Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Joseph, a prisoner at HMP Chelmsford, on 2 March 2021

A report by the Prisons and Probation Ombudsman

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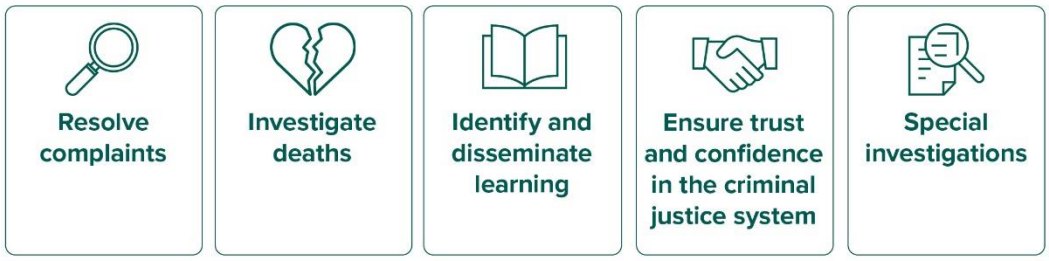
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Paul Joseph died in hospital on 2 March 2021, after being found hanging in his cell at HMP Chelmsford earlier that day. He was 46 years old. I offer my condolences to Mr Joseph's family and friends.

Mr Joseph arrived at Chelmsford on 24 February 2021 and later that day, staff started Prison Service suicide and self-harm monitoring (known as ACCT). However, staff stopped ACCT monitoring the next day. Mr Joseph was not being monitored when he was found hanging.

I am concerned that staff stopped ACCT monitoring after less than 24 hours. Staff ignored warnings from court staff that Mr Joseph had said he would kill himself if he was sent to prison and placed too much emphasis on Mr Joseph's presentation. They also failed to wait for Mr Joseph's mental health to be assessed before they stopped ACCT monitoring. I consider that staff showed poor judgement and stopped ACCT monitoring too soon. This is not the first time I have raised concerns about ACCT management at Chelmsford.

The reception nurse made a mental health referral when Mr Joseph arrived at Chelmsford. A mental health assessment should have been completed within 72 hours but Mr Joseph had not had one by the time he died.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **January 2022**

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Summary

Events

1. Mr Paul Joseph was remanded in prison custody on 24 February 2021, charged with attempted murder and kidnap, and sent to HMP Chelmsford. Mr Joseph told court staff he would kill himself if he was sent to prison. Court staff emailed and spoke to a nurse at Chelmsford to warn them about what Mr Joseph had said.

2. The nurse who saw Mr Joseph in reception started suicide and self-harm monitoring (known as ACCT) and referred Mr Joseph for a mental health assessment.

3. The next day, at the first ACCT case review, staff assessed Mr Joseph's risk as low and stopped ACCT monitoring.

4. During the afternoon of 2 March, staff went to Mr Joseph's cell to give him his medication. They saw Mr Joseph hanging from a bedsheet attached to the window bars. Staff began cardiopulmonary resuscitation (CPR) immediately and called an ambulance. Paramedics took Mr Joseph to hospital but he died that evening.

Findings

5. The officer who assessed Mr Joseph in reception did not know about the phone calls made by court staff. However, he was aware of the self-harm warnings for Mr Joseph. We are concerned that he did not properly record and assess Mr Joseph's risk factors for suicide and self-harm.

6. We are concerned that the ACCT was closed after less than 24 hours. The staff at the ACCT review were aware of what Mr Joseph had told court staff but did not address this with him. We saw no evidence that staff had done anything to mitigate Mr Joseph's risk. They also failed to wait for Mr Joseph's mental health to be assessed before closing the ACCT.

7. We have previously identified failures in the management of ACCT procedures at Chelmsford. In response to previous recommendations on this issue, we were told that new guidance had been issued to staff in August 2020. We are concerned that we have found the same issues arising in February 2021.

