

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nuno da Cruz, a prisoner at HMP Chelmsford, on 16 September 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*



© Crown copyright 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Nuno da Cruz was found hanged in his cell at HMP Chelmsford on 16 September 2018. He was 50 years old. I offer my condolences to Mr da Cruz's family and friends.

Mr da Cruz arrived at Chelmsford on the evening of 17 August, with several risk factors for suicide and self-harm. Prison staff monitored him under suicide and self-harm prevention procedures until the next morning.

The investigation found that the decision to stop suicide and self-harm monitoring was premature and was based on Mr da Cruz's presentation rather than his known risk factors. It also found that mental health staff did not properly identify or monitor his risk factors and that this aspect of his care was not equivalent to that he could have expected in the community.

Although it did not affect the outcome for Mr da Cruz, there was a delay in prison staff entering his cell and in calling a medical emergency code when he was found. We have raised delays in staff entering cells in medical emergencies with Chelmsford before.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

June 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	11

Summary

Events

1. On 17 August 2018, Mr Nuno da Cruz was remanded in prison custody charged with arson of the home he had shared with his partner. He was sent to HMP Chelmsford.
2. During a reception health screening that evening, the nurse noted that Mr da Cruz had several risk factors for suicide and self-harm, including the nature of his offence, that it was his first time in prison and that he had taken an overdose in May. At 8.20pm on 17 August, the nurse started suicide and self-harm prevention procedures (known as ACCT). Staff stopped ACCT monitoring the next morning but referred Mr da Cruz for a mental health assessment.
3. On 21 August, a nurse completed Mr da Cruz's mental health assessment. She had no immediate concerns but referred him to the multidisciplinary team (MDT) for possible review by a prison psychiatrist. Mr da Cruz was discussed at the MDT meeting on 23 August and it was decided that he should be reviewed by a prison psychiatrist. He had an appointment for 6 September but there is no evidence he was seen.
4. At 7.09am on 16 September, during a roll check, an officer saw Mr da Cruz with a ligature round his neck that was attached to the window frame in his cell. The officer called for assistance and once further staff arrived, they entered the cell, cut the ligature and began cardiopulmonary resuscitation (CPR). When ambulance paramedics arrived ten minutes later they decided that CPR should not continue as Mr da Cruz was clearly dead.

Findings

5. We consider that the decision to stop ACCT monitoring on 18 August, after only 14 hours, was premature and was based on Mr da Cruz's presentation rather than his known risk factors.
6. It appears that Mr da Cruz was never reviewed by a prison psychiatrist while he was at Chelmsford, despite the MDT deciding on 23 August that he required a review. Mr da Cruz was not seen by anyone from the mental health team after 28 August. The clinical reviewer found that the mental health team failed to properly identify or monitor Mr da Cruz's potential risk factors for suicide and self-harm and this aspect of his care was not equivalent to that he could have expected to receive in the community.
7. When Mr da Cruz was found hanged, there was a short delay in staff entering his cell and in calling a medical emergency code. Although the delay did not affect the outcome in this case, it is important staff act quickly and follow correct procedures in medical emergencies. We have raised delays in staff entering cells in medical emergencies with Chelmsford before.
8. Mr da Cruz had signs of rigor mortis when he was found so was clearly dead. Prison healthcare staff should have stopped CPR to preserve Mr da Cruz's dignity.

