

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert Chapman a prisoner at HMP Northumberland on 1 July 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

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

## Our Values

**We are:**

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

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

**Inclusive:** *we value diversity*

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

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

**OGL**

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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 Robert Chapman was found hanging in his cell on 1 July. He was 26 years old. I offer my condolences to Mr Chapman's family and friends.

Mr Chapman was remanded into custody in October 2015. He was sent to HMP Holme House and was subsequently transferred to HMP Durham. In March 2016, Mr Chapman was convicted and given a 78-month sentence. He was transferred to HMP Northumberland in April.

Mr Chapman had a history of mental illness and drug abuse and of attempted suicide and self-harm. I am concerned that reception staff at Durham did not identify Mr Chapman as being at risk of suicide and self-harm and do not appear to have considered the well-documented information about his risk when he returned from his court appearance.

Suicide and self-harm prevention procedures at HMP Northumberland were poor. Mr Chapman had a number of known risk factors which were significantly compounded by the news that his step-father had died. I am also concerned at the delay in calling an ambulance and the delay in breaking the news to Mr Chapman's family.

Finally, I am concerned at the evident availability of illicit drugs at Durham and Northumberland which the management of both prisons need to address.

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 2017**

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# Summary

## Events

1. On 14 October 2015, Mr Robert Chapman was remanded into custody at HMP Holme House. Mr Chapman had been in prison before and had served several custodial sentences, the last of which had ended in January 2015. Mr Chapman had a history of mental illness and drug abuse and of attempted suicide and self-harm.
2. On 15 October, Mr Chapman attempted suicide by hanging. He was resuscitated and taken to hospital and staff began ACCT procedures to support him. (Assessment, Care in Custody and Teamwork is the process the prison service uses to support those at risk of suicide and self-harm.) Mr Chapman was discharged from hospital on 21 October, and the ACCT plan was closed on 29 October. On 31 October 2015, Mr Chapman was transferred to HMP Durham.
3. On 21 March 2016, Mr Chapman appeared in court and, following trial, was convicted and sentenced to 78 months in custody. After he apparently took a deliberate overdose of illicit drugs, a suicide and self-harm warning form was completed at court. But on his return to Durham, no one considered that he was at risk of self-harm or suicide. On 23 March, Mr Chapman self-harmed again and staff then began ACCT procedures.
4. On 7 April, Mr Chapman was transferred to HMP Northumberland with the ACCT plan still open. On 11 April, the ACCT plan was closed.
5. On 1 July, an officer informed Mr Chapman that his step-father had died. At 8.58pm, another officer found Mr Chapman hanging in his cell and called for emergency medical assistance. Staff responded and started cardiopulmonary resuscitation (CPR). An ambulance was called at 9.02pm. Paramedics arrived at 9.20pm and, at 10.27pm, pronounced Mr Chapman dead.

## Findings

### Management of risk of suicide and self harm

6. The investigation found that Mr Chapman should have been managed under ACCT procedures when he returned to Durham from court on 21 March.
7. There were deficiencies in the operation of suicide and self-harm prevention procedures at Northumberland. Case reviews were not multidisciplinary and the assessment of Mr Chapman's risk failed to include consideration of all his risk factors. Plans were closed without any evidence that his risk of suicide and self-harm had reduced. ACCT procedures should have been put in place to support Mr Chapman when he received the news that his step-father had died.

### New Psychoactive Substances/Illicit drugs

8. We are concerned at the evident availability of illicit drugs at both Durham and Northumberland, particularly New Psychoactive Substances (NPS). The post-mortem and toxicology results show that Mr Chapman used illicitly-obtained prescription drugs at the time of his death, and he also may have used NPS.

## Emergency response

9. We are concerned about the emergency response. After officers called an emergency it took four minutes before support staff called an ambulance. While a quicker response may not have affected the outcome for Mr Chapman, it could be crucial in other circumstances.

## Liaison with the Mr Chapman's family

10. Northumberland did not follow national instructions and there was an unreasonable delay in breaking the news of Mr Chapman's death to his family.

