

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Collier, a prisoner at HMP/YOI Chelmsford, on 1 August 2020

A report by the Prisons and Probation Ombudsman



Our vision

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



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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 Richard Collier died after he was found hanged in his cell on 1 August 2020 at HMP Chelmsford. He was 61 years old. I offer my condolences to his family and friends.

Mr Collier had many clear risk factors for suicide and self-harm that should have prompted Chelmsford to consider monitoring him under Prison Service suicide and self-harm procedures (known as ACCT). It is difficult to understand why this did not happen.

I am very concerned that Mr Collier's risk factors were not properly considered by prison and healthcare staff and that opportunities to support him using Prison Service suicide and self-harm procedures were missed.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2022

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Summary

Events

1. On 30 July 2020, Mr Collier was remanded in custody to HMP Chelmsford. He had been charged with attempting to murder his wife the day before and told the police he had intended to kill his wife and then himself. He had never been to prison before and had no previous convictions. He was 61 years old.
2. Mr Collier's police, court and escort records documented that he had thought about cutting his wrists and hanging himself and included a suicide and self-harm warning form. When Mr Collier was remanded into custody, the court diversion team spoke to a mental health nurse at Chelmsford and also sent emails highlighting his risk of suicide.
3. When he arrived at Chelmsford, Mr Collier told a nurse that he had no thoughts of suicide or self-harm. Due to his index offence of attempted murder, the nurse automatically referred Mr Collier to the mental health team but did not consider he was at risk of suicide or self-harm.
4. Overnight, the prison's Safer Custody Team identified that Mr Collier was at risk of self-harm and emailed the supervising officer on his wing about this. The supervising officer should have conducted a welfare check on Mr Collier on the morning of 31 July but failed to do so.
5. At about midday, a mental health nurse conducted a paper-based triage of Mr Collier. After reviewing Mr Collier's paperwork, she decided he was not at risk of suicide or self-harm and that she did not need to see him in person, opting instead to refer him for a routine mental health assessment.
6. At around 8.00pm, the night patrol officer conducted the evening roll check. When he checked Mr Collier, he raised no concerns.
7. On 1 August at around 5.36am, while conducting his roll check, the night patrol officer saw Mr Collier standing at the back of the cell against a wall. He thought Mr Collier was fine and continued with his roll check.
8. At 6.50am, while conducting a second morning roll check, an officer saw Mr Collier hanging in his cell. As the officer did not have a radio on him, he shouted to the night patrol officer to radio a medical emergency 'code blue', indicating a life-threatening situation. Officers and nurses responded to the emergency, but as rigor mortis had clearly set in, they did not attempt cardio-pulmonary resuscitation (CPR). At 7.08am, paramedics confirmed Mr Collier had died.

Findings

Identifying Mr Collier's risk of suicide or self-harm

9. Mr Collier had many clear risk factors for suicide and self-harm. It was his first time in prison, he had been charged with a violent offence against a close family member (which put him at particular risk of suicide or self-harm), he told police and

court staff about thoughts of self-harm and suicide, and he arrived at Chelmsford with court, police and escort records that highlighted his risk.

10. The prison officer who saw him in Reception failed to notice Mr Collier's risk information. The nurse who carried out his reception health screen did not mention the court, escort and police records, or their contents, in his entry on Mr Collier's medical record.
11. The wing supervising officer did not conduct a welfare check on Mr Collier as he should have done when he was emailed a list of new prisoners with self-harm warnings on 31 July, including Mr Collier.
12. Although the mental health nurse was aware of Mr Collier's risk factors and his recent thoughts of suicide and self-harm, she did not see him in person, did not consider it necessary to take any action to safeguard Mr Collier, and did not refer him for an urgent mental health assessment.
13. We consider that these were all missed opportunities to put measures in place to protect Mr Collier and we find it difficult to understand why nothing was done. We cannot be sure that Mr Collier would not have taken his own life if he had been managed under ACCT procedures, but it is possible.
14. We have raised serious concerns about the operation of Chelmsford's suicide and self-harm prevention procedures in other investigations. The Governor must implement and embed our recommendations as a matter of urgency.