9. Staff notified Mr da Cruz's ex-partner of his death, who liaised with Mr da Cruz's family, including his brother who was his nominated next of kin. We are concerned that staff never made direct contact with Mr da Cruz's nominated next of kin.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that they:
 - identify risk factors and assess a prisoner's risk based on their risk factors and not just personal presentation; and
 - share information to provide collaborative care and treatment, in particular ensuring effective communication between healthcare and prison staff when there are potential concerns about a prisoner's mental health.
- The Head of Healthcare should review the mental health screening and assessment procedures to ensure a more robust and coordinated process to identify risk factors and triggers for suicide and self-harm.
- The Head of Healthcare should ensure that when an appointment does not go ahead, the prisoner's medical record is noted with the reason and a new appointment is arranged.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
 - staff enter cells as quickly as possible in a life-threatening situation; and
 - staff understand and use the appropriate emergency code when they discover a medical emergency.
- The Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare staff fully understand the circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.
- The Governor should ensure that following a death in custody appropriate contact is made and maintained with the nominated next of kin.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr da Cruz's prison and medical records. He interviewed 12 members of staff at Chelmsford during October and November and he spoke to one other staff member by telephone.
12. NHS England commissioned a clinical reviewer to review Mr da Cruz's clinical care at the prison. The investigator and clinical reviewer jointly interviewed some of the staff.
13. We informed HM Coroner for Essex of the investigation. The Coroner gave us Mr da Cruz's cause of death as asphyxiation due to hanging. We have sent the Coroner a copy of this report.
14. We contacted one of Mr da Cruz's brothers and Mr da Cruz's partner to explain the investigation process and to ask if they had any matters they wanted the investigation to consider. Neither the family or partner raised any specific matters that they wished the investigation to explore, although one of Mr da Cruz's brothers mentioned that both of the cells Mr da Cruz occupied had been extremely dirty and he had had to clean them himself.
15. We shared a copy of the initial report with Mr da Cruz's brothers and partner and they all provided responses to the report. Mr da Cruz's brothers said that further investigation was needed into why a prison psychiatrist did not see their brother and why he did not apparently act on information he received from the other prison psychiatrist. Mr da Cruz's brothers also questioned why the camera facing their brother's cell was not working and they questioned the evidence of the officers who last saw their brother and who were first on the scene when his death was discovered.
16. Mr da Cruz's partner said that he sent a letter to the prison's mental health in-reach team on 26 August setting out his concerns about his partner's mental health. He said that he received no response. Mr da Cruz's partner also raised the matter of the prison psychiatrist's involvement. Mr da Cruz's partner also said that Mr da Cruz was prevented from having contact with him and this would probably have affected him.

Background Information

HMP Chelmsford

17. HMP Chelmsford is a local prison which takes prisoners directly from court. It holds around 700 adult men. Essex Partnership University Trust provide healthcare.
18. 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

19. The most recent inspection of Chelmsford was in May and June 2018. Inspectors noted that the most worrying issue was the way men at risk of suicide and self-harm were managed. They pointed out that there had been 16 self-inflicted deaths in the previous eight years and they found that levels of self-harm and the use of constant watch were both very high. They noted that staff had become very risk averse, which meant that the procedures were often overused to the potential detriment of particularly vulnerable men. Inspectors noted that a high percentage of the operational staff were relatively inexperienced, having less than two years' service. However, they also found that prisoners were generally positive about relationships with staff, with the great majority saying that there was a member of staff they could approach if they had a problem. Inspectors found that mental health services were fragmented and largely reactive.

Independent Monitoring Board

20. 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 latest annual report for the year to 31 August 2018, the IMB reported that levels of self-harm, including suicide, continued to be a significant problem. The IMB also noted long delays in the delivery of care to prisoners with mental health problems. The IMB noted that it was pleased that the prison had been put in Special Measures as that would mean extra resources being allocated to staff training and refurbishment of the older wings.

Previous deaths at HMP Chelmsford

21. Mr da Cruz was the 14th prisoner to die at Chelmsford since September 2015. Of the previous deaths, eight were self-inflicted, two were from natural causes, and three were drugs related. There were two further deaths in the month following Mr da Cruz's death, both from natural causes. We have made findings previously about the failure of staff to identify prisoners at risk of suicide and self-harm and staff's over-reliance on a prisoner's presentation rather than their known risk factors. We have found deficiencies in the standard of mental healthcare provided. We have found delays in staff entering cells in medical emergencies and have previously raised the inappropriate use of CPR on prisoners who are already dead.

