Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lance Clark, a prisoner at HMP Chelmsford, on 28 November 2019

A report by the Prisons and Probation Ombudsman

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Lance Clark died on 28 November 2019 of a haemorrhage (severe blood loss) after he cut his neck at HMP Chelmsford. Mr Clark was 53 years old. I offer my condolences to Mr Clark's family and friends.

In his four months at the prison, Mr Clark cut his neck on 14 occasions, using a razor blade or a sharp item, and was taken to hospital for treatment on eight occasions. Healthcare staff warned him that he risked serious injury or death if he continued to cut himself.

Although Mr Clark was subject to suicide prevention measures, known as ACCT, for much of his time at Chelmsford, I am concerned that staff consistently underestimated his level of risk and failed to identify or address his risk factors. As a result, they stopped his ACCT monitoring prematurely and left him largely unsupported in the month before he died.

I repeat concerns from previous investigations about the operation of ACCT at HMP Chelmsford.

I agree with the clinical reviewer that Mr Clark should have received mental health support, given the extent of his self-harm. I am also concerned that there is no risk assessment process to manage the safe issuing of razors, contrary to national guidance.

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 **July 2021**

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Summary

Events

1. On 30 July 2019, Mr Lance Clark was sentenced to 11 weeks in prison for assaulting a police officer and theft and was taken to HMP Chelmsford. After he had served his sentence, he remained in prison on remand awaiting trial on further charges.

2. Between the end of July and 12 October, Mr Clark self-harmed 14 times by cutting his neck using a razor blade or another sharp item. He was taken to hospital eight times as a result. Healthcare staff told him he risked killing himself accidentally if he continued to cut his neck in the same place.

3. Mr Clark was subject to suicide prevention measures (known as ACCT monitoring) five times and staff held 25 ACCT case reviews. Mr Clark said that he self-harmed to cope with his many frustrations and concerns, including his mental health, family issues and an upcoming trial in November. The final ACCT was closed on 22 October as Mr Clark had not cut himself since 12 October and staff were satisfied that he had no current thoughts of self-harm.

4. In the month before he died, Mr Clark did not self-harm and he was not subject to ACCT monitoring. He worked as a cleaner on the wing. There are no entries in either his prison or medical record in this time.

5. On 27 November, Mr Clark threw his plate against the wall when collecting his evening meal. The next morning, staff decided to dismiss Mr Clark from his job because of his behaviour. An officer went to Mr Clark's cell to tell him. When the officer spoke to him, Mr Clark grabbed a razor from his table and cut his neck.

6. At 8.59am, the officer called a medical emergency code over the radio. Mr Clark walked out of his cell but was losing a lot of blood from his neck. Officers tried to stop the bleeding with towels. Four minutes later, two nurses arrived and also tried to stop the bleeding. At 9.15am, Mr Clark lost consciousness. Staff started cardiopulmonary resuscitation (CPR).

7. At 9.18am, ambulance paramedics arrived and continued with CPR. An emergency helicopter team arrived at about 9.36am and gave Mr Clark four units of blood, but he could not be resuscitated. At 10.01am, Mr Clark was pronounced dead.

Findings

8. The evidence suggests that Mr Clark did not intend to kill himself when he cut his neck on the day he died. We commend the prison and healthcare staff involved in the emergency response and we are satisfied they did everything they could, in very difficult circumstances, to try to save his life.

9. Although there was some good practice, we are concerned that staff failed to assess or manage Mr Clark's risk effectively.

10. They relied too heavily on how he presented and his repeated assertions that he had no further thoughts of self-harm and as a result, they consistently under-estimated his level of risk.

11. They failed to identify his key risk factors for suicide or self-harm - his inability to manage stress, his concerns about his family relationships and his anxiety about his trial at the end of November – or put measures in place to address them. As a result, these risk factors remained unresolved and Mr Clark's risk remained high.

12. They stopped his monitoring prematurely, leaving him largely unsupported in the month before he died.

13. Although we do not criticise the decision to dismiss Mr Clark from his job as a cleaner, we are concerned that not enough thought was given to how to break this news to him.

14. Although Mr Clark's self-harm was frequent and extreme and known to be potentially life-threatening, there is no evidence that consideration was given to managing Mr Clark under the enhanced ACCT case management process. As a result, there was inadequate multi-disciplinary or senior management input and junior managers were effectively left to manage Mr Clark's complex issues on their own.

15. Mr Clark did not have an allocated key worker, a further missed opportunity to help him during the days leading up to his death.

16. We are concerned that staff did not consider Mr Clark's access to razors or other sharp items at case reviews and that Chelmsford does not have a system for the issuing of razors, contrary to national guidelines.

17. The clinical reviewer concluded that the healthcare provided to Mr Clark was of a mixed standard and therefore not equivalent to that which he could have expected to receive in the community.

18. Although his physical healthcare was of a high standard, Mr Clark's mental healthcare was poor, as he did not receive any mental health input outside of ACCT case reviews, despite his prolific self-harm.

19. Referrals to relevant services providing psychological support and support for substance misuse were not followed up.

20. We are concerned that we have found similar failings in previous investigations into self-inflicted deaths at Chelmsford.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular, that they:
    - consider all risk factors when assessing a prisoner's level of risk and do not just rely on what the prisoner says or how he appears;
    - ensure caremaps reflect meaningful actions to address an individual's risks and protective factors;

    - ensure that the ACCT is not closed until the prisoner's concerns have been fully addressed and that post-closure reviews are carried out thoroughly; and
    - use the enhanced case management process where appropriate.
- The Governor should ensure that a copy of this report is shared with the CM and SOs A-H and that a senior manager discusses the Ombudsman's findings with them.
- The Governor should share a copy of this report with the Head of Safer Custody and personally discuss the Ombudsman's findings with him.
- The Prison Group Director for Hertfordshire, Essex and Suffolk should write to the Ombudsman setting out the steps he is taking to ensure that the lessons of this report are put into practice at Chelmsford.
- The Governor should put in place a local key worker policy which ensures that all prisoners have frequent, meaningful contact with an identifiable key worker in line with the national key worker programme, and that this contact is recorded.
- The Governor should put in place a system for the effective management of razor blades and sharp items, particularly for prisoners at risk of suicide or self-harm, in line with HMPPS's safety briefing of April 2019.
- The Head of Healthcare should put a system is in place to facilitate a patient referral for a review by a psychiatrist, including when a re-referral for an individual would be appropriate.
- The Head of Healthcare should work with IAPT to revise the procedures for the completion of self-assessment forms following an IAPT referral. This should include a system of healthcare prompting and/or supporting individuals who have been referred to the service in order to ensure that they are given the opportunity to complete the required self-assessment, before being discharged from the service without intervention.
- The Head of Healthcare should provide training to all staff, including agency RMNs, to equip them with tools that can be used to provide support for individuals who have a long history of self-harming.
- The Head of Healthcare should ensure that healthcare staff are aware of the requirement to complete the caremap, and have the knowledge and ability to complete it, as part of the ACCT process.
- The Head of Healthcare should share this report with Nurses A-I and discuss the Ombudsman's findings with them.

The Investigation Process

21. 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.