Emergency response

15. The control room officer delayed about three minutes before calling an ambulance after receiving the code blue call. Although it would not have saved Mr Collier's life, such a delay could be crucial in future medical emergencies.
16. We have no other concerns about the emergency response, which was otherwise prompt, professional and appropriate.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff who assess risk:
 - identify the risks associated with new prisoners' index offences, consider all external sources of information provided to them and update NOMIS and SystemOne accordingly; and
 - start ACCT procedures whenever a prisoner has significant risk factors, irrespective of their presentation or stated intentions.
- The Governor should undertake an internal investigation into the circumstances of Mr Collier's death, looking particularly, but not exclusively, at the actions/inactions of Officer A and Supervising Officer (SO) A, with a view to considering whether disciplinary action is appropriate.
- The Head of Healthcare should:

- undertake an internal investigation into the circumstances of Mr Collier's death, in particular the practice of Nurse A and Nurse B, and take any necessary actions based on the findings of the investigation;
 - consider whether the two nurses should continue to work in the prison while the investigation is conducted.
- The Governor should ensure that all staff are made aware of and understand PSI 03/2013, as well as local instructions, and their responsibilities during medical emergencies, including:
 - immediately calling an ambulance when a medical emergency code is called; and
 - promptly providing information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.
 - The Governor should ensure that there is a written medical emergency response protocol agreed with the local ambulance service about the procedures for emergency calls, in line with PSI 03/2013.

The Investigation Process

17. 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.
18. Although the investigator was unable to visit Chelmsford due to the COVID-19 pandemic, he obtained copies of relevant extracts from Mr Collier's prison and medical records and interviewed eight members of staff at Chelmsford via video link and telephone between September 2020, and January 2021. The reception nurse, Nurse B, failed to attend his pre-arranged interview with the PPO on 17 September. The investigator tried several times to contact him and rearrange the interview but was unable to track him down. His current whereabouts are unknown.
19. NHS England commissioned a clinical reviewer to review Mr Collier's clinical care at the prison. He joined the investigator for all the interviews with clinical staff and three interviews with non-clinical staff.
20. We informed HM Coroner for Essex of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. The Ombudsman's family liaison officer contacted Mr Collier's wife to explain the investigation, and to ask if she had any matters she wanted us to consider. A solicitor acting on behalf of Mr Collier's family wrote to us asking the following questions, which we have addressed in our report:
 - why did the prison not put appropriate protective measures in place in response to the Person Escort Record which noted that Mr Collier was at risk of self-harm or suicide;
 - why did the reception screening fail to recognise Mr Collier's risk of suicide and self-harm;
 - why did Mr Collier did not receive a mental health assessment; and
 - why were no other preventative measures put in place to mitigate Mr Collier's risk of suicide?
22. The PPO's investigation was suspended on 7 January 2021 after Essex Police told us they were conducting a criminal investigation related to Mr Collier's death. The PPO's investigation was re-opened on 2 September when it was confirmed that the police investigation had been concluded.
23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies.
24. Mr Collier's family received a copy of the draft report. The solicitor representing the Collier family raised several questions that do not impact on the factual accuracy or findings of this report. The clinical reviewer made two slight amendments to his Clinical Review in response to the family's questions, however his overall findings remain unaffected. We have provided clarification to the family by way of separate correspondence to them.

Background Information

HMP Chelmsford

25. 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. Castle Rock Group Medical Services (CRG) provide 24-hour healthcare. The prison has a twelve-bed inpatient unit.

HM Inspectorate of Prisons (HMIP)

26. The most recent full inspection of HMP & YOI Chelmsford was in May/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.
27. This report resulted in the prison being put under special measures and issued with a Prison Performance Support Plan by HMPPS.
28. In April 2019, HMIP reviewed Chelmsford's progress against the main recommendations made following 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.
29. HMIP carried out a further inspection in August 2021. The inspection report has not yet been published, but on 27 August, HM Chief Inspector of Prisons issued a rare Urgent Notification (UN) requiring immediate action from the Secretary of State for Justice to address violence, safety and poor conditions at Chelmsford. The concerns set out in the UN included:
 - Safety – HMIP found Chelmsford to be one of the country's most violent local prisons. There had also been eight self-inflicted deaths since 2018 and a further four non-natural deaths in three years. In addition, self-harm had continued to rise for the fourth successive inspection.
 - A negative staff culture – HMIP found that although some staff were committed and constructive, many others described very low morale, disillusionment and disengagement. Many staff, for example, failed to respond to even basic requests from prisoners and too many were dismissive in their dealings with prisoners or evidenced only limited empathy.

Almost half of the prisoners said that they had been victimised by staff, particularly those prisoners with disabilities and mental health problems.

- Lack of accountability and management oversight – HMIP found that this enabled poor performance and behaviour to go unchallenged. Many staff had witnessed poor behaviour among their peers and too few took responsibility for the duties to which they had been deployed. Emergency cell bells were often only answered after long delays.
- A poor daily regime - HMIP found that many prisoners were locked in their cell for almost 23 hours a day. This reflected COVID-19 restrictions but even in 2018 many prisoners had been locked in their cell for 22 hours a day. Plans to reintroduce a meaningful regime were limited and being implemented far too slowly.

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 2020, the IMB reported that there had been a reduction in the number of incidents of violence and self-harm during the first half of the year compared with the previous year. There was a sharp increase at the start of lockdown, but this subsequently reduced to pre-lockdown levels.

Previous deaths at HMP Chelmsford

31. Mr Collier was the 10th prisoner to die at Chelmsford since August 2018. Three of the previous deaths were self-inflicted, three were from natural causes and the remaining three were drug-related. Since Mr Collier's death, three more prisoners have taken their own lives at Chelmsford.
32. We have expressed concerns about the management of suicide and self-harm monitoring in the investigations of three previous self-inflicted deaths.
33. 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 the prison was developing a one-page guidance sheet for all staff on assessing risk and the procedures for supporting prisoners at risk. We were also told that the Group Safety Lead would review the current processes and their effectiveness, on behalf of the Prison Group Director, to develop relevant actions and assurance measures where deficiencies still exist by March 2019.

Assessment, Care in Custody and Teamwork (ACCT)

34. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and

interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

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

Key Events

36. On 29 July 2020, Mr Richard Collier was charged with the attempted murder of his wife. According to his Person Escort Record (PER), Mr Collier told the police that he had intended to kill his wife and then himself. Mr Collier had never been to prison before and had no previous convictions. He was 61 years old.
37. In police custody, Mr Collier was assessed by a community psychiatric nurse. Mr Collier told the nurse that he had recently had thoughts of suicide and self-harm, specifically cutting his wrists and hanging himself. When asked what had prevented him from acting on these thoughts, Mr Collier cited his wife and daughter as protective factors. Mr Collier also said there had been a recent deterioration in his mental health, including poor sleep, lack of appetite and poor concentration.
38. The community psychiatric nurse recorded in her report that Mr Collier presented with symptoms of clinical depression and anxiety, had financial concerns about the maintenance of his home (which caused him considerable stress) and that he felt everything he tried to do was wrong. She concluded that Mr Collier was at risk of suicide and self-harm, and that his risk would be increased if he was remanded into custody. The nurse recorded all these issues in a Custody Brief Summary Report.
39. On 30 July, Mr Collier appeared at Chelmsford Magistrates' Court and was refused bail. He was remanded into custody at HMP Chelmsford.
40. At 12.42pm, the court diversion nurse based at the court telephoned Nurse A in Chelmsford's mental health in-reach team to tell her about Mr Collier's risk of suicide and self-harm. Immediately after the phone call, the court diversion nurse emailed Mr Collier's Prisoner Warning Notice (which highlighted his risk level) and the accompanying Custody Brief Summary Report to Nurse A's email address. He also copied the email to a generic Prisoner Warning Notice inbox at Chelmsford, which the reception nurse also has access to and should check frequently throughout the day. The Prisoner Warning Notice stated the following in bold red font: "Immediate Risk: Self-Harm / suicide – previous thoughts of cutting his wrists and hanging. Risk increased if remanded into custody".

