Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Esson, a prisoner at HMP Rochester, on 12 February 2022

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.

If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Stuart Esson died in hospital on 12 February 2022, after he was found hanging in his cell in the Care and Separation Unit (CSU) at HMP Rochester on 10 February. He was 41 years old. I offer my condolences to his family and friends.

Mr Esson had a history of self-harm and suicidal thoughts and had been managed under suicide and self-harm monitoring procedures (known as ACCT) while serving previous prison sentences. He also had a history of poor mental health and substance misuse.

Mr Esson was at Rochester for six weeks and spent all of that time in the CSU. He could be difficult to manage, including that he started more than one dirty protest, and refused to move to a normal wing.

Staff began suicide and self-harm monitoring procedures (known as ACCT) on 8 February, when he tied a ligature around his neck. I am concerned that the decision to reduce the frequency of checks two days later was premature and did not take into account his presentation.

I am also very concerned that an officer failed to complete ACCT checks on Mr Esson on 10 February as they should have done and falsified the record.

The clinical reviewer concluded that the care Mr Esson received at Rochester was of a reasonable standard and equivalent to that which he could have expected to receive in in the community. She was, however, concerned that nursing staff were not sufficiently trained in ACCT procedures. They failed to review Mr Esson's medical information before attending his ACCT case reviews and failed to make relevant entries in his ACCT document.

It is disappointing that a number of the recommendations made in this report relate to record keeping and following required Prison Service policies and procedures.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **November 2023**

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Summary

Events

1. Mr Stuart Esson had a history of mental health problems (and was prescribed antipsychotic medication) and substance misuse. He had been in prison several times before.

2. On 24 October 2021, Mr Esson was remanded to HMP Nottingham. He had a history of starting dirty protests (where a prisoner chooses to defecate or urinate without using the facilities provided and sometimes covers their surroundings, clothing and body in faecal waste). He began one in the transport vehicle on his way to prison and so was taken straight to the prison's Care and Separation Unit (CSU – previously known as the segregation unit).

3. Mr Esson spent the majority of his time in the prison's CSU. He started dirty protests on several occasions. He said that he felt unsafe and asked to be transferred closer to his family in Scotland.

4. On 18 January, Mr Esson transferred to HMP Rochester, which he was angry and disappointed about. He refused to move to a standard wing and so he was again taken to the CSU.

5. At 7.30am on 8 February, an officer found Mr Esson with a ligature around his neck. Mr Esson was conscious but was taken to hospital as a precaution. Prison staff started suicide and self-harm monitoring procedures (known as ACCT). At around lunchtime, Mr Esson discharged himself from hospital and returned to Rochester. He returned to the CSU and staff placed him under constant supervision.

6. On 9 and 10 of February, staff held ACCT case reviews. Mr Esson had been displaying paranoid and impulsive behaviour, but staff reduced his level of observations to four observations per hour on 9 February, and two observations per hour on 10 February.

7. At 1.00pm on 10 February, an officer checked on Mr Esson. She saw him sitting under the sink with a ligature around his neck. The officer radioed an emergency medical code, staff went into the cell and began CPR. Paramedics arrived within ten minutes and took over his care and treatment. At 1.35pm, they took Mr Esson to hospital by emergency ambulance.

8. In hospital, Mr Esson was placed on life support. At 10.20pm on 12 February, it was confirmed that Mr Esson had died.

Findings

Management of ACCT procedures

9. Prison staff appropriately started ACCT procedures on 8 February, after Mr Esson tied a ligature around his neck. However, we consider that the decision to reduce his observations to two an hour on 10 February was inappropriate given ongoing concerns about his presentation, his increased anxiety and his impulsive behaviour.

10. We are concerned that a prison officer failed to complete ACCT checks on Mr Esson on 10 February as she should have done. She also falsified entries in Mr Esson's ACCT document to indicate that checks had been completed when they had not been.

Location in the Care and Separation Unit (CSU)

11. Segregation is known to negatively impact a prisoner's mental state and can increase the risk of suicide or self-harm. Mr Esson was often accommodated in the CSU while serving previous sentences in prison and he had also engaged in dirty protests dating back as far as 2011. His reasons for refusing location on a residential unit were not always clear, but evidence suggests that he used dirty protests as a way of remaining in the CSU.

12. Mr Esson spent the whole of his six weeks at Rochester in the CSU. He refused to move to a wing and staff were attempting to arrange a transfer for him. On the evidence available, it does not seem that being segregated – in itself – negatively impacted on his mental state or level of risk and we concluded it was not inappropriate to house him there.

Mr Esson's Primary and Mental Healthcare

13. The clinical reviewer concluded that the clinical care Mr Esson received at HMP Rochester was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She did, however, identify some areas of concern.

14. The clinical reviewer was concerned that nursing staff were not sufficiently trained in ACCT procedures. They failed to review Mr Esson's medical information before attending his ACCT case reviews and failed to make relevant entries in his ACCT document.

15. Healthcare staff failed to record on the segregation safety algorithm that Mr Esson was prescribed antipsychotic medication, and this was not updated during his time at Rochester. She was also concerned that healthcare staff were not always able to read the prisoner's medical records before completing a safety algorithm.

