

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Rocky Stenning a prisoner at HMP Chelmsford on 19 July 2018

**A report by the Prisons and Probation Ombudsman**

## Our Vision

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

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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

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

Mr Rocky Stenning was found hanged in his cell at HMP Chelmsford on 19 July 2018, nine days after he arrived. He was 26 years old. I offer my condolences to Mr Stenning's family and friends.

The documentation that accompanied Mr Stenning when he arrived at Chelmsford noted that he had a long history of mental health issues and had come from a secure mental health unit. He also had a history of heavy cannabis use, had made a previous suicide attempt and had just received a lengthy prison sentence. Despite these clear risk factors, staff assessed that he was not at risk of suicide and self-harm and placed him on the prison's main residential wing.

Over the next few days, staff noted that Mr Stenning was struggling to cope and at lunchtime on 19 July, they moved him to a smaller, quieter wing. Around three hours later, he was found hanged in his cell.

I am very concerned that Mr Stenning's risk factors for suicide and self-harm were not properly considered by prison reception staff and an opportunity to support him using Prison Service suicide and self-harm procedures was missed.

The investigation also found that Mr Stenning did not receive adequate care for his mental health at Chelmsford. Although mental health staff reviewed him, they did not address his risks and potential triggers for suicide and self-harm, or consider placing him on a Care Programme Approach, which is used to support those with complex mental health needs. I am not satisfied that the care Mr Stenning received was equivalent to that which he could have expected to receive in the community.

I am also concerned that agency nursing staff appeared to lack basic life support skills when attempts were made to resuscitate Mr Stenning.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**February 2019**

## **Contents**

Summary .....	1
The Investigation Process .....	4
Background Information .....	5
Key Events .....	7
Findings.....	11

# Summary

## Events

1. On 10 July 2018, Mr Rocky Stenning was sentenced to nine years imprisonment for wounding with intent and sent to HMP Chelmsford. He had bipolar disorder, a long history of mental ill-health and a history of attempted suicide. He had been sectioned under the Mental Health Act and had been in a mental health unit until he attended court for sentencing on 10 July.
2. When he arrived at Chelmsford, staff assessed that Mr Stenning was not at increased risk of suicide or self-harm and that he did not need to be monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT). However, over the next few days, staff identified that Mr Stenning was feeling overwhelmed on one of the main wings and at lunchtime on 19 July, he was moved to a smaller, quieter residential wing.
3. At around 2.26pm on 19 July, an officer found Mr Stenning hanging in his cell by a bed sheet attached to the window. Staff and ambulance paramedics were unable to resuscitate him and at 3.00pm, paramedics recorded that Mr Stenning had died.

## Findings

4. We are very concerned that, although Mr Stenning had several risk factors for suicide and self-harm when he arrived at Chelmsford, reception staff failed to identify these and instead relied on Mr Stenning's assertions that he had no thoughts of harming himself. As a result, an opportunity to support Mr Stenning under ACCT procedures was missed.
5. We are also concerned that staff again failed to identify Mr Stenning's risk factors when he was moved to a quieter wing on the day of his death after presenting as withdrawn, overwhelmed and vulnerable.
6. This is not the first time we have expressed concern about failures to identify risk factors for suicide and self-harm at Chelmsford.
7. The clinical reviewer found that the care Mr Stenning received for his mental health was not equivalent to that which he could have expected to receive in the community. Although Mr Stenning was reviewed by mental health staff at Chelmsford, they failed to address his risk factors for suicide and self-harm. Staff also failed to consider using the Care Programme Approach, used to support those with complex mental health needs.
8. The clinical reviewer also identified some concerns with the healthcare response when Mr Stenning was found hanging.
9. Due to an oversight by staff, Mr Stenning was not given access to the prison's PIN telephone system and was therefore unable to contact his family during his nine days at Chelmsford.
10. Mr Stenning's family were told of his death by fellow prisoners, who had contacted them using illicit mobile phones.

