Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Duncan Ford, a prisoner at HMP Chelmsford, on 2 March 2023

A report by the Prisons and Probation Ombudsman

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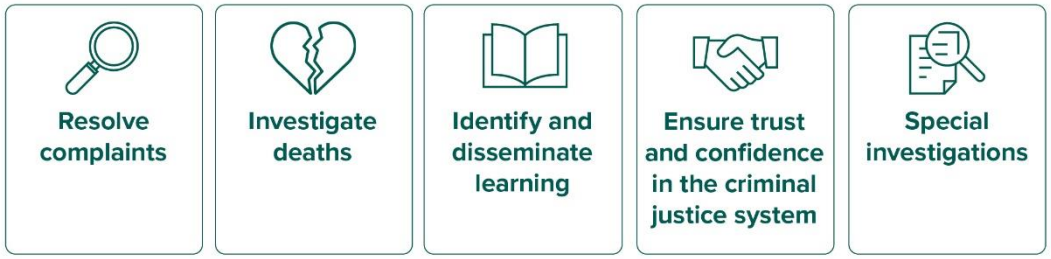
OUR VISION

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

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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Duncan Ford died of dilated cardiomyopathy, a disease of the heart muscle, on 2 March 2023 at HMP Chelmsford. He was 56 years old. I offer my condolences to Mr Ford's family and friends.

The clinical reviewer found that the clinical care provided to Mr Ford was equivalent to that which he could have expected to receive in the community. Mr Ford did not report any symptoms of physical illness and his death was unexpected.

Mr Ford had complex mental health needs which were generally well managed. The only notable non-clinical issue we found relates to the initial response when Mr Ford was found unresponsive. This has already been addressed by the Governor.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. On 17 November 2022, Mr Duncan Ford was remanded to HMP Chelmsford for various public order offences. He had a history of substance misuse issues and diagnoses for schizophrenia and bipolar disorder. Healthcare staff contacted his community GP to confirm his medications and made referrals to the mental health and substance misuse teams. Mr Ford reported no family history of long-term health conditions such as diabetes or heart disease.

2. Mr Ford was agitated on arrival so healthcare staff started suicide and self-harm procedures (known as ACCT) to provide additional support. The ACCT was closed the next day when his presentation improved.

3. A member of the mental health team saw Mr Ford weekly. He engaged well, though sometimes did not collect his medications. Staff encouraged Mr Ford to collect his medications and over time, compliance increased. His mental health improved, and he did not report any other health concerns.

4. On 1 March, Mr Ford flooded his cell and refused to explain why. Staff asked a member of the mental health team to see him. Mr Ford had to move cells due to the flooding and became agitated during the process, so handcuffs were applied. Mr Ford said he would go if the cuffs were removed, which staff did. He was successfully transferred to another wing.

5. When being locked into his cell for the night, Mr Ford swore at a prison officer and threw a plastic cup. During the evening, the prisoner in the neighbouring cell complained about Mr Ford being disruptive. The night officer tried to speak to him, but Mr Ford was abusive and would not engage. At around midnight, Mr Ford stopped making noise, and his neighbour heard him snoring.

6. At 5.12am during the morning routine check, Mr Ford was observed lying on the cell floor where he appeared to be sleeping. The night officer had seen him do it before and noted movement so did not raise an alarm. He returned at 5.36am to double check if Mr Ford was okay, and again thought he saw movement. At 6.00am, the night officer tried to gain a response from Mr Ford but could not get one. When prison officers arrived on the wing at 6.15am, he asked them to check on Mr Ford. They went into his cell and saw blood around his head so called for medical assistance. Mr Ford was not breathing and showed no signs of life. Nurses arrived, followed by paramedics, and it was agreed that Mr Ford had died.

Findings

Clinical care

7. The clinical reviewer concluded that Mr Ford received a good standard of healthcare in Chelmsford, which was equivalent to that which he could have expected to receive in the community.

8. Mr Ford did not report any physical health concerns so there was no indication of underlying disease. Mr Ford's main area of need was his mental health. Staff identified his mental health diagnoses and completed regular reviews. When Mr Ford did not collect his medication, staff encouraged him to comply with his prescription.

9. When a member of staff asked a mental health nurse to see Mr Ford on 1 March, the nurse said that she would but did not do so. We were unable to establish why as the nurse has since left employment, but the omission did not impact on the outcome for Mr Ford who died of natural causes.