16. Mr Esson was under the care of the Mental Health Team at HMP Nottingham but there was no formal handover of care between HMP Nottingham and HMP Rochester as there should have been.

Response to Mr Esson's concerns about his safety

17. Mr Esson believed that he was under threat from other prisoners on the CSU. Although this issue was recorded in the ACCT case reviews, we found no evidence that staff investigated Mr Esson's concerns.

Record Keeping

18. We found various examples of poor record keeping at Rochester, including in important segregation paperwork, contrary to national guidance.

Mr Esson's transfer from HMP Nottingham to HMP Rochester

19. Prison staff failed to carry out the correct procedures when transferring Mr Esson from HMP Nottingham to HMP Rochester.

Recommendations

- The Governor at HMP Rochester should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
    - staff understand the need to consider a prisoner's risk factors when assessing risk and that the level of observations is agreed by all those present at the review and reflects the immediate concerns; and
    - staff conduct ACCT observations in line with what is set out in the prisoners individual ACCT document and record these appropriately.
- The Governor should inform the PPO of the outcome of the disciplinary investigation into the actions of Officer A.
- The Head of Healthcare at HMP Rochester should ensure that:
    - healthcare staff read the prisoner's medical history prior to attending ACCT case reviews;
    - healthcare staff record their involvement with the ACCT case review in the ACCT document in accordance with PSI 64/2011; and
    - all healthcare staff complete the full two-day ACCT training course (version six).
- The Head of Healthcare at HMP Rochester should ensure that healthcare staff:
    - receive appropriate training to competently carry out segregation safety algorithm assessments; and
    - read any available medical history prior to undertaking a segregation safety algorithm.
- The Heads of Healthcare at HMP Rochester and HMP Nottingham should ensure there is a formal mental health handover when a prisoner is transferred between prisons.
- The Head of Healthcare and Mental Health In-Reach Manager should review and ensure that:
    - the roles and responsibilities of newly qualified nurses are appropriate to their level of experience and competency, and
    - newly qualified nurses receive appropriate ongoing support and supervision from managers and a mentor.

- The Governor of Rochester should ensure that any concerns raised by a prisoner about their safety are properly investigated and recorded appropriately.

- The Governor at HMP Rochester should:

    - review the current process for recording daily interactions, visits from other agencies and the regime for prisoners in the Care and Separation Unit and satisfy themselves that it fully adheres to the guidance set out in PSO 1700 Segregation;

    - review the current process for storing documentation and ensure it complies with PSO 1700 Segregation,

    - ensure CSU staff notify the Independent Monitoring Board when a prisoner is located in the Care and Separation Unit and that the safety algorithm is completed correctly to indicate that this action has been completed, and

    - ensure that dirty protests are managed in accordance with PSO 1700 Segregation, the Health and Safety at Work Act 1974 and COSHH Regulations 1999.

- The Governors of HMP Rochester and HMP Nottingham must ensure that when a prisoner located in the CSU is to be transferred every aspect of the process follows the guidance as set out in PSO 1700 Segregation.

The Investigation Process

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

21. The investigator visited Rochester on 22 February 2022. He obtained copies of relevant extracts from Mr Esson's prison and medical records.

22. The investigator interviewed 13 members of staff at Rochester and Nottingham between 22 March and 26 May.

23. NHS England commissioned a clinical reviewer to review Mr Esson's clinical care at the prison. The investigator and clinical reviewer completed a joint interview with the Head of Healthcare on 17 May.

24. We informed HM Coroner for Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

25. The Ombudsman's family liaison officer contacted Mr Esson's family to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. They did not ask any questions.

26. Mr Esson's family were provided with a copy of our initial report but did not respond to our findings.

27. HMPPS responded to our initial finding and accepted the recommendations made.

28. An inquest into Mr Esson's death was concluded on 22 January 2024. A jury found the cause of death to be suicide, but made the following comments:

    '… On the 10th of February 2022 at 13.05 (approx) Stuart Esson was discovered in cell 108 of the CSU at H.M.P. Rochester with a ligature around his neck which was secured to the wash basin. He was transferred to Medway Maritime Hospital in Gillingham where he was put on life support. On the 12th of February 2022, he was taken off life support and he was declared deceased, In addition, we are satisfied that the following circumstances are relevant to the death of Mr Esson: (i) Prison officers not having received sufficient information regarding his history, complexity and needs (ii) Independent Monitoring Board was not contacted which should have been paramount (iii) Segregation paperwork was apparently not managed in accordance with national guidance (iv) Falsification of records in relation to observations undertaken on 10th February 2022 (v) Lack of investigations into Mr Esson's concerns of threats from other prisoners which must have been a constant frustration and a known trigger (vi) The jury agreed that the prescribed antipsychotic medication was not recorded.