## Recommendations

- The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. First night procedures should recognise the additional vulnerabilities of newly arrived prisoners. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:
  - have a clear understanding of their responsibilities and the need to share all relevant information about risk;
  - consider and record all known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from their Person Escort Record (PER) and other sources;
  - document the information considered and the reasons for the decisions taken; and
  - start ACCT procedures whenever a prisoner has significant risk factors, irrespective of their stated intentions.
- The Prison Group Director for Hertfordshire, Essex and Suffolk should, by 31 March 2019, provide the Ombudsman with a report on the action he is taking to ensure that Chelmsford addresses deficiencies in the identification of prisoners at risk of suicide and self-harm.
- The Head of Healthcare should review the mental health screening and assessment procedures at Chelmsford so that:
  - there is a robust and timely process to identify risks and triggers for self-harm and suicide, and that all staff are familiar with national guidance contained in PSIs;
  - consideration is given to placing at-risk prisoners on an ACCT in their early days in custody until a full mental health assessment has been completed and record the reasons for their decisions; and
  - the Care Programme Approach is implemented where appropriate.
- The Head of Healthcare should:
  - review the mandatory training given to agency staff;
  - ensure agency staff are given appropriate training so they are competent to deal with emergency incidents and have sufficient Basic Life Support skills; and
  - ensure healthcare staff make an accurate and contemporaneous entry in a prisoner's medical record if they are involved in an emergency incident.

- The Governor should ensure that all prisoners who are subject to PSO 4400 arrangements when they first arrive are reviewed within 48 hours and PIN phone access is granted at the earliest opportunity.
- The Governor should review the local security strategy and ensure that everything possible is being done to prevent mobile phones entering the prison.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at Chelmsford, informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
12. The investigator visited Chelmsford on 30 July, and obtained copies of relevant extracts from Mr Stenning's prison and medical records. She interviewed two prisoners on E Wing.
13. NHS England commissioned a clinical reviewer to review Mr Stenning's clinical care at the prison.
14. The investigator interviewed nine members of staff at Chelmsford on 30 August, accompanied by the clinical reviewer. In addition, the investigator interviewed three members of staff and one ex-prisoner and the clinical reviewer interviewed two members of healthcare staff by telephone.
15. We informed HM Coroner for Essex and Thurrock of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. The investigator contacted Mr Stenning's family to explain the investigation. Mr Stenning's family wanted to know what support Mr Stenning received at Chelmsford and why he was not located in healthcare or on a wing where he could be closely observed, having just been moved from a secure mental health unit. Mr Stenning's family also wanted to know why he was not allowed to have access to a telephone.
17. Mr Stenning's family received a copy of the initial report, but did not identify any factual inaccuracies.
18. The prison received a copy of the report and identified some factual inaccuracies which have been amended. An action plan for the recommendations is annexed to the report.

## Background Information

### HMP Chelmsford

19. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It can hold up to 740 men aged 18 years and older. Essex Partnership University Trust provides healthcare.
20. Chelmsford is one of 11 prisons placed in Special Measures in June 2018. This means that HM Prison and Probation Service has determined the prison needs additional, specialist support to improve performance.

### HM Inspectorate of Prisons

21. The most recent inspection of HMP Chelmsford was in May 2018. Inspectors had significant concerns about the safety of Chelmsford, especially how men who were at risk of suicide and self-harm were managed. Support during prisoners' early days was found to be adequate, but reception processes were underdeveloped and arrangements at the first night centre were disorganised.
22. Inspectors noted there had been 16 self-inflicted deaths over the previous eight years, and four since their last inspection. Inspectors identified too many recommendations from the Prisons and Probation Ombudsman had not been implemented. Levels of self-harm and the use of constant watch were very high, and the care provided was often not good enough. Inspectors noted many staff had become very risk adverse, which meant these procedures were often overused, which in turn risked masking the needs of particularly vulnerable men. The almost complete lack of a broad strategic response to these issues was a major concern.
23. The inspection of health services was jointly undertaken by the Care Quality Commission (CQC). They found health provision had improved since the last inspection, but several key areas remained poor and that significant staffing shortages at every grade adversely affected service delivery and leadership. Mental health services were very stretched, partly due to the large number of ACCT reviews and staffing shortages. Overall the service was found to be too reactive and the range of support was inadequate. The Care Programme Approach (CPA) for men with severe and enduring mental illness was not used.