8. Mr Joseph should have had a mental health assessment within 72 hours of the referral. He had not had one in the six days he was at Chelmsford.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff:
  - consider all documentation that arrives with a prisoner so that they properly assess their risk of suicide and self-harm;
  - share important information about a prisoner's risk of suicide and self-harm; and
  - record the information considered and their reasoning when they decide not to start ACCT procedures.
- The Governor should ensure that a copy of this report is shared with Officer A and that a senior manager discusses the Ombudsman's findings with him.
- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that they:
  - consider all risk factors when assessing a prisoner's level of risk and do not just rely on what the prisoner says or how he appears;
  - ensure that the ACCT is not closed until measures have been put in place to mitigate the prisoner's risk and that risk has sufficiently reduced.
- The Governor should ensure that a copy of this report is shared with SO A and Officer B and that a senior manager discusses the Ombudsman's findings with them.
- The Head of Healthcare should ensure that prisoners referred for a standard mental health assessment are seen within 72 hours.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Joseph's prison and probation record.

11. NHS England commissioned an independent clinical reviewer to review Mr Joseph's clinical care at the prison.

12. They jointly interviewed seven members of staff on 6, 15, and 16 April. The investigator interviewed another officer on 4 May. Due to coronavirus restrictions, the interviews were conducted by telephone or video.

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

14. One of the Ombudsman's family liaison officers contacted Mr Joseph's family to explain the investigation and ask if they wanted to raise any issues. They raised no issues but asked for a copy of the report.

15. We shared our initial report with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies. They provided an action plan which is annexed to this report.

16. We provided Mr Joseph's next of kin with a copy of our initial report. They raised some inaccuracies and issues which have been addressed in separate correspondence.

Background Information

HMP Chelmsford

17. 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 12-bed inpatient unit.

18. 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 (HMIP)

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

20. 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.

21. 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 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

22. 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

23. Mr Joseph was the seventh prisoner to die at Chelmsford since March 2019. Three of the previous deaths were self-inflicted, two were from natural causes and one was drug-related.

24. We have previously expressed concerns about staff's assessment of prisoners' suicide risk and the management of suicide and self-harm monitoring at Chelmsford.

Assessment, Care in Custody and Teamwork

25. 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

26. On 24 February 2021, Mr Paul Joseph was remanded in prison custody, charged with attempted murder and kidnap, and sent to HMP Chelmsford. He had been in prison before, but not for many years.

27. Mr Joseph's Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons which sets out the risks they pose) noted that he had warning markers for self-harm. It said that he had made statements about self-harming in custody and said he had nothing to live for anymore. It also noted that Mr Joseph had depression, diabetes and epilepsy.

28. Court staff also completed a Prisoner Warning Notice (PWN) for Mr Joseph that they emailed to healthcare staff at Chelmsford. It said that Mr Joseph had self-harmed in the past, that his risk increased in a custodial setting and that he had recent and current suicidal thoughts. It noted that Mr Joseph said he had no plan to self-harm if bailed but would kill himself if he was sent to prison. Court staff telephoned the prison twice before Mr Joseph arrived and spoke to a nurse, to ensure they were aware of the concerns about him.

29. Officer A carried out the reception screening and completed a Custody Care Record for Mr Joseph. He noted that he had suicide and self-harm warnings on the PER. Next to the question, 'Have you got any current thoughts of self-harm or suicide?', Officer A wrote that Mr Joseph had said 'No', and added, 'States Serco are making something out of nothing.' When interviewed, Officer A said he did not know about the phone calls made by court staff.

ACCT: 24-25 February

30. A nurse carried out Mr Joseph's initial health screen in reception. He noted in Mr Joseph's medical record (SystmOne) that Mr Joseph said he had no thoughts of suicide or self-harm, and that he had never harmed himself before. The nurse noted that that this was contrary to the information in the PWN. The nurse started suicide and self-harm monitoring (known as ACCT). The nurse also referred Mr Joseph to the prison's mental health team.

31. Officer B carried out an ACCT assessment interview shortly after the nurse had opened the ACCT. Mr Joseph told her he felt fine and denied he had said anything about self-harm while at court. He said he had never self-harmed and had no intention of doing so.

32. Supervising Officer (SO) A saw Mr Joseph next, to complete an immediate ACCT action plan. He put Mr Joseph on hourly observations until they held the first ACCT case review. Mr Joseph was allocated a single cell on the Induction Unit. Prisoners usually stay there for one or two nights, but due to COVID-19, prisoners remained there for a minimum of ten days as a quarantine measure.

33. It was noted that Mr Joseph was on eight different medications, including medication for epilepsy and diabetes. A prison GP prescribed these for Mr Joseph.