Assessment, Care in Custody and Teamwork

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

Key Events

23. On 15 August 2018, Mr Nuno da Cruz was arrested and charged with arson of the home he shared with his partner. He stayed in police custody until 17 August, when he was remanded in prison custody and sent to HMP Chelmsford.
24. An officer told the investigator that there were delays in reception on the evening of 17 August so she sat and chatted with Mr da Cruz for around 30 minutes while he was waiting. Mr da Cruz said that he had never been in prison before and her own observation of him was that he seemed to be “a fish out of water” so she tried to reassure him. She asked him if he would receive any visits and he said that a neighbour might visit, although she was cross with him because of his offence. He said he had a partner, but then that he did not. He said his blood relations lived in South Africa. The officer said that Mr da Cruz spoke about using his time in prison to study. He seemed to relax during their conversation and she did not consider there were grounds for her to start suicide and self-harm monitoring (known as ACCT).
25. A mental health nurse completed Mr da Cruz’s reception health screen at 8.15pm. She noted that Mr da Cruz had taken an overdose in May 2018 and had spent three weeks in hospital. She noted that he appeared low in mood although he engaged well during the assessment. She told the investigator that she was from South Africa and so she spoke to him about their homeland to help gauge his mood. Although Mr da Cruz said that he did not have any thoughts of self-harm or suicide she decided that it was appropriate to open an ACCT. She considered he had several risk factors including his overdose in May, which she understood to have been a suicide attempt, his relationship with his partner had broken down, he was isolated as his family lived abroad, and it was his first time in custody.
26. An officer met Mr da Cruz on the morning of 18 August for an ACCT assessment interview. Mr da Cruz told her he was feeling a little stressed as this was his first time in custody, but he said that he had been out on exercise and association and had engaged with other prisoners. He also said that he had spoken to one of his friends by telephone and she would support him if he was feeling low. He said that he was not having suicidal thoughts.
27. An ACCT case review was held at 10.40am, following the assessment interview. The review was chaired by a supervising officer (SO) and was attended by Mr da Cruz, an officer and two mental health nurses. The SO told the investigator that he asked Mr da Cruz if he had gone to association that morning and he said he had, and had spoken to some of the other prisoners. Mr da Cruz said he was feeling better than he was the previous evening. He said he was a self-employed artist and he was intending to keep himself busy in prison and was hoping to do an art course. He also said that it was a weight off his shoulders that his long-term relationship had ended. Mr da Cruz said that he could not give a specific reason for taking an overdose in May 2018, other than it was build-up of several issues. He said that he had no intention of harming himself again. The SO said that Mr da Cruz was very positive compared to many others in prison for the first time and that everyone at the review was content for the ACCT to be closed.

28. One of the two mental health nurses at the ACCT review told the investigator that the other nurse at the review was a new member of staff who attended as part of her prison induction. He said that Mr da Cruz was very quiet at the start of the review but he grew more positive as the review progressed. He said that there were no indications that Mr da Cruz was having any thoughts of suicide and he agreed that the ACCT should be closed. He said that he was concerned however about the overdose that Mr da Cruz had taken and he also mentioned that he suffered from undiagnosed depression. Following the review, he referred Mr da Cruz for a formal mental health assessment.
29. On 21 August, a mental health nurse saw Mr da Cruz following the referral on 18 August. He said that Mr da Cruz did not have an extensive history of mental health illness, but he did report a history of low mood, possibly linked to relationship difficulties. Mr da Cruz said that the overdose he had taken in May 2018 had been an impulsive act and he had not realised at the time that he could have sought support from mental health services. The nurse said that he had no immediate concerns that Mr da Cruz was at risk, but he referred him to the multidisciplinary team for possible review by the prison psychiatrist.
30. Mr da Cruz was discussed at the weekly multidisciplinary team meeting on 23 August and an appointment was made for him to be reviewed by the psychiatrist on 6 September.
31. Also on 23 August, a nurse made a note in Mr da Cruz's medical record to say that she had received a telephone call from a psychiatrist from Tower Hamlet's Clinical Commissioning Group who was concerned about Mr da Cruz's mental state. The nurse noted that she informed the psychiatrist that Mr da Cruz was under the care of the prison's mental health team.
32. On 26 August, a SO saw Mr da Cruz for an ACCT post-closure interview. She noted that Mr da Cruz was engaging in wing activities and there had been no issues since the ACCT was closed. She noted that there was no need for the ACCT to be reopened.
33. On 28 August, a nurse saw Mr da Cruz for a mental health review pending his appointment with the psychiatrist. She noted that Mr da Cruz appeared calm and stable in mood and was well kempt. He said he was doing a maths course, that he was sleeping and eating well and was "going very well".
34. On 31 August, Mr da Cruz was moved from F Wing, the induction wing, to B Wing, one of the standard residential wings.
35. Mr da Cruz had an appointment to see one of the two prison psychiatrists on 4 September, but he missed the appointment as he had a social visit from a friend.
36. On 6 September, Mr da Cruz had an appointment with a prison psychiatrist but there is no evidence he was seen. The psychiatrist made no entry in Mr da Cruz's medical record and he failed to respond to enquiries from the investigator and the clinical reviewer about the appointment.
37. On 9 September, an officer visited Mr da Cruz to introduce herself as his key worker. This was the first time she had met him and she told him about her role as his key worker. Mr da Cruz told her that he had felt unsettled when he first

came to the prison as he had not known what to expect, but he had met several prisoners on the wing of a similar age to him which made him feel better. He said that he was doing maths and that he would be interested in other courses once he had completed his maths course. He mentioned he enjoyed painting and she told him that there was a graphics course he could do. The officer told the investigator that Mr da Cruz seemed positive and not down in any way. She also said that his cell was very clean and tidy, which was a positive indicator. She said that they spoke for around 30 minutes and Mr da Cruz had been pleasant and in good spirits.