22. The investigator obtained copies of relevant extracts from Mr Clark's prison and medical records.

23. The investigator interviewed six members of staff and a prisoner at HMP Chelmsford on 24 and 27 January 2020 and two members of staff by telephone on 31 March 2020.

24. NHS England commissioned a clinical reviewer to review Mr Clark's clinical care at the prison. She conducted three joint interviews with the investigator.

25. We informed HM Coroner for Essex of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

26. One of the Ombudsman's family liaison officers contacted Mr Clark's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Clark's mother asked whether Mr Clark was appropriately located, if his risk of self-harm was properly managed and whether he should have been transferred to a secure psychiatric hospital under the Mental Health Act due to his prolific self-harm. The family's questions have been addressed in this report.

27. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

28. Mr Clark's next of kin received a copy of the report and they did not make any corrections or comments.

Background Information

HMP Chelmsford

29. HMP & YOI Chelmsford is a local prison that takes adult and young adult men directly from the courts. It can hold nearly 730 men, including around 70 young adults. Essex Partnership University NHS Foundation Trust was commissioned to provide 24-hour healthcare until 1 April 2019, when Castle Rock Group Medical Services (CRG) took over the contract. The prison has a twelve-bed inpatient unit.

30. Between 3 May 2018 and 2 July 2019, Chelmsford was under special measures. This means that HM Prisons and Probation Service had determined that it needed additional, specialist support to improve its performance.

HM Inspectorate of Prisons

31. The most recent full inspection of HMP & YOI Chelmsford was in May and June 2018. Inspectors were concerned at how the prison managed prisoners at risk of self-harm and suicide. There had been 16 self-inflicted deaths over the previous eight years, and four since the last inspection, but too many recommendations from the PPO had not been implemented. Inspectors found that levels of self-harm were very high and that the care was often not good enough. They also found that many staff had become very risk averse, which meant that ACCT procedures were often overused, which in turn risked masking the needs of particularly vulnerable men. They were concerned about the almost complete lack of a broad strategic response to these issues.

32. Inspectors also found that the mental health services were fragmented and largely reactive. Mental health nurses consistently covered staffing gaps in primary care, which meant that casework and assessments often failed to meet the patients' needs. They also found that there were no psychological, counselling or group support services.

33. In April 2019, HMIP reviewed Chelmsford's progress against the main recommendations made during their inspection in June 2018. Inspectors found that the levels of self-harm remained high and the number of self-inflicted deaths remained worrying, but there had been reasonable progress in improving the quality of care for prisoners in crisis or at risk of self-harm. They found that the quality of ACCT paperwork had improved. However, the prison needed to keep recommendations from the PPO under constant review to ensure that progress was sustained.

34. Inspectors found that positive partnership working between CRG, the new healthcare provider, and the prison was evident, with several examples of proactive joint strategic and operational work. There was a clear pathway for patients needing mental health support and staff effectively reviewed patient risks. PPO recommendations relating to healthcare were monitored well, and there had been good progress in this area.

Independent Monitoring Board

35. 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 2019, the IMB reported that the number of open ACCTs had reduced and remained low, though the number of incidents of self-harm had doubled during the reporting year. They found that Safer Custody staff regularly reviewed open ACCTs.

Previous deaths at HMP Chelmsford

36. Mr Clark was the 12th prisoner to die at Chelmsford since August 2017. Five of the previous deaths were self-inflicted, three were drug-related and three were from natural causes.

37. We have expressed concerns about the management of suicide and self-harm monitoring in all the previous self-inflicted deaths.

38. In September 2018 and again in February 2019, we escalated these concerns to the Prison Group Director for Hertfordshire, Essex and Suffolk. We were told in response that Chelmsford continued to deliver the agreed national training plan for suicide and self-harm training to all staff, including partner agencies, on a weekly basis, and that in addition the prison was developing a one-page guidance sheet to provide clear guidance to all staff on assessing risk and the procedures for supporting prisoners at risk. We were also told that, on behalf of the Prison Group Director, the Group Safety Lead would review the current processes and their effectiveness to develop relevant actions and assurance measures where deficiencies still exist by March 2019.

39. In three of the previous self-inflicted deaths we also made recommendations designed to address deficiencies in mental health care.

Assessment, Care in Custody and Teamwork

40. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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.

41. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. 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.

Key worker scheme

42. The key worker scheme – which has been in place across the prison estate since March 2019 - is designed to help reduce violence and self-harm in prisons by encouraging meaningful contact and positive relationships between officers and prisoners. As key workers, all prison officers will hold a small caseload of around six prisoners. They will meet regularly and provide supportive challenge to prisoners, to motivate them to use their time in custody to best effect. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

Key Events

43. On 30 July 2019, Mr Lance Clark was sentenced to 11 weeks in prison for assaulting a police officer and theft. Mr Clark was sent to HMP Chelmsford. This was not his first time in prison.

ACCT 30 -31 July

44. Mr Clark had cut his face before coming to prison and said that he had suicidal thoughts and that he had tried to kill himself by cutting his throat three times in the past. He said that he was depressed to be back in prison. He also said that he was stressed because he had recently broken up with his partner and about an outstanding court hearing on further charges which was due to take place at the end of August.

45. Officers in reception assessed that Mr Clark was at risk of suicide or self-harm and started ACCT monitoring.

46. At the initial health screening, a nurse recorded that Mr Clark had a history of depression and anxiety, although he had never been assessed by a psychiatrist or admitted to a mental health hospital. Mr Clark also reported a significant history of substance misuse in the community and in prison, including cocaine and heroin. The nurse recorded that Mr Clark had a history of self-harm in prison in 2009, 2010, 2011 and 2016. The nurse assessed that Mr Clark was not suitable to have medication in his possession and referred Mr Clark to the mental health team.

47. Supervising Officer (SO) A and Nurse A from the mental health team carried out an ACCT review on 31 July. SO A recorded that Mr Clark was in good spirits and said that although he had been feeling low when he entered custody, he was now feeling more positive. He said he had been homeless and started hanging out with the wrong people and taking crack cocaine, but he thought he now had an opportunity to get his life back on track in prison and rebuild his relationships with his children and grandchildren. He was concerned that he had not had any medication since arriving in prison and said that his mind sometimes raced with negative thoughts, and the medication helped slow things down so he could make sense of them. He was also concerned about having nowhere to live on release and wanted help with his crack cocaine use. He also said he wanted to move to C Wing as he had friends there.

48. SO A recorded that she had made an appointment for him to see the GP about his medication, advised him to attend his three-day induction course and speak to NACRO about his housing, and said she would refer him to Full Circle for support with his drug issues. She and Nurse A concluded that Mr Clark was not at risk of suicide or self-harm and closed the ACCT. The post-closure review was set for 6 August.

49. On 1 August, a prison GP prescribed Mr Clark quetiapine (an antipsychotic) for depression and diazepam for anxiety. (The diazepam prescription was gradually reduced and was discontinued on 27 August.)