## Recommendations

- The Governor of Durham should ensure, in line with PSI 64/2010, that measures are in place for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception staff:
  - Have a clear understanding of their responsibilities and the need to share all relevant information about risk;
  - Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including information from PERs and other sources;
  - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
- The Director of Northumberland should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Understanding their responsibilities and the need to share all relevant information about risk;
  - Considering and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm;
  - Assessing the level of risk and recording the reasons for decisions;
  - Conducting ACCT reviews as specified in the national instructions.
- The Governor of Durham and the Director of Northumberland should ensure there is an effective supply and demand reduction strategy to help eradicate the availability of New Psychoactive Substances and other drugs, and that staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances.
- The Director of Northumberland should ensure that all prison staff are made aware of and understand PSI 03/2013, *Medical Emergency Response Codes* and their responsibilities during medical emergencies which:
  - Ensures staff immediately call for an emergency ambulance when a medical emergency code is used;

- Ensures that an emergency response protocol is in place with the ambulance service;
- The Director at Northumberland should ensure that when a prisoner dies, the next of kin is informed without undue delay in accordance with national instructions.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Chapman's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Chapman's clinical care at the prison.
14. The investigator interviewed nine members of staff and one prisoner at Northumberland in August, three jointly with the clinical reviewer. The clinical reviewer interviewed one member of healthcare staff by phone.
15. We informed HM Coroner for North Northumberland of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Chapman's family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. Mr Chapman's family wanted to know if he had received treatment for depression. They wanted to know why, as Mr Chapman had previously attempted suicide, he was not being closely monitored. They also wanted to know the reason there was a delay in informing them of Mr Chapman's death. Mr Chapman's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

# Background Information

## HMP Durham

17. HMP Durham is a local prison serving the courts of Durham, Tyneside, and Cumbria, and holds approximately 1,000 men. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

## HM Inspectorate of Prisons

18. The most recent inspection of HMP Durham was conducted in October 2016. Inspectors reported that, since the previous inspection in 2013, the prison was still not safe enough and not sufficiently respectful. Inspectors found that more prisoners felt unsafe and there was clear evidence that illicit drugs were readily available in the prison. Inspectors observed both commendable interaction and care by many staff but also too much disengagement and lack of care by others. Inspectors noted that outcomes in work, learning and skills, and the prison's delivery of resettlement had deteriorated. Inspectors found the provision of health care was reasonable, with some excellent mental health interventions.

## Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report to October 2016 the IMB reported that healthcare staff recruitment was a major issue for the prison. The IMB noted concerns that the prison was over-crowded and operated at all times close to its operational capacity, with cells built for single occupancy nearly all occupied by two prisoners. The IMB also reported that the number of violent incidents had increased and the lack of CCTV evidence prevented perpetrators being brought to justice.

## HMP Northumberland

20. HMP Northumberland is a training prison operated by Sodexo, predominantly holding prisoners from the North East. The prison holds up to 1,300 men. Care UK provides healthcare services between 7.30am and 8.15pm each day.

## HM Inspectorate of Prisons

21. In the report of the most recent inspection of Northumberland conducted in September 2014, inspectors noted that there had been three self-inflicted deaths since their last inspection in 2012. Monitoring of the implementation of the Prisons and Probation Ombudsman's recommendations into deaths at the prison had lapsed. The number of prisoners assessed as being at risk of suicide or self-harm and being monitored under ACCT procedures was relatively low. Inspectors found the quality of care they received and of mental health services were good. There were a high number of violent incidents and many prisoners felt unsafe. Inspectors noted that the management and monitoring of bullying and violence reduction had received little attention in the months before their inspection.

## 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 31 December 2015, the IMB found that the prison had settled down after major change in 2014, but that the level of self-harm remained a concern. Incidents of self-harm had increased by 20% since 2014. The number of closed visits, banned visitors and drugs finds had increased, which indicated tighter control of drugs entering the prison. The IMB reported that violence, disruptive behaviour and self-harm levels fluctuated, and safety remained an important focus.

