

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Anthony Warren, a prisoner at HMP Chelmsford, on 15 August 2019**

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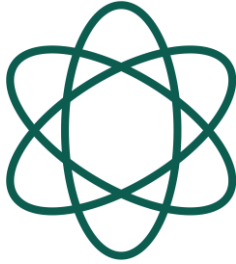
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## Our vision

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



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**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

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

**OGL**

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

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

Mr Anthony Warren was found hanging in his cell at HMP & YOI Chelmsford on 15 August 2019. He was 28 years old. I offer my condolences to Mr Warren's family and friends.

Mr Warren self-harmed at least 24 times in the 24 days he spent at Chelmsford. This persistent self-harming behaviour made it very difficult to manage him and keep him safe.

However, although staff at Chelmsford monitored Mr Warren under Prison Service suicide and self-harm prevention procedures throughout his time at Chelmsford, I consider that they underestimated his risk of suicide and failed to put adequate measures in place to reduce his risk. I also consider that there were a number of failings in the management of these procedures.

Mr Warren spent 11 days in the prison's segregation unit shortly before his death and I am concerned that as staff regularly changed the rule used to authorise his segregation, Prison Service policy did not require a Segregation Review Board to be held during this time. I am also concerned that healthcare staff completed Initial Segregation Health Screens inaccurately and that the Deputy Governor did not formally authorise Mr Warren's continued segregation on occasions.

Mr Warren had several mental health issues. I am concerned that generally healthcare staff did not see Mr Warren proactively but instead only saw him when he had hurt himself or during suicide and self-harm monitoring procedures.

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 McAlister CB**  
**Prisons and Probation Ombudsman**

**March 2023**

# Contents

Summary .....	1
The Investigation Process.....	5
Background Information.....	6
Key Events.....	8
Findings .....	17

# Summary

## Events

1. On 22 July 2019, Mr Anthony Warren was remanded in prison custody, charged with assault, and sent to HMP Chelmsford.
2. Mr Warren had a history of antisocial personality disorder, attention deficit hyperactivity disorder (ADHD), manic depression and post-traumatic stress disorder (PTSD). Healthcare staff prescribed Mr Warren various medications, including pregabalin (used to treat anxiety), risperidone (an anti-psychotic drug used to treat schizophrenia and bipolar disorder) and citalopram (an antidepressant).
3. On arrival at Chelmsford, an officer began Prison Service suicide and self-harm monitoring (known as ACCT) as Mr Warren had cuts to his neck, head and arm. Between 22 July and 14 August, staff held 26 ACCT case reviews with Mr Warren. During the reviews, Mr Warren said that he was self-harming because he was concerned about his partner, was concerned for his safety or because he needed a variety of items, including telephone credit, a vape and his medication. The attendees assessed Mr Warren's level of risk, which varied between low, raised and high; and set observations during each review. During the same period, Mr Warren self-harmed on at least 24 occasions, usually by tying ligatures around his neck.
4. On 28 July, after staff placed him on three separate disciplinary charges, Mr Warren was moved to the prison's segregation unit. He spent 11 days in the segregation unit before moving to D Wing on 8 August.
5. Between 5 and 7 August, three members of healthcare staff asked prison managers to remove Mr Warren's bedding, clothing and laces, and to put him in anti-ligature clothing. On each occasion, prison managers refused the request but did not discuss this during subsequent ACCT case reviews.
6. At 1.30pm on 15 August, an officer visited Mr Warren's cell and found him hanging from a ligature. The officer shouted for staff assistance, then called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing). Other officers and healthcare staff quickly responded. They started cardiopulmonary resuscitation (CPR), inserted an airway, gave Mr Warren oxygen and attached a defibrillator.
7. The control room called for an ambulance at 1.32pm. Paramedics reached Mr Warren at 1.38pm but they were unable to resuscitate him and, at 2.07pm, an air ambulance doctor declared that he had died.

## Findings

### Assessment of Mr Warren's risk of suicide and self-harm

8. Mr Warren was on an ACCT throughout the 24 days he spent at Chelmsford. During that time, Mr Warren self-harmed at least 24 times and staff held 26 ACCT case reviews. We recognise that Mr Warren's persistent self-harming behaviour made it very difficult to manage him and keep him safe.

9. However, we consider that staff underestimated Mr Warren's risk of suicide and self-harm by not placing enough weight on his numerous incidents of self-harm, unresolved concerns and mental health issues.
10. Although there was good practice – for example, most ACCT case reviews were multi-disciplinary, we also found a number of deficiencies with the ACCT process, including that prison managers did not appropriately consider three requests from healthcare staff for Mr Warren to be put in anti-ligature clothing, ACCT case reviews were not held as planned, and staff occasionally did not observe him as specified.

### **Segregation**

11. Mr Warren was segregated for 11 days. If he had been segregated under Prison Rule 45 throughout this period, the prison would have been required to hold an Initial Segregation Review Board within 72 hours. This requirement did not apply in Mr Warren's case because the rule used to authorise his segregation changed on four occasions. We consider that an Initial Segregation Review Board should take place within 72 hours of a prisoner's segregation, regardless of which Prison Rule applies to the segregation.
12. We are also concerned that the wrong rule was used to authorise Mr Warren's segregation after three inconclusive disciplinary hearings, that two nurses incorrectly completed his Initial Segregation Health Screens, and that there is no record that some Defensible Decision documents were authorised by the Governor or Deputy Governor.

### **Mental health**

13. We agree with the clinical reviewer that, despite some areas of good practice, Mr Warren's mental health care was often reactive, following an incident of self-harm, rather than proactive. There was little evidence that Mr Warren received any direct intervention from mental health staff other than them attending ACCT case reviews or seeing him after incidents of self-harm.