50. On 2 August, Nurse B assessed Mr Clark's mental health as part of his secondary health screen. Mr Clark told Nurse B that he believed that he had depression and

attention deficit hyperactivity disorder (ADHD). Nurse B recorded that Mr Clark did not have a formal mental health diagnosis, but that he had a history of substance misuse. Nurse B assessed that Mr Clark did not have a mental illness and did not require any follow up from the mental health team.

ACCT 6-7 August

51. On the evening of 6 August, Mr Clark cut his neck. A nurse recorded that Mr Clark said he had self-harmed "because he wanted to see healthcare for back pain". The nurse treated the wound and started ACCT procedures. She referred him to the GP and to the mental health team.

52. On 7 August, an officer carried out an ACCT assessment. He recorded that Mr Clark said he had self-harmed because he was stressed about the fact that his partner was not replying to his attempts to contact her, and because he thought he might be having a stroke because of pain in his back. He said he had not intended to take his own life, although he had attempted suicide by cutting his throat in 2013 and 2014. He wanted to stay free of drugs and engage with mental health services and move to C Wing. The officer recorded that Mr Clark said he was now feeling better and had no current intentions, thoughts or plans of suicide or self-harm. He was happy to engage with staff and he was fully aware of the Listener, Insider and Samaritan phone services available to him if he needed support.

53. Later that day Mr Clark had an ACCT review with SO B. He recorded that Mr Clark said that he had self-harmed on impulse the previous day because of anger but was now feeling better. He was moving to C Wing that afternoon, had an appointment with a GP on 13 August about his back pain, and said he had no current thoughts of self-harm or suicide. SO B concluded that Mr Clark's risk was low, and he closed the ACCT.

ACCT 8 August – 2 September

54. On the morning of 8 August, an officer opened an ACCT after Mr Clark told her that he was feeling vulnerable about being in prison, that "people have taken him for granted", and that he "feels like opening his neck". He also told her that he had been thinking about jumping in front of a train to end his life before he entered prison. He said he needed vapes as they would take his stress levels down. Mr Clark was punching himself in the head while the officer was talking to him.

55. A few hours later Mr Clark cut his neck but refused medical attention. About an hour later, he made three deep slashes to his neck. Healthcare staff closed them with steri-strips and applied a dressing.

56. An officer then carried out an ACCT assessment. He recorded that Mr Clark said he had self-harmed because of his frustration at not being able to contact his partner and that he was struggling without vapes. Mr Clark said he had a history of serious self-harm and attempted suicide. The officer recorded that Mr Clark said that things were too much for him and he had nothing to live for and nothing to look forward to on his release from prison. However, when asked, he said he had made no specific plans to kill himself.

57. At the subsequent ACCT review, conducted by SO C and Nurse B, SO C recorded that he had arranged to have Mr Clark's partner's telephone numbers added to his PIN phone account. He also noted that Mr Clark wanted to rebuild his relationships with his family, including his children, and that he was due to go to court at the end of August, when he was hoping to be released. Staff assessed that Mr Clark was at low risk of suicide or self-harm, but that he should remain on the ACCT with two hourly observations and a review on 13 August.

58. SO C put in place an ACCT caremap which included four key actions: telephone contact with Mr Clark's partner, to complete the three-day induction course (so he could obtain employment), and appointments with a psychiatrist and with a GP for a medication review.

59. Later that day, at a Multi-Disciplinary Team (MDT) meeting, a psychiatrist, a nurse and a member of the safer custody team reviewed Mr Clark's mental health referral. (They did not see Mr Clark in person.) The psychiatrist noted that Mr Clark had a long history of self-harm. Mr Clark's risk to himself was assessed as being medium-high, with a "risk of immediate self-harm if his demands are not met". They assessed that Mr Clark did not need to be seen by a psychiatrist because he did not show signs of having an acute mental illness and that his mental health needs could be managed by a GP. They also referred Mr Clark to IAPT (a service that provides psychological therapies to prisoners suffering from anxiety and depression) and Full Circle (for psychological support for his substance misuse issues). They recorded that Mr Clark could be re-referred to the psychiatrist if there were any further concerns.

60. On 9 August, a mental health practitioner acknowledged the IAPT referral and recorded that they were waiting for Mr Clark's self-assessment forms before they could work with him. Four weeks later, she recorded that Mr Clark had been discharged from the IAPT service as he had not submitted his forms. Mr Clark did not receive any support from IAPT for his mental health whilst he was in prison.

61. On 10 August, Mr Clark made a deep, 7 cms long cut to his neck and was taken to A&E for treatment because of the location and severity of his injury.

62. SO D and Nurse C carried out an ACCT review when he returned from hospital. Mr Clark said that he did not want to kill himself, but that small things built up and he self-harmed as a coping mechanism to release stress or anger. Mr Clark was positive about the help he had received at hospital and from prison staff. He also said he had now received some reading glasses which meant he would be able to complete the three-day induction course and so obtain employment. He said he had no current thoughts of self-harm or suicide.

63. SO D recorded that Mr Clark was in good spirits and that she had known him over the years he had been coming to prison and that she felt content that he was telling them the truth and did genuinely feel in a much better place. Mr Clark said he would speak to staff if he started to feel down. SO D and Nurse C assessed that Mr Clark was at low risk of suicide or self-harm. ACCT observations were set hourly, with a review on 12 August.

64. On 12 August, SO B and Nurse D held an ACCT case review. Mr Clark said that he self-harmed to cope with frustration, rather than hurting someone else. Mr Clark said that he suffered from extreme mood swings and thought about self-harming

when he was low. He talked about issues with his former partner and his concerns about being homeless when he left prison. He was expecting to go to court on 27 August and hoped to be sentenced because he needed a period of reflection.

65. SO B and Nurse D assessed that Mr Clark was at low risk of suicide or self-harm. SO B noted that Mr Clark presented as quite stable but that he would still need the support of an ACCT. He was to be observed once in the morning and once in the afternoon with a recorded conversation and hourly during the night. The next ACCT review was set for 16 August.

66. Around 5.00pm on 14 August, an officer recorded that Mr Clark had told her that he wanted to end his life and that there would be "a bloodbath" that night. She submitted an intelligence report and informed SO E, the wing SO. The next morning, 15 August, Mr Clark made a deep, five-inch long cut to his neck using a razor blade. He was taken to A&E for treatment.

67. SO F and Nurse E held an ACCT review when he returned from hospital. Mr Clark said that he felt very depressed as he had nothing to live for when he left prison and was having thoughts of self-harm. He did not know when he would be released as he was still waiting for his court hearing. He said that he was concerned that his anti-anxiety medication was being reduced and was worried that he was about to run out of vape capsules and could not afford any more. SO F arranged for Mr Clark to be put on the three-day induction course from 16 August so he could obtain employment to pay for more capsules. He updated the caremap to reflect this and to refer Mr Clark to a GP and a psychiatrist for a medication review. SO F and Nurse E assessed that Mr Clark's level of risk of self-harm or suicide was raised and they increased his observations to every 30 minutes throughout the day and night, with a review on 20 August.