### Independent Monitoring Board

24. 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.
25. 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 considered that the

general shortage of resources continued to make it difficult to ensure the safety of prisoners and staff.

### **Previous deaths at HMP Chelmsford**

26. Mr Stenning was the 12<sup>th</sup> prisoner to die at Chelmsford since July 2015 and the seventh to take his own life. Our investigations into these deaths found that staff's assessment of prisoners' risk of suicide and self-harm was inadequate, and improvement in mental health care was needed. In April 2018, we escalated our concerns to the Prisons Group Director for Hertfordshire, Essex and Suffolk. There have been four further deaths since Mr Stenning's, one self-inflicted, one from natural causes and two are awaiting classification.

### **Assessment, Care in Custody and Teamwork**

27. 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.
28. 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.
29. 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*.

## Key Events

30. Mr Rocky Stenning was detained under Section 3 of the Mental Health Act at Basildon Mental Health Unit (BMHU) on 28 March 2018. He was informally discharged in June but remained at BMHU until 10 July, when he attended Basildon Crown Court for sentencing. Mr Stenning was sentenced to nine years imprisonment for wounding with intent and taken to HMP Chelmsford. This was not his first time in prison.
31. Mr Stenning arrived at Chelmsford around 4.30pm on 10 July. Court staff had recorded on the 'risk indicator' form in his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons and which sets out the risks they pose) that Mr Stenning had been diagnosed with bipolar disorder and prescribed antipsychotic medication to treat the symptoms. There was nothing noted on the risk indicator form about any suicide or self-harm risk, or that Mr Stenning had been received at court from a mental health unit, though there was an entry made at 12pm on the history sheet of the PER form, 'vulnerable due to mental health issues and coming to court from Basildon Mental Health Unit today'.
32. A nurse completed the initial healthscreen at 6.54pm and noted Mr Stenning did not have any physical health issues. She recorded that Mr Stenning was paranoid and did not want to share a cell, but that he had no thoughts of suicide or self-harm. She recorded Mr Stenning had bipolar disorder and referred him for a mental health assessment. She recorded that Mr Stenning had previously tried to hang himself, and that a recent life event had increased his risk, but did not consider Mr Stenning needed to be supported by Prison Service suicide and self-harm prevention measures (known as ACCT).
33. An officer completed the cell sharing risk assessment (CSRA) and recorded that Mr Stenning had stated he was racist, due to an incident on a previous sentence when he was assaulted. She noted that Mr Stenning said he had no current thoughts of suicide or self-harm, but was shocked by the length of his sentence. She recorded on the CSRA that Mr Stenning's risk to others was 'high due to healthcare' and the CSRA is stamped 'PSO 4400 H' (Prison Service measures to prevent prisoners contacting victims of harassment). When interviewed, the officer said she had no recollection of her contact with Mr Stenning, but noted the writing either side of the PSO 4400 stamp was different and recorded by someone else (not identified).
34. A nurse completed the health assessment section of the CSRA. She recorded Mr Stenning was at increased risk, but gave no specific details of what she based this assessment on. The authorisation for the CSRA assessment was not completed.
35. An officer completed Mr Stenning's first night induction and basic custody screening tool 1 (BCST1 – an assessment of immediate risks and needs). He recorded in Mr Stenning's prison record that Mr Stenning disclosed he had attempted to take his own life aged 16 after the death of his father (by suicide), but had no current thoughts of suicide or self-harm and did not have any specific issues. He recorded that Mr Stenning was subject to PSO 4400. He said he did

not remember the specifics of their conversation, but he recalled that there was 'something' about Mr Stenning's answer or explanation of his offence or a comment about a previous harassment, that alerted him to the possibility that PSO 4400 might apply.