### **IAPT**

14. Throughout the ACCT process, prison and healthcare staff decided that Mr Warren would benefit from counselling from IAPT. However, Mr Warren's time in the segregation unit and his regular self-harming behaviour meant that they would not see him, though we are concerned that this was not clear to all staff or Mr Warren.

### **Family liaison**

15. On two occasions, Mr Warren listed his partner as his next of kin. However, we are concerned that the prison disregarded his choice and contacted his grandmother after he died.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they:
  - consider all risk factors, including suicidal statements, current self-harming behaviour and previous suicide attempts, when assessing a prisoner's risk;
  - appropriately record every act of self-harm;
  - consider the use of anti-ligature clothing or what items should be removed from prisoners at risk of self-harm during ACCT case reviews;
  - hold multidisciplinary ACCT case reviews as scheduled;
  - invite and ensure the attendance of the residential manager at an ACCT case review when a prisoner moves from the segregation unit to a residential wing; and
  - adhere to the frequency of observations set out in the ACCT document.
- The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including ensuring that they:
  - authorise a prisoner's continued segregation under Prison Rule 45 if an initial disciplinary hearing is inconclusive;
  - complete Initial Segregation Health Screens accurately and fully; and
  - formally authorise a Defensible Decision document for any prisoner segregated while on an open ACCT.
- The Head of Healthcare should discuss Nurse A and Nurse B's inaccurate Segregation Health Screens with them and ensure that they understand the importance of completing these documents accurately.
- The Director General of Prisons of HM Prison and Probation Service should amend Prison Service Order 1700 to ensure that an Initial Segregation Review Board is held within the first 72 hours of a prisoner being placed in segregation, regardless of which Prison Rule applies to the segregation.
- The Head of Healthcare should ensure that prisoners who self-harm receive one to one interventions separate to any treatment following a self-harm incident.
- The Governor, the Head of Healthcare and the Head of IAPT should ensure that:
  - all staff are aware of the circumstances that prevent IAPT from accepting a prisoner's referral; and
  - the Self-Referral Form is amended to ensure that all prisoners are aware of the circumstances that prevent IAPT from accepting a referral.

- The Governor should ensure, in line with PSI 64/2011, that:
  - when a prisoner changes their next of kin, staff update the prisoner's NOMIS prison record promptly;
  - staff understand that restrictions on contact are limited to prisoners and not staff acting as family liaison officers; and
  - staff check all relevant records, including a prisoner's electronic medical record, for details of any family.

## The Investigation Process

16. 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. Three prisoners responded.
17. The investigator visited HMP Chelmsford on 23 August 2019. He obtained copies of relevant extracts from Mr Warren's prison and medical records, and interviewed three prisoners.
18. NHS England commissioned an independent clinical reviewer to review Mr Warren's clinical care at the prison.
19. The investigator interviewed 18 members of staff at Chelmsford on 30 September and 2 and 23 October, and one member of staff by telephone on 8 October. The clinical reviewer accompanied the investigator for the interviews on 8 and 23 October.
20. We informed HM Coroner for Essex of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
21. One of the Ombudsman's family liaison officers contacted Mr Warren's mother and partner to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Neither Mr Warren's mother nor his partner responded to her letter, her telephone call or her text message.
22. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out one factual inaccuracy. We amended the fourth bullet of the first recommendation and removed the associated paragraph (122) as a result. HMPPS provided an action plan which is annexed to this report.

## Background Information

### HMP & YOI Chelmsford

23. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men over the age of 18 years. Castle Rock Group (CRG) Medical Services provides 24-hour healthcare. The prison has a 12-bed inpatient unit.
24. Between 3 May 2018 and 2 July 2019, Chelmsford was under special measures. This means that HM Prison and Probation Service had determined that it needed additional, specialist support to improve its performance.

### HM Inspectorate of Prisons

25. The most recent inspection of HMP Chelmsford was in May and June 2018. Inspectors were concerned at how the prison managed prisoners at risk of self-harm and suicide. They found that levels of self-harm were very high, that the care provided was often not good enough and that many staff were risk averse.
26. Inspectors also found that the use of the segregation unit was comparatively low and that the regime was limited but delivered consistently. They found that 36 prisoners on open ACCTs had been held in the segregation unit and that the paperwork to justify these decisions varied in quality. They found that targets for prisoners were generic and did not address their needs or issues.
27. They 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.
28. 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, though 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.
29. They also found that there was a clear pathway for patients needing mental health support and that staff effectively reviewed patient risks.

### Independent Monitoring Board

30. 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 self-harm among prisoners was a serious problem, though they noted that the Safer Custody department had recruited more officers and that a new strategy to reduce self-harm had been introduced.
31. The IMB found that the physical condition of the segregation unit was poor, though Segregation Review Boards were managed sensitively and appropriately. They also

found that there were lengthy delays for psychiatry to see prisoners with mental health problems.

## Previous deaths at HMP Chelmsford

32. Mr Warren was the 11<sup>th</sup> prisoner to die at Chelmsford since August 2017. Four of the previous deaths were self-inflicted, three were drug-related and three were from natural causes. There has been one subsequent self-inflicted death. We have previously made recommendations about the management of suicide and self-harm monitoring.

## Assessment, Care in Custody and Teamwork

33. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.
34. 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 multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
35. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm, to self, to others and from others (Safer Custody)*.

## Segregation units

36. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.
37. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental wellbeing of the prisoners and whether there are any apparent clinical reasons to advise against continuing segregation.