## Previous deaths at HMP Northumberland

23. Mr Chapman's death was the fourth self-inflicted death we have investigated at Northumberland since 2015. We have previously identified the need for effective assessments of prisoners at risk of suicide and self-harm.

## Assessment, Care in Custody and Teamwork (ACCT)

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. 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. 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 *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

## New Psychoactive Substances

25. New Psychoactive Substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
26. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence, and intimidation.
27. In July 2015, we published a Learning Lessons Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness

among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

## Key Events

### HMP Holme House

28. On 14 October 2015, Mr Robert Chapman was remanded in custody to HMP Holme House charged with burglary, use of offensive weapons and supply of Class A drugs. Mr Chapman had served numerous custodial sentences and his last sentence had ended on 16 January 2015. He had a significant history of mental illness and drug abuse and of attempted suicide and self-harm.
29. When Mr Chapman arrived at Holme House he appeared to be under the influence of illicit substances. He was agitated, had fixed and dilated pupils, and had raised blood pressure of 154/117. Mr Chapman was immediately transferred to the inpatient healthcare wing for monitoring.
30. On 15 October, at 4.49am, an officer found Mr Chapman with a ligature made from shoe laces around his neck. Staff called an emergency code blue which indicates a person found unresponsive or with breathing difficulties. An officer cut the ligature and noted that Mr Chapman was fully responsive. Staff opened an ACCT immediately.
31. At 9.00am, Mr Chapman collapsed in his cell and was taken by ambulance to hospital. Mr Chapman admitted to staff that he had “plugged” (a common prison term for secreting drugs in the body). He thought the wrapping of one of the drugs had burst inside him. This would have caused an unintentional overdose.
32. Doctors admitted Mr Chapman to the intensive care unit and placed him in a medically-induced coma. Mr Chapman remained in hospital until the 21 October when he returned to prison. He was seen by a member of the mental health team on his return to Holme House. He was assessed as being well, with no obvious mental health issues and was discharged from mental health care. After Mr Chapman returned from hospital, two multidisciplinary ACCT reviews were held and the ACCT plan was closed on 29 October. On 31 October, Mr Chapman was transferred to HMP Durham.

### HMP Durham

33. On 18 December, a specialist mental health practitioner assessed Mr Chapman to consider his suitability for cognitive behavioural therapy (CBT). Mr Chapman said he felt paranoid, he believed that people talked about him and that he was going to be stabbed. He said he had felt this way for three to four months. He also said that prison officers were “firing darts” at him, but recognised that these beliefs were “in his head”. She recorded that Mr Chapman was not suitable for CBT, due to his paranoid thoughts. However, she referred him to the mental health team for a further assessment.
34. On 6 January 2016, Mr Chapman declined a mental assessment with a community psychiatric nurse. Mr Chapman said he did not need to attend as he was “okay”. However, on 13 January, she saw Mr Chapman and completed a brief mental health assessment. Mr Chapman said he had previously been in hospital for mental health issues and had seen the community mental health crisis team. She referred Mr Chapman to be assessed by a psychiatrist.