38. The officer said that she usually worked on C Wing so in the following days had only one or two passing encounters with Mr da Cruz when they would have exchanged greetings.
39. On 10 September, Mr da Cruz received a visit from his eldest brother, who lived in South Africa but was in Europe on holiday. They spent two hours together. His brother said that Mr da Cruz seemed well both physically and emotionally, and he had said he was getting on well with the prisoner in the next cell. At the end of the visit, Mr da Cruz gave him a list of items he wanted, which included a sketch book and a book on art.
40. The maths tutor told the investigator that the maths course comprised four half-day sessions a week and Mr da Cruz attended regularly. (Mr da Cruz's first class was on 28 August and his last class was on 13 September.) The tutor said that Mr da Cruz was quiet, but did interact with other pupils, though on a selective basis. He said that he had several conversations with Mr da Cruz about the politics of South Africa and a conversation about the mathematics of fine art. He said that there was nothing to indicate that Mr da Cruz might be at risk of harming himself.
41. A SO, who worked on B Wing, spoke to the investigator on behalf of staff on B Wing. She said that her personal interactions with Mr da Cruz were minimal, but her contact with him, and the reports she received from her staff, were that Mr da Cruz was self-sufficient, polite and compliant with the regime. She said that prisoners at Chelmsford were of a wide range of different ages so there was nothing unusual in Mr da Cruz's age of 50. She said that there was nothing to suggest that Mr da Cruz was fearful or struggling in any way.
42. Mr da Cruz had a wide circle of friends outside prison and he used the telephone most days. His last telephone call was to a friend at 6.20pm on 15 September. He told her about aspects of prison life, including that she would not be able to send him emails, only letters. He told her that not much would be happening with him until the start of his trial. The friend asked if she could send him money and he said it would be easiest if she sent money via a mutual friend. Mr da Cruz told his friend that he was not being bothered by other prisoners. This conversation was typical of Mr da Cruz's conversations with his friends.
43. An officer completed a roll check of B Wing at 8.45pm. He told the investigator that there were no issues during the night.

16 September

44. At around 5.30am on 16 September, Officer A started a morning roll check. He told the investigator that he saw Mr da Cruz lying in bed and he was breathing. He remembered this because the prisoner in the cell next door to Mr da Cruz was on an open ACCT. (There was no CCTV footage of Officer A checking Mr da Cruz's cell because the camera for that side of the landing was not working properly at the time, but the investigator checked the other prisoner's ACCT document and noted that it contained an entry made by Officer A at 5.40am.)
45. Officer B started a day shift at about 7.00am on 16 September and he carried out a further roll check. CCTV shows that he reached Mr da Cruz's cell at 7.09am. Officer B said that when he looked into the cell he saw Mr da Cruz with a ligature round his neck, which was attached to the window frame. He said that Mr da Cruz's feet were on the floor and he was leaning forward with his head down.
46. Officer B radioed for staff assistance and called out to Officer A who was in the wing office a few metres away. Officer A arrived within 30 seconds and the officers entered the cell. Officer A supported Mr da Cruz's body while Officer B tried to cut the ligature. The ligature was made from a sheet and Officer B said that it was too thick for his anti-ligature knife to cut through. He asked Officer A to lift Mr da Cruz higher and he was then able to pull the ligature away.
47. The officers placed Mr da Cruz on the floor and Officer A began to give chest compressions. Officer A said that it was not clear to him that Mr da Cruz might already be dead. More officers arrived at 7.10am. Officer C called a medical emergency code blue (which indicates a prisoner is unconscious or having breathing difficulties) and the control room called an ambulance. Officer D tried to give Mr da Cruz oxygen using a face mask but the oxygen cylinder did not work, so he used the manual pump to pump air. A second oxygen cylinder was brought, which did work.
48. Nurses also arrived. A nurse checked Mr da Cruz for a pulse but could not find one and he noted that Mr da Cruz was cold to the touch. He told the clinical reviewer that he then tried to insert an airway into Mr da Cruz's trachea to help administer oxygen, but he found that Mr da Cruz's jaw was locked. It was only at that point that he realised there were signs of rigor mortis. He said that as Mr da Cruz was not otherwise showing obvious signs of rigor mortis he considered it appropriate to continue with cardiopulmonary resuscitation (CPR) pending arrival of the paramedics.
49. Staff continued to give chest compressions and Mr da Cruz was checked with a defibrillator, which advised that no shock should be given and that attempts at CPR should continue. Ambulance paramedics arrived at 7.20am and advised that attempts at resuscitation should cease because Mr da Cruz was dead.