68. On 19 August, Mr Clark cut his neck badly again, and was taken to A&E to have the wound stitched.

69. SO F and Nurse F from the mental health team carried out an ACCT review on 20 August. Mr Clark said that he had self-harmed because he was stressed after a legal visit, but that he now felt good and wanted to get his life back on track. He also said he wanted to attend the three-day induction course so he could obtain employment. SO F recorded that he had asked for Mr Clark to be put on the course at the earliest opportunity, and he updated the caremap to this effect. Mr Clark then asked SO F for more vape capsules and, when this was refused, he said that he would try to kill himself if he did not receive more capsules. SO F recorded that he thought Mr Clark was trying to manipulate the ACCT process to get what he wanted. He assessed that Mr Clark's level of risk of suicide or self-harm remained high and that he should remain on 30-minute observations, with a review on 27 August.

70. On 21 August, Mr Clark removed the stiches from his neck wound and made another cut above it with a plastic knife. He was taken to A&E for treatment and stitches. He told a nurse that he hated his life and wanted to die.

71. SO G carried out an ACCT review during the night after his return from hospital and recorded that Mr Clark was in good spirits. She assessed that Mr Clark's level of risk had not changed since the last review, so remained high.

72. On 23 August, Mr Clark had an initial assessment with the substance misuse team, Full Circle. (There is no record of any follow up.)

73. On 27 August, Mr Clark self-harmed by interfering with the cut on his neck. He refused to allow healthcare staff to clean the wound and told a nurse that he was going to kill himself by cutting his vein.

74. SO E and Nurse C held an ACCT review. Mr Clark said that he had self-harmed because he did not have any vape capsules to smoke. Mr Clark also repeated that he was worried about his upcoming trial (when he said he expected to receive a 12-month sentence), about the possibility of being homeless on release and about the reduction in his antidepressant medication. He also said that he wanted to be employed as a wing cleaner. He said he had had a visit from his mother, which had gone well. He said he had a lot coming up and things could get on top of him. SO E and Nurse C assessed that Mr Clark's level of risk of suicide or self-harm remained raised. They agreed that the ACCT would remain open for another week "to allow time for the up and coming events to take place".

75. On 2 September, SO F and Nurse D held another ACCT review. SO F recorded that Mr Evans was in very good spirits. He had not self-harmed over the previous week and had started to work as a wing cleaner, which meant he was more focussed and settled. Mr Clark said that he wanted to continue "keeping himself busy" with his cleaning job and that he was feeling good about himself and sleeping much better. SO F recorded that there were no outstanding issues on the caremap. They decided that Mr Clark's risk of suicide or self-harm was low and that the ACCT monitoring could be stopped. SO F planned an ACCT post-closure review by 9 September.

ACCT 5 September – 8 October

76. On the morning of 5 September, Mr Clark pressed his cell bell. When an officer answered it, he found Mr Clark standing on the sink in his cell with a belt around his neck and attached to the window bars. He removed the belt and started ACCT monitoring. He recorded that Mr Clark was very distressed and said that he did not have anything to live for.

77. During the ACCT assessment later that day, Mr Clark told an officer that he was feeling stressed and depressed because his family did not want to contact him, and his court hearing had been put back to November. Although being a wing cleaner helped him, he had not been unlocked that day and this had caused his thoughts to spiral downwards. Mr Clark said that, on occasions, he felt suicidal but that he had no immediate plan to end his life.

78. The next day, SO E and Nurse F carried out an ACCT review. Mr Clark said that he had started to think about hanging himself more and more after the suicide of another prisoner at Chelmsford in August and had finally tried it. He also said that he felt very unsettled on the wing. SO E recorded that healthcare staff had stopped prescribing diazepam and that Mr Clark said that he did not want his quetiapine to be increased as it made him drowsy. The nurse added a medication review as an action on the ACCT caremap and a dental appointment, as Mr Clark complained of pain in his teeth. SO E and Nurse F assessed that Mr Clark's risk was raised.

79. ACCT reviews were held on 9 September and on 12 September, when Mr Clark said that the cleaning job was helping a lot and that the wing staff were very supportive, but that he was still stressed about his forthcoming trial. The caremap action for a medication review was still outstanding. On 12 September, his observations were reduced from 30-minute to one hourly intervals.

80. On 17 September, Mr Clark scratched his neck with a razor blade.

81. He was later seen by a psychologist, at the request of the Head of Safer Custody. She recorded that Mr Clark said he was stressed because of his upcoming trial and because he had a poor relationship with his children and grandchildren. He also wanted to move to a smaller wing. She later contacted SO F about some of the issues Mr Clark was struggling with and emailed his key worker to suggest ways he could support Mr Clark. She also noted that she thought it would help if Mr Clark was given self-help materials to work on his emotional management, but that Mr Clark said he could not do this at present because he had no reading glasses.

82. The next day, during an ACCT case review, Mr Clark told SO F and Nurse F that he had self-harmed because he was low in mood and stressed about his court case in November. SO F recorded that Mr Clark was doing very well on the wing, working as a cleaner and attending the gym regularly. When asked, Mr Clark said that he had not had any further thoughts of harming himself since he had done so the previous day. SO F and Nurse F assessed that Mr Clark's level of risk of suicide or self-harm was low.

83. On 20 September, Mr Clark was given a warning after being abusive to an officer and was told that his behaviour was not appropriate for someone working in the trusted position of cleaner. Shortly afterwards, he cut his neck again, re-opening a previous wound. He was seen by healthcare. A few hours later he self-harmed again by cutting the scar tissue on his neck and causing significant blood loss. As the wound would not stop bleeding after being stitched, he was taken to A&E but later discharged himself as he did not want to wait.

84. Later, during an ACCT case review Mr Clark told a Custodial Manager (CM) that self-harm helped him with frustration, but that he did not want to hurt himself. Mr Clark said that prisoners on the wing were "trying to push his buttons and treat him badly" and that he took his anger out on himself, rather than hurting others. The CM discussed the possibility of a move to another wing, but Mr Clark did not want to move, because he did not want to lose his cleaning job. The CM assessed that Mr Clark's level of risk was raised and that he should continue to be observed at 30-minute intervals.

85. At an ACCT review on 21 September, Mr Clark was low in mood, talking about his forthcoming trial and the fact that he would have nothing on release. His observations were unchanged.

86. On 24 September, Mr Clark cut his neck again with a razor, which caused heavy bleeding. He was taken to A&E for stitches but discharged himself without treatment.

87. SO F and Nurse B carried out an ACCT review when he returned. Mr Clark said that he had cut his neck because he wanted to end his life because he had broken his vape pen. SO F arranged for him to get a new one. Mr Clark repeated that he

was stressed about his court appearance in November. He also repeated that he was not happy on his wing. SO F recorded an action on the caremap to review Mr Clark's location. Mr Clark said that he did not think about killing himself all the time, but he was impulsive and felt depressed on occasions. SO F and Nurse B assessed that Mr Clark's risk of suicide or self-harm was high.

88. The psychologist saw Mr Clark after the ACCT review on 24 September and again on 25 September, when SO F was also present. Mr Clark said he had a good relationship with SO F and could talk to officers on the wing, but that he was unhappy on the wing. He also said he struggled to cope when he was alone in his cell. The psychologist left him with some mindfulness work books to complete. SO F updated the caremap to record that Mr Clark was going to have a look at D Wing next week, as it was thought he might benefit from a quieter environment.