34. On 25 February, a healthcare support worker carried out Mr Joseph's second health screen. They discussed his epilepsy and diabetes. She used template questions

on SystmOne to assess Mr Joseph's mental health. Mr Joseph's answers indicated he might have anxiety or depression. She checked on SystmOne that Mr Joseph had already been referred to the mental health team, which she saw he had.

35. Mr Joseph's first and only ACCT review was held later that afternoon. He attended the review with SO A, Officer B and a mental health nurse.

36. SO A noted that Mr Joseph engaged fully with the review and appeared cheerful and sociable. Mr Joseph said he was frustrated at being in prison, because he was innocent. He said he was very keen to keep busy and would be hoping for employment. He also mentioned he had not received any medication since arriving at Chelmsford. SO A noted that healthcare staff were aware and were checking it out.

37. Staff assessed Mr Joseph's risk of suicide and self-harm as low, and closed the ACCT. They scheduled a post-closure review for 3 March.

26 February – 1 March

38. Chelmsford use a 7 Day Post-Closure Monitoring Form to check that a prisoner is coping without the support of an ACCT. This was not completed for Mr Joseph on 25 or 26 February but was for the next three days. On 27 February, staff noted that Mr Joseph was frustrated about not being able to read and write and not having any help with this. On 28 February, staff noted that they had helped Mr Joseph complete his canteen sheet and that he seemed more settled. On 1 March, staff noted that they had helped Mr Joseph apply for a PIN phone account (the prison's telephone system) and that he seemed calm and settled.

2 March

39. On the morning of 2 March, Mr Joseph asked an officer whether he was able to use his telephone yet. The officer said he could. Mr Joseph made four telephone calls that day. The investigator listened to them. Mr Joseph gave no cause for concern. Mr Joseph spoke about his release and further chances to apply for bail. The last call was at 1.30pm.

40. At approximately 2.30pm, an officer unlocked Mr Joseph for exercise. Although it was a nice day, Mr Joseph said he did not want to go out and remained in his cell.

41. At approximately 4.00pm, an officer accompanied a pharmacy technician giving prisoners their medication. They arrived at Mr Joseph's cell at 4.24pm. The officer opened the door and immediately saw Mr Joseph, in a seated position, slumped forward, with a ligature made from a bedsheet tied around his neck and attached to the window bars. The officer called for a second officer and lifted Mr Joseph to ease the pressure. The second officer ran in and immediately radioed an emergency code blue call (indicating a life-threatening medical emergency). He used an anti-ligature knife to cut the bedsheet and the officers lowered Mr Joseph to the floor. They noted that Mr Joseph was very pale and felt cold. They checked for signs of life, but found none, so the second officer began chest compressions. The first officer took over, and then a custodial manager.

42. Healthcare staff responded to the emergency call and arrived at Mr Joseph's cell at 4.27pm. A nurse noted a deep ligature mark on Mr Joseph's neck, and that he looked very pale, but he did not feel cold to her. He was not responsive or breathing. The nurse attached defibrillator pads to Mr Joseph's chest and inserted an airway. Staff continued cardiopulmonary resuscitation (CPR) throughout. The nurse took over chest compressions, which she continued until paramedics arrived at the cell at 4.35pm. They took over Mr Joseph's CPR, attached an automatic defibrillator and found a faint pulse. The ambulance left the prison with Mr Joseph at 5.43pm. He was treated at Broomfield Hospital, but pronounced dead at 10.12pm.

Contact with Mr Joseph's family

43. The prison appointed an officer as the family liaison officer. He telephoned Mr Joseph's next to kin, his partner, on 2 March, to inform her that Mr Joseph had been taken to hospital. A prison manager also spoke to her. Mr Joseph's partner was with him when he died.

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

Support for prisoners and staff

45. After Mr Joseph was taken to hospital, a prison 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.

46. The prison posted notices informing other prisoners of Mr Joseph'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 Joseph's death.

Post-mortem report

47. The post-mortem report concluded that Mr Joseph died from asphyxiation from hanging.

Findings

Managing Mr Joseph's risk of suicide and self-harm

Risk assessment in reception

48. 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.

