He said he had tried to reassure Mr Sampson but Mr Sampson was becoming increasingly anxious. He said Mr Sampson did not say he was planning suicide that night, but he thought he looked like "a broken man" and he was very concerned he might harm himself. He then saw Officer A and went towards her, gesturing towards Mr Sampson. (He put his hand around his neck and pulled upwards as if to indicate hanging.) He spoke to her for about 30 seconds and as he did, she looked back along the landing at Mr Sampson.

62. The prisoner told us that he had told Officer A he was very worried about Mr Sampson and that officers needed to keep a close eye on him. He said she said she would pass the information on. Officer A told the Investigator she could not remember exactly what the prisoner had said to her or whether he had made any gestures. When we first interviewed her, she told us he had said Mr Sampson was "upset", but she could not remember any other details about what he had said.

63. At 3.27pm, Mr Sampson dialled his partner's number and left a message lasting just over a minute. He was very upset and crying, said he could not cope anymore and that this would be the last time she heard from him. He asked her to tell his mum he loved her. Afterwards, he called his partner and his mother a few more times but got no answer and went back to his cell.

64. The prisoner and Officer A walked towards his cell, but the prisoner signalled to her to stop and he went into Mr Sampson's cell alone. They spoke together for over ten minutes. The prisoner said that Mr Sampson did not say that he intended to kill himself but he was still worried about him. However, he thought that Mr Sampson's mood had improved when he left.

65. At 3.30pm, Officer A wrote in the ACCT record that Mr Sampson was crying and in a really low mood. She told us that he would not say why he was upset. She did not think this was strange, as she had seen him cry before when he was on the phone.

66. Between 4.37pm and 4.39pm, Mr Sampson called his partner and mother again but did not get through. The third time he called his partner, he left a message, saying he could not do this anymore and hoped she was happy with the decision she had made. He wanted her to remember him. He ended by saying he hoped she answered the phone when he rang again after 6.00pm.

67. Mr Sampson refused tea around 4.45pm. At 6.15pm, Officer B took a breakfast pack of cereal to him in case he felt hungry later. At 6.18pm, Mr Sampson phoned his partner and left a message that if she had answered the phone he would have told her she had just saved his life. Mr Sampson said he could not go on and was going to end it. He said he had left some notes in his cell and one of them was for her.

68. A few minutes later, all prisoners were locked in their cells for the night. Officer B checked Mr Sampson at 7.00pm and wrote in the ACCT record that he was smoking and said he was okay.

69. Mr Sampson's mother called the prison between 7.15pm and 7.30pm and spoke to the custodial manager in charge of the operation of the prison at the time. (His mother thought she had been put through to an officer on D Wing.) Mr Sampson's mother told him that her son had left messages threatening to harm himself and asked if someone could check he was okay and if Mr Sampson could call her back to reassure her. He said Mr Sampson's mother had not asked for him to be allowed to call her and that, in any case, it would have been too late for prisoners to make phone calls. Mr Sampson's mother asked him to tell Mr Sampson that everything was positive (meaning with his relationship) and she would speak with him as soon as she could.

70. The custodial manager thought Mr Sampson's mother was very concerned about him because of the messages, although she did not say that he had threatened to kill himself. He said that he would ask someone to check on Mr Sampson.

71. The custodial manager asked an SO, who was working in reception, to check that Mr Sampson was alright as his mother was concerned about him. The SO said he had thought his mother was worried, but not gravely concerned. He went to D Wing and looked in on Mr Sampson at 7.40pm, who was sitting on the bed, watching television. He thought Mr Sampson looked okay, and went to the wing office without speaking to him. Officer B told the SO that Mr Sampson was being monitored under ACCT procedures and had seemed okay when she had last checked him. The SO did not record that he had checked Mr Sampson in the ACCT record or the wing observation book.

72. Just before 8.00pm, Officer B checked Mr Sampson, who was watching television. She said he smiled and said he had had some coffee. The officer did not tell him that his mother had called the prison, concerned about him and what she had said. A little while later, the custodial manager checked with the SO, who told him he had been to see Mr Sampson who was fine. The custodial manager decided that he did not need to do anything else.

73. The night orderly officer had arrived for his shift (the manager in charge of the prison at night) just before Mr Sampson's mother called. He knew that the SO had been asked to check Mr Sampson. The SO later rang him to ask if he could leave work early. The night orderly officer asked him about Mr Sampson, and he said that he was lying on his bed watching television when he went to see him. Neither the custodial manager nor the night orderly officer contacted the duty governor about the phone call from Mr Sampson's mother, as Chelmsford's local instructions indicate they should.