    We the jury believe that Stuart Esson did suspend himself by fashioning a ligature from his bedsheet. It was his intention to take his own life. It is possible that these issues contributed to Stuart Esson's death: (i) The evaluation of risk of self-harm to Stuart Esson on 10th of February 2022 (ii) the levels of observation put in place

after the ACCT review on 10th of February 2022 (iii) The level of training and experience involved in the ACCT review on 10th of February 2022 …'

Background Information

HMP Rochester

29. HMP/YOI Rochester is a Category C resettlement prison, holding up to 695 adult and young male prisoners across seven residential units, and a separate Care and Separation Unit (CSU.) Oxleas NHS Foundation Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

30. The most recent inspection of HMP/YOI Rochester was in October 2021. Inspectors reported that the documented reasons for segregation were generally adequate, but behaviour targets were generic, healthcare staff did not always attend segregation reviews, and little attention was paid to reintegration planning, with objectives which were not tailored to the individual prisoner. Some useful data was presented at the segregation monitoring and review group, but inspectors said that it was not clear how this information was used to effect change.

Independent Monitoring Board

31. 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 March 2021, the IMB reported that the way in which Good Order and Discipline reviews were handled had changed and had taken some time to settle in. The Board found that most reviews and adjudications were conducted carefully, fairly and appropriately.

Previous deaths at HMP Rochester

32. Mr Esson was the third prisoner to die at Rochester since April 2018. Of the previous deaths one was self-inflicted, and one was from natural causes. There are no similarities between the findings in this investigation and previous ones.

Assessment, Care in Custody and Teamwork

33. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide 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.

34. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

Key Events

35. On 6 August 2018, Mr Stuart Esson was sentenced to 40 months in prison for burglary. On 9 April 2020, he was released from prison but a year and a half later, he was recalled to HMP Nottingham for burglary and driving offences.

1. **HMP Nottingham**

36. On 24 October 2021, on his way from court to HMP Nottingham, Mr Esson started a dirty protest in the transport vehicle. As a result, when he arrived at the prison, he was taken straight to the Care and Separation Unit (CSU), and he did not go through the normal reception procedures.

37. In the CSU, an officer completed Mr Esson's first night interview. He recorded that Mr Esson had a history of self-harm and suicidal thoughts and had previously been managed under suicide and self-harm monitoring procedures (known as ACCT). Mr Esson denied any current thought or intent to harm himself. The officer also recorded that Mr Esson had mental health issues and had a history of substance misuse. He noted that he had been assessed as being a high risk to other prisoners because he had a history of assaulting other prisoners and using unauthorised weapons.

38. Because Mr Esson was on a dirty protest and refused to comply with staff instructions, nursing staff were unable to complete his initial health screening (which should take place on the day the prisoner arrives). A nurse completed a segregation safety algorithm and concluded Mr Esson was medically fit to be held in the CSU and referred him to the prison's mental health team for assessment.

39. On 28 October, a nurse completed Mr Esson's initial health screen. Mr Esson said that he had self-harmed within the past twelve months and had previously overdosed with medication. His current medication was recorded as pregabalin (used to treat anxiety) and olanzapine, an antipsychotic medication used in the treatment of schizophrenia and bi-polar disorder. Mr Esson had been prescribed this medication to treat his diagnosed complex personality disorder (PD).

40. Later that day, Mr Esson agreed to move from the CSU to G wing.

41. On 9 November, a mental health worker completed a mental health assessment. Mr Esson engaged well and was pleasant and polite. She recorded that there was no evidence that Mr Esson was at risk from himself. Mr Esson told her that he had been diagnosed with generalised anxiety disorder and personality disorder and had experienced significant paranoia. He said that he started dirty protests in prison because he was told that prison officers would not assault him if he was covered in faeces. He also said that he liked covering himself in faeces and admitted that this was unusual. He said that he always overthought situations which led to frustration and occasionally self-harm, including banging his head against walls or solid objects and punching objects, and said that he would like to address this. She recorded that Mr Esson was under the care of the mental health team and that a further appointment was booked for the following week.

42. Mr Esson spent some time on G wing, but staff found his behaviour challenging, and, on 13 November, he was moved back to the CSU.

43. On 24 November, Mr Esson was sentenced to a further two years and four months in prison for the offences that led to his recall.

44. Over the following weeks, Mr Esson engaged in several dirty protests. He told staff that he would only end his protests if staff arranged for him to transfer to another prison.

45. On 31 December, a Senior Probation Officer (SPO) and the Deputy Governor saw Mr Esson in the CSU. The Deputy Governor told Mr Esson that she would pass on his request for a transfer to the relevant department and acknowledged that he said he wished to go to HMP Oakwood because he had previously said that he felt safe there. Mr Esson said that his home was in Aberdeen and that he intended to live there after his release.

46. Over the weeks that followed, Mr Esson began to settle in the CSU. Staff continued to explore the possibility of his transfer to another prison, but Oakwood refused to take him. On the 18 January, arrangements were made for his transfer to Rochester prison, but no one discussed this with him.

HMP Rochester

47. Mr Esson transferred to Rochester on 20 January 2022. On his arrival, Mr Esson told staff that he would not move to the wing and so he was placed in the CSU. The duty manager that day told the investigator that his first knowledge of Mr Esson was when he refused to move on to the wing. Staff gave him a brief background including that Mr Esson had thought he would be moving north to be nearer his family in Scotland. The duty manager was not aware of Mr Esson's challenging behaviour and dirty protests or that he had spent the majority of his time in the CSU at Nottingham.