49. Officer A who assessed Mr Joseph when he arrived at Chelmsford, noted that there were self-harm markers on the Person Escort Record (PER) but that Mr Joseph said he had no thoughts of suicide or self-harm. He did not open an ACCT. When interviewed, Officer A said he did not know that court staff had telephoned the prison to warn them of concerns about Mr Joseph and that, if he had known, he would have opened an ACCT. We are concerned that this important information from court staff was not shared with reception staff.

50. In addition, although we accept that Officer A did not have access to all the relevant information about Mr Joseph, we are concerned that he did not properly consider the risk factors that were on the PER and did not record his reasoning for not opening an ACCT. We are also concerned that he placed too much emphasis on Mr Joseph's presentation and not enough on his risk factors.

51. We recommend:

The Governor and Head of Healthcare should ensure that reception staff:

- **consider all documentation that arrives with a prisoner so that they properly assess their risk of suicide and self-harm;**
- **share important information about a prisoner's risk of suicide and self-harm; and**
- **record the information considered and their reasoning when they decide not to start ACCT procedures.**

The Governor should ensure that a copy of this report is shared with Officer A and that a senior manager discusses the Ombudsman's findings with him.

Premature closure of ACCT

52. The nurse appropriately opened an ACCT for Mr Joseph at around 6.00pm on 24 February, the day he arrived. However, less than 24 hours later at the first ACCT review, staff assessed Mr Joseph's risk as low and closed the ACCT. We consider this showed poor judgement and that staff closed Mr Joseph's ACCT far too soon.

53. When he opened the ACCT, the nurse noted in the Concern and Keep Safe section of the ACCT document that Mr Joseph had told court staff that he would kill himself if he had to go to prison on remand. We have seen no evidence that staff addressed this with Mr Joseph at the ACCT review. When interviewed, SO A, the ACCT case manager, said that he had assessed Mr Joseph's risk as low because he had been looking to the future by asking about employment, and had been laughing and joking. We consider that staff placed too much emphasis on Mr Joseph's presentation rather than the risk factors that had been flagged to them. Nothing was done to try to understand these risk factors or to mitigate them. We are also concerned that staff at the ACCT review did not identify that a mental health referral had been made or consider awaiting the outcome of that before closing the ACCT.

54. We have raised concerns about the operation of ACCT at Chelmsford in previous investigations into self-inflicted deaths at the prison. In response to a previous recommendation about poor assessment of risk and ACCT management, we were told that new guidance had been produced and circulated in August 2020, and that since then three newsletters had been issued to remind staff about important aspects of ACCT management. We are, therefore, very concerned to have identified similar failings in this investigation. We would have made a recommendation to the Prison Group Director for Hertfordshire, Essex and Suffolk but note that, following a previous recommendation, he is due to write to the Ombudsman in September 2021, about the outcome of the review into staff culture at Chelmsford. We make the following recommendations:

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

- **consider all risk factors when assessing a prisoner's level of risk and do not just rely on what the prisoner says or how he appears;**
- **ensure that the ACCT is not closed until measures have been put in place to mitigate the prisoner's risk and that risk has sufficiently reduced.**

The Governor should ensure that a copy of this report is shared with SO A and Officer B and that a senior manager discusses the Ombudsman's findings with them.

Mental health referral

55. Emergency mental health referrals should be seen within 24 hours at Chelmsford, and standard referrals within 72 hours. The reception nurse who saw Mr Joseph on the day he arrived at Chelmsford, 24 February, noted that he had made a mental health referral for him. However, Mr Joseph had not had a mental health assessment by the time he died, six days later. The Head of Healthcare said the mental health team had not received Mr Joseph's referral. This is concerning.

56. The clinical reviewer found that mental health services for Mr Joseph at Chelmsford were not wholly equivalent to that he could have expected to receive in the community. He was concerned that Mr Joseph's threats and history of self-harm

were not fully acknowledged during the ACCT process and that Mr Joseph had not received a mental health assessment at the time of his death. We recommend:

The Head of Healthcare should ensure that prisoners referred for a standard mental health assessment are seen within 72 hours.

Inquest

57. At the inquest, which concluded on 3 November 2023, the jury recorded a narrative conclusion. They found that the ACCT should have been left open on 25 February and that Mr Joseph should have been provided with continued support using ACCT procedures. They concluded that Mr Joseph did not receive adequate care or support from prison or healthcare staff at Chelmsford and there were numerous serious failures in deploying the care and support that Mr Joseph was entitled to.

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