Contact with Mr da Cruz's family

50. Two SOs were appointed as family liaison officers (FLOs). Mr da Cruz had named his eldest brother in South Africa as his next of kin and one of the FLOs made several unsuccessful attempts to telephone him starting from 9.00am. At 10.00am, the FLOs visited the home of one of Mr da Cruz's friends. The friend

was not at home but the staff were met by her son who contacted Mr da Cruz's ex-partner. One of the FLOs had several conversations with Mr da Cruz's ex-partner both that day and the next and learned that Mr da Cruz's brother and parents were on holiday. Mr da Cruz's ex-partner said that he would break the news of Mr da Cruz's death. All further communication between the prison and Mr da Cruz's family was made via his ex-partner. The prison offered to contribute to the cost of Mr da Cruz's funeral but the offer was not taken up by the family.

Support for prisoners and staff

51. A prison manager debriefed the officers involved in the response when Mr da Cruz was found. The staff care team also offered support.
52. The prison posted notices informing other prisoners of Mr da Cruz's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr da Cruz's death.

Post-mortem report

53. Mr da Cruz's post-mortem report recorded his cause of death as asphyxiation due to hanging.

Findings

Management of Mr da Cruz's risk of suicide and self-harm

54. Prison Service Instruction (PSI) 64/2011, *Managing prisoners at risk from self, from others and to others (Safer Custody)*, provides a non-exhaustive list of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. The PSI 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, including starting ACCT procedures if necessary.
55. Mr da Cruz presented with the following risk factors for suicide and self-harm when he arrived at Chelmsford on the evening of 17 August:
 - his drug overdose in May;
 - the nature of his offence at the home he shared with his partner;
 - the breakdown of his relationship and separation from his partner;
 - distance from his family;
 - history of depression; and
 - first time in custody.
56. The reception nurse identified Mr Cruz's risk factors and she started ACCT monitoring at around 8.20pm. We consider that this was an appropriate decision.
57. Mr da Cruz had his first ACCT case review at 10.40am the next morning. Mr da Cruz said that he was feeling better than the previous day and had no thoughts of suicide or self-harm. Staff decided to close the ACCT.
58. We consider that the decision to close the ACCT at that stage, only 14 hours after it was opened, was premature. We consider that staff were unduly influenced by Mr da Cruz's positive engagement and assurances that he had no intention of harming himself. Staff at Chelmsford did not know Mr da Cruz, his risk factors remained and it was identified at the review that he should have a full mental health assessment.
59. In February 2016, we published a Learning Lessons Bulletin which examined self-inflicted deaths of prisoners within the first month of custody. We found that in many instances staff based their assessments on the prisoner's presentation and their statements that they had no thoughts of suicide or self-harm. We noted that known risk factors, such as a history of suicidal behaviour, were often overlooked.
60. We acknowledge that Mr da Cruz seemed to settle at Chelmsford and that nothing occurred during the following weeks to suggest that he was having any thoughts of suicide or self-harm. However, we consider that it would have been prudent to have kept the ACCT open at least until a time when he had been fully assessed by the mental health team.

61. We make the following recommendation:

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

- **identify risk factors and assess a prisoner's risk based on those risk factors and not just personal presentation; and**
- **share information to provide collaborative care and treatment, in particular ensuring effective communication between healthcare and prison staff when there are potential concerns about a prisoner's mental health.**

Mental health care

62. The clinical reviewer found that while Mr da Cruz's mental health care at Chelmsford was broadly equivalent to that which he could have expected to receive in the community, there were aspects of his care that were not equivalent. She noted that he was seen or reviewed by up to five different mental health nurses in his first 11 days in the prison but he saw no one from the mental health team in his final 19 days. He was not seen after 28 August. An appointment with a prison psychiatrist was scheduled for 6 September but there are no notes in Mr da Cruz's medical record to indicate he was seen. The clinical reviewer concluded that the mental health team did not adequately identify, monitor or coordinate Mr da Cruz's potential risk factors and triggers for suicide and self-harm.