## Key Events

38. On 19 July 2019, Essex Police arrested Mr Anthony Warren and charged him with assaulting his partner. While in police custody, Mr Warren cut his arms and neck and tried to tie clothing around his neck. On 22 July, Mr Warren was remanded into prison custody and sent to HMP Chelmsford. While travelling to Chelmsford, Mr Warren threatened the escort officers, headbutted and punched the cell wall and covered himself with faeces.
39. When Mr Warren arrived at Chelmsford, an officer began Prison Service suicide and self-harm monitoring (known as ACCT) as Mr Warren had cuts to his neck, head and arm. The officer noted that Mr Warren was low in mood, worried about his partner and had spoken about being molested by his uncle. Mr Warren listed his partner as his next of kin during a first night interview with an officer and during an ACCT Assessment Interview with a different officer.
40. Later that evening, a nurse saw Mr Warren for an initial health assessment. The nurse noted that Mr Warren had hurt himself within the last 12 months, though he denied having any thoughts of suicide or self-harm. The nurse noted that he did not show any symptoms of mental health issues.
41. At 10.30am, a Supervising Officer (SO) held the first ACCT case review with Mr Warren, an officer and a mental health nurse. Mr Warren said he was in a new relationship and that his partner had helped him change for the better. The SO reminded Mr Warren about the Listeners (prisoners trained by the Samaritans) and the Samaritans' telephone line. The attendees assessed that Mr Warren presented a high risk of suicide and self-harm (on a scale of low, raised and high) and they set the level of observations at one an hour.
42. The SO added two actions to Mr Warren's caremap (designed to identify the main areas of concern and the actions required to reduce risk): that he needed to speak with Full Circle (who provide psychosocial support for people with substance misuse issues) and that he needed counselling with IAPT, a NHS programme delivering talking therapies.
43. Later that day, a nurse saw Mr Warren for a secondary health assessment. Mr Warren said he had been diagnosed with antisocial personality disorder, attention deficit hyperactivity disorder (ADHD), manic depression and post-traumatic stress disorder (PTSD). The nurse referred him for a mental health assessment.
44. Later that day, a nurse saw Mr Warren for a mental health assessment. The nurse recorded that Mr Warren was known to the mental health team and he had been diagnosed with ADHD, depression, anger management issues and cannabis misuse. The nurse also recorded that Mr Warren had a long history of self-harm if his demands were not met or if he was angry or frustrated. During the assessment, Mr Warren said he felt better and had no thoughts of suicide or self-harm. The nurse planned to discuss him with a psychiatrist.
45. Later that evening, a prison GP prescribed Mr Warren pregabalin (used to treat anxiety) and risperidone (an antipsychotic used to treat schizophrenia and bipolar disorder). The following day, a nurse prescriber prescribed Mr Warren concerta XL (used to treat ADHD) and citalopram (an antidepressant).

46. Between 8.37pm and 8.47pm, Mr Warren tied two ligatures around his neck because he had not received his medication. A nurse responded and explained that Mr Warren would receive his dose soon. Mr Warren said that he did not want to kill himself.
47. At 9.00pm, a Custodial Manager (CM) held the second ACCT case review with Mr Warren and a nurse. The CM recorded that Mr Warren tied a ligature due to medication issues but the issue had been resolved so he had calmed down. The attendees assessed that Mr Warren presented a low risk of suicide and self-harm and they kept the level of observations the same.
48. That same day, the Nurse Manager and a reducing reoffending worker, sent separate referrals for Mr Warren to be seen by Forward Trust's IAPT Service. A Forward Trust practitioner sent a self-referral form to Mr Warren.
49. At 3.20pm on 24 July, Mr Warren tied a ligature around his neck. A nurse responded, found that Mr Warren was breathing and alert, and noted that he shouted at officers as he wanted telephone credit and a telephone call.
50. At 4.30pm, a CM held the third ACCT case review with Mr Warren, a SO and a nurse. Mr Warren said that he tied a ligature because he was "sick of being lied to" and that he wanted telephone credit and a vape. He also said that he was concerned about his pregnant partner. The CM recorded that Mr Warren did not say anything about wanting to hurt himself or take his own life and that he was goal orientated. The attendees assessed that Mr Warren presented a low risk of suicide and self-harm and they kept the level of observations the same.
51. The CM added an action to Mr Warren's caremap for the prison to check on his partner. The CM found out that she was okay and passed this information onto Mr Warren.
52. Between 8.40pm and 9.40pm, Mr Warren tied two ligatures around his neck and banged his head on the wall. A nurse recorded that Mr Warren had threatened to use the ligature if he was not given a vape.
53. At 10.20am on 25 July, a SO held the fourth ACCT case review with Mr Warren, a mental health nurse and an officer. Mr Warren apologised for his recent behaviour and said that he had tied ligatures because he wanted vape capsules and telephone credit. They discussed the risk from tying ligatures and Mr Warren said that he did not want to die. The attendees assessed that Mr Warren's level of risk had not changed, though they increased the level of observations to two an hour.
54. The SO added an action to Mr Warren's caremap to contact a forensic psychologist to see if she could help Mr Warren.
55. Following the ACCT case review, a nurse recorded in Mr Warren's medical record that he had ligatured six times on 24 July, though only three of these ligatures are recorded in his medical record or other prison documentation.
56. At 11.30am, Mr Warren tied a ligature around his neck. A nurse responded and found that Mr Warren was talking and that his vital signs were normal. The nurse recommended that Mr Warren be put on constant watch.