89. On 27 September, SO F and Nurse G held an ACCT review. Mr Clark said that he still had thoughts of harming himself and of ending his life but had chosen not to follow the thoughts. Mr Clark said that he was in a better mood now because he had received a letter from his mother and was looking forward to a visit from his brothers on 6 October. SO F and Nurse G assessed that Mr Clark's risk of suicide or self-harm was low and reduced his observations to hourly, with a quality conversation morning and afternoon. The next review was set for 3 October.

90. On the morning of 28 September, Mr Clark cut his neck with a razor blade and was taken to A&E for treatment because of the position and depth of the wound. He returned to prison later that day with internal and external stitches and antibiotics to prevent infection. SO F put him back on 30-minute observations.

91. The next day, Mr Clark told SO F and Nurse B that he had cut his neck because he had nightmares caused by the side effects of his nicotine patches. He said that he did not want to harm himself or end his life. SO F and Nurse B assessed that Mr Clark's level of risk was low.

92. On 3 October, SO F conducted another ACCT review. Mr Clark said his mood was very good, that he felt like a new man and was looking forward to seeing his brothers on 6 October. The only outstanding action on his caremap was the possibility of moving wings, but Mr Clark said he did not want to move because he was happy on C Wing and enjoying his job. SO F, therefore, marked the action as closed. Observations were reduced to a quality conversation morning and evening and hourly observations during the night.

93. On 8 October, SO F and Nurse H closed Mr Clark's ACCT because he had not self-harmed since 24 September and said that he had no thoughts of self-harm or suicide. Mr Clark said that he was happy to be in touch with his mother and brothers. He said that he was hoping to get out of prison following his court hearing and start rebuilding his relationship with his children. He also said he felt more comfortable on the wing now that he had moved cells. SO F recorded that Mr Clark had recently moved to another cell on C wing and felt more comfortable. SO F scheduled an ACCT post-closure review for 15 October.

ACCT 12 October – 22 October

94. On 12 October, Mr Clark cut his neck again and tried to open his old neck wound. A nurse reviewed Mr Clark and assessed that he had obvious blood vessel

damage. Mr Clark was taken to A&E, but the wound could not be stitched because there was too much scar tissue. A nurse reviewed Mr Clark when he returned to prison and told him that if he continued cutting his neck in the same place, he could do irreparable damage or kill himself.

95. SO F opened an ACCT with hourly observations.

96. On 13 October, SO F and Nurse E held an ACCT review. Mr Clark said he had self-harmed because he was feeling stressed about his trial in November. SO F recorded that Mr Clark said that he did not want to end his life and did not have any further thoughts of self-harm. SO F reminded Mr Clark that he risked his life if he cut his neck again, and recorded that Mr Clark said that he "would do his best to try to refrain from harming himself in the future". He said he was happy on the wing, especially working as a cleaner, and was looking forward to his family visiting him on 20 October, his birthday.

97. SO F and Nurse E assessed that Mr Clark's risk of suicide or self-harm was low. SO F recorded that Mr Clark did not have any issues for the caremap, but that they had decided to leave the ACCT open "due to the fact that [Mr Clark] harming himself has been relatively frequent over recent months". Observations were reduced to a quality conversation in the morning and evening and hourly observations at night. The next review was set for 17 October.

98. SO F chaired another ACCT review on 17 October. He recorded that Mr Clark was agitated and stressed because he would be 53 on 20 October and had nothing to show for his life, and because he was also anxious about his daughter visiting him as he had not seen her for two years. SO F asked him if there was anything that needed to be put on the caremap, but Mr Clark said he could not think of anything. SO F discussed the possibility of closing the ACCT because there were no issues on the caremap and Mr Clark had not self-harmed since 12 October, but it was agreed to leave it open until after the stress of Mr Clark's birthday and the visit. Observations remained the same.

99. On 22 October, the psychologist saw Mr Clark. She recorded that he was in a positive mood and had had a good visit from his mother and two of his daughters. He now had reading glasses and agreed he would try to keep a journal of his feelings. She said she would see him again in a week to see if further support was required. There is no record that she saw Mr Clark again before he died.

100. Later that day, SO A and Nurse I held an ACCT review. SO A recorded that Mr Clark seemed well and had enjoyed his recent family visit. He said that his family's support made him feel stronger and able to move forward with his life. Mr Clark was positive about the likely outcome of his trial at the end of November. He said that he had no intention of harming himself. SO A and Nurse I decided that Mr Clark was no longer at risk of suicide or self-harm and closed the ACCT.

101. On 29 October, SO H carried out Mr Clark's post-closure review. Mr Clark told SO H that he was "not completely okay" as his court case was still ongoing, but that he did not think that he needed the support of ACCT monitoring.

November 2019

102. Over the next month, Mr Clark did not self-harm. Neither officers nor healthcare staff recorded anything in his prison or medical records. Mr Clark's brothers and daughter visited him on 10 November. From 4 November until 17 November, Mr Clark tried to call his mother and a friend several times, but the calls were not answered.

103. A prisoner, who was a friend of Mr Clark's, told the investigator that Mr Clark struggled with his mental health and that his moods were "very up and down". He said Mr Clark was "a big character on the wing", got on well with staff and other prisoners and engaged in "banter" with everyone, although there were times when he just asked to be left alone and would get very upset over seemingly trivial matters. He said Mr Clark was happier in the weeks before his death because he had developed a better relationship with his family, but that he was worried about his court case, which kept being postponed.

104. The prisoner said he had mental health problems himself that caused him to self-harm, so he sympathised with Mr Clark's problems, and he and another prisoner had tried to support Mr Clark. He thought that Mr Clark self-harmed when he could not cope and that he did not necessarily want to die. He considered that Mr Clark did not get enough support from healthcare as he said that Mr Clark's self-harm was extreme in nature and that he had been told that if he kept cutting his neck he could kill himself. He said that the job as wing cleaner was very important to Mr Clark as it kept him busy and meant he spent less time alone in his cell brooding about things. Mr Clark took great pride in doing a good job and was very pleased when he received praise. He also said that he knew Mr Clark sometimes 'self-medicated' with illicit drugs.

Events of 27 and 28 November 2019

105. At about 4.30pm on 27 November, Mr Clark went to collect his food from the wing servery. SO F said that Mr Clark was not happy with his food, became angry and threw it against the wall. Mr Clark was taken back to his cell by an officer and locked up. (This was Mr Clark's first violent incident at Chelmsford.) There is no evidence that anyone spoke to Mr Clark after the incident.

106. At 7.40am the next morning, SO F discussed Mr Clark's behaviour during a morning briefing with five officers. Wing cleaning jobs are much sought after by prisoners as they allow more time out of cell, and for this reason they are only allocated to trusted and well-behaved prisoners. SO F and the officers concluded that Mr Clark's behaviour the previous day was not that expected of a wing cleaner and they therefore decided to dismiss Mr Clark from his cleaning job. An officer agreed to tell him. SO F told the investigator that he would have spoken to Mr Clark himself later and told him that he could have the job back in a couple of weeks if he demonstrated good behaviour.

107. CCTV shows that at 8.58am, the officer went to Mr Clark's cell and stood in the open doorway. He told Mr Clark that he was going to be dismissed from his cleaning job because of his behaviour the previous day. He said that Mr Clark stood up and started to shout at him. Mr Clark said that he had thrown food at the servery because he was stressed. He told Mr Clark that he could speak to SO F if

he was not happy with the decision, and they would review it. He said that Mr Clark then grabbed a razor from his table and cut his neck.

108. CCTV shows that at 8.59am, the officer closed the door - he said he closed it because he feared for his personal safety - and called a code red over the radio (indicating a medical emergency involving severe blood loss). A prisoner heard shouting, went to Mr Clark's cell and looked through the observation panel. He then shouted that healthcare staff were needed urgently.

109. CCTV shows that at 9.00am, the officer opened the door of Mr Clark's cell again, immediately after the prisoner shouted for assistance. Mr Clark walked out of the cell. The officer said that Mr Clark was screaming that he was dying, and that "a lot of blood flew out of Mr Clark's neck" and went over him as well. Staff arrived on the landing and they put Mr Clark on a pool table where they could treat him more easily. They put a pillow under his head, and they tried to keep the wound closed. Mr Clark was panicking, struggling with staff and saying that he did not want to die.

110. The CM, who was the Orderly Officer, also arrived on the wing and radioed the communications office to make sure an ambulance was on its way as he could see immediately that the situation was very serious. The duty governor also arrived.

111. Mr Clark was bleeding profusely, and the CM tried to stop the bleeding by putting pressure on the wound with a towel. He asked Mr Clark to remain calm, but he said that Mr Clark was panicking, saying that he could not breathe and was going to die and wanted to speak to his mother on the phone. The fact that Mr Clark was struggling so much made the bleeding worse.

112. At 9.01am, the control room officer called an ambulance. CCTV shows that at 9.02am, a nurse arrived and tried to stop Mr Clark's bleeding. Another nurse got to the cell at 9.07am. More officers arrived and they all tried to stop the bleeding. At 9.14am, the ambulance arrived at the prison's gate.

113. At 9.15am, Mr Clark lost consciousness and on the nurses' instructions the officers moved him from the pool table to the floor. The CM started CPR and then healthcare staff took over.

114. Ambulance paramedics arrived at the wing at 9.18am and continued resuscitation efforts. An emergency helicopter medical team arrived at about 9.36am and took over Mr Clark's care. He was given four units of blood, but he could not be resuscitated and, at 10.01am, he was pronounced dead.

Contact with Mr Clark's family

115. At 10.51am, the prison's family liaison officer went to Mr Clark's mother's house and broke the news of his death. He offered support.

116. On 3 January 2020, Mr Clark's funeral took place. The prison contributed to the costs of the funeral, in line with national instructions.

Support for prisoners and staff

117. After Mr Clark's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

118. The prison posted notices informing other prisoners of Mr Clark'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 Clark's death.

119. The prisoner and friend of Mr Clark's said that he had received support from staff on the wing who knew he had been good friends with Mr Clark. However, he said that he had found the thought of speaking to the PPO investigator very distressing and he had asked for support from mental health staff but had not received it.

Post-mortem report

120. A post-mortem examination established the cause of death as haemorrhage (severe blood loss) and laceration of the neck. We are currently waiting for a copy of the toxicology report.

Findings

Assessment and management of risk

121. Mr Clark had been warned that he risked killing himself if he cut his neck again. However, the evidence suggests that Mr Clark probably did not intend to take his life when he cut his neck on 28 November and that his death was the unintended consequence of a further act of self-harm. We have considered whether anything could have been done to reduce the risk of him self-harming and so putting his life at risk.

122. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures for identifying, managing and supporting prisoners at risk of suicide or self-harm using the ACCT process.

123. Staff at Chelmsford appropriately identified that Mr Clark was at risk both when he first arrived at the prison and after his frequent acts of self-harm, and there was some good practice. For example, timely ACCT assessments and reviews were held; a mental health nurse attended most of the ACCT reviews; and the reviews were well recorded. However, we are concerned that overall staff did not adequately assess or manage his risk.

Assessment of risk

124. Although an ACCT was appropriately opened when Mr Clark arrived at Chelmsford, we considered that it was closed prematurely the next day. We recognise that many prisoners arrive in prison with problems and staff cannot place them all on an ACCT. However, Mr Clark had cut himself immediately before coming into prison and disclosed a history of serious self-harm and suicide attempts, and substance misuse and mental health problems. Although he said he felt better the next day, we consider that staff should have monitored him for longer before closing the ACCT.

125. In the event, he self-harmed a week after his arrival. Although another ACCT was immediately opened, that was also closed after only one day after Mr Clark said that he felt fine and had no thoughts of suicide or self-harm. Two days after the ACCT was closed, Mr Clark self-harmed again twice.

126. Between 30 July and 12 October, Mr Clark self-harmed on 13 occasions by cutting his neck and once by putting a makeshift noose round his neck. He had to be taken to A&E for treatment on eight occasions. He was told that his repeated self-harm could result in him accidentally killing himself. We are concerned that, despite Mr Clark's frequent acts of self-harm, staff consistently underestimated his level of risk. At 18 of his 25 ACCT case reviews, it was agreed that his level of risk was low and only twice did the case review consider that Mr Clark was at high risk of self-harm.

127. We are concerned, for example, that on 27 September, SO F and Nurse G assessed that Mr Clark's level of risk was low. We find it difficult to understand how they can have reached this conclusion given that Mr Clark had cut himself seriously just three days before and that at this point he had self-harmed 12 times and been taken to A&E six times in just two months. In fact, he went on to self-harm again

the very next day. Despite this, SO F and Nurse B again assessed his risk as low the following day.

128. We are also concerned that SO A and Nurse I assessed that Mr Clark was not at risk of suicide or self-harm at his last ACCT case review on 22 October because Mr Clark appeared positive, had not self-harmed for 10 days and said he had no intention of doing so again.

129. We have said repeatedly over many years that staff too often assess a prisoner's risk based on how he appears and what he says, and do not give sufficient weight to the risk factors that give rise to the self-harm. This is another such case. We are concerned that staff repeatedly accepted Mr Clark's assertions that he felt better and had no further thoughts of self-harm as evidence that he was no longer at risk, and that they did not learn from the fact that he consistently went on to self-harm again, often within one or two days.

130. Staff did not appear to recognise that Mr Clark self-harmed impulsively in response to stress and that, while he may genuinely have felt better for a while after doing so, he was likely to self-harm again spontaneously when his stress levels rose again. For example, on 10 August, SO D recorded that Mr Clark was in good spirits and that, from her previous knowledge of him, she believed he was telling the truth when he said he felt much happier. Despite this, Mr Clark cut himself badly only five days later.

131. Staff repeatedly judged Mr Clark's risk on the basis of how he was feeling and what he said when they asked him if he had any current thoughts of self-harm. On 13 October, SO F recorded that Mr Clark had said he was happy, had no thoughts of self-harm and that "he would do his best to try to refrain from harming himself in the future". Unfortunately, this was not something that staff could rely upon as a guide to the level of risk Mr Clark posed to himself. What mattered was whether the risk factors that caused Mr Clark's stress and led him to self-harm had been addressed. While those risk factors existed, Mr Clark remained at risk of self-harm. As a result of focussing on Mr Clark's presentation, rather than his risk factors, staff consistently misjudged his risk.

Management of risk

132. The focus on Mr Clark's presentation also meant that staff failed to identify his key risk factors and to put measures in place that might have reduced his risk.

133. Mr Clark's key risk factors were his mental health (his inability to manage his stress other than by self-harming, and his worries about his antidepressant medication), his family relationships and his upcoming trial. He mentioned them, especially his concerns about his trial, at virtually every ACCT assessment during his four months at Chelmsford, but they remained acutely unresolved.

134. Despite his concerns about his antidepressant being stopped and his more general concerns about his mental health, the medication review did not take place, he did not have a formal mental health review and he received virtually no help in managing his stress. Despite his repeated concerns about his family relationships, there is no evidence that anyone considered trying to involve his family in his ACCT reviews. And despite his repeated assertions that his forthcoming trial was causing

him a great deal of stress, no support was put in place for him in the days before the trial at the end of November.

135. We would have expected these key risk factors to have featured in the ACCT caremaps. However, while six actions were identified and updated in the last two caremaps (covering the periods 8 August to 2 September and 5 September to 8 October) none properly addressed these key issues. As a result, we consider that staff stopped ACCT monitoring prematurely on 8 October and Mr Clark was left without support in the month before he died. During that time, he had to deal with two risk factors which were known to cause him stress: he was due to go to court a few days after he died and Mr Clark had been unable to speak to his mother.

136. At the post-closure ACCT review on 29 October, Mr Clark told SO H that he was "not completely okay" because he was still worried about his forthcoming trial. If the trial had been identified as a risk factor, as it should have been, the caremap should have included actions to provide Mr Clark with support and it would have been clear that Mr Clark remained at risk of self-harm. As it was, SO H did not plan any supportive measures or consider re-opening the ACCT.

137. We are also concerned that SO F repeatedly asked Mr Clark to say what actions should be included in the caremap and then closed the ACCT when Mr Clark could not suggest any. Although it is good practice to ask prisoners to contribute their own ideas, staff cannot assume that the prisoner necessarily has insight into his risks. The responsibility for identifying risk factors and putting actions in place to mitigate them, rests with staff and not with the prisoner.

Protective factors

138. A further concern is that staff failed to identify Mr Clark's protective factors, the most important of which was his job as a cleaner that enabled him to keep busy and reduced the time he spent alone in his cell. Mr Clark repeatedly said that this was very important to him. We are very concerned that, despite this, no thought seems to have been given to how his dismissal should be broken to him.

139. We recognise that certain standards of behaviour are expected from wing cleaners and we do not say that the decision to dismiss him was wrong. SO F said that he considered Mr Clark's welfare before making the decision and considered other disciplinary action and we are satisfied that he did not make this decision lightly.

140. However, Mr Clark was known to be impulsive and to self-harm even in response to apparently trivial triggers – such as breaking his vape pen. We would, therefore, have expected SO F to have thought carefully about how, when and where to break what Mr Clark was likely to see as devastating news. This was particularly important as staff should have been aware that Mr Clark's trial – a major risk factor – was due to take place in a couple of days.

141. Indeed, the fact that Mr Clark had behaved in such an out of character way when he threw his food against the wall, should have been seen as a sign that he was under stress and therefore at risk of self-harm. If Mr Clark's inability to manage stress had been identified as a risk factor, as it should have been, his behaviour the day before his death should have prompted staff to speak to him to check his wellbeing and consider whether his risk of self-harm was raised. We are therefore very concerned

that after the final ACCT was closed on 22 October, there is no evidence that wing officers and healthcare staff had any meaningful interaction with Mr Clark.

The enhanced ACCT review process and multi-disciplinary working

142. Although we have been critical of the way staff assessed and managed Mr Clark's risk, we are concerned that staff at SO rank were largely left to manage the complex problems he posed without adequate support.

143. Mr Clark's self-harm was of an extreme, life-threatening nature, requiring medical intervention and frequent attendance at A&E. Where prisoners display these kinds of behaviours, PSI 64/2011 gives Governors the discretion to manage them under the enhanced ACCT case review process. This involves all relevant disciplines (including mental health and psychology) in ACCT case reviews and more senior prison staff than typical ACCT management, with ACCT reviews being chaired at a minimum by a Custodial Manager.

144. Although occasional ACCT reviews were chaired by a CM, and the Head of Safer Custody asked a psychologist to see Mr Clark in September, we have seen no evidence that any consideration was given to managing Mr Clark under the enhanced case management process when he continued to self-harm. We think this would have been beneficial in terms of ensuring a high level, multi-disciplinary approach to the problems Mr Clark posed.

145. We are concerned, for example, that the Head of Healthcare told us that he was not aware of Mr Clark before he died because he was only made aware of "prolific self-harmers". We are also concerned that although a psychologist saw Mr Clark on three occasions in September and once in October, she did not attend ACCT reviews and was not therefore engaged in the management of Mr Clark's self-harm or in advising prison staff on how best to manage him. There is no evidence that she continued to work with Mr Clark for the last month of his life after the ACCT was closed. We consider that psychological support to help Mr Clark manage his stress better should have been a key action on his caremap and that this was a significant omission.

146. We have more to say about this below under Clinical Care.

147. In summary, we consider that staff failed to assess or manage Mr Clark's risk appropriately and that, as a result, he remained at high risk of suicide or self-harm throughout his time at Chelmsford.

148. We have raised concerns about the operation of ACCT at Chelmsford in our previous investigations into self-inflicted deaths at the prison. We are, therefore, very concerned to have identified similar failings in this investigation about poor assessment of risk, failure to manage risk and protective factors through effective caremaps and inadequate support for those at risk of suicide or self-harm.

149. In some of the cases we investigate across the Prison Service staff have failed to follow the ACCT procedures – which is a relatively easy problem to put right. That was not the case here where the fundamental problem was that staff relied on how Mr Clark presented and failed to identify his risk factors for self-harm effectively. That is more difficult to deal with and we would encourage senior managers at Chelmsford to think imaginatively about how they can get this message across to

staff. At the time of writing, there have been no further self-inflicted deaths at Chelmsford in the six months since Mr Clark died, and we hope that is grounds for cautious optimism about the prison's ability to tackle the problem.

150. We make the following recommendations:

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

- **consider all risk factors when assessing a prisoner's level of risk and do not just rely on what the prisoner says or how he appears;**
- **ensure caremaps contain meaningful actions to address an individual's risks and make use of protective factors;**
- **ensure that the ACCT is not closed until the prisoner's concerns have been fully addressed and that post-closure reviews are carried out thoroughly; and**
- **use the enhanced case management process where appropriate.**

The Governor should ensure that a copy of this report is shared with the CM and with SOs A-H and that a senior manager discusses the Ombudsman's findings with them.

The Governor should share a copy of this report with the Head of Safer Custody and personally discuss the Ombudsman's findings with him.