Emergency response

10. When the night officer saw Mr Ford apparently asleep on the cell floor, he did not raise any concerns. He completed two further checks on Mr Ford a short while later and did not obtain a response but thought he saw him breathing so was not overly concerned. When prison officers arrived on the wing, the night officer asked them to check Mr Ford. They entered the cell and found him unresponsive with no signs of life. A call for assistance was made in line with emergency protocols.

11. Managers have met with the night officer to reflect on and address the learning. Reminders on expectations for entering cells when a response cannot be obtained from a prisoner have been issued to the wider workforce, to ensure staff understand their responsibilities and emergencies are quickly identified. We do not make a recommendation.

The Investigation Process

12. We were informed of Mr Ford's death on 2 March 2023. 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.

13. The investigator visited Chelmsford. He obtained copies of relevant extracts from Mr Ford's prison and medical records.

14. The investigator interviewed three members of staff and one prisoner at Chelmsford in June 2023.

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

16. 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.

17. The Ombudsman's family liaison officer contacted Mr Ford's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

19. We sent a copy of our initial report to Mr Ford's sister. She did not notify us of any factual inaccuracies.

Background Information

HMP Chelmsford

20. HMP Chelmsford is a local prison with capacity for around 730 men and around 70 young adult men. Castle Rock Group Medical Services (CRG) provide 24-hour healthcare services.

21. Between 3 May 2018 and 2 July 2019, Chelmsford was in 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

22. The most recent inspection of HMP Chelmsford was in August 2022. Inspectors reported that staff and management had made strong efforts to improve on the previous poor inspection report. There were staff shortages in the healthcare department, particularly in the mental health team.

Independent Monitoring Board

23. 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 2022, the IMB recommended that key workers were given adequate time to perform their role.

Previous deaths at HMP Chelmsford

24. Mr Ford was the ninth prisoner to die at Chelmsford since March 2020. Of the previous deaths, six were apparently self-inflicted, one was due to natural causes, and one was drug related. We have previously made a recommendation about staff entering cells in an emergency.

Assessment, Care in Custody and Teamwork (ACCT)

25. 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.

26. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. 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.

27. 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

28. In October 2022, Mr Duncan Ford was released from HMP Chelmsford and detained in hospital under the Mental Health Act. He was discharged on 9 November but was later charged with various public order offences and remanded back to HMP Chelmsford on 17 November. The person escort record (PER) that arrived with Mr Ford carried a suicide and self-harm warning, noting previous self-harm. The PER noted that he had taken an overdose of his medication on 15 November and said that he would take his own life if he was sent to prison.

29. A nurse completed Mr Ford's reception health screening. His basic medical observations (such as blood pressure, heart rate, breathing etc) were all within normal levels. Mr Ford said he had learning difficulties and she noted his diagnoses of hypertension, schizophrenia and bipolar disorder. She noted that he was agitated and hostile. She made a referral to the substance misuse team and the mental health team.

30. An officer held a reception interview. Mr Ford said that he had spent time in Chelmsford before and knew what to expect. He was aware of support available if he needed it. He declined access to the telephone system, saying that he had nobody to contact.

31. Later the same day, Mr Ford saw a mental health nurse for an initial mental health and substance misuse assessment. He was agitated, unable to assure the nurse that he could keep himself safe, had recently taken an overdose and had an intention to end his life. The nurse opened suicide and self-harm monitoring procedures (known as ACCT) to provide additional support.

32. Healthcare staff contacted Mr Ford's community GP to confirm his medication. The community GP confirmed that Mr Ford received a regular depot injection (an injection formulation of medication enables gradual release over time and less frequent administration) of one of his schizophrenia medications but had not been engaging with the surgery or collecting his other medications. Staff referred him to the GP at Chelmsford for an assessment of his medication needs, which was completed, and the medications were later prescribed.

33. That afternoon staff concluded that Mr Ford was in good spirits and had no desire to end his life. They agreed to close ACCT procedures.

34. On 19 November, a prison paramedic completed Mr Ford's secondary health screening. Mr Ford said he had sustained a head injury some years previously. He had a family history of high blood pressure but no other long term health conditions such as diabetes, asthma, cancer, heart conditions or epilepsy in his family. He did not have any outstanding medical appointments.

35. On 22 November Mr Ford received his first depot injection. Healthcare scheduled his next one for 17 December (it was then brought forward to 14 December).

36. Mr Ford saw a member of the mental health team for weekly mental health reviews. He engaged well, though it was noted that he sometimes did not collect his medications. He did not keep a telephone appointment with the psychiatrist on 21 December but otherwise continued to engage with the mental health team.

37. Mr Ford received his next depot injection on Monday 16 January. On 17 January Mr Ford was prescribed procyclidine to alleviate side-effects of anti-psychotic medication.

38. On 18 January, Mr Ford saw the psychiatrist at Chelmsford. He was worried about being released so staff organised for a care plan to be formulated to support him in the community. Mr Ford said his anxiety was high at times so the doctor altered his medication. He did not report any other health concerns.

39. Mr Ford did not collect his medication on 24 or 25 January. At a mental health review that day he was acting out of character and being aggressive. The nurse referred him for a review with the psychiatrist and arranged for a member of the pharmacy department to speak to Mr Ford. A pharmacy technician visited Mr Ford, who said that he had been unwell and did not want to come out of his cell. He had not reported it, so she passed the message on to the primary care team.

40. The psychiatrist saw Mr Ford on 26 January. He was concerned that not taking his medication was affecting Mr Ford but would not make any changes to the prescription until Mr Ford recommenced taking it regularly. That afternoon Mr Ford did not collect his medication, so the pharmacist took it to his cell.

41. On 27 January, a nurse went to hold a mental health review with Mr Ford, but he was agitated. He threw a cup at the wall and hit his head against it. He refused to engage with the review.

42. Over the following week, Mr Ford acknowledged his behaviour and apologised to the mental health team. He took his medications and presented as well-kempt and co-operative. He reported no health concerns.

43. Mr Ford did not collect his medication on 9 February but complied with his scheduled depot injection, which was administered on 14 February. Over the following weeks, Mr Ford did not always collect his medication as prescribed, but there were no recorded concerns about his general health.

1 March

44. On the morning of 1 March, an officer noticed that Mr Ford had flooded his cell. She asked if he was okay, but he was abusive and threw water at the door. She informed a Custodial Manager (CM), who was that day's orderly officer (responsible for the day to day running of the prison). The CM spoke to Mr Ford. She asked if he was okay, and Mr Ford said that he was fine. She asked him why he had flooded his cell, and Mr Ford did not want to engage but said he was fine now. The CM asked if he wanted to see a nurse or a member of the mental health team, and Mr Ford said that he was taking his medication and did not want to see anyone. The CM spoke to a nurse, who confirmed that Mr Ford was under the care of the mental health team and records showed compliance with his medications and regular support. The CM asked if someone from the team would see Mr Ford and the nurse said that she would see him that afternoon.

45. After approximately 30 minutes, the officer returned to Mr Ford's cell to unlock him to collect his medication. Mr Ford apologised for his earlier behaviour and went to the medication hatch.

46. Mr Ford returned to his cell. The officer told him that he would need to move cells. The water from the flood had made the floor unsafe and the door stiff. Mr Ford said that he did not want to move. He resisted the move and officers initially applied handcuffs, which they quickly removed when he agreed to move to the new cell.

47. Later on, Mr Ford came out of his cell during the association period but had limited interactions with other prisoners. He was mainly sitting on the stairs and watching the other prisoners on the wing. At 4.45pm, he collected his meal, and on return to his cell appeared to be angry. An officer asked if he was okay, but Mr Ford threw an empty plastic container towards him. The officer told him that this was unacceptable behaviour and that he would reduce his privileges. He was no longer entitled to a television.

48. At 8.44pm the prisoner in the cell next to Mr Ford activated his cell call bell. An Operational Support Grade (OSG) responded, and the prisoner told him that Mr Ford was being disruptive. The OSG tried to speak to Mr Ford via his observation panel, but Mr Ford swore and spat towards him. The OSG therefore left the cell. He did not hear, or hear about, any further disruption from Mr Ford's cell.

49. The prisoner on the other side of Mr Ford later told staff that he could hear Mr Ford shouting and moving about his cell until approximately midnight. He then heard snoring. Staff do not check on prisoners through the night unless there are specific arrangements in place, for example ACCT monitoring. Mr Ford was not subject to any special arrangements, and he did not activate his cell call bell, so staff did not see him overnight.

2 March

50. When the OSG began his morning routine check, CCTV shows that he reached Mr Ford's cell at 5.12am. Mr Ford was apparently asleep on the floor. The OSG said that he had previously worked night shifts on the wing and had seen Mr Ford sleeping on the floor before. He said that he noted chest movement and moved on. However, there was something that left him unsatisfied, and he later returned to the cell to check on Mr Ford again. CCTV shows this was at 5.36am. The OSG thought he saw movement and heard breathing. He returned to the cell at 6.00am and once more thought he could see movement but was concerned that something was not quite right. He tried to get a response from Mr Ford, without success.

51. Shortly after, two officers arrived to collect prisoners who were due to attend court that morning. While they were unlocking cells, the OSG asked them to check on Mr Ford as he had not been able to get a response from him. They went to the cell, and Officer A opened the door. CCTV shows this was at 6.15am. Mr Ford did not move, and Officer A asked Officer B to radio for a member of healthcare staff. As he went further into the cell, he saw blood around Mr Ford's head. He told Officer B to call a code blue emergency (meaning a prisoner unconscious and/or having difficulty breathing). This prompted the control room to call an ambulance. Ambulance Service records show that the call was received at 6.16am.

52. Officer A checked for a pulse, but was unable to find one, noting that Mr Ford was stiff and cold. He tried to move Mr Ford in order to begin cardiopulmonary resuscitation (CPR), but his body was too stiff to move. Another officer arrived and also checked Mr Ford but was also unable to find a pulse and could not move his

arms because they were stiff. Two nurses arrived and one of them assessed Mr Ford. He was not breathing, had no pulse, and there was evidence of rigor mortis. Ambulance paramedics arrived at 6.25am and assessed Mr Ford. At 6.30am they confirmed that he had died.

Contact with Mr Ford's family

53. A member of Chelmsford's chaplaincy team was appointed as family liaison officer (FLO). He identified Mr Ford's recorded next of kin and, with a colleague, travelled to their address to inform them of what had happened. There was nobody at the property and the telephone number listed went straight to voicemail. They returned on two occasions and attempted telephone contact but did not receive a response.

54. The following day, local police provided contact details for Mr Ford's mother. The FLO and a colleague travelled to her address and told her what had happened. In line with guidance, Chelmsford offered a contribution to the costs of Mr Ford's family.

Support for prisoners and staff

55. After Mr Ford's death, a senior 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.

56. The prison posted notices informing other prisoners of Mr Ford'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 Ford's death.

Post-mortem report

57. Post-mortem tests showed that Mr Ford died as a result of dilated cardiomyopathy, a disease of the heart. The pathologist found no signs of other non-natural factors that caused or contributed to Mr Ford's death. Toxicology test results showed no significant findings.

Findings

Mr Ford's healthcare

58. The clinical reviewer concluded that Mr Ford's physical and mental healthcare was equivalent to that which he could have expected to receive in the community. Mr Ford did not report any physical health issues and so it is unclear if he was experiencing any symptoms related to his heart disease.

59. Clinical staff identified Mr Ford's mental health issues, reconciled his medications and completed weekly reviews to monitor his conditions. When he did not comply with his medications, staff encouraged him to do so or brought it to his cell.

Emergency response

60. Policy on entering cells at night is contained in Prison Service Instruction (PSI) 24/2011 *Nights Function – Management and Security of Nights.* The PSI says that night staff may unlock a cell on their own if there is or appears to be immediate danger to life. Staff must perform a dynamic risk assessment and should not take action that they feel would put them in danger.

61. When conducting the roll check, the OSG saw Mr Ford apparently asleep on the cell floor. He had seen Mr Ford sleeping on the cell floor previously and did not think it unusual. OSGs on night duty do not carry cell keys but have an emergency key in a sealed pouch. He said in interview that he was confident that he noted movement from Mr Ford and that this was not an emergency situation. He returned to make sure that Mr Ford was okay, and again thought he noted movement. When he returned a third time, he tried to gain a response from Mr Ford but did not get one. In interview he said that he still did not think this was an emergency, but when the prison officers who had standard cell keys came onto the wing, he asked them to check on him.

62. In response to the learning, Chelmsford have issued notices to staff instructing them to obtain a positive response from prisoners during routine checks to ensure they are safe and well. Even though the OSG did not think the situation was an emergency, he did not call for assistance when he was unable to get a response from Mr Ford.

63. Following Mr Ford's death, the Head of Safety, Segregation, Diversity and Inclusion and the Safer Custody Department manager met the OSG to discuss the learning. They ensured that he understood the circumstances in which he was able to enter a cell and explained that if he had concerns about a prisoner then he should attempt to get a response from that prisoner and call for assistance. The Safer Custody Department manager also issued a notice to all staff reminding them of previously published material stressing the need to gain a positive response from prisoners during checks. Given Chelmsford have taken steps to address the learning with the OSG and the wider workforce, we do not make a recommendation.

Inquest

64. The inquest, held on 15 March 2024, concluded that Mr Ford died from natural causes.

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