57. At 12.28pm that day, a CM held the fifth ACCT case review with Mr Warren, a nurse and a CM. The CM recorded that Mr Warren had tied a ligature and that staff had needed to start cardiopulmonary resuscitation (CPR). The CM told Mr Warren that he was not allowed to contact his partner so Mr Warren said that he was going to kill himself. The attendees assessed that Mr Warren presented a high risk of suicide and self-harm and they put him on constant watch.
58. At 3.25pm on 26 July, a CM held the sixth ACCT case review with Mr Warren, the Nurse Manager and the Head of Healthcare and Equality. Mr Warren asked for counselling and the Nurse Manager planned to refer him to IAPT. He said that he did not want to kill himself but was frustrated with “the system”. The attendees assessed that Mr Warren presented a low risk of suicide and self-harm and they reduced the level of observations to two an hour.
59. The CM added an action to Mr Warren’s caremap to make a referral to IAPT.
60. At approximately 10.30pm, Mr Warren tied a ligature around his neck. A nurse responded, gave Mr Warren paracetamol for a sore back and dressed a head wound that he had sustained in police custody.
61. At 11.00pm, a CM held the seventh ACCT case review with Mr Warren, a nurse and an officer. Mr Warren said that he tied a ligature to see a nurse about a head wound and that he had no desire to end his life. The attendees assessed that Mr Warren’s level of risk had not changed and they kept the level of observations the same.
62. That same day, the forensic psychologist created a Staff Guidance for Constant Supervision, which aimed to give a positive experience for Mr Warren, and a Safety Case Formulation, which aimed to explain the reasons for his self-harm behaviours.
63. At 10.00am on 27 July, a SO held the eighth ACCT case review with a nurse. Mr Warren did not attend as he did not want to talk with the SO. The SO recorded that Mr Warren had abused prison staff and other prisoners during association, so they had put him back in his cell. The attendees assessed that Mr Warren’s level of risk had not changed and they kept the level of observations the same.
64. At 6.50pm, Mr Warren damaged his cell observation panel and an officer placed him on a disciplinary charge.
65. At 11.45pm, Mr Warren opened old wounds on his left arm. A nurse responded and dressed his wounds. Mr Warren told the nurse that he wanted to move from F Wing because he feared for his life.
66. At 10.30am on 28 July, a SO held the ninth ACCT case review with Mr Warren, a nurse and an officer. Mr Warren said he was paranoid about cleaners wanting to hurt him, so the attendees held the review in his cell. He said that he had hurt himself as he wanted a move off F Wing. He also said he was worried that his partner had had a miscarriage. The attendees assessed that Mr Warren’s level of risk had not changed and they kept the level of observations the same.
67. Later that morning, Mr Warren smeared excrement around his cell observation panel, threw excrement at another prisoner and threw pieces of broken glass onto the prison landing. A SO placed him on two disciplinary charges.

68. At approximately 4.00pm, staff moved Mr Warren to the segregation unit to await a disciplinary hearing. Ten minutes later, Nurse A completed an Initial Segregation Health Screen and recorded that there were no clinical reasons to advise against segregating Mr Warren. On the form, Nurse A answered 'no' to the question "Has the person self-harmed in this period of custody / are they on an open ACCT Plan OR is the person currently taking any anti-psychotic medication?"
69. Later that afternoon, a locum psychiatrist and a nurse tried to see Mr Warren for a psychiatric review. Mr Warren said that he felt unwell so the psychiatrist referred him to the prison GP. A prison GP saw Mr Warren and sent him to hospital, due to an infected lip.
70. At 9.30am on 29 July, the Head of Healthcare and Equality held the tenth ACCT case review with Mr Warren, a nurse and a SO. Mr Warren said he had used glass from his broken observation panel to cut his arm and he had thought about slashing his throat. Mr Warren said that he had received an upsetting letter from his partner, who thought she had had a miscarriage, and that he had asked for support from a Listener but he did not see one, which had caused his behaviour to escalate. The Head of Healthcare and Equality said that his IAPT referral was being followed up. The attendees assessed that Mr Warren presented a raised risk of suicide and self-harm and they kept the level of observations the same.
71. The Head of Healthcare and Equality added three actions to Mr Warren's caremap: to check with A Wing about his property, to follow up on concerns that he had about staff behaviour and to arrange packaged food.
72. At 11.05am, during a disciplinary hearing for damaging his cell observation panel, Mr Warren said that he had done this to allow him to cut his arms. A senior prison manager adjourned the hearing as an officer needed to give evidence.
73. At 5.10pm, Mr Warren tied a ligature around his neck. A nurse responded and found that Mr Warren was crying, emotional and saying that nobody understood his situation.
74. At 12.00pm on 30 July, the Head of Healthcare and Equality held the 11th ACCT case review with Mr Warren, a nurse and an officer. She recorded that Mr Warren had ligatured twice since the previous ACCT case review, though only one of these ligatures is recorded in his medical record or other prison documentation. Mr Warren said that flashbacks about the abuse he had suffered as a child caused him to want to end his pain. The nurse said he should not talk about it until he saw a professionally trained counsellor. She said she would ask IAPT to prioritise Mr Warren's referral. The attendees assessed that Mr Warren presented a high risk of suicide and self-harm and they put him on constant watch.
75. At 4.40pm, Mr Warren tied a ligature around his neck. A nurse responded and found that Mr Warren was alert and coherent.
76. At 10.00am on 31 July, the Head of Healthcare and Equality held the 12th ACCT case review with Mr Warren, a nurse and a CM. Mr Warren said that he had ligatured as he was upset that his property could not be located and he was concerned about his safety. Mr Warren said that he refused to move to E Wing as he felt unsafe being so close to F Wing. The attendees assessed that Mr Warren's level of risk had not changed and they kept the level of observations the same.