36. Mr Stenning was placed on E Wing, the integrated drug treatment services (IDTS) wing, because there was no space on the induction unit. Despite healthcare staff being aware of his history of substance misuse, Mr Stenning was never referred for assessment.
37. On 11 July at 12.01pm, a mental health nurse recorded that he had received the mental health assessment referral. He noted Mr Stenning had a history of bipolar disorder, had recently been sectioned under the Mental Health Act, and that the psychiatric report prepared for the court hearing had recommended that Mr Stenning be assessed by the prison's mental health team.
38. Later that day, Mr Stenning was discussed at the mental health team referral and allocations meeting, which was attended by mental health nurses and an officer from Full Circle, the psychosocial support team for substance misuse. A nurse recorded in Mr Stenning's prison record the dates Mr Stenning had been detained at BMHU, that he was a cannabis user and that he was known to the community mental health team.
39. At 12.08pm, a supervising officer (SO) recorded on Mr Stenning's prison record that he had received a self-harm warning form and had spoken to Mr Stenning. The SO told the investigator he had met Mr Stenning earlier that morning and made the entry at the first opportunity. He noted Mr Stenning was 'still finding his feet but currently has no thoughts of self-harm or suicide'. He told Mr Stenning an offender supervisor (responsible for his sentence planning and liaising with external probation services) would be allocated within a week and advised what support was available to him at Chelmsford. The SO noted 'No need for an ACCT at this time'.
40. At 3.48pm, a prison psychiatrist and a nurse met with Mr Stenning. The psychiatrist recorded that Mr Stenning had never self-harmed and denied any thoughts or plans. He noted Mr Stenning had been sectioned under the MHA several times previously, was a heavy cannabis user and that his sentence was 'sinking in'. He recorded that Mr Stenning wanted his medication reinstated and that he would review his medication when they next met. He prescribed Mr Stenning with antipsychotic medication (Depakote and aripiprazole) and medication to treat anxiety and to help him sleep (clonazepam and zopiclone). He scheduled a review for 20 July. Mr Stenning took his medication as prescribed.
41. On 11 July (no time recorded) an administrator in the public protection team, recorded on Mr Stenning's prison record that a risk alert for domestic violence perpetrator had been made active. She did not create an alert for PSO 4400, as it did not apply.
42. On 13 July, a probation worker was allocated as Mr Stenning's offender supervisor, but she did not meet Mr Stenning before he died.

43. On 18 July, a resettlement worker completed the BCST2. She noted that Mr Stenning said he had no drug or alcohol issues, intended to return home on release, had no restraining orders imposed on him and had the support of his family. No other issues were identified.

#### Thursday 19 July

44. An officer recorded in Mr Stenning's prison record at 10.35am that he had been asked by a SO to speak to Mr Stenning about moving to D Wing. The officer recorded, 'He [Mr Stenning] presented as withdrawn and quite overwhelmed by his surroundings on a main population wing... he spoke open and honestly about how he was feeling and struggled to maintain eye contact. He had recently arrived here after being in a secure unit in Basildon. Wing staff state Rocky is not a discipline issue and due to his level of vulnerability I believe he is suited for D Wing. At no point did Rocky possess [sic] any thoughts of suicide or self-harm'.
45. Mr Stenning was moved to D Wing between 11.00am and 12 noon. A SO made an entry on Mr Stenning's prison record at 12.47pm, 'Moved to D Wing which he [Mr Stenning] thanked me for sorting out for him, said thank you for helping me to get to a wing that will be suited to me. No other issues raised.'
46. An officer said that he introduced himself to Mr Stenning, who said he was okay, and organised a sandwich for him as he had not had lunch because of moving wings. Mr Stenning was locked in his cell.
47. Closed circuit television (CCTV) shows at 2.26pm, an officer walked down the stairs, directly opposite Mr Stenning's cell, to start his roll check. The officer looked into Mr Stenning's cell and immediately unlocked the door and entered, while shouting for staff assistance. There were prisoners on the stairs and one prisoner went to the door of Mr Stenning's cell and also shouted for staff. Mr Stenning was hanging in his cell by a sheet attached to the window.
48. Less than a minute later, two officers responded and they went into the cell. The officer already in the cell continued to support Mr Stenning, while another officer removed the ligature and radioed a code blue medical emergency (used where a prisoner is unconscious or has breathing difficulties). They lowered Mr Stenning to the floor and started cardiopulmonary resuscitation (CPR).
49. At 2.28pm, four more officers responded and a nurse arrived carrying a red medical emergency bag. The nurse walked past Mr Stenning's cell, she looked in, but continued to the wing office on the opposite side of the landing. A minute later another nurse arrived and instructed officers to move Mr Stenning out of the cell so they had more space. The first nurse returned with a blue/black medical emergency bag. The second nurse attached an automatic external defibrillator (AED) to Mr Stenning, which indicated there was no shockable heart rhythm. Three more nurses, the clinical manager and a healthcare assistant also arrived to assist as did a prison GP. Staff continued CPR until paramedics arrived.
50. East of England Ambulance Service records show they received a request for an emergency ambulance at 2.27pm. Paramedics arrived at the prison at 2.32pm and were with Mr Stenning at 2.33pm. An air ambulance landed in the grounds