63. We make the following recommendations:

The Head of Healthcare should review the mental health screening and assessment procedures to ensure a more robust and coordinated process to identify risk factors and triggers for suicide and self-harm.

The Head of Healthcare should ensure that when an appointment does not go ahead, the prisoner's medical record is noted with the reason and a new appointment is arranged.

Emergency response

Delay in entering cell and calling medical emergency code

64. When Officer B checked Mr da Cruz at 7.09am, he saw him at the back of the cell with a ligature round his neck, which was attached to the window frame. He said that Mr da Cruz's feet were on the ground and he was leaning forward with his head down. Officer B said he could tell that Mr da Cruz was in trouble and needed help. He said that he was not scared to go into the cell, but that he wanted to know that other staff were coming to help him before entering. He called out to Officer A who was in the wing office and they entered the cell together around 30 seconds later. He also called for staff assistance and other officers joined them a minute or so later. Officer C radioed a code blue medical emergency, which triggered the calling of an ambulance by control room staff.

65. We recognise that it can be difficult for staff in such situations to make instant decisions and that there was only a very short delay in staff entering Mr da Cruz's cell, but when there is a potentially life-threatening situation, it is essential to act quickly. Officer B could see that Mr da Cruz was hanging by a ligature and, given he had no fears for his safety, he should have gone into the cell immediately.
66. PSI 3/2013 on medical emergency response codes, issued in February 2013, requires Governors to have a protocol with guidance to staff on how to communicate the nature of a medical emergency. This ensures that staff take the relevant equipment to the incident and that there are no delays in calling an ambulance.
67. While we are satisfied that on this occasion the delays in entering Mr da Cruz's cell and in calling a code blue emergency were minimal and made no difference to the outcome, it is nevertheless vital that prison staff understand their role in a medical emergency as early intervention when a person is found hanging might save their life. We have identified delays in staff entering cells in medical emergencies in previous investigations at Chelmsford. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **staff enter cells as quickly as possible in a life-threatening situation; and**
- **staff understand and use the appropriate emergency code when they discover a medical emergency.**

Resuscitation efforts

68. When Officer A checked Mr da Cruz he noticed no signs of rigor mortis and he started CPR. It was only when a nurse tried to insert an airway that he realised that Mr da Cruz's jaw was locked. Despite this, the nurse considered it appropriate to continue with CPR pending the arrival of paramedics.
69. In September 2016, the National Medical Director at NHS England wrote to the Heads of Healthcare for prisons in England and Wales to introduce new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation after a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 which state: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines give examples of futility as including the presence of rigor mortis. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased.
70. It is clear that there were no immediate signs of rigor mortis and that it was therefore appropriate for staff to commence CPR. We appreciate that the nurse then had a difficult decision to make. CPR was underway when he arrived and it was only when he tried to insert the airway that he recognised there were signs

of rigor mortis. In the circumstances, he did not have the confidence to declare that CPR should stop. We are reluctant to criticise the nurse, but we nevertheless make the following recommendation:

The Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare staff fully understand the circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.

Contact with Mr da Cruz's family

71. Following Mr da Cruz's death, prison staff made several attempts to contact his next of kin, his eldest brother in South Africa, but were unsuccessful. Staff visited one of Mr da Cruz's friends and then contacted Mr da Cruz's ex-partner, who told them that Mr da Cruz's brother and parents were on holiday. Mr da Cruz's ex-partner contacted Mr da Cruz's family and continued to act as a liaison point between the prison and the family.
72. Having had no success in contacting Mr da Cruz's family, we consider that it was reasonable for staff at Chelmsford to consider other options. We also consider it was reasonable for them to accept Mr da Cruz's ex-partner's offer to contact the family. However, Mr da Cruz had clearly indicated that his next of kin was his brother and once the prison became aware that he had returned from holiday, we consider that direct contact should have been made with him to ensure that he was fully aware of the circumstances surrounding his brother's death and to make arrangements for ongoing contact. We make the following recommendation:

The Governor should ensure that following a death in custody appropriate contact is made and maintained with the nominated next of kin.

**Prisons &
Probation**

Ombudsman
Independent Investigations