77. The Head of Healthcare and Equality also added two actions to Mr Warren's caremap to contact healthcare about an arm operation and to seek advice from the police.
78. At 3.30pm on 1 August, the Head of Residence Two held the 13th ACCT case review with Mr Warren, a nurse and a SO. Mr Warren said that he had had positive conversations with escort staff when in hospital and so was focusing on his future and his children. He said that he would cope with things that he did not like by writing down what he was looking forward to rather than hurting himself. The attendees assessed that Mr Warren presented a low risk of suicide and self-harm and they reduced the level of observations to two an hour.
79. The following day, Mr Warren completed his Forward Trust IAPT self-referral. Mr Warren completed the Mental Health Screening Tools section, which showed that he had severe depression and severe anxiety disorder.
80. At 8.45pm, Mr Warren tied a ligature around his neck because he was unhappy at being placed on four disciplinary hearings. An officer discussed the hearings and convinced Mr Warren to pass him the ligature.
81. At 3.00pm on 3 August, the Head of Business Assurance held the 14th ACCT case review with Mr Warren, a nurse and an officer. Mr Warren said that he had ligatured the previous day because he was concerned for his partner. He said he wanted to prove that he was settled by getting a wing job. The attendees assessed that Mr Warren's level of risk had not changed and they reduced the level of observations to one an hour.
82. At 8.00pm, Mr Warren tied a ligature around his neck and threatened to hang himself. A nurse responded and found that no medical intervention was needed.
83. At 8.30pm, a CM held the 15th ACCT case review with Mr Warren and an officer. Mr Warren said an officer had asked him how his partner was and this had caused him to think about her and his issues. The attendees assessed that Mr Warren's level of risk had not changed, though they increased the level of observations to two an hour.
84. At 9.30pm, Nurse B completed an Initial Segregation Health Screen and recorded that there were no clinical reasons to advise against segregating Mr Warren. On the form, Nurse B answered 'no' to the question about whether Mr Warren was on an ACCT
85. At 2.10pm on 4 August, the Head of Business Assurance held the 16th ACCT case review with Mr Warren, a nurse and an officer. Mr Warren said that he had no problems and had found it useful to call the Samaritans. He said that the previous evening was an isolated incident triggered by being asked about his partner. Mr Warren said that he wanted to return to a normal location because the segregation unit had become too noisy for him. The attendees assessed that Mr Warren's level of risk had not changed and they reduced the level of observations to one an hour.
86. At 6.40pm, Mr Warren tied a ligature around his neck. Prison staff responded and removed the ligature.
87. Later that evening, a CM held the 17th ACCT case review with Mr Warren, a nurse and an officer. The CM recorded that Mr Warren had tied a ligature as his vape was

not working. Mr Warren said he had no further thoughts of self-harm. The attendees assessed that Mr Warren's level of risk had not changed and they kept the level of observations the same.

88. Between 1.58pm and 2.15pm on 5 August, Mr Warren tied two ligatures around his neck. A nurse responded on both occasions and checked his vital signs. The nurse recorded that Mr Warren constantly threatened to hurt himself and that he had tied the second ligature tightly. The nurse and the Primary Care clinical lead asked officers to remove Mr Warren's bedding, clothing and laces, and to put him in anti-ligature clothing but the Head of Residence Two refused the request.
89. At 3.00pm, the Head of Business Assurance held the 18th ACCT case review with Mr Warren, a nurse and an officer. The Head of Business Assurance recorded that Mr Warren would start to receive support from a psychologist shortly and from IAPT once he left the segregation unit. Mr Warren said that his recent incidents of self-harm were in response to low level stimuli that would not normally concern him. He agreed to write down his issues and share more with staff. The attendees assessed that Mr Warren's level of risk had not changed and they kept the level of observations the same.
90. At 8.20pm, a CM held the 19th ACCT case review with Mr Warren, a nurse and an officer. The CM recorded that Mr Warren had tied a ligature as he was upset about being held in the segregation unit. The attendees assessed that Mr Warren presented a raised risk of suicide and self-harm and they increased the level of observations to two an hour.
91. Between 8.28pm and 9.00pm, Mr Warren tied two ligatures around his neck. A nurse responded on both occasions, checked his vital signs and recorded that Mr Warren demanded a move to C Wing and to be given a vape.
92. Between 8.30am and 9.05am on 6 August, Mr Warren tied two ligatures around his neck. A nurse responded on the second occasion and found that Mr Warren was alert and orientated. The nurse asked an officer to remove Mr Warren's bed linen and to put him on constant watch but the officer said that there was "nothing they could do for him".
93. At 2.00pm, the Head of Healthcare and Equality held the 20th ACCT case review with Mr Warren, a nurse and an officer. Mr Warren said being segregated was affecting him and he wanted to be on C Wing. The Head of Healthcare and Equality said that he needed stability in his self-harming behaviour and to show other ways of dealing with his frustration. Mr Warren said he had a colouring book, which was helping, but that he wanted access to a television. The attendees assessed that Mr Warren's level of risk had not changed and they reduced the level of observations to one an hour.
94. The Head of Healthcare and Equality added four actions to Mr Warren's caremap: to contact healthcare about his medication, to contact Nacro about his universal credit, to contact the correspondence department about him getting stamps and to contact the police about his historical abuse.
95. At 12.58pm on 7 August, Mr Warren tied a ligature around his neck. A nurse responded but Mr Warren refused any medical intervention. The nurse asked a CM to consider putting Mr Warren in anti-ligature clothing.