of the prison, but was not required. Paramedics continued resuscitation but at 3.00pm, recorded that Mr Stenning had died.

### **Contact with Mr Stenning's family**

51. Chelmsford appointed a SO as the family liaison officer (FLO). He and another FLO started the process of identifying Mr Stenning's next of kin.
52. Chelmsford received two telephone calls from Mr Stenning's sister stating that prisoners had informed her of the situation by mobile phone and that Mr Stenning had either died or had been taken away by air ambulance. A member of staff from the safer custody team spoke to Mr Stenning's sister around 4.00pm and told her prison staff were on their way to visit the family and would explain what had happened. At 4.25pm, the FLO arrived at Mr Stenning's sister's address and told her that Mr Stenning had died. They offered their condolences and support.
53. The FLO remained in contact with Mr Stenning's sister until his funeral, which took place on 14 August. The prison contributed towards the cost, in line with national policy.

### **Support for prisoners and staff**

54. A hot debrief was held for all staff involved in the emergency response.
55. The prison posted notices informing other prisoners of Mr Stenning'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 Stenning's death. The prison held memorial services for Mr Stenning for E and D Wing prisoners.

### **Post-mortem report**

56. The post-mortem report shows that Mr Stenning died from hanging. Toxicology tests detected a very low concentration of cannabis in Mr Stenning's blood, along with his prescribed drugs, which were within the therapeutic range.

# Findings

## Assessment and management of Mr Stenning's risk

57. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, 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. The risk factors that applied to Mr Stenning included mental health issues, recent discharge from a mental health unit, history of suicide attempt, substance misuse issues and receiving a long sentence.
58. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in 2014, we identified that too often reception assessments place too much weight on staff's perception of the prisoner and do not consider all relevant information. We reinforced these messages in another learning lessons bulletin, issued in February 2016, about early days and weeks in custody.
59. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.
60. Prison Service Instruction (PSI) 07/2015 - *Early Days in Custody*, which covers reception processes, is clear that staff should examine all information, including the PER, to identify any immediate needs and risks, and to assess the risk of self-harm. It says that staff should note all relevant information in the appropriate record, and that they should inform other staff and act on the information identified, where necessary.
61. When Mr Stenning arrived at Chelmsford on 10 July 2018, the PER that accompanied him noted his mental health issues and that he had arrived at court from a mental health unit. The nurse told the investigator that she 'glanced' at the psychiatric report that arrived with Mr Stenning, and was unaware of his father's suicide, another possible risk factor. All staff should be alert to the increased risk of suicide and self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including beginning suicide and self-harm prevention procedures, if necessary. During interviews it was clear not all staff were familiar with the information contained in the PSIs about identifying possible risks and triggers.
62. We are also concerned that staff did not identify that Mr Stenning was at increased risk on the day of his death, even though he was moved to a quieter wing because he presented as 'withdrawn', 'quite overwhelmed' and vulnerable. Again, staff relied on the fact that he did not express any thoughts of suicide and self-harm, rather than considering his risk factors.