48. The duty manager said that he signed the paperwork confirming that Mr Esson would be held in the CSU under prison rule 53 (where a prisoner is to be charged with an offence against discipline at an adjudication hearing), for his refusal to move on to a wing. He told the investigator that he would have gone to the CSU to complete the documentation and would also have completed a section of the safety algorithm. However, the safety algorithm was not signed by a manager until the next day. Prison staff also failed to notify the Independent Monitoring Board (IMB) that Mr Esson had been located in the CSU as they should have done.

49. A nurse saw Mr Esson in the CSU to complete the medical section of the safety algorithm. He told her that he had just been transferred, that he was fine and just wanted his medication. She administered his medication. She then completed the safety algorithm paperwork but wrongly answered 'no' to the question whether the individual was in receipt of or had been prescribed antipsychotic medication.

50. The following day, a senior nurse saw Mr Esson to complete his initial health screen. Mr Esson was angry that he had been transferred to Rochester. He said that he would be starting a dirty protest that day. Mr Esson said that he did not have any thoughts or intent to harm himself. She recorded that Mr Esson was anxious, agitated and very on edge, but that he was polite and had engaged in conversation. She also noted that Mr Esson had previously used illicit drugs but declined any support from the prison's substance misuse team.

51. The senior nurse noted that Mr Esson had previous contact with mental health services and that he had a history of personality disorder and schizophrenia (although there was no evidence of a formal diagnosis of the latter). She completed a routine referral to the mental health team, due to both his history of mental health issues and because she knew that time in the CSU could cause further mental health problems.

52. On 21 January, a duty governor completed the CSU daily duty governor rounds and saw Mr Esson. He signed the safety algorithm and recorded that that Mr Esson had presented as a really angry individual. He told Mr Esson that if he agreed to move to a residential wing it would be easier to deal with his issues, but Mr Esson said that he would not leave the CSU. The duty governor spoke to the Head of the Offender Management Unit (OMU) to get more information about why Mr Esson had been transferred to Rochester. He said that he was told that Mr Esson was transferred there because of his previous poor behaviour and that Nottingham had accepted two prisoners from Rochester in return. There is no evidence to indicate that a review took place to explore the reasons why Mr Esson refused to move to the wing.

53. On 24 January, a mental health nurse completed a desktop triage on the mental health referral the senior nurse had submitted. She reviewed Mr Esson's medical record. She told the investigator that she had no immediate concerns about Mr Esson's well-being and that, as a result of her triage, he would be seen weekly as a part of the mental health team's CSU rounds, rather than being added to the mental health in-reach team's caseload. She said that she was not aware of any handover of Mr Esson's care from the mental health or healthcare team at Nottingham.

54. Nursing staff and senior prison staff continued to see Mr Esson daily in the CSU, but they did not record all the contact they had with him in his electronic prison record as they should have done. The prison said that this was an oversight.

55. On 2 February, an officer recorded that Mr Esson's behaviour was beginning to deteriorate because he only wanted to transfer to two other prisons. She noted that he said he had assaulted staff in the past and was refusing to listen to staff who tried to offer him advice. He said that he would start a dirty protest soon and had asked for bags to put his clothing and property in.

56. The officer told the investigator that she knew very little about Mr Esson. She said that after a couple of days, a member of the mental health team telephoned the CSU to inform them that they had looked at Mr Esson's mental health history, that he had a number of mental health issues and staff should be aware of him (the same information was recorded in Mr Esson's medical record). She said that after receiving this information, staff were wary of Mr Esson when unlocking him because his behaviour could be 'up and down'.

57. On 3 February, a Custodial Manager (CM) recorded on Mr Esson's record that he had read the previous entry by the officer and following previous conversations that he had with Mr Esson, he found his mood increasingly erratic and unpredictable. He recorded that he had instructed CSU staff that they should only unlock Mr Esson when three officers were present. He recorded no concerns about Mr Esson's risk of suicide or self-harm.

58. On 6 February, an officer recorded that Mr Esson had declined all activities offered to him, including exercise, his lunch and dinner. He told staff that he believed everyone in the CSU was after him. He had also passed notes to staff saying that he believed that both he and his family were under threat and that he was fearful for his and his family's safety. There is no evidence to indicate that staff explored or followed up his concerns.

59. On 7 February, the prison held a complex case review meeting to discuss Mr Esson because he continued to refuse to move to a wing. Those who attended expressed concern about Mr Esson's mental state and noted that he had requested a transfer to either a Category C or B prison or a forensic psychiatric hospital. Staff recorded that Mr Esson was refusing to engage and that he had been writing letters of concern about his family's safety. A nurse considered that his behaviour was in line with his diagnosis of personality disorder. She recorded that Mr Esson was to be added to the mental health team's referral caseload and that the Mental Health In-Reach Team (MHIRT) would review him.

Events of 8 and 9 February

60. At 7.05am on 8 February, an officer began checking prisoners on the CSU. She looked through the observation panel of Mr Esson's cell and saw him sitting on the floor with a ligature around his neck. She radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties) and control room staff called an ambulance immediately. Staff attended, entered Mr Esson's cell and released the ligature from his neck. Mr Esson was conscious and breathing but was gasping for air. As a precaution, staff sent him to hospital, accompanied by officers. They also started suicide and self-harm prevention procedures (ACCT).

61. Mr Esson was in hospital for a few hours. He refused further treatment and discharged himself from hospital and returned to the prison around lunchtime.

62. Prison staff placed Mr Esson under constant supervision in a safe cell (a cell with a gate instead of solid door to allow for additional monitoring, and sometimes with reduced ligature points) in the CSU. He was unhappy about this and at 12.10pm, he started a dirty protest. He smeared faeces over his body and on the inside of the gate of his cell. He stopped his dirty protest at around 1.30pm and cleaned up his faeces.

63. At 3.00pm that afternoon, a senior manager chaired an ACCT case review. Mr Esson said that he did not want to be under constant supervision and that he did not mean to harm himself when he tied the ligature around his neck. The meeting recorded that Mr Esson was very paranoid about other prisoners on the unit attacking him. He denied any previous suicide attempts or self-harm, but staff checked his prison record and noted that ACCT procedures had been started thirteen times in the past. The manager recorded that Mr Esson's suicide attempt was significant and that his mood had not stabilised enough to reduce the level of observations. The meeting agreed that Mr Esson should remain under constant supervision.

64. A mental health nurse attended the review and recorded on Mr Esson's medical record that Mr Esson came to the meeting asking to be taken off constant supervision. He recorded that the ligature mark around Mr Esson's neck was very

prominent and red. Mr Esson continued to request a transfer north. Mr Esson was not willing to hear about the difficulties in securing a transfer for him. Staff told him that it would take time and that they were doing their best.

65. Mr Esson said that he was under threat from other prisoners who had labelled him a "grass" and that they had a plan to steal keys from staff and enter his cell and attack him. Mr Esson said that he would sit with his back to the cell door to prevent it from opening. Despite Mr Esson voicing his concerns about his safety and believing that he was under threat, there is no evidence that staff investigated his concerns or looked into the matter further.

66. Despite his protests about being under constant supervision, Mr Esson settled down and no issues were recorded for the remainder of the day.

67. At 2.20pm on 9 February, a senior manager chaired a multidisciplinary constant supervision review meeting. Mr Esson presented as much better, and the manager recorded that he was calm and not agitated. Mr Esson had been engaging well with the officer covering his constant supervision, had eaten, and had slept for around 8 hours. Mr Esson said that he had not intended to take his own life the day before, but it was a 'moment of madness'.

68. A nurse attended the review and recorded on Mr Esson's medical record that he was calm and kempt in his appearance, was feeling much better in his mental state and that he had said that he had not been in a good place the previous day. Staff told Mr Esson that he needed to be open to engaging with the mental health team, which he agreed to do. The review team agreed that the frequency of observations would be gradually reduced from constant supervision to observations every fifteen minutes (four per hour).

Events of 10 February

69. On 10 February, a duty governor visited the CSU that morning. When she went to speak to Mr Esson, he talked very quietly, almost whispering, and said, 'I really need to speak to you on your own'. She said that such requests are not unusual and that she told Mr Esson she would come back to speak to him when she had completed her duty governor rounds.

70. At around 11.00am, when she had completed her rounds, the duty governor asked an officer to bring Mr Esson to the adjudication room to speak to her. However, while she was waiting, other staff arrived to attend Mr Esson's ACCT case review. She said that she wanted to stay for the review because Mr Esson had asked to speak to her. When Mr Esson came into the room, he told her that he was 'under terrible threat' on the unit. She said that she tried to reassure him that the other prisoners had not been unlocked at the same time as him and that he was safe, but she said that this seemed to do little to alleviate his anxiety. She said that she did not stay for the entire ACCT case review as she was needed elsewhere.

71. A SO chaired the ACCT case review. Staff from the safer custody team, chaplaincy and a nurse also attended. The SO recorded that Mr Esson was very paranoid and spoke about other prisoners trying to gain access to his cell and attack him. The meeting tried to reassure him that he was safe on the unit. However, Mr Esson spoke about other prisoners overpowering staff to get their keys to open his cell.

The SO said that he tried to move the conversation forward to find out how Mr Esson was doing, but Mr Esson kept going back to the belief that he was going to be attacked.

72. After telling the review group about his fears, Mr Esson left the room and returned to his cell. The meeting continued to discuss Mr Esson's behaviour and presentation without him and recorded that it was a concern. The nurse told the meeting that the psychiatrist was visiting the following Monday and that she would try and get them to see Mr Esson. The meeting recorded that Mr Esson could be impulsive and as such, should remain on a high level of observations. They reduced the frequency of observations from four per hour to two per hour. The meeting did not feel that there was any indication that Mr Esson would attempt suicide again or self-harm.

73. The SO told the investigator that they reduced the level of observations because the meeting did not feel that there was any indication that Mr Esson was at risk of suicide or self-harm. He said that Mr Esson was just focused on what would happen to staff and how other prisoners would attack them to get to him. He said that Mr Esson was paranoid, but that staff would carry out extra checks on him.

74. The nurse told the investigator that Mr Esson was more agitated during the review than he had been the previous day. She said that he was showing more signs of paranoia about what might happen to him, but staff constantly reassured him that he was safe. She agreed that Mr Esson's presentation was more negative than the previous day. When asked whether she was happy with the decision taken to reduce observations, she told the investigator that she could not recall any discussion taking place on the level or frequency of the observations.

75. CCTV shows that at 11.09am, Mr Esson returned to his cell. At 11.27am, an unidentified officer handed Mr Esson his lunch. At this time, staff did not update Mr Esson's ACCT document to indicate if they had any interaction with him, but at 12.00pm, Officer A made an entry in the ACCT document to say that she had completed an observation check. CCTV footage shows that she did not check him. During that morning, she made several entries in the ACCT document recording that she had completed observation checks but, again, CCTV shows that she did not do so.

76. At 12.30pm, Officer B arrived for her shift on the CSU and staff provided a handover. She told us that she was not advised of any relevant issues with Mr Esson and staff did not mention anything about the ACCT case review that took place earlier that morning.

77. At 12.35pm, Officer B completed a routine count of all prisoners in the CSU. She looked into Mr Esson's cell, and he was sitting on the floor and appeared to be writing. She asked him if he was all right and he said, 'yes, thanks'. She continued with the count.

78. At 1.00pm, Officer B said that she passed Mr Esson's cell as she was leaving the unit. She decided to look in on him because an ACCT observation was due. She looked through the observational panel of his cell door and saw him sitting beneath the sink with a ligature around his neck, attached to the taps. She said that she

called to Mr Esson and kicked the door to try and get a response, but he did not respond. She then radioed a code blue.

79. Officer B said that she remained at the door but did not immediately enter the cell. She said that she completed her own dynamic risk assessment and took into consideration that she was on her own and was aware that Mr Esson had a history of threatening violence and unpredictable behaviour. Another officer attended within a minute, and they immediately entered the cell and cut the ligature from around Mr Esson's neck then started CPR.

80. More prison and nursing staff arrived, and they moved Mr Esson from his cell onto the landing. Staff attached a defibrillator while others continued with CPR. Paramedics arrived ten minutes later and continued with Mr Esson's care and treatment. An air ambulance responded to the incident, but Mr Esson was not stable enough to be taken to hospital by air and instead was taken by road.

81. On arrival at hospital, Mr Esson was placed on life support. As was routine at that time, Mr Esson was tested for the COVID-19 virus and the result was positive. It was agreed between the prison and hospital that Mr Esson's next of kin would be informed and allowed time to get to the hospital before any other decisions were made. Further tests confirmed that Mr Esson had no brain activity and in consultation with his next of kin, a decision was made to withdraw life support.

82. At 10.20pm on 12 February, it was confirmed that Mr Esson had died.

83. Following Mr Esson's transfer to hospital, prison staff searched his cell and found a note he had written which said that his next of kin details could be found on his telephone account, that he loved his family, but had had enough of life.

Contact with Mr Esson's family

84. An officer was appointed as the prison's family liaison officer. She kept regular contact with Mr Esson's next of kin and offered support.

85. The prison contributed towards the costs of Mr Esson's funeral in line with national policy.

Support for prisoners and staff

86. After Mr Esson was taken to hospital, all staff including those from the healthcare team were debriefed to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support to staff.

87. The prison posted notices informing other prisoners of Mr Esson's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Esson's death.

Post-mortem report

88. The post-mortem report gave Mr Esson's cause of death as irreversible hypoxic cerebral hypoxia caused by hanging. No illicit drugs were detected in Mr Esson's body.

Findings

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

89. 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 (known as ACCT) that staff should follow when a prisoner is assessed as being at risk of suicide and self-harm.

90. Prison Service Order (PSO) 1700, Segregation states that a prisoner on an open ACCT plan must only be kept in segregation under exceptional circumstances whereby they are such a risk to other that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate.

91. Prison staff started ACCT procedures for Mr Esson on 8 February 2022, when they found him with a ligature around his neck in his cell. ACCT procedures remained open and on his return from hospital that afternoon, staff placed him under constant supervision because of the perceived level of risk. A multidisciplinary review was held the same day and it was decided to keep the same frequency of observations in place. The next day, the review group reduced the level of observations to four per hour. We have concluded that this first reduction in observations was reasonable given that Mr Esson's presentation had improved. We also consider it was reasonable given Mr Esson's continued refusal to relocate elsewhere, for him to have remained on the segregation unit after the ACCT was opened.

92. However, we are concerned that, during the review meeting on 10 February, a SO, the safer custody staff, chaplaincy and a nurse reduced the frequency of Mr Esson's observations to two per hour on the basis that there was no indication that he would attempt suicide or self-harm. We consider that this was premature and not based on an objective assessment of his risk. Mr Esson had ligatured on 8 February and repeatedly denied that he had any thoughts of doing so. He was a complex man with challenging behaviour, housed in the CSU. Staff also had ongoing concerns that he could be impulsive, was very paranoid and continued to believe that he was going to be attacked despite assurances. Mr Esson had walked out of the review and staff considered that his behaviour and presentation was a concern. Despite these factors, and the group agreeing he should remain on a high level of observations, the SO recorded that the frequency of observations would reduce to two per hour. We do not consider this to be a high level of observations and conclude that the reduction in the frequency of observations was premature.

93. Our investigation found that, on 10 February, Officer A falsified the ACCT documents. She recorded that she had carried out Mr Esson's ACCT observation checks but CCTV footage shows that she did not do so. While the lack of observations did not impact directly on Mr Esson's death, in other cases, poor practice and falsifying documents could have a far more serious outcome.

94. The Governor told us that he is conducting an internal disciplinary investigation into Officer A's actions. We make the following recommendation:

The Governor at HMP Rochester should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **staff understand the need to consider a prisoner's risk factors when assessing risk and that the level of observations is agreed by all those present at the review and reflects the immediate concerns; and**

- **staff conduct ACCT observations in line with what is set out in the prisoners individual ACCT document and record these appropriately.**

The Governor should inform the PPO of the outcome of the disciplinary investigation into the actions of Officer A.

Location in the Care and Separation Unit (CSU)

95. PSO 1700 Segregation, acknowledges the specific risks of holding vulnerable prisoners in segregation. It notes that rates of suicide among segregated prisoners is high, and that segregation should only be used as a last resort. Prisoners monitored under ACCT procedures can be segregated but only when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate. We have considered whether, in the circumstances, it was appropriate to hold Mr Esson in the segregation unit when his risk of suicide and self-harm was raised, and he was on an ACCT.

96. Mr Esson had spent a large amount of time in CSU's while serving previous sentences in prison and he had also engaged in dirty protests dating back as far as 2011. His prison record notes that he often asked to be segregated rather than remain on a standard wing. His reasons for refusing location on a residential unit were not always clear, but evidence suggests that he used dirty protests as a way of remaining in the CSU.

97. Mr Esson was at Rochester for around six weeks and spent of that time in the CSU. When he arrived at Rochester, Mr Esson immediately refused to move onto the wing. Staff clearly found him challenging to manage and he engaged in at least one dirty protest at Rochester. Staff were trying to arrange a transfer for Mr Esson, but this was not easy due to his history of difficult behaviour. We consider that being segregated did not seem, on the evidence available, to have added to Mr Esson's distress or risk and it is difficult to see how Rochester could have managed this differently.

Mr Esson's Primary and Mental Healthcare

98. The clinical reviewer concluded that the clinical care Mr Esson received at Rochester was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She did, however, identify some areas of concern.

99. The clinical reviewer was concerned about the lack of informed healthcare input into Mr Esson's ACCT. She considered that the decision to reduce Mr Esson's ACCT observations did not take into account the well-documented link in his medical record between his episodes of emotional dysregulation and his increased risk of suicide and self-harm, and that he had a very recent incident of ligaturing two days

earlier. The Head of Healthcare told us that there were gaps in ACCT training for healthcare staff.

100. The clinical reviewer also found that healthcare staff did not consistently record their involvement with Mr Esson in his ACCT document as they should have done, which is a mandatory requirement of PSI 64/2011.

101. She was also concerned that the nurse who attended most of Mr Esson's ACCT case reviews, was a newly qualified member of staff and had significant decision-making responsibility at those reviews given his complex mental health history and risk profile. The Head of Healthcare acknowledged that newly qualified staff needed sufficient support and experience before managing complex prisoners. The clinical reviewer considered that it was still early days in the nurse's career at HMP Rochester and she needed more training and support. We recommend:

The Head of Healthcare at HMP Rochester should ensure that:

- **healthcare staff read the prisoner's medical history prior to attending ACCT case reviews;**
- **healthcare staff record their involvement with the ACCT case review in the ACCT document in accordance with PSI 64/2011; and**
- **all healthcare staff have received ACCT training.**

102. The clinical reviewer noted that another nurse made an error on the CSU safety algorithm and failed to indicate that Mr Esson was on antipsychotic medication. The error was not corrected during his time at Rochester. She was also concerned that the nurse did not know that there was a section for recording antipsychotic medication on the safety screen. She considered that while, on balance, this did not have an adverse impact on Mr Esson's care, the section on antipsychotic medication forms part of the safety algorithm assessment for important reasons and needs to be addressed for future cases. We recommend:

The Head of Healthcare at HMP Rochester should ensure that healthcare staff:

receive appropriate training to competently carry out segregation safety algorithm assessments; and

- **read any available medical history prior to undertaking a segregation safety algorithm.**

103. Based on his mental health history, a senior nurse appropriately made a routine referral to the prison's mental health in-reach team when Mr Esson arrived at Rochester. The referral was triaged three days later by a nurse, who decided, based on his history, that he did not need to be placed on the team's caseload at that time, or undergo a more detailed mental health assessment. However, the nurse noted that Mr Esson would continue to be seen by nursing staff daily and a member of the mental health team weekly as part of their routine CSU rounds.

104. Although he was not on the mental health team's caseload, staff from the team attended all ACCT reviews, and arrangements were made on 10 February for Mr

Esson to be seen by a visiting psychiatrist the following week. The clinical reviewer was satisfied that Mr Esson received appropriate mental health support at Rochester.

105. At HMP Nottingham, Mr Esson was under the care of the mental health team but there was no formal handover of care between the healthcare teams at HMP Nottingham and HMP Rochester. A formal handover of care, as set out in PSO 3050 Continuity of healthcare for prisoners, would have informed a proactive approach to the mental health care available to him at Rochester. We recommend:

2. **The Heads of Healthcare at HMP Rochester and HMP Nottingham should ensure there is a formal mental health handover when a prisoner is transferred between prisons.**

3. The Head of Healthcare and Mental Health In-Reach Manager should review and ensure that:

- **the roles and responsibilities of newly qualified nurses are appropriate to their level of experience and competency, and**
- **newly qualified nurses receive appropriate ongoing support and supervision from managers and a mentor.**

106. The clinical reviewer made an additional recommendation about IT access for healthcare staff which we do not repeat in this report but which the Head of Healthcare will need to address.

Staff response to Mr Esson's concerns about his safety

107. Mr Esson told staff that he feared for his and his family's safety. He passed notes to CSU staff saying that he believed that he was under threat from other prisoners on the unit and voiced these concerns during the ACCT case reviews.

108. We accept that staff recognised that Mr Esson was showing signs of paranoia, in keeping with his diagnosis of personality disorder. However, we found no evidence that prison staff took any action to investigate Mr Esson's concerns, such as reviewing CCTV to see whether any prisoners had approached his door or speaking with unit staff to assure themselves that he was not, indeed, under threat. We make the following recommendation:

The Governor of Rochester should ensure that any concerns raised by a prisoner about their safety are properly investigated and recorded appropriately.

Record keeping

109. We found various examples of poor record keeping during the investigation, including important segregation and dirty protest documentation. Prison Service Order (PSO) 1700 Segregation sets out the processes that must be followed when a prisoner is segregated, including how often and by whom records should be updated, and how they should be stored.

110. While Mr Esson's NOMIS transfer record indicates that duty managers saw him daily in the CSU, they did not always record their interaction with him in his segregation file as they should have done.

111. The prison was unable to provide us with all of the documents relating to Mr Esson time in the CSU. We received a copy of the safety algorithm, the authorisation for Mr Esson's initial segregation when he arrived at Rochester and the CSU daily record sheets from 24 to 26 January. The prison was unable to locate paperwork relating to Mr Esson's segregation during February.

112. We found no documented evidence that the IMB had been informed when Mr Esson arrived in the CSU at Rochester or that they had subsequently visited him while he was segregated. The relevant section on the safety algorithm had not been completed.

113. PSO 1700 Segregation also provides guidance on how dirty protests should be managed, including the records that must be kept. Mr Esson engaged in dirty protests at Rochester, but we found that processes for recording this were not followed. We make the following recommendation:

The Governor at HMP Rochester should:

- **review the current process for recording daily interactions, visits from other agencies and the regime for prisoners in the Care and Separation Unit and satisfy themselves that it fully adheres to the guidance set out in PSO 1700 Segregation;**
- **review the current process for storing documentation and ensure it complies with PSO 1700 Segregation,**
- **ensure CSU staff notify the Independent Monitoring Board when a prisoner is located in the Care and Separation Unit and that the safety algorithm is completed correctly to indicate that this action has been completed, and**
- **ensure that dirty protests are managed in accordance with PSO 1700 Segregation, the Health and Safety at Work Act 1974 and COSHH Regulations 1999.**

Mr Esson's transfer from HMP Nottingham to HMP Rochester

114. PSO 1700 Segregation clearly sets out guidance for the process that should be followed when a prisoner located in a CSU is transferred to another prison, including how decisions to transfer are made and information that should be shared with a receiving prison.

115. While at Nottingham, Mr Esson made clear his wish to transfer, but said that he particularly wanted to move closer to his home location of Aberdeen. The evidence provided suggests that the decision to transfer Mr Esson to Rochester was made following a meeting with a Deputy Governor and a SPO on 31 December. This was not recorded as a review board and no other parties attended. We saw no evidence that the correct process was followed when pursuing the transfer and we found that little information about Mr Esson was shared with Rochester in advance

of his arrival. This is particularly concerning given Mr Esson's complex and challenging presentation and his known mental health concerns.

116. Mr Esson had not been told he was moving to Rochester in advance and was clearly angry and upset that he was no closer to Aberdeen.

117. We are concerned that the guidance set out in PSO 1700 was not followed in respect of the transfer process or actions that followed. We make the following recommendation:

The Governors of HMP Rochester and HMP Nottingham must ensure that when a prisoner located in the CSU is to be transferred every aspect of the process follows the guidance as set out in PSO 1700 Segregation.

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