96. At 1.00pm, a CM held the 21st ACCT case review, though Mr Warren did not attend. The CM recorded that Mr Warren had tied a ligature, which had snapped, and then immediately tied another ligature. Prison staff had entered Mr Warren's cell and removed his bedding. The CM assessed that Mr Warren presented a high risk of suicide and self-harm and he increased the level of observations to five an hour.
97. At 2.30pm, the Deputy Governor held the 22nd ACCT case review with Mr Warren, a nurse and an officer. Mr Warren said that he had tied a ligature after receiving news that a friend had taken their life. The Deputy Governor recorded that Mr Warren's issues had previously been discussed. The attendees assessed that Mr Warren's level of risk had not changed and they reduced the level of observations to two an hour.
98. Between 6.10pm and 7.20pm, Mr Warren tied three ligatures around his neck. A nurse responded on the first two occasions and found that the first ligature was tight enough to interrupt but not stop Mr Warren's breathing. The nurse noted that officers were stripping Mr Warren's cell of all possible ligature materials, though an officer wrote in Mr Warren's observation record that if his behaviour continued, he would be put in anti-rip clothing.
99. At 11.00am on 8 August, the Head of Business Assurance held the 23rd ACCT case review with Mr Warren, a nurse and a member of the chaplaincy team. The Head of Business Assurance recorded that Mr Warren was more settled with no thoughts of self-harm. Mr Warren accepted a move to D Wing as this would allow him to start his IAPT sessions. The attendees assessed that Mr Warren presented a low risk of suicide and self-harm and they reduced the level of observations to one an hour. Mr Warren moved to D Wing at 12.15pm.
100. At 2.20pm on 9 August, Mr Warren tied a ligature around his neck. A nurse responded and found that Mr Warren did not need any treatment.
101. Minutes later, a SO held the 24th ACCT case review with Mr Warren. The SO recorded that Mr Warren had tied a ligature around his neck because he wanted his canteen (items from the prison shop) and was not prepared to wait for it. The SO also recorded that in discussion with two CMs, they decided that Mr Warren did not need an ACCT case review after every act of self-harm unless the method or severity changed. The SO assessed that Mr Warren's level of risk had not changed and she increased the level of observations to two an hour. She also set the next ACCT case review for 10 August (there is no record that this took place).
102. On 11 August, a psychiatrist and a nurse saw Mr Warren for a psychiatric review. Mr Warren asked for a change of medication as he felt citalopram was ineffective, and said he wanted help with his PTSD symptoms. He also said he felt supported and stable in the prison so was not planning to hurt himself. The psychiatrist prescribed mirtazapine (an antidepressant) to replace the citalopram prescription and planned to see him in six to eight weeks.
103. At 10.30am on 14 August, a SO held the 25th ACCT case review with Mr Warren and a nurse. Mr Warren said that he felt better on D Wing as he was sleeping, eating, drinking and taking his medication. Mr Warren said he had fleeting thoughts of self-harm but that he had been speaking with his partner regularly and that she helped to lift his mood. The attendees assessed that Mr Warren's level of risk had

not changed and they reduced the level of observations to one every two hours during the day and one an hour at night.

## 15 August 2019

104. Between 6.30am and 11.29am, Mr Warren telephoned a friend and left messages on her voicemail. The calls referred to him contemplating suicide, being concerned about £750 being stolen and being concerned about how his friend, partner and brother were doing.
105. At approximately 10.00am on 15 August, an officer spoke to Mr Warren to complete a Self-Harm Investigation Form. Mr Warren said that he felt better on D Wing and that Officer A had offered him a lot of support. The officer recorded that Mr Warren became visibly upset talking about the abuse he had suffered and that he was keen to start counselling. The officer also noted that Mr Warren had been involved in 12 self-harm incidents between 1 and 9 August, though there is no record in his medical record or other prison documentation that elaborates on the incident on 1 August.
106. At 11.53am, Mr Warren telephoned a friend and spoke to her for eight minutes. They discussed whether his partner had cheated on him and whether his partner had spoken with the police about the domestic abuse charges.
107. At 12.05pm, an officer wrote in Mr Warren's observation record that he had been banging his door as he wanted to speak to Officer A. The officer said that Officer A was busy so Mr Warren told him to "piss off".
108. At 1.30pm, an officer visited D Wing to deliver a letter to Mr Warren. The officer opened the observation panel to tell Mr Warren that it had been delivered and saw him hanging from a ligature at the back of the cell. The officer shouted for staff assistance, then called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing). A SO and two officers responded and they entered the cell. An officer cut the ligature, which was made from a torn bed sheet and had been attached to a window bar, and they moved him onto the landing. An officer then started CPR.
109. The Primary Care Clinical Lead, a nurse and a healthcare assistant quickly responded to the code blue emergency. They inserted an airway, gave Mr Warren oxygen and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.
110. The control room log noted that they called for an ambulance at 1.32pm. The East of England Ambulance Service sent an ambulance and an air ambulance to the prison and they reached Mr Warren at 1.38pm and 1.48pm respectively. Paramedics took over the resuscitation attempt and gave Mr Warren adrenaline and naloxone (used to block or reverse the effects of opiate medication, especially during suspected overdoses). They were unable to resuscitate him and, at 2.07pm, an air ambulance doctor declared that he had died.

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

111. Following Mr Warren's death, the prison appointed an offender supervisor and an officer as the prison's family liaison officers. At approximately 3.00pm, they visited the home address of Mr Warren's grandmother and broke the news of his death. Mr Warren's grandmother said that it was more appropriate for Mr Warren's mother to act as his next of kin and she asked the family liaison officers to visit her.
112. Later that afternoon, the family liaison officers visited the home address of Mr Warren's mother to break the news of his death, though his mother and sister had already been told by another prisoner at Chelmsford. They offered their condolences and support.
113. The family liaison officers continued to support Mr Warren's mother and sister until his funeral, which was held on 26 September. The prison contributed towards the costs of the funeral in line with national instructions.

## **Support for prisoners and staff**

114. After Mr Warren's death, the Head of Residence Two debriefed the prison and healthcare 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.
115. The prison posted notices informing other prisoners of Mr Warren'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 Warren's death.

## **Post-mortem report**

116. The post-mortem examination found that the cause of Mr Warren's death was asphyxiation due to hanging.
117. A toxicological analysis found that Mr Warren had used cannabis at some point prior to his death, but that he had not used cannabis recently and that it would not have had an effect on him at the time of his death.

# Findings

## Assessment of Mr Warren's risk of suicide and self-harm

118. 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 processes that should be followed when an ACCT has been opened. This includes that the case review team must review the level of risk that a prisoner presents, taking into account all available information, that the case review team must consider whether any items need to be removed and that ACCT case reviews must be held as planned or when a trigger is activated.
119. The PSI also says that the residential manager for the receiving unit must be invited when a prisoner moves from the segregation unit, that case reviews must be multidisciplinary where possible, that case reviews must consider whether any additional needs should be added to the prisoner's caremap and that staff must follow the planned frequency of observations. Guidance on these processes is also contained in the ACCT documentation which sets out the circumstances for a prisoner to be assessed as a low, raised or high risk of suicide and self-harm.
120. Mr Warren had been on an ACCT for 24 days before his death. During that time, Mr Warren self-harmed at least 24 times and staff held 26 ACCT case reviews. Despite Mr Warren's frequent acts of self-harm, we are concerned that some ACCT case reviews underestimated his level of risk. On four occasions, between the first and second, the fifth and sixth, the 12th and 13th and the 22nd and 23rd ACCT case reviews, staff decided that Mr Warren's risk had decreased from high to low. We consider that these decisions were made too quickly and despite Mr Warren having carried out another act of self-harm.
121. We are also concerned that the prison did not have a complete picture of Mr Warren's acts of self-harm since a nurse and the Head of Healthcare and Equality, on 25 and 30 July respectively, referred to incidents that are not recorded in his medical record or other prison documentation. We are concerned that this failure increased the chance of underestimating Mr Warren's risk.
122. On 5, 6 and 7 August, the Primary Care Clinical Lead and two nurses asked prison staff to consider removing Mr Warren's bedding and placing him in anti-ligature clothing. On each occasion, prison managers rejected the request, though the reasons were not recorded in the ACCT. We are concerned that these requests were not discussed in subsequent ACCT case reviews, that the reasons to justify the decisions were not recorded and that there was a lack of consistency between healthcare and prison staff on the level of risk that he presented.
123. Additionally, during the 24th ACCT case review, a SO planned the next case review for 10 August, though there is no record that a case review took place on that day. While this decision did not change the outcome for Mr Warren, we are concerned that the prison missed a planned ACCT case review.
124. We are also concerned that, although prison managers set the required observations during each ACCT case review, there were 80 instances when staff did not carry out the observations at the agreed frequency.

125. While less significant issues than those above, we are concerned that D Wing's residential manager did not attend a pre-discharge ACCT case review before Mr Warren's move from the segregation unit, and that two case reviews were not multidisciplinary despite taking place during the day. We make the following recommendation:

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

- **consider all risk factors, including suicidal statements, current self-harming behaviour and previous suicide attempts, when assessing a prisoner's risk;**
- **appropriately record every act of self-harm;**
- **consider the use of anti-ligature clothing or what items should be removed from prisoners at risk of self-harm during ACCT case reviews;**
- **hold multidisciplinary ACCT case reviews as scheduled;**
- **invite and ensure the attendance of the residential manager at an ACCT case review when a prisoner moves from the segregation unit to a residential wing; and**
- **adhere to the frequency of observations set out in the ACCT document.**

## **Segregation**

126. Prison Service Order 1700, Segregation, sets out the processes that should be followed when a prisoner is segregated. This includes that if a disciplinary hearing is inconclusive then continued segregation can only be authorised under Prison Rule 45, Good Order or Discipline; that a segregation review board must be held within 72 hours for prisoners segregated under Rule 45; and that healthcare staff must complete an Initial Segregation Health Screen.
127. Staff placed Mr Warren on three disciplinary charges, one on 27 July and two on 28 July; and on the latter date, staff moved Mr Warren to the segregation unit to await an unspecified disciplinary hearing. These disciplinary hearings took place over two days, one on 29 July, which was adjourned to allow the reporting officer to attend; and two on the following day, which were adjourned because Mr Warren was on constant watch. Despite each disciplinary hearing being inconclusive, Mr Warren stayed in the segregation unit under Prison Rule 53, Awaiting an Adjudication (a disciplinary hearing) to Start, until 1 August. We are concerned that the prison did not authorise Mr Warren's continued segregation under Rule 45 and that, in not doing so, did not hold a Segregation Review Board at all and certainly not within 72 hours.
128. Mr Warren spent 11 days in the segregation unit and healthcare staff completed 11 Initial Segregation Health Screens during that time. The majority were completed accurately though we are very concerned that Nurse A and Nurse B, on 28 July and 3 August respectively, did not note that Mr Warren had recently self-harmed, was on an open ACCT and was taking antipsychotic medication. While the authorising Duty Governors recognised that Mr Warren was on an open ACCT and considered alternative options, we are concerned that the Health Screens were not completed

accurately and that key information could have been missed by the authorising managers.

129. As Mr Warren was on an open ACCT while segregated, senior prison managers completed Defensible Decision documents to explain that they had considered but discounted other locations and options for him. On three occasions, on 30 and 31 July and on 3 August, there is no record that the Governor or Deputy Governor had authorised Mr Warren's continued segregation.
130. The Deputy Governor told the investigator that she was confident that she would have discussed all Mr Warren's Defensible Decisions during her afternoon operational debriefs and that she would only sign the form if physically in the segregation unit. Although it is probable that the Deputy Governor authorised all of Mr Warren's Defensible Decision documents, having done so for six out of nine, without a formal signature or minutes of the operational debrief we cannot be certain. We are concerned that without a formal process to review Defensible Decision documents, a prisoner could be segregated on an open ACCT without proper authorisation. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including ensuring that they:**

- **authorise a prisoner's continued segregation under Prison Rule 45 if an initial disciplinary hearing is inconclusive;**
- **complete Initial Segregation Health Screens accurately and fully; and**
- **formally authorise a Defensible Decision document for any prisoner segregated while on an open ACCT.**

**The Head of Healthcare should discuss Nurse A and Nurse B's inaccurate Segregation Health Screens with them and ensure that they understand the importance of completing these documents accurately.**