63. Nobody who had contact with Mr Stenning assessed that he had an increased risk of suicide and self-harm. We found that staff did not properly consider Mr Stenning's risk factors when he arrived at Chelmsford and there was no record of why prison and healthcare staff decided that ACCT procedures were unnecessary, other than how Mr Stenning presented. We therefore make the following recommendation:

**The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. First night procedures should recognise the additional vulnerabilities of newly arrived prisoners. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:**

- **have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **consider and record all known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from their Person Escort Record (PER) and other sources;**
- **document the information considered and the reasons for the decisions taken; and**
- **start ACCT procedures whenever a prisoner has significant risk factors, irrespective of their stated intentions.**

62. We have expressed concerns about deficiencies in the identification of prisoners at risk of suicide and self-harm in the past and in April 2018, we copied our report on a previous self-inflicted death to the Prison Group Director so he could satisfy himself that effective action was taken to address these deficiencies. We now make the following recommendation:

**The Prison Group Director for Hertfordshire, Essex and Suffolk should, by 31 March 2019, provide the Ombudsman with a report on the action he is taking to ensure that Chelmsford addresses deficiencies in the identification of prisoners at risk of suicide and self-harm.**

## **Management of Mr Stenning's clinical care**

### ***Mental health care***

63. The clinical reviewer concluded that the mental health care Mr Stenning received at Chelmsford was not equivalent to the care he could have expected to receive in the community. Despite being reviewed by the mental health services, the allocations process and the prison psychiatrist during his short time at Chelmsford, Mr Stenning's risks and triggers for suicide and self-harm were not identified or addressed.
64. Mr Stenning arrived at Chelmsford having been recently discharged from a secure mental health unit, but no consideration was given to using the Care

Programme Approach (CPA - an NHS system of delivering mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm) to identify a care coordinator and plan his care. On arrival at the prison he presented as paranoid and did not want to share a cell. A psychiatrist reviewed Mr Stenning the next day, partly because of concerns about his potential for aggressive behaviour but also to ensure that he received his prescribed medication without further delay. (The reception GP did not review or prescribe Mr Stenning's medication when he arrived on 10 July. The investigator was unable to establish why. The psychiatrist said that he had raised this with the healthcare manager and the lead psychiatrist but he said not having medication for a short period would have no significant impact.)

65. While Mr Stenning was assessed quickly by the psychiatrist, a more comprehensive assessment of his risks and needs was not completed before he took his own life. The focus was on ensuring he received his medication and because Mr Stenning appeared to display no obvious signs of distress, he was not considered to be at a heightened risk. We therefore make the following recommendation:

**The Head of Healthcare should review the mental health screening and assessment procedures at Chelmsford so that:**

- **there is a robust and timely process to identify risks and triggers for self-harm and suicide, and that all staff are familiar with national guidance contained in PSIs;**
- **consideration is given to placing at-risk prisoners on an ACCT in their early days in custody until a full mental health assessment has been completed and the reasons for decisions are recorded; and**
- **the Care Programme Approach is implemented where appropriate.**

### *Substance misuse*

66. Mr Stenning was documented to be a heavy cannabis user. He was initially placed on E Wing, the substance misuse wing at Chelmsford, but only because there were no spaces on the induction unit. He was discussed at a referral meeting on 11 July, which included members of the mental health services and a representative from Full Circle, a service delivered by Phoenix Futures which works with offenders with complex needs, including substance misuse. However, the outcome of the meeting was to complete a mental health assessment and Mr Stenning was not seen by the substance misuse service.
67. The clinical reviewer considered that Mr Stenning did not receive adequate support with his substance misuse issues, and the care was not equivalent to that which he could have expected to receive in the community. We therefore make the following recommendation:

**The Head of Healthcare should ensure that all prisoners with a history of substance misuse issues are fully assessed to identify their risks and needs.**