35. On 7 March, a community psychiatric nurse saw Mr Chapman for a mental health review. The nurse noted that Mr Chapman continued to express paranoid ideas. Mr Chapman said he believed that officers at Holme House poisoned his food and that officers at Durham were trying to shoot him at night. He described his mood as consistently low. Mr Chapman said he enjoyed going to the gym, listening to music and taking drugs. He said when he was in the community he would use cocaine when his mood was low. Mr Chapman said he had no thoughts of self-harm. The nurse recorded that drug use increased Mr Chapman's paranoia, and made him impulsive to attempting suicide. The nurse recorded that he would see him again before deciding on any treatment pathway.
36. On the evening of 20 March, a nurse saw Mr Chapman as he said he was incontinent of faeces and had fallen and hurt his ear. He also said he was going to attend court the next day. She recorded that she saw Mr Chapman in his cell and it was clear that his bowels had not been opened and there was no sign of any injury to his ear. She also recorded that Mr Chapman's speech was slurred, his eyes were blood shot and he was unsteady on his feet; all signs that he was under the influence of an illicit substance. She recorded that she returned later in the night to check on Mr Chapman, and he and his cellmate were talking about the drugs they had taken.
37. On 21 March, Mr Chapman appeared at Crown Court. The Person Escort Record Form (PER) records that Mr Chapman arrived at court at 8.54am and was put in a single cell. At 1.10pm, he refused the offer of a sandwich and a drink. At 5.37pm, Mr Chapman was convicted of aggravated burglary, use of offensive weapons, and possession with intent to supply Class A drugs. He was sentenced to 78 months imprisonment. At 5.50pm, court custody staff called an ambulance as Mr Chapman was in an incoherent state and appeared to have taken an illicit substance. He was taken to hospital. Court custody staff completed a suicide and self-harm warning (SSHW) form because they considered Mr Chapman may have intentionally taken an overdose. These documents are intended to alert staff in all criminal justice agencies which come into contact with a prisoner, about his or her risk of suicide and self-harm.
38. At 8.30pm, Mr Chapman was discharged from hospital without the need for treatment and returned to prison. At 9.20pm, he arrived back at Durham, accompanied by the escort record and the SSHW form. An officer recorded in Mr Chapman's prison computer record that he had returned from court and appeared under the influence of an illicit substance, but made no reference to the SSHW form from the court. Mr Chapman asked to see a member of the mental health team the next day. There is no entry in Mr Chapman's medical record that shows anyone from healthcare saw him on his return. No-one considered Mr Chapman's risk of self-harm or suicide.
39. On 22 March, a nurse saw Mr Chapman for a mental health review, because of the SSHW. Mr Chapman said he felt fine but did want to be supported by the mental health team. She recorded that Mr Chapman had an appointment with a community psychiatric nurse on 24 March, and was on the waiting list to see the visiting psychiatrist.

40. The same day a drugs worker saw Mr Chapman for a substance misuse review. Mr Chapman said he was “tripping” while at court, had hallucinations and kept passing out. He said he had drunk “hooch” (illegally brewed alcohol) and taken gabapentin (intended for neuropathic pain and anxiety) the day before he went to court. He said he had no thoughts of self-harm.
41. On 23 March, Mr Chapman self-harmed by making a cut to his inner right thigh. Mr Chapman told staff he had done this because he was “fed up with his life”. He said he had tried to hang himself but his cellmate stopped him. He said he had bought pregabalin illicitly on the wing. Staff recorded that Mr Chapman appeared under the influence of an illicit substance, opened an ACCT, and placed him on constant watch. His wound was treated by healthcare staff.
42. Between 24 March and 6 April, five ACCT reviews were conducted, all but one were multidisciplinary. The level of observations was reduced from constant to hourly on 25 March and from hourly to three times during the day and three times during the night, on 29 March.
43. On 7 April, a supervisory officer (SO), an officer and a drugs worker held an ACCT case review with Mr Chapman. No one from the mental health team was present or contributed to the review. The SO recorded that Mr Chapman was being transferred to HMP Northumberland that afternoon. Mr Chapman said that he was happy to be moved and had no thoughts of self-harm or suicide. The SO assessed Mr Chapman as being at low risk of self-harm, left the level of observations unchanged, and set the next review date for 8 April.