The Prison Group Director for Hertfordshire, Essex and Suffolk should write to the Ombudsman setting out the steps he is taking to ensure that the lessons of this report are put into practice at Chelmsford.

The key worker scheme

151. One form of support that we would have expected to see in place for Mr Clark once the final ACCT was closed would have been conversations with his key worker. In September, the psychologist emailed Mr Clark's key worker suggesting ways in which he could support Mr Clark, but there is no record that Mr Clark's key worker ever spoke to him. This was a missed opportunity to support Mr Clark with his court appearance, family issues and his employment and to identify how he was coping.

152. We are very concerned that Chelmsford does not have a local key worker policy and that the scheme did not appear to be working well there at the time of Mr Clark's death. We recommend:

The Governor should put in place a local key worker policy which ensures that all prisoners have frequent, meaningful contact with an identifiable key worker in line with the national key worker programme, and that this contact is recorded.

Access to razors

153. Mr Clark repeatedly used razors or other sharp items to inflict serious cuts to his neck to the point where it put his life at risk. We are therefore concerned that staff did not consider Mr Clark's access to razors during ACCT case reviews.

154. Healthcare staff told the investigator that a prisoner's access to razors was a security matter for officers. The Head of Safer Custody told the investigator that there was no system in place to risk assess or manage the issuing of razors or sharps to prisoners at Chelmsford. The CM and SO F and SO H said that it would not have been possible to restrict Mr Clark's access to razors because he could have got them from any other prisoner on the wing.

155. In April 2019, the Prison Service issued a safety briefing about the management of razors in prisons. This requires that access to razors and other sharp items should be discussed at ACCT case reviews and the outcome reflected in the caremap for all prisoners subject to ACCT monitoring. While we recognise the difficulties of managing access to razors when prisoners are on normal location, we make the following recommendation:

The Governor should put in place a system for the effective management of razor blades and sharp items, particularly for prisoners at risk of self-harm or suicide, in line with HMPPS's safety briefing of April 2019.

Clinical Care

156. The clinical reviewer concluded that the healthcare provided to Mr Clark was of a mixed standard and, therefore, not equivalent to that which he could have expected to receive in the community.

Physical healthcare

157. The clinical reviewer concluded that Mr Clarke's physical health care was of a very good standard, demonstrating good practice and equivalence.

158. She found that healthcare staff treated Mr Clark's self-harm injuries appropriately and that hospital referrals were timely and clinical follow ups were managed well. She considered that healthcare staff should be commended for their quality clinical interventions when managing Mr Clark's self-harm injuries.

159. The clinical reviewer also considered that the emergency response on 28 November was in line with national guidelines and demonstrated good practice.

Mental health care

160. The clinical reviewer found that some aspects of Mr Clark's mental health care also demonstrated good practice and equivalence.

161. His initial and secondary reception screens were accurately completed and identified all relevant information about his mental health. He was referred to the mental health team without delay. An evidence-based tool was used to inform Mr Clark's early assessment by the mental health team. Referrals to IAPT and Full

Circle were also completed by healthcare without delay. Mr Clark was prescribed appropriate medication which was regularly reviewed. The reduction and subsequent discontinuation of diazepam was appropriate and in line with recommended prescribing guidelines. Mental State Examinations were also regularly carried out during ACCT reviews to inform the clinical assessment of Mr Clark's mental health, and a mental health nurse was present for the majority of Mr Clark's ACCT reviews.

162. However, the clinical reviewer also identified a number of areas where the care Mr Clark received was not equivalent to that he could have expected in the community.

163. She was concerned that after Nurse B's secondary health screen on 2 August, Mr Clark was not seen or assessed by a mental health nurse or any other member of the mental health team for the four months he was at the prison, outside of the ACCT reviews. His contact with mental health services remained limited to ACCT reviews only. Although Mr Clark was told that he could ask to see the mental health team at any time, there was no proactive intervention or support from the mental health service.

164. At a multidisciplinary team meeting with the psychiatrist on 8 August, it was agreed that Mr Clark did not need psychiatric intervention at that time. However, Mr Clark was not re-referred for discussion or to see the psychiatrist again at any point over the next four months, despite his serious and ongoing self-harm. This also meant that the medication he was receiving for anxiety was not reviewed by the psychiatrist, who may have offered a different clinical view about the appropriate treatment.

165. We share the clinical reviewer's concern that Mr Clark did not receive specialist mental health input, despite his serious self-harm. We consider that this was a missed opportunity to consider whether Mr Clark could be offered additional support for his stress and anxiety with a view to reducing his self-harm.

166. The clinical reviewer was also concerned that no mental health plan or risk management strategy was put in place when ACCT monitoring was stopped on 22 October.

167. There is also no documented evidence of any concerns being raised by healthcare staff during Mr Clark's ACCT reviews about his access to razor blades. The clinical reviewer said that this was not in line with NICE Guidance 66, which requires practitioners to set out the interventions to reduce risks.

168. The clinical reviewer was also concerned that Mr Clark did not receive any intervention or treatment following the referrals to IAPT and Full Circle.

169. He was discharged from the IAPT service on 18 August because he did not complete and return his self-assessment forms. There is no evidence that healthcare staff prompted Mr Clark to complete the forms or followed up on his need for access to the service, and it is not clear whether Mr Clark was aware that his failure to return them was going to result in his discharge. The clinical reviewer considered that input from the service may have helped Mr Clark manage a reduction in his self-harm.

170. Full Circle assessed Mr Clark on 23 August but there is no evidence of any follow up. Intervention from the service may have assisted Mr Clark with his substance misuse issues.

171. The clinical reviewer concluded that Mr Clark's death, as a result of impulsive self-harming by cutting his neck with a razor blade, may have been foreseeable. She found that a lack of quality in some aspects of his healthcare contributed to substandard intervention and management of Mr Clark's ongoing self-harm risk.

172. We make the following recommendations:

The Head of Healthcare should put a system in place to facilitate a patient referral for a review by a psychiatrist, including when a re-referral for an individual would be appropriate.

The Head of Healthcare should work with IAPT to revise the procedures for the completion of self-assessment forms following an IAPT referral. This should include a system of healthcare prompting and/or supporting individuals who have been referred to the service in order to ensure that they are given the opportunity to complete the required self-assessment, before being discharged from the service without intervention.

The Head of Healthcare should provide training to all staff, including agency RMNs, to equip them with tools that can be used to provide support for individuals who have a long history of self-harming.

The Head of should ensure that healthcare staff are aware of the requirement to complete the caremap, and have the knowledge and ability to complete it, as part of the ACCT process.

The Head of Healthcare should share this report with Nurses A-I and discuss the Ombudsman's findings with them.

Detention under the Mental Health Act

173. Mr Clark's family asked whether Mr Clark should have been transferred to a secure psychiatric hospital for mental health treatment given his repeated self-harm.

174. The clinical reviewer considered that there was no evidence to suggest that Mr Clark required detention under the Mental Health Act or transfer to a mental health hospital. She said that Mr Clark had the capacity to make informed choices and decisions and was not suffering from any disturbances or psychosis (such as hearing or seeing things, that are not present in reality) which would have made sectioning appropriate.

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