## Emergency response

68. Staff called a medical emergency code appropriately when they discovered Mr Stenning and an ambulance was requested without delay in line with PSI 03/2013 – *Medical Emergency Response Codes*. The clinical reviewer concluded that, overall, the emergency response was largely equivalent to the care Mr Stenning would have received in the community. However, the clinical reviewer raised concerns about some aspects of the healthcare response.
69. The first nurse to arrive at Mr Stenning's cell continued walking past it to the wing office. She said that her priority was to collect the emergency bag, including the defibrillator, as staff were already undertaking CPR. By the time she got back to the cell, another nurse had arrived and had taken control.
70. The second nurse to arrive told the clinical reviewer that she had not been assigned the role of emergency response nurse but, when she heard the code blue, she responded and coordinated the resuscitation attempt. She attached the defibrillator, inserted an airway and shouted for someone to get the oxygen. She said she expected it to be ready for use immediately, but the two qualified nurses present could not attach the correct mask or turn on the oxygen cylinder. She said she received more support from the healthcare assistants present than the qualified nurses.
71. The second nurse said she asked for the suction machine to remove some vomit from Mr Stenning's throat, but neither of the nurses could identify that piece of equipment. She also told the nurses to measure Mr Stenning's pulse and oxygen levels, but she believed they were unable to. The nurse said while she was checking Mr Stenning's pulse, one of the nurses pulled out the airway when she attempted to use the suction machine and, when she attempted to reinsert it, she put it in upside down. That nurse has since left Chelmsford.
72. The first nurse to get to Mr Stenning's cell did not make an entry in Mr Stenning's medical record about her involvement in the emergency response, and the entry made by the other nurse was inaccurate. The first nurse told the investigator that she had panicked when she was asked to open the oxygen cylinder and had been unable to open it. She accepted she probably needed more training, even though she had recently completed basic life support (BLS) training which she had arranged herself.
73. The healthcare manager said only one agency is used to provide healthcare staff and they are responsible for meeting minimum standards of training and skills. She was surprised that a nurse had arranged her own BLS training. The healthcare manager said the Deputy Director from Essex Partnership University Trust, which provides healthcare services at Chelmsford would be meeting with the agency to review training for staff.
74. The healthcare manager also said there had been 'historical dynamics' between the different teams of healthcare staff and she was working on enabling staff to work more closely together and to support each other. She said she would speak to all healthcare staff about the need for complete and accurate records.

75. The clinical reviewer has made several recommendations in her report which the Head of Healthcare should consider. We make the following recommendation:

**The Head of Healthcare should:**

- **review the mandatory training given to agency staff;**
- **ensure agency staff are given appropriate training so they are competent to deal with emergency incidents and have sufficient Basic Life Support skills; and**
- **ensure healthcare staff make an accurate and contemporaneous entry in a prisoner's medical record if they are involved in an emergency incident.**

**Access to PIN phone**

76. Mr Stenning was not given access to the prison's PIN telephone system while he was at Chelmsford. The officer who initially flagged that PSO 4400 might apply, said he was learning the induction process from more experienced staff and this was one of the first induction interviews he had completed. He said reception was particularly busy on 10 July, with around 18 new prisoners to interview. When he interviewed Mr Stenning he saw an historical alert for harassment, but did not know the details of his current offence and he thought it might be relevant from something Mr Stenning had said.
77. The officer said he had been told by more experienced staff that if he was in any doubt whether PSO 4400 applied, he should answer 'yes' to temporarily restrict PIN phone access. The information would then be reviewed within 48 hours by wing staff, security and the Public Protection Team (PPT) who would consider whether restrictions should be applied, and then PIN phone restrictions would be lifted to enable authorised numbers to be added.
78. The investigator interviewed the business hub manager for the PPT. She said an alert had previously been put on Mr Stenning's prison record in March 2010, because of information contained in an OASys risk assessment, and that this was probably what flagged the possibility of PSO 4400 restrictions to first night staff. She said this was not unreasonable, but that her team reviewed Mr Stenning's PSO 4400 status on 11 July, and did not add an alert (alerts are there to flag any potential risks) to Mr Stenning's prison record as it did not apply.
79. Wing staff should have set up PIN phone access for Mr Stenning but never did so. Although there is no evidence Mr Stenning asked prison staff about telephone access, it is clear from his records that contact with his family was a protective factor. All prisoners should have the ability to contact their families and we therefore make the following recommendation:

**The Governor should ensure that all prisoners who are subject to PSO 4400 arrangements when they first arrive are reviewed within 48 hours and PIN phone access is granted at the earliest opportunity.**

## Access to mobile telephones

80. We are concerned that Mr Stenning's family learnt of his death from other prisoners using illicit mobile phones. This was very distressing for his family and we consider that the prison needs to do more to prevent prisoners gaining access to mobile phones. We therefore make the following recommendation:

**The Governor should review the local security strategy and ensure that everything possible is being done to prevent mobile phones entering the prison.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations