Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rohan McCollin, a prisoner at HMP Chelmsford, on 2 June 2021

A report by the Prisons and Probation Ombudsman

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Rohan McCollin died on 2 June 2021, after being found hanging in his cell at HMP Chelmsford. He was 49 years old. I offer my condolences to Mr McCollin's family and friends.

Mr McCollin arrived at Chelmsford on the afternoon of 1 June and had been there for only around 13 hours when he was found hanging. The staff who saw Mr McCollin in reception, and during his induction, assessed that he was not at risk of suicide or self-harm. I am satisfied that their assessments were reasonable, and that staff could not have predicted or prevented Mr McCollin's death.

I make no recommendations.

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 **January 2022**

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Summary

Events

1. On 1 June 2021, Mr Rohan McCollin was remanded in prison custody, charged with grievous bodily harm against his brother, and sent to HMP Chelmsford.

2. Mr McCollin arrived at Chelmsford in the early afternoon. His Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons which sets out the risks they pose) contained no suicide or self-harm warnings and no record of any mental health concerns. Staff noted that Mr McCollin was calm, polite and engaged well. They assessed that Mr McCollin was not at risk of suicide or self-harm.

3. Mr McCollin was placed in a cell on the induction wing. Newly arrived prisoners are checked three times overnight. An operational support grade (OSG) checked Mr McCollin at 8.00pm and there were no issues. During the next check, at approximately 3.25am, the OSG saw Mr McCollin kneeling on the floor and then noticed a ligature. He called a medical emergency code and waited for other staff to arrive before entering the cell. Staff and nurses responded and tried to resuscitate Mr McCollin until paramedics took over his care at approximately 3.38am. They were unsuccessful and pronounced his death at 4.42am.

4. Mr McCollin had made some notes on the cover of his induction booklet which indicated he had intended to take his life.

Findings

5. We are satisfied that the staff who carried out Mr McCollin's reception screening, and his induction, assessed his risk of suicide and self-harm appropriately. We consider that their assessments that Mr McCollin was not at risk of suicide were reasonable based on the information available to them.

6. The OSG who found Mr McCollin called a medical emergency code but did not enter the cell. He told the investigator that although he could see a ligature, he was unsure whether it was a ruse and therefore decided to wait for other staff to arrive before going into the cell. We consider that as the situation was not entirely clear and he knew nothing about Mr McCollin, this was a reasonable decision.

7. We make no recommendations.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

10. NHS England commissioned a clinical reviewer to review Mr McCollin's clinical care at the prison.

11. The investigator and clinical reviewer jointly interviewed eight staff members. Due to coronavirus restrictions, the interviews were conducted by telephone or video.

12. We informed HM Coroner for Essex and Thurrock of the investigation. He sent us a copy of Mr McCollin's post-mortem and toxicology reports. We have sent the coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr McCollin's family to explain the investigation and ask if they wanted to raise any issues. They asked whether Mr McCollin had been told that his brother had come out of a coma as they were concerned that he might have thought he had died. They also asked what measures were in place to prevent prisoners on remand from taking their own lives and whether Mr McCollin's mental health had been taken into account. We have addressed these issues in this report.

14. We shared our initial report with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies.

15. We provided Mr McCollin's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

HMP Chelmsford

16. HMP 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 12-bed inpatient unit.

17. Between 3 May 2018 and 2 July 2019, Chelmsford was under special measures. This meant that HM Prison and Probation Service (HMPPS) had determined that it needed additional, specialist support to improve its performance.

HM Inspectorate of Prisons

18. The most recent full 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. 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.

19. 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.

20. HMIP carried out a further inspection in August 2021. On 27 August, HM Chief Inspector of Prisons issued an 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

21. 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 noted there was 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

22. Mr McCollin was the tenth prisoner to die at Chelmsford since June 2019. Five of the previous deaths were self-inflicted, two were from natural causes and two were drug related. There were no significant similarities with the findings from our previous investigations.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT until all the actions are completed.