74. At 8.45pm, Officer B handed over to a night patrol officer on D Wing. The night patrol officer thought that Officer B had mentioned Mr Sampson's phone calls, but not that his mother had called or that there was any increased concern about him. Officer B could not remember exactly what she had said to the night patrol officer.

75. At 8.50pm, the night patrol officer checked the prisoners for a security count. He thought that Mr Sampson was in bed at the time and had waved to indicate he was okay. Between 9.40pm and 9.45pm he went to Mr Sampson's cell for an ACCT check. The cell was dark but he shone his torch in, and saw Mr Sampson hanging from a ligature made of torn bed sheets and other material, which was

tied to the window bars. He radioed an emergency medical code (he initially used code two, which indicates a blood-related emergency, but quickly amended this to a code one, for a prisoner who is unconscious and not breathing. Either code should alert the control room to call an ambulance immediately). The officer in the control room logged the emergency code at 9.35pm, but this time appears incorrect as, using ambulance records and CCTV footage, we believe that the night patrol officer called at 9.45pm.

76. Two other night patrol officers got to Mr Sampson's cell a minute later. For security reasons, staff on wings do not carry standard keys at night, but have a cell key in a sealed pouch to use in an emergency. One officer used his emergency key, unlocked the cell door and went in. As he did more staff approached the cell. This was 9.47pm. Mr Sampson was in a seated position in front of the window and an officer cut and removed the ligature from around his neck. The officers laid Mr Sampson on the floor. The officer checked Mr Sampson but could not find a pulse. He said that Mr Sampson's eyes were fixed open and he was pale. The officers decided to move Mr Sampson onto the landing to allow more room for cardiopulmonary resuscitation, as the cell was cramped. This was two minutes after they had gone into the cell.

77. Officers had not yet started resuscitation when a nurse arrived 20 seconds later. She told us she was on her way to C Wing (quite near D Wing) when she had heard the emergency radio message. Because the officer who was with her did not have the right keys, they had to go to D Wing via reception.

78. The nurse assessed Mr Sampson but could not find a pulse. She said that Mr Sampson was warm to the touch. An officer began chest compressions, while the nurse left the landing and came back about 45 seconds later with an oxygen cylinder and face mask, which she put on Mr Sampson. The night patrol officer and a healthcare assistant went to collect emergency equipment, including a defibrillator. The nurse attached the defibrillator but it found no shockable heart rhythm. The nurse and the night orderly officer alternated in giving chest compressions.

79. Ambulance records show they received an emergency call at 9.49pm, four minutes after the night patrol officer had radioed the emergency code. (The prison incident log states the ambulance was called at 9.36pm, but we believe this time to be wrong.) The ambulance arrived at Chelmsford at 9.57pm, and the first paramedic reached the cell at 9.59pm. More ambulance crew and paramedics followed and took over emergency treatment. At 10.40pm, the paramedics recorded that Mr Sampson had died.

80. Mr Sampson had left several letters and notes in his cell, explaining his actions. Some of the letters were dated 4 September and timed at 3.50pm and 4.00pm.

Contact with Mr Sampson's family

81. The Head of Operations at Chelmsford and a custodial manager, a trained family liaison officer, went to Mr Sampson's mother's home to break the news of his death. They arrived at 1.20am. One of Mr Sampson's brothers was in another prison and Chelmsford arranged for his mother to visit him the next day to tell him what had happened.

82. An officer took over as the primary family liaison officer the next day and kept in regular contact with Mr Sampson's mother. The prison offered help towards the funeral arrangements and costs in accordance with national instructions.

83. Mr Sampson's mother told us that someone from the prison had called her on the Monday after his death, to check whether she was happy to be on the list of telephone numbers that her son could ring. She was very upset about this and did not consider that the prison had apologised properly for their mistake. This would have been a routine check by someone who had not been informed that Mr Sampson had died. Understandably, this was very distressing for Mr Sampson's mother. It is not possible to rectify this now but we have drawn the matter to the attention of the prison which will need to ensure that its procedures do not allow this to happen again.

Support for prisoners and staff

84. After Mr Sampson's death, the Head of Operations debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

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

Post-mortem report

86. A post-mortem examination found that Mr Sampson had died from suspension or hanging. Toxicology tests found mirtazapine and a trace amount (suggestive of previous, not recent use) of nordiazepam (from diazepam) in his blood.

Findings

Management of the risk of suicide

87. Staff began ACCT procedures to support Mr Sampson, twice at Chelmsford. The first time was on 3 August, shortly after he arrived at the prison and had threatened to kill himself if he was taken to the first night centre. This monitoring ended two days later. The second time was on 12 August, when he was tearful and had threatened to hang himself. This period of ACCT monitoring continued until Mr Sampson's death. The investigation identified some procedural failings in ACCT procedures, especially during the second ACCT period, particularly the lack of healthcare and other multidisciplinary involvement in case reviews, and poor management of the caremap.

88. Prison Service Instruction PSI 64/2011 requires that case reviews should be multidisciplinary where possible. The PSI contains a mandatory action that there is a member of healthcare staff at the first case review. However, there is no record of members of the healthcare team attending any of the six case reviews held for Mr Sampson during the second period of ACCT monitoring and no record of any other input from the healthcare team. This is particularly concerning because of Mr Sampson's mental health issues and problems with his medication.

89. PSI 64/2011 states that caremap actions should have detailed and time-bound actions aimed at reducing the risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress and cover issues such as cell sharing, time out of cell, access to regime activities and family contact. The initial caremap, written on 14 August, said Mr Sampson needed to see the healthcare team about his medication and Atrium for counselling. The caremap was never updated to reflect how these issues had been progressed. An SO acknowledged when interviewed that he should have written in the caremap at later reviews. At the review on 4 September, Mr Sampson raised issues such as lack of tobacco, wanting a cellmate and having panic attacks. The SO told us that he did not add them as the issues had been discussed and Mr Sampson seemed content. However, as he had still not received tobacco and did not have a cellmate, we do not consider that these issues had been addressed and that they should have been added to the caremap.

90. We consider there were at least three occasions on 4 September, in addition to the ACCT case review that morning, when staff should have identified or considered whether Mr Sampson's risk of suicide had increased: when the counsellor and therapist reported her concerns; when a prisoner told Officer A about Mr Sampson's risk; and when Mr Sampson's mother telephone the prison. (We discuss the response to the latter separately below.)

91. When the counsellor and therapist saw him, Mr Sampson was tearful, said he had fleeting thoughts of suicide and that he made a noose a few days before. She alerted officers to this but there is no evidence that this resulted in any meaningful intervention, a search of his cell or any review of Mr Sampson's risk.

92. That afternoon, another prisoner alerted Officer A that Mr Sampson was very upset and he was concerned that he might harm himself. She said that she

could not recall what the prisoner had told her, but we are satisfied from the CCTV footage and from speaking to the prisoner, that he made his concerns very clear. Although she wrote in the ACCT record that Mr Sampson was upset, there is no record that she talked to Mr Sampson about how he was feeling and she did not take any further action. We consider she should have at least discussed the prisoner's concerns about Mr Sampson with a senior manager. This should have led to a review of Mr Sampson's risk and possible additional support, including increased levels of observations. (We understand that the prison is investigating Officer A's response further.)

93. We consider that the ACCT procedures were not effective and not in line with national instructions. We are concerned that there were some clear signs that Mr Sampson's risk of suicide and self-harm increased during the day on 4 September but the response was inadequate. We cannot know whether better ACCT procedures and more effective intervention would have prevented Mr Sampson's actions but not enough was done to ensure his safety. 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 instructions, including:

- **A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.**
- **Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated.**
- **Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves.**
- **Holding ACCT reviews whenever an event occurs that could mean the prisoner is at increased risk.**

Response to Mr Sampson's mother's telephone call on 4 September

94. Prison Service Instruction 64/2011, which contains guidance on safer custody, states that:

*All staff who receive information, including from concerned family members … must communicate their concerns immediately to the Residential, Daily or Night Operational Manager**,** and/or consider opening an ACCT Plan and make a record in an appropriate source e.g. observation book, NOMIS, Security Information Report, ACCT Plan.* [The italics denote a mandatory instruction.]

95. PSI 64/2011 also states that:

In addition to planned case reviews, where an ACCT trigger is activated (i.e. event actually occurs) or there are other concerns such as increases in frequency or lethality e.g. from cutting to using ligatures, or information is received from family/friends or other external parties, a case review must be held. The case review will consider if another assessment is required.

96. Chelmsford has its own Information Sharing Protocol, issued as a Governor's Notice to Staff on 30 March 2015. This states that, in addition to the provisions of PSI 64/2011, such as reviewing the prisoner's risk, the duty governor must be informed of family concerns verbally and by e-mail.

97. Mr Sampson's mother called Chelmsford on the evening of 4 September because she was understandably very concerned about the messages he had left. Although the custodial manager who took the call asked an SO to check on Mr Sampson, this was very poorly communicated. The SO told us that he did not think that Mr Sampson's mother was gravely concerned about him, and therefore did not speak to Mr Sampson when he went to see him. He did not record the check in the ACCT record, as he should have done. The custodial manager did not make a written record of the time, content of the call or actions taken, and did not speak to the duty governor. He did not ask the SO to pass on the message of reassurance from his mother about his relationship with his partner.

98. The custodial manager told us that he had expected the SO to speak to Mr Sampson and decide what further action was required. We consider that this was a reasonable expectation and it is difficult to understand what purpose the SO thought would be achieved by simply looking at Mr Sampson through the door. At the very least he should have talked to him and let him know that his mother was concerned about him. While not routine, subject to their discussions, he should have considered allowing Mr Sampson to speak to his mother, which might have provided reassurance to them both. We note that no one thought to telephone Mr Sampson's mother back, although the local policy requires that staff should update the person who had the concern.

99. Information about Mr Sampson's mother's call was not recorded properly. The custodial manager did not communicate this to the duty governor, as the local policy requires and no one held an ACCT review, as the mandatory instruction in PSI 64/2011 states should happen in these circumstances. We consider that this was a missed opportunity to have properly assessed Mr Sampson's increased risk of suicide and self-harm. We make the following recommendation:

The Governor should ensure that effective action is taken when families report concerns about a prisoner's state of mind, including that an appropriate manager should speak to the prisoner about the concerns, review the level of risk, and record the information and action taken in the prisoner's record.

Mr Sampson's regime

100. Although Mr Sampson had been identified as at risk of suicide and self-harm, he had an extremely restrictive regime, which was little different from segregation when he had no cellmate. This cannot have been good for his mental health and yet it was without the safeguards that apply to someone who is segregated, where there is a requirement that segregation should be used only in exceptional circumstances for someone regarded as at risk of suicide and self-harm.

101. On 20 August, Mr Sampson was punished with 21days loss of association for allegedly using threatening, abusive or insulting words or behaviour. This was

apparently the standard punishment at Chelmsford for such an offence. However, the consequence for Mr Sampson, who had no allocated activity, was that he was effectively confined to his cell, except for a daily period of exercise, a shower, collecting meals and when he was unlocked for telephone calls. His regime was additionally curtailed by being placed on the basic regime.

102. PSI 47/2011, which covers disciplinary procedures in prisons, requires adjudicators to take account of the likely impact on the prisoner, including their health and welfare. There is no evidence that the manager at the hearing considered this and the fact that Mr Sampson received the standard punishment for this offence suggests otherwise. We consider that further decisions resulting from the adjudication, such as reducing him to a basic regime should also take a prisoner's welfare into account and there is no record that this was reviewed as it should have been.

103. In our review of March 2015, setting out learning from self-inflicted deaths in prisons in 2013/14, we noted that a number of prisoners who killed themselves had had less than two hours a day out of their cell in the week before they died and this had increased significantly from the year before. (From 2% to 14%.) One of the lessons we identified was that the cumulative impact of restrictions on regime such as segregation, adjudication punishments, being moved to the basic regime and access to work needed to be taken into account. Lack of activity or lack of income can leave prisoners vulnerable prisoners even more vulnerable. We are concerned that there was little evidence of any consideration of the impact of Mr Sampson's restricted regime on his mental wellbeing. We make the following recommendation:

The Governor should ensure that managers imposing punishments at adjudications, and taking associated decisions afterwards, fully consider the likely impact on the health and welfare of the prisoner.

Clinical care

104. The clinical reviewer judged that Mr Sampson's medical care was not equivalent to that he could have expected in the community. In her review she had made a number of recommendations which the Head of Healthcare will need to address. We set out some of the key findings below.

105. We are concerned about the prescribing of Mr Sampson's diazepam. The clinical reviewer said that Mr Sampson had been appropriately prescribed a low-level dose of diazepam initially. Prison Service Order 3050, which covers continuity of healthcare, requires healthcare staff to make efforts to obtain information from a prisoner's GP or any other relevant service with which he has had recent contact. No one requested Mr Sampson's community GP records to check his diazepam prescription, whether he had been prescribed other medication or whether there was other relevant medical history which would have informed his treatment. As a result, the dose of diazepam was never confirmed.

106. When a psychiatrist saw Mr Sampson on 21 August, he wrote in his summary of that meeting that he expected Mr Sampson's medication (diazepam and mirtazapine) to be continued. He did not consider the dose and the GP was responsible for repeat prescribing. Three prescriptions for diazepam (each one

for seven days) were issued for Mr Sampson, the last one finished on 25 August. A GP told us he did not know why Mr Sampson's prescription for diazepam stopped and why the pharmacy or nurses had not identified this. (As noted above, an ACCT review on 25 August, with no healthcare representation, had wrongly concluded that Mr Sampson's medication issues had been resolved and this was not followed up through the ACCT caremap process.)

107. The clinical reviewer was concerned that Mr Sampson's diazepam was stopped without a GP review, and that Chelmsford could not provide a medication administration chart for Mr Sampson to show when he was given his medication.

108. Guidelines from the National Institute for Health and Care Excellence (NICE) state that patients should withdraw gradually from diazepam where possible. The main symptom of withdrawal is increased anxiety. On 4 September, Mr Sampson told the counsellor that he had not had diazepam for a few days on 4 September and appeared agitated. She shared this information at the multidisciplinary meeting at lunchtime which was attended by three nurses, including a nurse from the mental health team, who was with the psychiatrist when he had advised that Mr Sampson should continue to take diazepam.

109. We consider that this should have led to an urgent GP review but the multidisciplinary meeting decided that as Mr Sampson had not attended a GP appointment on 27 August, he should make a new appointment himself. The Head of Healthcare told us that they monitor non-attendance at GP appointments, and that Mr Sampson had declined the appointment. However, there is no record of this. We would have expected this to have been recorded in both the ACCT ongoing record and in his SystmOne medical record. SystmOne records show that Mr Sampson twice asked for his diazepam to be reviewed – on 6 and 19 August - and we consider it is unlikely that he would have declined an appointment when he had been asking to see the GP for a medication review.

110. A GP accepted that there had been a failure in the primary care system both in confirming Mr Sampson's diazepam use in the community and its appropriate continuation in the prison. We make the following recommendation:

The Head of Healthcare should ensure that:

- **Community GP records are requested in accordance with PSO 3050.**
- **Appropriate mental health assessments are completed and recorded, using recognised diagnostic tools.**
- **Prescriptions for diazepam are not discontinued without a GP review.**
- **Medication administration sheets are completed appropriately.**

Emergency response

111. Mr Sampson's family were concerned that they had been given different times for when Mr Sampson was found hanged. We found that the radio message record system was eight minutes slower than the control room clock, which had led to different times being recorded and in some initial confusion about the emergency response times. We have drawn this to the Governor's attention, as all recording devices in the prison should be set to the correct time.

112. PSI 03/2013, Medical Response Codes, requires governors to have a medical emergency response code protocol and states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The instruction states that, when a medical emergency is called, the control room should call an ambulance immediately and there should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed. Chelmsford has a local protocol in line with PSI 03/2013.

113. The officer in the control room said he rang 999 as soon as he received the code one emergency. He timed this at 9.36pm. However, the East of England Ambulance Service received the call at 9.49pm, and the paramedics arrived on the wing at 9.59pm. Using this time, and comparing it to CCTV footage of the wing, we believe that the night patrol officer called the emergency fourteen minutes earlier, at 9.45pm.

114. In the investigation report into a death at Chelmsford in March 2015, we recommended that control room staff should be briefed that they should call an ambulance as soon as an emergency code is used. The report was issued very shortly before Mr Sampson's death. In response, Chelmsford told us that all control room staff had been reminded of their responsibilities in an emergency, and the local instruction about medical emergency codes was reissued in February 2016.

115. The clinical reviewer reviewed the CCTV footage of the resuscitation attempt and had some concerns that the officer who initially administered chest compressions did not have an effective technique. The nurse left to get equipment rather than performing chest compressions herself or supervising the officers. No one brought emergency equipment to the scene immediately in response to the emergency code and there was a delay while the nurse left to collect oxygen. There was a further delay in using the defibrillator. Some staff said they did not know where the emergency equipment was kept.

116. Paramedics made a long and sustained attempt to resuscitate Mr Sampson but were unsuccessful and we cannot know whether a more effective initial response from prison staff would have changed the outcome. We understand that the prison has recently re-issued instructions about emergency procedures. Our experience is that many prison staff do not see or read written instructions and because of the repeated deficiencies, we consider that there is a need to reinforce instructions through training and face to face briefings. We make the following recommendation:

The Governor should ensure that staff are fully trained and briefed about how to respond in a medical emergency and that there are sufficient competent staff on duty at all times to administer effective basic emergency treatment until qualified professionals arrive.

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