### **HMP Northumberland**

44. When Mr Chapman arrived at Northumberland later that afternoon, he saw a nurse. The nurse recorded that Mr Chapman had a history of self-harm and attempted suicide, and a history of drug abuse. Mr Chapman said he had no thoughts of self-harm. He said he had self-harmed while at Durham because he was “in a bad place” after being sentenced. He also said that while in prison he had swallowed a bag of NPS known as ‘Spice’, which burst inside him and he attempted suicide. She referred Mr Chapman to the mental health team.
45. A prison custody officer (PCO) conducted the first night induction with Mr Chapman. He recorded that Mr Chapman had no concerns about being at Northumberland and he had been seen by healthcare staff. Mr Chapman was allocated a cell on Houseblock 9. All cells on Houseblock 9 are single cells.
46. On 8 April, a senior prison custody officer (SPCO) and the PCO held an ACCT case review with Mr Chapman. No one from the mental health team was present or contributed to the review. Mr Chapman said he was happy to be at Northumberland. He said he had no thoughts of self-harm and what he had done to himself in the past was “stupid”. Mr Chapman asked for the ACCT to be closed. The SPCO assessed that Mr Chapman was at low risk of self-harm but the ACCT should remain open to offer Mr Chapman support for a further few days. The level of observations was increased to four observations during the day and four observations during the night. The next review was set for 11 April.

47. On 11 April, the SPCO and a PCO held an ACCT case review with Mr Chapman. No one from the mental health team was present or contributed to the review. Mr Chapman said he had settled well at Northumberland and had some friends on his houseblock. He said he had no thoughts of self-harm. The SPCO assessed that Mr Chapman was at low risk of self-harm. He also reviewed the caremap and saw that all the actions had been closed while Mr Chapman had been at Durham. All those present agreed that the ACCT should be closed and a post closure interview was set for 18 April.
48. On 12 April, a visiting psychiatrist saw Mr Chapman. Mr Chapman said that since being at Northumberland he had had no thoughts of self-harm or suicide. He said that when he was in a low mood he used drugs to help him cope. He said he had been prescribed citalopram (for depression) and mirtazapine (for depression) in the past but did not find them helpful. She recorded that Mr Chapman had a long history of drug misuse, using cocaine and crack cocaine in particular. He also had little understanding of how his drug use exacerbated his problems. She recorded that Mr Chapman had no psychotic symptoms and that he should engage with the substance misuse team. She noted that if Mr Chapman complained of low mood doctors should consider prescribing a non-sedative anti-depressant.
49. On 16 April, a member of the mental health team saw Mr Chapman for a mental health review. Mr Chapman said he had had depression in the past but had no current issues with his mental health and he denied any thoughts of suicide or self-harm. At interview she said Mr Chapman did not present with any obvious mental health issues and denied experiencing any of the paranoid ideas that he had previously experienced while at Durham. She was aware from reading Mr Chapman's medical record that he had experienced problems in the past, and she therefore added him to her caseload for a further review. She arranged a routine follow up appointment for Mr Chapman to see her on 4 July. Mr Chapman was not seen again by anyone from the mental health team before he died.
50. On 18 April, a SPCO held the ACCT post closure interview with Mr Chapman. Mr Chapman said that he had support from family and staff, he had a job as a cleaner and liked going to the gym. He had no thoughts of suicide or self-harm.
51. On 27 April, substance misuse recovery co-ordinator saw Mr Chapman for a review as suggested by the psychiatrist. Mr Chapman said he had settled well at Northumberland and had not used any illicit substances since he arrived. He discussed with Mr Chapman the effects of illicit substances, including 'Spice'.
52. On 9 June, the substance misuse recovery co-ordinator saw Mr Chapman for a further substance misuse review. Mr Chapman told him that he was drug free and did not want to do any group work or self-help work as he had done it all before in the past and did not want to repeat it. He recorded that he would see Mr Chapman again in a few weeks to see whether or not he wanted to continue with support.

## Events of Friday 1 July

53. Prison phone records show that at 2.14pm on 1 July, Mr Chapman spoke to his father. The investigator has listened to this call. Mr Chapman's father told him that his step-father had died. Mr Chapman was inconsolable and said he did not know what to do he would do without his step-father. Mr Chapman asked his father for a photograph of his step-father. Mr Chapman's father said the family was going to visit him the next day. The call ended with Mr Chapman and his father saying they loved each other.
54. Mr Chapman went to the office where two PCOs were working. One PCO told the investigator that Mr Chapman was in a very distressed state and crying. Mr Chapman told the staff that his stepfather had died. The staff allowed Mr Chapman to make two calls to his family from the office. Calls made from office phones are not recorded. The PCO said Mr Chapman spoke to members of his family, who were coming to visit him the next day. He said that he and his colleague requested a chaplain to come and see Mr Chapman.
55. The chaplain at Northumberland told the investigator that he saw Mr Chapman at approximately 2.30pm, and spent over an hour with him. He said that he went to Mr Chapman's cell where they said prayers, lit a candle and played music. Mr Chapman asked him to arrange a memorial service for his stepfather and he agreed to do this. He said that Mr Chapman gave him no concerns that he was at risk of self-harm otherwise he would have opened an ACCT immediately.
56. Prison phone records confirm that Mr Chapman made two further calls at 4.01pm and 4.36pm. The investigator listened to both calls. The first was to his partner. Mr Chapman was very upset and asked his partner to contact his sister to tell her how upset he was. Mr Chapman said he loved his stepfather as if he'd been a parent. On ending the call, he said that he was looking forward to seeing his partner the next day. The second call was to his father and lasted for just 49 seconds. Mr Chapman asked how his mother was and whether she had seen his stepfather after he had died. Mr Chapman's father asked him to call his sister, but Mr Chapman ended the call abruptly, saying "I'm going".
57. A fellow prisoner told the investigator he occupied the cell next to that of Mr Chapman. He said he knew Mr Chapman from their time together at Durham. Mr Chapman told him he had taken pregabalin that morning, and that he was looking forward to his family visit the next day. He said Mr Chapman was unsteady on his feet and appeared intoxicated.
58. A PCO said that on Fridays prisoners are locked in their cells at approximately 5.15pm, until the following morning. He said that when he locked Mr Chapman into his cell, Mr Chapman thanked him for the support he had received that afternoon. He said Mr Chapman gave no indication that he had any intention of harming himself, otherwise he would have opened an ACCT.
59. At 8.10pm, a PCO answered Mr Wright's cell bell. Mr Wright asked him to check on the prisoner in the next cell as he had been given bad news earlier that day. The prisoner told the investigator that he told the PCO that Mr Chapman had said he intended to kill himself due to stepfather's death.

60. The PCO explained that when he went to Mr Chapman's cell, he was sitting on the floor by the cell door. Mr Chapman said he had blacked out by the sink, had fallen and cut his lip. The PCO used the office phone to summon assistance. A SPCO and two PCOs responded.
61. When the staff arrived at Mr Chapman's cell, he was still sitting on the floor by the door. The staff asked him to move and he got up and sat on the bed. The four members of staff entered the cell and found that Mr Chapman had a small cut to his lip. There was fluid on the floor, and a back cover and battery from a mobile phone. Mr Chapman said that he had fallen over when he had got off the toilet. He said he had a sore side and cut his lip from falling over. A PCO told the investigator that Mr Chapman appeared under the influence of an illicit substance and Mr Chapman denied having a mobile phone. The staff left the cell with the phone cover and battery. The SPCO instructed a PCO to inform an operational support grade (OSG) and the night patrol member of staff to monitor Mr Chapman. The PCO told the investigator he left the prison at 8.45pm after handing over to the OSG.
62. At 8.50pm, the OSG began the roll check at the start of the night shift. When she reached Mr Chapman's cell at 8.58pm, she opened the observation panel and saw him in a slumped position near the sink with a purple cord around his neck. She radioed an emergency code blue. (This is used for prisoners who are unresponsive or having difficulty breathing.) The control room log shows that the code blue was made at 8.58pm and an ambulance was called immediately.
63. At 9.01pm, a SCPO and two PCOs arrived and immediately entered the cell, cut Mr Chapman down and started cardiopulmonary resuscitation (CPR). Staff also used an automated external defibrillator (which administers electrical shocks to restore a normal heart rhythm). The defibrillator found no shockable rhythm, so the staff continued with CPR until the paramedics arrived and took over Mr Chapman's care.
64. North East Ambulance Service (NEAS) records show the 999 call was received at 9.02pm and ambulances were dispatched at 9.03pm. Ambulance technicians arrived at the prison at 9.10pm and took over Mr Chapman's care. At 9.33pm, paramedics arrived and at 10.27pm, pronounced Mr Chapman dead.
65. Following Mr Chapman's death, Northumberland Police attended the prison and his cell was searched. Seven different medications were found (none of which had been prescribed to Mr Chapman), along with what appeared to be two wraps of NPS and a mobile phone.