Key Events

24. On 1 June 2021, Mr Rohan McCollin was remanded in prison custody, charged with grievous bodily harm against his brother, and sent to HMP Chelmsford. This was not his first time at Chelmsford.

25. An officer saw Mr McCollin in reception at approximately 2.35pm. He had Mr McCollin's Person Escort Record (PER) which had details of his alleged offence. There were no self-harm warnings or mental health concerns on the PER. He told the investigator that he spoke to Mr McCollin for approximately 20 minutes and discussed Mr McCollin's offence. Mr McCollin said he knew his brother was in hospital and alive. He said he was aware that this type of offence against a family member could be a potential trigger for suicide and self-harm, so asked whether Mr McCollin had any history, or thoughts, of harming himself. He said he had not. He said that Mr McCollin engaged well, was not upset and was calm, chatty and bubbly.

26. A nurse carried out a reception health screen with Mr McCollin. She had read his PER before she saw him. Mr McCollin told her he had stabbed his brother, who was in hospital. Mr McCollin had cuts and bruises and said he had got these during the fight. She gave him painkillers. Mr McCollin said he had no thoughts of suicide or harming himself, and no history of self-harm. She noted Mr McCollin's blood pressure was high and he told her he felt anxious. She said she would check it again the next day at a secondary health screen and offered him a referral to the prison's mental health team for assessment. Mr McCollin declined. He said he was not on any anxiety medication as he managed it himself. She told him she could give him an anxiety pack as a distraction, which he accepted.

27. Mr McCollin told the nurse he was concerned about a family history of diabetes, and she said she could arrange a test for him. She said she got the impression Mr McCollin was planning ahead. She considered his mood seemed very stable and he seemed to accept his situation. She said he was very polite and engaged well.

28. Staff took Mr McCollin to the induction wing (B Wing) where he met an officer for a first night interview. Mr McCollin said he had no thoughts of suicide or self-harm. The officer explained the role of Listeners and Samaritans and what help was available to him and told him to press his cell bell should he need anything. Mr McCollin asked what jobs might be available to him at Chelmsford and how long it would take him to move on to an enhanced wing.

29. A little later, the officer replaced Mr McCollin's television aerial, because his television was not working, and swapped his kettle which was faulty. He said Mr McCollin seemed fine on both occasions. He last saw him at 5.30pm.

30. Newly arrived prisoners are checked three times during their first night. Operational Support Grade (OSG) A on night duty on B Wing, checked Mr McCollin at 8.00pm as part of his first roll count.

31. OSG A next checked Mr McCollin at approximately 3.25am, on 2 June. He turned on the cell light and looked through the observation panel. He saw Mr McCollin was on his knees and thought he was praying at first and then he saw a ligature. (The

ligature had been made from a bedsheet, tied around Mr McCollin's neck and to the window bars.) He immediately radioed an emergency code blue call (indicating a life-threatening medical emergency). He was not sure that staff in the control room had heard his call as he had spoken quietly and had not got an immediate confirmation, so he called a code blue again. He also radioed for permission to go into the cell, which the Custodial Manager (CM), the Night Orderly Officer (the person in charge of the prison that night), granted. OSG A waited for other staff to arrive before going into the cell.

32. An officer and another OSG were the first to respond to the code blue. The officer and OSG A went into Mr McCollin's cell. OSG A cut the ligature around Mr McCollin's neck, while the officer cut the end of the ligature which had been tied to the bars and they laid him on the floor. The officer noticed that Mr McCollin felt cold, and his tracksuit bottoms were wet. OSG A checked for signs of life but found none. The officer also checked Mr McCollin's pulse but could not find one.

33. The CM arrived at the cell with an officer. The officer checked Mr McCollin for signs of life, while the CM started chest compressions. At some point, an officer took over from her until healthcare staff arrived.

34. Two nurses arrived at Mr McCollin's cell at 3.30am, with an emergency bag and defibrillator. They took over CPR and attached the defibrillator, which did not advise Mr McCollin should be shocked. Another nurse arrived and the three nurses continued CPR until paramedics arrived at 3.38am and took over. They pronounced Mr McCollin's death at 4.42am.

35. Mr McCollin had written on his induction booklet: "Don't revive!", "It's time," "Turn the lights down low," and "Nothing has changed, no lessons have been learned".

Contact with Mr McCollin's family

36. Police told Mr McCollin's nominated next of kin, a friend, that he had died. The prison's family liaison officer contacted Mr McCollin's family and next of kin.

37. The prison contributed to the cost of Mr McCollin's funeral, in line with national guidelines.

Support for prisoners and staff

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

39. The prison posted notices informing other prisoners of Mr McCollin'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 McCollin's death.

Post-mortem report

40. The post-mortem report concluded Mr McCollin had died from asphyxiation from hanging. His toxicology result noted the presence of cannabinoids (cannabis-

derived compounds). Cannabinoids may be detected for several days after last exposure so Mr McCollin may have used cannabis before entering prison.

Findings

Management of Mr McCollin's risk of suicide and self-harm

41. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures for identifying, managing and supporting prisoners at risk of suicide and self-harm using the ACCT process. PSI 07/2015, Early Days in Custody, sets out the procedures for assessing prisoners' risk of suicide and self-harm when they arrive in reception. It says that the PER and any other available documentation must be examined in reception to assess the risk of suicide and self-harm, and all relevant information about the prisoner should be noted in the appropriate record and forwarded to other staff as necessary.

42. Mr McCollin's PER contained no suicide or self-harm warnings and no mental health concerns. However, a violent offence against a family member is a known risk factor for suicide and self-harm. The reception officer told us that they were aware of the additional risks associated with Mr McCollin's offence (he had assaulted his brother) and that he discussed Mr McCollin's offence with him and explored his risk of suicide and self-harm at length. He said that Mr McCollin was calm, chatty and gave no cause for concern. The reception nurse said that Mr McCollin was engaged and appeared to be planning ahead so she had no concerns. The officer who conducted the first night interview also noted that Mr McCollin talked about future plans.

43. We consider that staff assessed Mr McCollin's risk of suicide and self-harm appropriately and that their assessments that he was not at risk were reasonable based on the information available to them.

Opening a cell at night

44. OSG A, who found Mr McCollin kneeling on the floor of his cell at around 3.25am on 2 June and saw a ligature, called a medical emergency code but did not enter the cell. He told the investigator that when other staff arrived, he was asking for permission from the Night Orderly Officer (NOO) to go into the cell.

45. Chelmsford's Nights operating policy 2019 says, "Entries into cell must be kept to an absolute minimum during the night state. When it is considered necessary for a cell door to be opened the NOO must be contacted. The NOO will attend the scene accompanied by at least 2 other members of staff." However, it goes on to say that if a member of staff finds a prisoner in a situation where their life may be in danger, they must consider entering the cell immediately if safe to do so. (This is in line with PSI 24/2011, Management and Security of Nights, which says that preservation of life must take precedence and that where there is, or appears to be, an immediate danger to life, then cells may be unlocked without the authority of the NOO and an individual member of staff may go into the cell on their own.)

46. When interviewed, OSG A said that he did not know Mr McCollin and, although he could see a ligature, it was unclear where this was attached, and he was unsure whether it might be a ruse. He therefore waited for other staff to arrive before going

into the cell. We consider that the situation was unclear to the OSG and that his decision not to enter the cell alone was reasonable in the circumstances.

Mr McCollin's clinical care

47. The clinical reviewer was satisfied that Mr McCollin's received a good standard of physical and mental health care, which was equivalent to what he would have received in the community. She had no concerns about Mr McCollin's reception screening, which was completed in line with guidelines.

Inquest

48. At the inquest, heard from 12 to 20 December 2022, the jury concluded that Mr McCollin died from suicide.

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