HMP Chelmsford

41. When Mr Collier got to Chelmsford that evening, his PER noted his alleged index offence, his age and that he seemed in a low mood. The PER said:

"Police Sargent (sic) told us offence was supposed to be a murder/suicide. Asked male how he feels and replied, "Not good" ... Stated recent thoughts of cutting his wrists and hanging attempt ... States undiagnosed mental health issues, has irrational behaviour."
42. At around 6.30pm, Officer A had a brief introductory conversation with Mr Collier and noted on the prison's information management system (NOMIS) that he had no thoughts of suicide or self-harm and that he would see the mental health nurse. In interview, she said that she did not remember seeing the suicide and self-harm warning information in Mr Collier's PER, but now knows that it was on there. She

said the format of the PER document had recently changed which had confused her.

43. During an initial health screen, Nurse B described Mr Collier's mood on his electronic medical record (SystemOne) as "normal" and recorded that he had "no suicidal thoughts". He also recorded on SystemOne that it was Mr Collier's first time in a secure setting, and that he had recently been diagnosed with anxiety by his GP but had not received any medication for his mental health. Due to the nature of his alleged offence, he automatically referred Mr Collier for a mental health assessment.
44. Although Nurse B was provided with Mr Collier's PER, Prisoner Warning Notice and Custody Brief Summary Report, he did not mention them, or their contents, in his SystemOne entry. Instead, he recorded that Mr Collier had "no risk information".
45. Later that evening, an officer carried out Mr Collier's Introduction to Custody interview. Mr Collier told the officer that he had no thoughts of suicide or self-harm, that he had never self-harmed before and that he did not want to speak to a Listener (under which prisoners trained by the Samaritans provide support to other prisoners). After the interview, Mr Collier was taken to his cell on B Wing, the prison's induction wing, and checked once overnight.

31 July

46. Overnight, the prison's Safer Custody Team identified that Mr Collier had been received into custody with self-harm warnings. At 9.30am on 31 July, they sent an email to Supervising Officer (SO) A on B Wing with a list of the prisoners who had arrived with a self-harm warning the previous day. One of those listed was Mr Collier. (These emails are sent to the induction wing SO every day.)
47. The Safer Custody Manager told the PPO that the SO is expected to conduct a welfare check on each listed prisoner by speaking to them to see if they have any thoughts of suicide or self-harm. SO A saw the email but did not take any action. In interview, he said he was "not fully aware" he had to conduct welfare checks on the prisoners and thought the email was only a "heads up ... for future reference". (The SO had been in his role on B Wing for around two and a half months when Mr Collier died.)
48. That morning Nurse A of the prison's mental health team reviewed the Prisoner Warning Notice, the Custody Brief Summary Report and Mr Collier's medical record. Following her review, she decided not to assess him face to face or start ACCT procedures. She told the investigator that she did not think it was necessary to take such action as it appeared from Nurse B's SystemOne entry that Mr Collier was stable, in a normal mood and had no thoughts of suicide and self-harm. She also said that Mr Collier had cited his wife and daughter as "protective factors" preventing him from harming himself. (She said she was not aware that Mr Collier's wife was the victim of his alleged offence.) She opted for a routine referral for a mental health assessment. She said this was expected to happen within three days but could take longer.
49. There is no information about Mr Collier's movements on 31 July. There is no record of officers speaking to Mr Collier or of him raising any concerns.

50. At around 7.00pm, an officer accidentally went to Mr Collier's cell, looking for another prisoner. At interview, the officer told us that he made a joke about the situation and that Mr Collier laughed.
51. At around 8.00pm, the night patrol officer, an Operational Support Grade (OSG), checked all prisoners on B Wing. At interview, the OSG told us that he remembered Mr Collier standing in the middle of his cell with the lights on. He said he wished Mr Collier a good evening and asked him if he was 'okay' and he replied "fine". This was the last time Mr Collier was seen alive.
52. At interview, the OSG told us that he checked the prisoner in the cell next to Mr Collier at least once an hour during the night because he was subject to ACCT monitoring. He said he did not see or hear anything from Mr Collier's cell during these checks.