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

66. Due to the time of day and distance between the family home and Northumberland, the Deputy Director asked the police to break the news to Mr Chapman's sister. No attempt was made to ask another prison closer to Mr Chapman's sister's address to do so. Northumberland Police then tasked Cleveland Police to break the news as Mr Chapman's sister's address was situated in their force area. It was 11 hours after Mr Chapman's death before the news was given to his sister.

67. On 2 July, at 4.45pm, a prison family liaison officer contacted Mr Chapman's sister by phone to offer condolences and support. She made arrangements to visit the family. On 5 July, she and a PCO visited Mr Chapman's sister to offer support. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

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

68. The Deputy Director debriefed the staff who had been involved in the emergency response. The staff were offered the support of the prison's care team.
69. The prison posted notices informing staff and prisoners of Mr Chapman's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Chapman's death.

### **Post-mortem report**

70. A post-mortem examination, conducted by a Home Office Forensic Pathologist, confirmed that the cause of Mr Chapman's death was hanging. The toxicology results confirmed Mr Chapman had used diazepam (a tranquiliser) and zopiclone (a sleeping tablet) at the time of his death. Mr Chapman had not been prescribed these medications while in custody. Mr Chapman may have also used 5F-ADB (a synthetic cannabis substitute - NPS). Toxicology results indicated Mr Chapman had not used alcohol.

# Findings

## Assessment of Risk of Suicide

### HMP Durham

71. The policy document covering safer custody, Prison Service Instruction (PSI) 64/2011, lists a number of risk factors and potential triggers for self-harm and suicide. These include recall to custody, previous self-harm, mental health issues and drug abuse. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

72. PSI 64/2011 specifically states the following mandatory action:

*“Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form”*

73. When Mr Chapman returned to Durham from court on 21 March 2016, reception staff did not appropriately assess his risk of suicide and self-harm and did not take any action to support him. This was despite the suicide and self-harm warning form that had been completed at court and the risk identified on his escort record.

74. We consider that staff at Durham should have immediately opened an ACCT to support Mr Chapman when he returned from court. We make the following recommendation:

**The Governor of Durham should ensure, in line with PSI 64/2011, that measures are in place for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception staff:**

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from PERs and other sources;**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

### HMP Northumberland

75. PSI 64/2011 requires ACCT case reviews to be multidisciplinary wherever possible. We are concerned that, at Northumberland, neither of Mr Chapman’s case reviews were multi-disciplinary. In particular, there was no healthcare representative at either case review, nor did they make any contribution to the reviews. Whether or not reviews are multi-disciplinary, it is implicit that ACCT

reviews, which are based on teamwork, should include contributions from healthcare staff especially in cases where a prisoner has mental health issues. The ACCT was closed on 11 April, just four days after Mr Chapman arrived at Northumberland, based on staff perceptions of his behaviour and demeanour.