131. Mr Warren was segregated between 28 July and 8 August, and prison staff frequently changed the Prison Rule used to authorise his segregation. He was segregated under Rule 53 on days one to four, Rule 45 on days four to six, Rule 55, Cellular Confinement, on days six to eight, and Rule 45 on days eight to 11.
132. We recognise that under Prison Service policy, set out in PSO 1700, the 72-hour time limit for holding an Initial Segregation Review Board only applies in the case of prisoners segregated under Rule 45. As prison staff frequently changed the Rule authorising Mr Warren's continued segregation and he did not spend 72 hours under Rule 45, the decision not to hold a Review Board was, therefore, in line with Prison Service policy.
133. However, Mr Warren was segregated for 11 days. While we accept that the prison had followed the policy correctly, we are concerned that there appears to be a gap in the policy.
134. The PSO recognises that a prisoner's mental health is likely to decline when they are kept in segregation. One of the purposes of the Initial Segregation Review Board is to discuss any concerns about how the prisoner is coping with segregation and to consider whether segregation continues to be appropriate or whether additional steps are needed to safeguard the prisoner's mental health. We take the

view that this is necessary within the first 72 hours of segregation, irrespective of which Prison Rule the prisoner is segregated under. If an Initial Segregation Review Board had taken place in Mr Warren's case, it would have given an extra opportunity to identify any decline in his mental health and to offer additional support. We make the following recommendation:

**The Director General of Prisons of HM Prison and Probation Service should amend Prison Service Order 1700 to ensure that an Initial Segregation Review Board is held within the first 72 hours of a prisoner being placed in segregation, regardless of which Prison Rule applies to the segregation.**

135. We made a similar recommendation following our investigation of a prisoner who hanged himself at HMP Manchester in June 2017. In their response, dated January 2019, HMPPS said:

"In light of the PPO's recommendation, we will look to review our policy on segregation in 2019, including by determining the right level of safety oversight for all prisoners' segregation for any reason."

## **Mental health**

136. We agree with the clinical reviewer that there were some areas of good practice with regard to Mr Warren's mental health care. These included that mental health staff attended most of Mr Warren's ACCT case reviews, that he consistently saw the same members of staff, that he was actively involved in decisions about his care and that staff prescribed him appropriate medication.
137. However, despite areas of good practice, we share the clinical reviewer's concern that Mr Warren's mental health care was often reactive, following an incident of self-harm, rather than proactive. There was little evidence, apart from the psychiatric review, that Mr Warren received any direct intervention from mental health staff other than them attending ACCT case reviews or seeing him after incidents of self-harm.
138. We are also concerned that mental health staff focused unduly on the apparent need-led reasons why Mr Warren had ligatured, such as him demanding a vape, rather than on his underlying mental health issues. Overall, we agree with the clinical reviewer that Mr Warren's mental health care was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners who self-harm receive one to one interventions separate to any treatment following a self-harm incident.**

## **IAPT**

139. The IAPT Referral form, completed by a Nurse Manager and a reducing reoffending worker, explains the six conditions that will prevent IAPT accepting a prisoner's referral, and says they will not accept prisoners who are "in crisis or at moderate to high risk of harm to self or others" or those who "are deemed a risk to the safety of staff by one or more agencies in the prison environment". In contrast, the Self-

Referral Form, completed by Mr Warren, does not refer to any conditions that will prevent IAPT accepting a prisoner's referral.

140. Throughout Mr Warren's ACCT process, prison and healthcare staff decided that he would benefit from counselling from IAPT. However, as Mr Warren spent a substantial part of his time in custody in the segregation unit and was regularly self-harming, IAPT were unable to see him. While most staff that we interviewed were aware of these restrictions, we are concerned that two nurses were not aware of them. We are also concerned that the Self-Referral Form does not make any reference to the circumstances that prevented IAPT from seeing Mr Warren. As a result, he may mistakenly have expected to receive counselling shortly after completing the form. We make the following recommendation:

**The Governor, the Head of Healthcare and the Head of IAPT should ensure that:**

- **all staff are aware of the circumstances that prevent IAPT from accepting a prisoner's referral; and**
- **the Self-Referral Form is amended to ensure that all prisoners are aware of the circumstances that prevent IAPT from accepting a referral.**

## **Family liaison**

141. PSI 64/2011 sets out the guidance and mandatory actions for prison staff to follow for identifying a prisoner's next of kin. This includes that information about the next of kin must be kept up to date and that reasonable steps must be taken to review the prisoner's records for details of any family.
142. While at Chelmsford, Mr Warren listed his partner as his next of kin during a first night interview with an officer and an ACCT Assessment with a different officer. Despite this, Mr Warren's electronic prison record was not updated.
143. When Mr Warren died, an offender supervisor and the Head of Safer Custody reviewed his prison file to find his next of kin. The offender supervisor told the investigator that they noted that Mr Warren had listed his partner as his next of kin but that she had been recorded as "NTC" [not to contact]. Using this information, they decided that it was more appropriate to contact Mr Warren's grandmother, who he had listed as his next of kin during a previous custodial sentence, rather than his partner or his mother (who, according to his medical record, he had listed as his next of kin when he joined a new doctors' surgery on 11 March 2019).
144. We are concerned that the prison disregarded Mr Warren's choice, did not update his prison record and believed that "not to contact" extended to prison staff informing his partner of his death. We are also concerned that the prison did not review all available documentation, which included his medical record, so did not find out that Mr Warren had named his mother as his next of kin more recently than his grandmother. We make the following recommendation:

**The Governor should ensure, in line with PSI 64/2011, that:**

- **when a prisoner changes their next of kin, staff update the prisoner's NOMIS prison record promptly;**

- **staff understand that restrictions on contact are limited to prisoners and not staff acting as family liaison officers; and**
- **staff check all relevant records, including a prisoner's electronic medical record, for details of any family.**

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