1 August

53. At around 5.30am on 1 August, the OSG carried out a routine morning roll check, and got to Mr Collier's cell at 5.36am. He said he looked through the cell observation panel and saw Mr Collier standing at the back of his cell with his eyes open looking towards him. As it was not fully light yet, he used a torch to see Mr Collier more clearly. At interview, he said that he may have said "good morning" to Mr Collier, but could not remember. Mr Collier did not respond. The OSG said he had no concerns and continued to check the rest of the wing.
54. During another roll check at 6.50am, an officer looked through Mr Collier's observation panel. He thought he saw Mr Collier trying to hang himself and so immediately went into the cell. He realised straight away that Mr Collier was already hanging from a ligature made from a prison bed sheet attached to the cell window bars. As the officer did not have a radio on him, he stepped out of the cell and shouted to the OSG to radio a medical emergency code blue, indicating a life-threatening situation. The prison control room log recorded this at 6.50am. Ambulance records show that an ambulance was called at 6.53am.
55. The officer took Mr Collier's weight (to stop any further damage to his neck) and, as he did so, noticed that rigor mortis (stiffening of the limbs that occurs after death) had set in. After radioing the code blue, the OSG went into the cell and removed the ligature from around Mr Collier's neck. The officer placed his hands underneath Mr Collier's arms and moved him to the landing so that cardio-pulmonary resuscitation (CPR) could be performed.
56. At interview, the OSG, a trained ambulance technician, told us that Mr Collier was stiff and that rigor mortis had set in. He checked for a pulse, but Mr Collier was not breathing. At this point, the OSG said Mr Collier was already dead and placed a sheet over him.
57. At around 6.55am, a nurse arrived with other prison officers in response to the code blue call. The nurse examined Mr Collier and agreed that CPR should not be attempted as there were signs of rigor mortis.
58. When the paramedics arrived, they assessed Mr Collier and confirmed his death at 7.08am.

Contact with Mr Collier's family

59. At around 10.18am on 1 August, the prison family liaison officer (FLO) telephoned Mr Collier's sister and told her that Mr Collier had died. At 11.00am, he visited her home.
60. Chelmsford contributed to the costs of Mr Collier's funeral in line with Prison Service instructions.

Support for staff

61. After Mr Collier's death, the Duty Governor chaired a debrief for staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The three members of staff who had already gone off duty were contacted separately. The staff care team also offered support.

Post-mortem report

62. A post-mortem examination identified Mr Collier's cause of death as asphyxiation due to hanging. The toxicology examination revealed nothing significant.

Findings

Identifying Mr Collier's risk of suicide or self-harm

63. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.
64. We have considered whether staff at Chelmsford should have recognised Mr Collier as at risk and begun ACCT procedures to support him.
65. Mr Collier had many clear risk factors: he was 61 years old and in prison for the first time; he had allegedly just committed a violent offence against a close relative; he had admitted recent thoughts of suicide and self-harm; he was suffering from anxiety; his mood was low; and he had financial concerns. These risk factors were set out in Mr Collier's PER (provided to Officer A and Nurse B) and the Prisoner Warning Notice and accompanying Custody Brief Summary Report (provided to Nurse B and Nurse A), and the court liaison team had spoken to and emailed Nurse B and the prison to highlight Mr Collier's risk of suicide.
66. Officer A failed to notice the suicide and self-harm risk information on Mr Collier's PER when he arrived at Chelmsford. She should have reviewed the PER in detail, spotted the risk information and recorded it on NOMIS. This was a key element of her role and we are very concerned that she did not review all the documentation available to her thoroughly. We consider that this was the first missed opportunity to place Mr Collier on an ACCT.
67. Nurse B's SystemOne entry on 30 July did not mention the information provided to him in the PER, the Prisoner Warning Notice and the Custody Brief Summary Report. He should have reviewed the risk information on these documents and used it in his assessment of Mr Collier. We have not been able to interview him, but we consider it very unlikely that he would have recorded that Mr Collier had "no risk information" if he had read the key risk information that he arrived with. Instead, he appears to have relied on Mr Collier's presentation. We are very concerned that like Officer A, Nurse B appears not to have performed his role properly. We consider this was another missed opportunity to identify Mr Collier's risk and put appropriate supportive measures in place.
68. Overnight, the prison's Safer Custody Team appropriately identified Mr Collier as being at risk of suicide and emailed SO A in the morning to tell him so. We consider that the SO should have conducted a welfare check on Mr Collier when he received their self-harm warning email at 9.30am on 31 July. We are very concerned that he said he was unaware that he was supposed to do this. It is difficult to understand why he thought he had been sent the information if he was not expected to act on it or what he meant by saying he thought it had been sent to him "for future reference". Although we cannot say whether a welfare check would have identified Mr Collier as being at high risk of suicide or self-harm and led to an ACCT being opened, we consider this to be another missed opportunity to check on his well-being.

69. The prison's Safer Custody Team told us that their emails now include instructions to the SOs, making it clear to them that welfare checks must be conducted for every prisoner listed with a self-harm warning. We consider this to be an appropriate measure to ensure that the process is followed correctly going forward but it is worrying that something so obvious has had to be spelled out.
70. In interview, Nurse A told us that she relied on Nurse A's SystemOne entry when she conducted her paper-based mental health triage for Mr Collier on 31 July. She said she had, however, reviewed the Prisoner Warning Notice and Custody Brief Summary Report and was therefore aware of Mr Collier's risk factors and his recent thoughts of suicide and self-harm. She also confirmed that she had spoken to the nurse from the court diversion team on 30 July, and that he had given her advanced warning of Mr Collier's arrival and his level of risk. We are very concerned that, despite this, she chose not to place Mr Collier on an ACCT, refer him for an urgent mental health assessment or speak to him in person. We consider this to be another serious failing in the identification and management of Mr Collier's risk of suicide or self-harm.
71. We consider that the failure of reception staff to highlight Mr Collier's risk information, the failure of the first night SO to conduct a welfare check, the failure of Nurse A to conduct a thorough mental health assessment, and the failure of all the staff involved to place him on an ACCT were missed opportunities. Staff should have recognised Mr Collier's risk and immediately begun ACCT procedures to support and safeguard him. If they had identified his high risk of suicide or self-harm, appropriate supportive measures could have been put in place and Mr Collier's death may have been prevented.
72. We are particularly concerned that a number of different staff failed to recognise Mr Collier's significant risk factors. This was not an isolated mistake made by one person. It was a succession of poor judgements by different people, which suggests that staff at Chelmsford generally do not have a good understanding of risk assessment or its importance.
73. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff who assess risk:

- **identify the risks associated with new prisoners' index offences, consider all external sources of information provided to them and update NOMIS and SystemOne accordingly; and**
- **start ACCT procedures whenever a prisoner has significant risk factors, irrespective of their presentation or stated intentions.**

The Governor should undertake an internal investigation into the circumstances of Mr Collier's death, looking particularly, but not exclusively, at the actions/inactions of Officer A and Supervising Officer (SO) A, with a view to considering whether disciplinary action is appropriate.

The Head of Healthcare should:

- **undertake an internal investigation into the circumstances of Mr Collier's death, in particular the practice of Nurse A and Nurse B and take any necessary actions based on the findings of the investigation;**
- **consider whether the two nurses should continue to work in the prison while the investigation is conducted.**

Roll check by OSG on 1 August

74. At 5.36am on 1 August, the OSG checked Mr Collier's cell using a torch (as it was still not fully light) and said he saw Mr Collier standing at the back of his cell with his eyes open. He had no concerns for Mr Collier's welfare. However, just over an hour later an officer discovered Mr Collier hanging (in the same position as before). By this time Mr Collier had advanced rigor mortis, meaning that he had been dead for some hours.
75. We accept that the OSG did not realise it, but we consider that Mr Collier was almost certainly already dead during the roll count at 5.36am. Due to the extent of the rigor mortis described when he was eventually found, we do not think that the outcome would have been any different for Mr Collier, even if the OSG had realised that Mr Collier was hanging at that time.

Emergency response

76. Prison Service Instruction (PSI) 03/2013 requires Governors to have a medical emergency response code protocol, which instructs staff how to communicate the nature of a medical emergency using agreed emergency codes and ensures that the control room calls an ambulance immediately as soon as an emergency code is called. Chelmsford's Medical Emergency Response Codes Policy for 2019/2020 mirrors the protocol in the PSI.
77. The control room officer recorded in his handwritten log that he received the code blue call from the OSG at 6.50am. Although he did not note the time that he called an ambulance, the Ambulance Service call record (which is exact) says it was 6.53am. We are concerned that there appears to have been a three-minute delay from receiving the code blue to calling an ambulance.
78. At interview, the control room officer said he waited to obtain further information (specifically whether Mr Collier was breathing and responsive) before calling an ambulance. We consider that it is not essential to obtain such information before making the call for an ambulance, as it can be provided to ambulance staff later as soon as it is known. Although it would not have saved Mr Collier's life if the ambulance had been called earlier, as he had been dead some time when he was found, such a delay could be crucial in future medical emergencies.
79. We appreciate that ambulance staff may ask for additional information to enable them to prioritise the call. However, this information will not always be available immediately in a prison setting. For this reason, it is important that prisons have a written medical emergency response protocol agreed with the local ambulance service about the arrangements for emergency calls.

80. We recommend:

The Governor should ensure that all staff are made aware of and understand PSI 03/2013, as well as local instructions, and their responsibilities during medical emergencies, including:

- **immediately calling an ambulance when a medical emergency code is called; and**
- **promptly providing information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.**

The Governor should ensure that there is a written medical emergency response protocol agreed with the local ambulance service about the procedures for emergency calls, in line with PSI 03/2013.

81. In other respects, we are satisfied that the emergency response was prompt, professional and appropriate.

Contact with Mr Collier's family

82. Mr Collier's family were concerned that more than three hours passed before his sister was told of his death. The investigator examined the FLO log and was satisfied that the slight delay was reasonable: the FLO had made additional checks with the police before contacting Mr Collier's family due to the sensitive nature of his alleged index offence.

Inquest

83. From 7 to 18 November 2022, the inquest into Mr Collier's death took place. The conclusion was that Mr Collier's death was suicide, and that he took his own life whilst the balance of his mind was disturbed.

84. A narrative verdict was recorded, which noted that HMP Chelmsford reception staff seriously failed to adequately assess and recognise suicide and self-harm (SASH) risks that were reflective of all information within Mr Collier's PER and Prisoner Warning Notice documents. The risk assessment mostly reflected Mr Collier's presentation during his face-to-face reception processing and mental health screening consultation.

85. The verdict noted that, based on information available to prison reception staff during Mr Collier's induction to Chelmsford, Mr Collier should have been referred for an urgent mental health assessment upon his reception at the prison. The verdict added that important information concerning Mr Collier's level of SASH risk failed to be communicated effectively between the various prison healthcare staff responsible for Mr Collier's safeguarding.

86. The verdict noted that the prison officers working in reception at the time of Mr Collier's induction had only a basic and inadequate understanding of, and competence in, their duties and relevant processes and policies. As a result, an ACCT could, and should, have been raised for Mr Collier by the reception staff who were first to see him on his arrival at HMP Chelmsford. In addition, all staff

(including healthcare) involved in the induction process had opportunities to open an ACCT for Mr Collier but failed to do so. This failure denied Mr Collier of the additional level of safeguarding afforded by the ACCT process.

87. As a result of the above findings, the verdict concluded that prison and healthcare staff at Chelmsford did not afford Mr Collier an adequate level of care and safeguarding whilst in custody. In addition, it is evident that the level of training and competency of prison and healthcare staff undertaking important roles did not deliver the level of support to which Mr Collier should have been entitled. Furthermore, the level of support provided to Mr Collier was not up to the standard expected by senior prison and healthcare staff. Evidence provided indicated that this is an underlying problem within the prison's service, which is cause for grave concern.

Sue McAllister CB
Prisons and Probation Ombudsman

February 2022

**Prisons &
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