76. Mr Chapman had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic report about risk factors in self-inflicted deaths published in April 2014, and in Prison Service instructions. He had been sentenced, had mental health issues, had a history of attempted suicide, and abused drugs.
77. Further, on 1 July, Mr Chapman received the news that his stepfather had died and was extremely upset. While he received support from discipline staff and a chaplain, no-one considered Mr Chapman's risk of self-harm or suicide and did not open an ACCT. Later that evening, Mr Chapman was found to be under the influence of an illicit substance and had a cut lip. Again, no-one considered Mr Chapman's risk of self-harm and no ACCT was opened.
78. We are very concerned that staff at Northumberland did not open an ACCT to support Mr Chapman on 1 July. Mr Chapman had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic reports and in Prison and Probation Service instructions: he had received news of a death of a close relative, had a history of self-harm and attempted suicide, had mental health issues, and a history of drug abuse. We make the following recommendation:

**The Director of Northumberland should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **Understanding their responsibilities and the need to share all relevant information about risk;**
- **Considering and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm;**
- **Assessing the level of risk and recording the reasons for decisions;**
- **Conducting ACCT reviews as specified in the national instructions.**

### **New Psychoactive Substances (NPS)**

79. Mr Chapman admitted his history of illicit drug use. Indeed, he said taking drugs was something he enjoyed. He agreed to work with substance misuse recovery groups at Durham but did not do so at Northumberland. He had been admitted to hospital on two occasions for potential drug overdoses. There are concerns that use of NPS can produce a range of bizarre behaviours or paranoia. Mr Chapman was frequently found by staff to be under the influence of an illicit substance. No one considered whether Mr Chapman's actions might have been influenced directly by drug use.
80. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm.

The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. We make the following recommendation:

**The Governor of Durham and the Director of Northumberland should ensure there is an effective supply and demand reduction strategy to help eradicate the availability of New Psychoactive Substances and other drugs, and that staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances**

### Clinical Care

81. The clinical reviewer judged that, overall, the care that Mr Chapman received from healthcare staff at Northumberland was equivalent to that he could have expected to receive in the community.
82. The clinical reviewer commented that Mr Chapman appeared to have had limited insight into the effect that illicit substances had on his mental health. Mr Chapman admitted that he turned to drugs when his mood was low or in reaction to stressful circumstances. Toxicology results confirm that Mr Chapman had taken illicitly obtained prescription drugs prior to his death and may have used NPS.

### Emergency Response

83. PSI 03/2013, *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring that staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.
84. When the OSG found Mr Chapman hanging in his cell at 8.58pm on 1 July, she correctly used her radio to call an emergency code blue. The control room log shows that the 999 call was made at 8.58pm. However North East Ambulance Service records show they received the 999 call at 9.02pm. This discrepancy of four minutes indicates a delay between the code blue being called and the 999 call being made. This short delay may not have affected the outcome for Mr Chapman; however, it might be crucial in other emergencies in the future. We make the following recommendation:

**The Director of Northumberland should ensure that all prison staff are made aware of and understand PSI 03/2013 *Medical Emergency Response Codes* and their responsibilities during medical emergencies which:**

- **Ensures staff immediately call for an emergency ambulance when a medical emergency code is used;**

- **Ensures that an emergency response protocol is in place with the ambulance service.**

#### **Liaison with Mr Chapman's family**

85. Mr Chapman's family were concerned about the length of time it had taken to inform them of Mr Chapman's death. Prison Rule 22 states that when a prisoner dies, the governor should inform next of kin "at once". PSI 64/2011 states that where possible, the family liaison officer and another member of staff should visit the next of kin in person and that this should be done quickly to ensure that the prisoner's family does not hear of the death by other means. The PSI goes on to say that where the prison is located a long distance from the family, consideration must be given to requesting the assistance of a FLO from the nearest prison.
86. The Deputy Director asked the police to inform Mr Chapman's family of his death due to the distance they lived from the prison and the time of day Mr Chapman had died. No consideration was given to contact the nearest prison, HMP Holme House, to seek their assistance. As the family address was in Cleveland police force's area, they were asked by Northumberland Police to break the news. We consider that there was too long a delay in informing Mr Chapman's family and this was not given the priority which Prison Rules require. We make the following recommendation:

**The Director of Northumberland should ensure that when a prisoner dies, the next of kin is informed without undue delay in accordance with national instructions.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations