

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Daniel Weighman, a prisoner at HMP Chelmsford, on 6 January 2023**

**A report by the Prisons and Probation Ombudsman**

## 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



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Daniel Weighman was found hanged in his cell at HMP Chelmsford on 3 January 2023, and died in hospital on 6 January. He was 38 years old. I offer my condolences to his family and friends.

Mr Weighman told staff on the night of 1 January that he would harm himself. Prison staff considered starting suicide and self-harm prevention procedures (known as ACCT) but did not do so, as they should have done. Two days later, when Mr Weighman harmed himself by making superficial cuts to his neck, staff started ACCT procedures. However, Mr Weighman was found hanged in his cell two hours later.

The clinical reviewer concluded that the healthcare Mr Weighman received at Chelmsford was partially equivalent to that which he could have expected to receive in the community but reported that there were missed opportunities to identify his history of mental health issues. Despite subsequent referrals to the mental health team, he was not assessed at Chelmsford. We also identified the need for healthcare staff to have adequate ACCT training.

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**

**February 2024**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings .....	14

# Summary

## Events

1. On 15 October 2022, Mr Daniel Weighman was recalled to HMP Chelmsford for breaching his licence conditions. He had a history of mental health issues and self-harm. Mr Weighman told the reception nurse that he had no thoughts of suicide or self-harm or any mental health issues. It was noted that he appeared to be in good spirits.
2. During his first months at Chelmsford, Mr Weighman appeared settled and prison staff allowed him to see his brother, who was also at the prison.
3. Mr Weighman was a heavy vape user and would ask his family to transfer money for vapes. Mr Weighman shared a cell and appeared to get on well with other prisoners but preferred to socialise in or near his cell.
4. On 1 January 2023, Mr Weighman threatened to harm himself if he was not given sleeping tablets or moved to a single cell.
5. On 2 January, Mr Weighman's cellmate asked to be moved to another cell as he said Mr Weighman was taking his property and kept him up all night, watching television. Staff moved Mr Weighman's cellmate to another cell the following day to prevent them fighting.
6. On the morning of 3 January, Mr Weighman told staff that he was hearing voices, did not want to leave his cell and wanted to move to the healthcare unit. Staff tried to contact the mental health team to find out if Mr Weighman was under their care but were unable to get through. Later that afternoon, prison staff found Mr Weighman with superficial cuts to his neck and started suicide and self-harm monitoring procedures, known as ACCT.
7. At around 6.24pm, officers found Mr Weighman unresponsive in his cell. When staff went into the cell, they found that he had tied a ligature around his neck. Officers and emergency response staff started resuscitation procedures. Ambulance paramedics arrived and Mr Weighman was taken to Broomfield Hospital for further treatment. However, he died on 6 January.

## Findings

8. On 1 January, Mr Weighman told staff that he would harm himself if he was not given sleep medication. Although staff considered starting ACCT monitoring procedures, they did not do so and missed an opportunity to assess his risk. Staff did not record why they decided not to start ACCT procedures.
9. Healthcare staff had not received adequate ACCT training.
10. Staff at Chelmsford had no meaningful contact with Mr Weighman. The keyworker scheme was not operating fully at the time due to staffing pressures. We cannot not know if Mr Weighman would have shared his anxieties with staff if they had had more contact with him.

11. Although Mr Weighman had a history of mental health issues and self-harm, the reception nurse was unaware of this as Mr Weighman did not tell her about it and she had no access to his medical history during his initial health screen. She said that if she had seen his medical records, she would have referred him immediately to the mental health team.
12. There was a missed opportunity for the mental health team to assess Mr Weighman after a referral on 4 November. This did not happen because of staffing pressures. A referral made on 3 January was missed due to deficiencies in the way that mental health referrals were made.

## **Recommendations**

- The Governor and Head of Healthcare should ensure that:
  - staff know when and how to start ACCT monitoring procedures, including when a prisoner threatens self-harm;
  - staff record why they did not start ACCT procedures if they are not considered necessary; and
  - healthcare staff receive ACCT training.
- The Head of Healthcare must ensure that staff access prisoners' SystemOne medical record before undertaking their initial health screen.
- The Head of Healthcare should write to the Ombudsman to set out how she has assured herself that the new referral system to the mental health team is robust and responsive and that there are timely mental health assessments following referrals to the mental health team.

## The Investigation Process

13. The Prisons and Probation Ombudsman (PPO) was notified of Mr Weighman's death on 6 January 2023.
14. 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.
15. The investigator obtained copies of relevant extracts from Mr Weighman's prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Weighman's clinical care at the prison.
17. The investigator interviewed sixteen members staff and two prisoners at HMP Chelmsford, some jointly with Mr McMorrow.
18. We informed HM Coroner for Essex of the investigation. He provided us with a copy of the post-mortem and toxicology reports. We have sent him a copy of this report.
19. We contacted Mr Weighman's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Weighman's next of kin raised no issues.
20. Mr Weighman's next of kin received a copy of the initial report. They did not make any comments.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and Castle Rock Group Medical Services pointed out some factual inaccuracies and the PPO report has been amended accordingly.
22. Castle Rock Group Medical Services also pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer, who amended their report.

## Background Information

### HMP Chelmsford

23. HMP Chelmsford is a category B local prison that takes adult and young adult men directly from the courts. It can hold around 713 men. Castle Rock Group Medical Services provide 24-hour healthcare services. The prison has a 12-bed inpatient unit.

### HM Inspectorate of Prisons

24. Inspectors carried out a full unannounced inspection in August 2021. Following the inspection, the Chief Inspector of Prisons invoked the Urgent Notification process because he was so concerned about the conditions at Chelmsford. He reported that the programme of special measures and other initiatives HMPPS introduced to drive improvement since the previous inspection in 2018 had not worked.
25. Inspectors noted an inadequate response to high levels of suicide and self-harm at the prison. They reported that self-harm incidents had increased significantly, the safer custody team was not properly resourced, and staff lacked confidence in using ACCT monitoring procedures. Despite flaws identified during their previous inspection and subsequent failings identified by the PPO, outcomes had deteriorated, recommendations had not been achieved and prison leaders had repeatedly failed to address deficiencies with ACCT procedures.
26. Inspectors recommended that work to prevent suicide or self-harm should be improved significantly and ACCT procedures should be delivered proactively and robustly.
27. Inspectors reported a negative culture among some prison staff, including a lack of respect, compounded by lack of management oversight, which went unchallenged.
28. Inspectors noted that plans to relaunch the key worker scheme had been unambitious and would not provide consistent one-to-one support for prisoners.
29. Inspectors reported on the significant shortage of healthcare staff and in the mental health and pharmacy teams which had impacted on the delivery of services. They noted an over-reliance on agency staff, particularly in the mental health team, which meant that service continuity could not be guaranteed.
30. Inspectors carried out an independent review of progress in August 2022. They found that there had been reasonable progress in the work to prevent suicide and self-harm and PPO recommendations were regularly reviewed to ensure that processes were embedded.
31. Inspectors reported that staff were much more confident in using ACCT procedures and the quality of reviews and care planning had improved. Most prisoners to whom inspectors spoke said they felt supported by staff while on an ACCT. Inspectors noted that quality assurance took place regularly and learning was shared with managers.

32. Inspectors reported that despite attempts to increase the number of keyworker sessions with prisoners, they remained very limited.

## **Independent Monitoring Board**

33. 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 annual report for the year to August 2022, the IMB reported that there was good interaction between staff and prisoners and good care was provided to those who needed support. The IMB reported that although there had been no self-inflicted deaths since their last report, incidents of self-harm remained high, 65% of which was through superficial scratching and cutting.

## **Previous deaths at HMP Chelmsford**

34. Mr Weighman was the fifth prisoner to take his life at Chelmsford since January 2020. Our investigation report into one of those deaths identified the failure of prison staff to record their rationale when a decision was made not to monitor a prisoner under ACCT procedures and of the need for prisoners to be assessed by the prison's mental health team within 72 hours.
35. There have also been two further apparently self-inflicted deaths since Mr Weighman's death. Our investigation report into one of these deaths identified failures in the ACCT process. Following our recommendation to address these deficiencies in November 2023, the Prison Group Director for Hertfordshire, Essex and Suffolk wrote to the PPO, setting out the outcome of his review into the measures introduced to improve ACCT management at HMP Chelmsford. We also recommended that healthcare staff should act on mental health referrals appropriately.
36. There has been one death from natural causes and one drug-related death since January 2020. Since Mr Weighman's death, there have been two further deaths from natural causes. There are no similarities between our investigation findings in this report and those of the previous deaths.

## **Assessment, Care in Custody and Teamwork**

37. 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 prisoners. As part of the process, a care plan which includes support and intervention, should be in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

# Key Events

## Background

38. On 14 June 2019, Mr Daniel Weighman was sentenced to 28 days in prison for theft, assault and possession of drugs. He was sent to HMP Chelmsford. On 26 July, he was sentenced to a further two years and four months for burglary. He had been monitored under suicide and self-harm prevention procedures, known as ACCT, during previous sentences.
39. In September and October 2019, Mr Weighman tried to hang himself and told staff that he had heard voices. He was monitored under ACCT procedures and was under the care of the mental health team.
40. On 11 May 2020, Mr Weighman was released from Chelmsford on licence.

## HMP Chelmsford

41. On 15 October 2022, Mr Weighman was recalled to prison for breaching his licence conditions. (The sentence for which he was recalled ended on 11 November, but he remained in custody on remand, charged with two further offences, including actual bodily harm.)
42. A mental health nurse completed his initial health screen. She did not have access to Mr Weighman's previous medical records. The Head of Healthcare told us that medical records could only be accessed once the initial health screen had been completed. The nurse noted that he had denied current or previous thoughts of suicide or self-harm. She noted that Mr Weighman appeared agitated, restless and was rude when answering questions. The next day, it was confirmed that that Mr Weighman was not prescribed any medication.
43. During his first night interview, an officer noted that Mr Weighman was in good spirits. When asked about his previous self-harm, Mr Weighman said he had been in a "bad place".
44. On 18 October, Mr Weighman was moved to E wing after his brother, who was also at Chelmsford, asked for them to be near to each other. (His brother told the investigator that his brother had been "upbeat" about the move. Although they lived on different spurs of the wing, staff allowed them to meet almost every day.)
45. On 21 October, a healthcare administrator noted that Mr Weighman's medical record had been merged with his previous prison medical record.
46. On 4 November, a healthcare administrator completed Mr Weighman's second health screen. She reviewed his mental health self-assessment which he had completed during his early days in custody. She did not see him in person. In the assessment, Mr Weighman indicated that he had felt depressed daily for two weeks and had been troubled by repeated thoughts. She referred him to the mental health team. (She was not medically qualified but had some training to complete the task, had been asked to review the assessment as no healthcare assistant was available due to staff shortages.)

47. The healthcare administrator emailed the mental health team leader to tell her that Mr Weighman needed to see the mental health team. (Although the mental health team leader confirmed receipt of the email, Mr Weighman was not subsequently assessed by the mental health team.)
48. Mr Weighman's brother described him as "a bit of a recluse" who "never had any trouble". He said his brother stayed in his cell most of the time but did not believe he was being bullied, in debt or involved in drugs.
49. In December, Mr Weighman spoke to his sister by telephone on several occasions. (Prisoners' telephone calls are recorded but are not routinely monitored by HMPPS. Prison staff were therefore not aware of the content of Mr Weighman's calls. The investigator listened to the recordings as part of the investigation.) He asked her to transfer money into the accounts of other prisoners and hoped that he would be tagged when released which he said would be better than being in prison. Mr Weighman's brother said he brought his brother coffee and vapes when he visited him. He said that Mr Weighman helped him, and arranged money transfers so he could buy vapes for him.
50. In a telephone call to his sister on 22 December, Mr Weighman again talked about his release and his hope of being given a suspended sentence. Mr Weighman asked his sister again to transfer money to other prisoners as he owed "double back" and had "bought three boxes". (Mr Weighman was likely talking about vapes borrowed or bought from other prisoners.) In a call to his sister the following day, Mr Weighman again talked about buying vapes. (Mr Weighman did not sound stressed or upset during the call but his conversations indicated his frustration about being in prison.) In telephone calls to his sister in December, Mr Weighman talked about the transfer of money to buy vapes and his court case. He said he hoped to get a community order as being in prison was "doing his head in".
51. On 31 December, Mr Weighman spoke to his sister, told her he was "good" and discussed money transfers. When his sister asked again how he was, he replied, "Same old shit." He sent her his love. (Mr Weighman appeared quieter than in previous telephone calls with his sister.)
52. An officer who worked on E Wing, said that Mr Weighman spent a lot of time in his cell as the wing was busy, he socialised with prisoners with whom he got on well and he was a heavy vape user. The officer said that had never seen Mr Weighman under the influence of drugs and he had never talked about self-harm.
53. A Supervising Officer (SO), the manager on E Wing, said that Mr Weighman never talked about self-harm and there was no indication that he was being bullied, that he was isolating himself or was involved in the prison drug culture.
54. Mr Weighman's cellmate for around three weeks before his death said that when Mr Weighman first moved in with him, he appeared "all right" but then started to deteriorate. He said he had tried to help Mr Weighman, but it got to a point where Mr Weighman talked to himself so much that it "rubbed him up the wrong way". He said he told officers, including the SO, that something was wrong with Mr Weighman around New Year.

55. At around 5.30pm on 1 January 2023, Mr Weighman rang his cell bell. Officer A, who had been an officer for around seven months, responded and Mr Weighman told her that he only wanted to speak to an SO or Governor. When she told him no one was available, he asked to speak to the healthcare team.
56. Officer A asked a prison paramedic to speak to Mr Weighman. He told her that it would not be appropriate for him to do so if there was no medical need. The officer told him that Mr Weighman seemed stressed and angry. He said she told him that Mr Weighman “had sort of threatened to self-harm if he was not seen”. He said he told her that he would telephone Mr Weighman in his cell.
57. When the prison paramedic did so, Mr Weighman asked for sleeping tablets. He told him this was not possible as a GP needed to prescribe them. He said Mr Weighman said he felt as though he was going to harm himself. He told him that he would ask the prison GP to consider his request for sleeping tablets. He said Mr Weighman was “frustrated and argumentative” and had asked for his name so he “knew who to blame” if the prescription was not made.
58. Officer A said that the prison paramedic called her back and said that Mr Weighman had threatened to harm himself if he was not given sleeping tablets and discussed with her whether he or she should start ACCT monitoring. She told him she would open the ACCT.
59. Officer A said that as she started to open the ACCT, Officer B asked her if she had heard Mr Weighman say that he would harm himself. She said she had not. She said that Officer B told her that ideally, the prison paramedic should start ACCT monitoring as Mr Weighman had told him that he would harm himself. She said she could not recall Mr Weighman telling her that he would harm himself.
60. The prison paramedic said that Officer A told him that Officer B would speak to Mr Weighman because ACCT monitoring might not be needed as Mr Weighman had “not physically self-harmed”.
61. Officer B said that Officer A told him that Mr Weighman had asked to move to a single cell. He spoke to Mr Weighman and told him that as a standard risk prisoner, he would not be moved to one. He said Mr Weighman was angry and hit the cell door. He said that Officer A asked whether she should start ACCT procedures. He told her that if she thought there was a risk, she should do so. He also said that Mr Weighman’s request to move cells may be goal-orientated.
62. Officer A said that she called the prison paramedic back and told him that he should start ACCT procedures as Mr Weighman had told him that he would harm himself. She said that she told him that Mr Weighman’s threat to harm himself appeared goal-orientated as he had made the threat after being told he would not get sleeping tablets. She said she told him that he should decide whether to start ACCT monitoring. She said she did not hear from him again.
63. The prison paramedic said he told Officer A that as Mr Weighman had told them both that he would harm himself, ACCT monitoring should be started. He said that she agreed and said she would open the ACCT document. He said that a little later, she told him that Officer B had told her he would need to open the ACCT as Mr Weighman had told him that he would harm himself.

64. Officer B said that if he had known that the prison paramedic was not going to open an ACCT, he would have opened one with Officer A.
65. The prison paramedic said that Officer A told him that ACCT monitoring was not needed as Mr Weighman appeared to be “manipulating”, but that he would be monitored over the course of the evening. He contacted the prison GP about Mr Weighman’s request for sleep medication.
66. Officer A said she checked on Mr Weighman twice before she left the prison at 8.30pm. She said that on both occasions, Mr Weighman was sitting on his bed, watching television, and she had no concerns about him.
67. On 2 January, the cellmate told the SO that he needed to move out of Mr Weighman’s cell, as Mr Weighman was taking items he had bought from the prison shop and had kept him up for the previous three nights, watching television and pacing up and down their cell. She told him that she would try and move him to another cell the next day.
68. At around 11.00am, a mental health nurse and locum advance nurse medical practitioner and prescriber remotely reviewed the prison paramedic’s request for the GP to prescribe Mr Weighman sleep medication. He noted that a face-to-face consultation was not needed, and he prescribed a short course of promethazine (an antihistamine sometimes used to aid sleep).

### **Events of 3 January 2023**

69. At 9.15am on 3 January, Mr Weighman spoke to his sister. They briefly talked about a money transfer that had not gone through. Mr Weighman told his sister he would call her back with further details and that he loved her. (Mr Weighman sounded okay during the telephone call.)
70. That morning, Mr Wilson was moved to another cell.
71. At around 10.15am, Officer C unlocked Mr Weighman for the morning regime. He said Mr Weighman told him that he was hearing voices, did not want to leave his cell but wanted to move to the healthcare unit. The officer told a colleague to tell the SO and to contact the mental health team. The officer, who had not seen Mr Weighman for a couple of weeks, said that his behaviour had changed dramatically, and he planned to check on Mr Weighman throughout the day.
72. Mr Weighman’s brother said that he visited Mr Weighman in his cell that morning and gave him vapes and clothing. He said Mr Weighman appeared okay.
73. Officer C said that Mr Weighman kept saying that he needed to go to the healthcare unit. The officer said he initially thought that as Mr Weighman vaped a lot, he might have wanted to move because he was in debt, but Mr Weighman told him that this was not the case.
74. At around 11.00am, the SO tried to phone the mental health team several times but no one answered. There was no voicemail facility to leave a message.

75. At 12.02pm, the SO emailed the Head of mental health. She wrote that Mr Weighman had said he was hearing voices and she asked if he was under the care of the mental health team. She said that this was the first time that she had been told that Mr Weighman was hearing voices. The email was sent to the Head's personal work email address, rather than the generic mental health team email address, and she did not pick the email up until after Mr Weighman's death.
76. Officer C said Mr Weighman rang his cell bell several times that afternoon to ask when he would be moved to the healthcare unit as he was hearing voices.
77. At around 3.15pm, Mr Weighman's brother visited him again and spoke to him at his cell door. He said he told his brother that he would bring more vapes when he was unlocked to collect his evening meal. He Weighman said that his brother appeared okay and described him as being "as sweet as a nut". He said that as it was some time before Mr Weighman would be unlocked, he went back to his own spur.
78. At around 4.10pm, the SO unlocked Mr Weighman for his evening meal and noticed that he had made several superficial cuts to his neck. She said that Mr Weighman told her that he had harmed himself and did not want to leave his cell in case people saw him. She radioed for healthcare to attend and asked Officer C to speak to Mr Weighman to find out why he had cut himself. She returned to the wing office to start ACCT monitoring procedures. The officer visited Mr Weighman, who said he was hearing voices, he wanted to go to the healthcare unit and denied being in debt or bullied. The SO said Mr Weighman did not want to talk to her or the officer, and that this was not unusual as he had never interacted much with staff.
79. The prison paramedic went to Mr Weighman's cell to treat him. He said that although Mr Weighman refused to engage with him, he let him dress his wounds and told him that he had used a razor to cut himself which another prisoner had given him.
80. The SO said that Officer C told her that Mr Weighman did not want to talk but had said that he was not being bullied and was not in debt. She asked him to ask Mr Weighman's brother to talk to him.
81. Mr Weighman's brother said that when he arrived at the cell, he tried to find out what was wrong, but Mr Weighman told him to leave three times. Despite this, he remained, helped clean his brother's wound, comforted him and told him that he could visit his spur the following day.
82. Officer C said he left Mr Weighman's brother with him, hoping that Mr Weighman might say more without an officer present. He noted that Mr Weighman was keen to move to his brother's spur the next day for extra support and had said he had enough vapes for the night.
83. The SO completed the ACCT immediate action plan. She noted that Mr Weighman was in a cell on his own after an argument with his cellmate. Mr Weighman was put on hourly observations until his assessment the following day.
84. Mr Weighman's brother said the SO asked him if Mr Weighman was in debt. He said he told her that his brother "was not cutting up to get a smokers pack" and had

plenty of vapes. She said Mr Weighman's brother told her that Mr Weighman was "doing me out of pocket at the moment with vapes". He said he thought that the SO would monitor Mr Weighman every fifteen minutes.

85. The SO checked on Mr Weighman again at 4.45pm and allowed his brother to return to talk to him and give him his evening meal (which Mr Weighman did not eat). Mr Weighman's brother said that before he left his brother, he embraced him and told him to promise that he would not do anything stupid.
86. At around 5.10pm, Mr Weighman's brother returned to his cell for the routine evening roll check. The SO reminded Mr Weighman that he could move to his brother's spur the following morning which she said he was happy about. She said that he had given his brother more vapes, that Mr Weighman had seemed settled and hugged his brother before he left.
87. The SO said that Mr Weighman's brother told her that he did not want to share a cell with his brother as they would end up fighting. She said that she had planned to move Mr Weighman the following day because of the time and logistics involved in facilitating the move.
88. The SO said that Mr Weighman's brother told her that Mr Weighman was not hearing voices but had been told he was looking at 16 months imprisonment. She said that he told her that he understood that his brother could not be taken immediately to the healthcare unit.
89. At 5.14pm, Mr Weighman was checked during the roll count. At 5.58pm, Officer D checked on him. She said that he was sitting on his bed, watching television, did not speak but acknowledged her.
90. At 6.24pm, Officer D completed another ACCT check. She said that Mr Weighman was lying on the floor of the cell on his front. The officer said she could not see him properly, as he was lying behind the privacy screen of the toilet, which obscured the top part of his body. She said his face was not in view. She called Mr Weighman's name, but he did not respond.
91. At 6.25pm, concerned about Mr Weighman and unsure what was happening, Officer D radioed for staff assistance and switched on her body-worn camera. A Prison Education Instructor (PEI) and another officer responded immediately and when she saw them arrive on the wing, she went into the cell.
92. Officer D said she tapped Mr Weighman on the shoulder and called his name, but he did not respond. The PEI removed a covering from the cell light so that the officers could see better. He noticed that Mr Weighman had a ligature around his neck and had tried to hang himself. (Mr Weighman had tied the ligature, made of a bed sheet, to the top bunk of his bed, and it appeared that the ligature had snapped, and Mr Weighman had fallen to the floor, with the top of his body obscured by the toilet privacy screen.)
93. The other officer passed the PEI a cut-down tool as he was not carrying one. The PEI cut the ligature from Mr Weighman's neck and at 6.27pm, he radioed the control room to tell them that it was a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties).

94. The officers laid Mr Weighman on his back, and the officer and PEI started cardiopulmonary resuscitation (CPR).
95. The prison paramedic was in the healthcare unit when he heard the initial call for staff assistance, and he made his way directly to the wing. He arrived at the cell at 6.27pm, immediately assessed Mr Weighman, established that he was in cardiac arrest and took over CPR. An officer collected the emergency response bag from the wing office. A nurse and other healthcare staff arrived soon afterwards and assisted the paramedic. Ambulance paramedics arrived at 6.42pm and Mr Weighman was moved to the landing at 6.45pm. At 7.44pm, Mr Weighman was taken to Broomfield Hospital for further treatment. Mr Weighman's family were told about the incident and visited him in hospital. Due to the severity of Mr Weighman's condition, the prison arranged for Mr Weighman's brother to visit his brother in hospital on 4 January.
96. At 4.00pm on 6 January, life support was removed from Mr Weighman, and he was pronounced dead at 5.08pm. Members of his family were with him when he died.

### **Contact with Mr Weighman's family**

97. At 8.20pm on 3 January, a prison chaplain broke the news to Mr Weighman's family that Mr Weighman had been found hanging in his cell and had been taken to Broomfield Hospital for treatment. Mr Weighman's family subsequently visited him in hospital and were with him when he died. On 4 January, staff at Chelmsford made arrangements for Mr Weighman's brother to visit his brother in hospital. Chelmsford contributed to Mr Weighman's funeral expenses in line with national instructions.

### **Support for prisoners and staff**

98. On 4 January, the Head of Residential Services debriefed staff following the incident and staff and prisoners, including Mr Weighman's brother, were offered support. A postvention response, used to support staff and prisoners after a death in prison, was not initiated after Mr Weighman's death.

### **Post-mortem report**

99. A post-mortem examination found that Mr Weighman died from suspension by ligature. Toxicology results found traces of ketamine, a drug used in emergency medical care, but it was noted that the toxicology results had no bearing on Mr Weighman's death.
100. The toxicology report also identified that tablets were found in a Vitamin D bottle in Mr Weighman's cell. It noted that the toxicology laboratory should be told if the identity of the tablets became known or further testing was needed. We have no further information about this.

### **Information received after Mr Weighman's death**

101. Mr Weighman's brother told the investigator that something was not right about Mr Weighman while at Chelmsford. He said that his brother talked about other prisoners, but he had reassured him that they were his friends.
102. Mr Weighman's brother said that Mr Weighman had told him and some officers, including Officer D, that he was hearing voices. He said that his brother was not in a good place and needed to be seen by the mental health team. He said he had asked staff to "keep an eye" on him. He said that staff told him that his brother was alright but had become withdrawn.
103. Mr Weighman's brother said that his brother's cellmate had told him that he had wanted to stop sharing a cell with Mr Weighman because he was talking to himself and hearing voices.
104. The cellmate told the investigator that Mr Weighman did not take drugs. He said that Mr Weighman had talked about swallowing a razor blade days before the incident and as a result, he had thrown a razor blade away. He said he had told an officer, whose name he did not recall, that Mr Weighman was "not doing well" and "might do something".
105. Chelmsford carried out an immediate investigation after Mr Weighman's death. During an interview with the cellmate, he told staff that he was being bullied by Mr Weighman, that Mr Weighman was stealing his property and that his own mental health was deteriorating. He said he believed that Mr Weighman had not meant to kill himself but was seeking attention. He said he did not tell Mr Weighman that he was moving cells as he did not want to upset him. Contrary to what he told the PPO investigator, he told prison staff that Mr Weighman might have been holding or using illicit drugs.

# Findings

## Assessment of Mr Weighman's risk

106. PSI 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. Staff should assess a prisoner's risk of suicide and self-harm based on all known risk factors rather than on the prisoner's presentation and what the prisoner tells them.
107. Mr Weighman was a quiet prisoner who kept to himself much of the time, mixing only with a few prisoners. Mr Weighman's brother and cellmate told us that concerns about Mr Weighman had been raised with prison staff before he harmed himself on 3 January 2023. However, we found no evidence of this or that he was threatened or bullied at Chelmsford.
108. When Mr Weighman threatened to harm himself on 1 January, an ACCT was not opened as it should have been. Staff accounts differ about why not, and no one took responsibility for starting ACCT procedures, instead passing the accountability to someone other than themselves. There is no record of a defensible decision to explain why ACCT procedures were not started and the decision-making was poor and confused. Staff missed an opportunity to identify through the ACCT assessment and multidisciplinary review whether Mr Weighman's risk had increased.
109. During the investigation, it became apparent that healthcare staff were not adequately trained in ACCT procedures. The Head of Healthcare said that she struggled to get ACCT training for healthcare staff and healthcare staff had been pulled from ACCT training to allow officers to attend.
110. The Prison Group Director for Hertfordshire, Essex and Suffolk wrote to the Ombudsman in November 2023 in response to our recommendation in a previous investigation report in which we asked him to assure us that the measures introduced at Chelmsford to improve ACCT management were leading to sustained improvement. He told us that he and the Governor of Chelmsford had reviewed the senior management team to ensure safety and other key areas had consistent leadership. He set out the detail of significant changes that had been made to manage ACCT procedures. While we welcome these numerous changes and are pleased that safety is being prioritised at Chelmsford, we want to ensure that the particular deficiencies we identified in this investigation report, which were not specifically addressed in the Prison Group Director's letter, are addressed. We therefore make the following recommendation:

### **The Governor and Head of Healthcare should ensure that:**

- **staff know when and how to start ACCT monitoring procedures, including when a prisoner threatens self-harm;**
- **staff record why they did not start ACCT procedures if they are not considered necessary; and**

- **healthcare staff receive ACCT training.**

## **Keyworker scheme**

111. We found no evidence that Mr Weighman shared his concerns with staff until 1 January or that he gave them any reason to consider that he was at imminent risk of suicide before then.
112. However, there is no evidence that staff had any meaningful contact with Mr Weighman at Chelmsford before 1 January. There are no meaningful conversations recorded in his prison record and the keyworker scheme at the prison was not operating fully at the time due to staffing pressures. Had wing staff had more regular and significant contact with Mr Weighman, it is possible they might have become aware of Mr Weighman's increasing risk. However, Mr Weighman appeared to have been a private man and we cannot know whether he would have shared this anxieties with staff.
113. During the investigation, we were told that 85% of prisoners at Chelmsford now have a key worker. Given this, we make no recommendation, but the Governor will wish to monitor key work delivery.

## **Clinical issues**

114. The clinical reviewer concluded that the physical healthcare that Mr Weighman received at Chelmsford was of a reasonable standard and equivalent to that which he could have expected to receive in the community. However, the clinical reviewer considered that the mental healthcare that Mr Weighman received was not of the required standard and was not equivalent to that which he could have expected in the community.

## **Reception screen and mental health referrals**

115. The clinical reviewer concluded that Mr Weighman's initial health screen on 15 October was not carried out to an appropriate standard. The clinical reviewer reported that the reception nurse did not have access to Mr Weighman's medical records when she carried it out. We found that the nurse could only access medical records once she had completed the initial health screen, therefore the nurse was unable to refer to the record prior to completing the reception screen. We were told that once the reception screen record is completed, full access to the records is possible, and could have been accessed by the nurse during reception. However, the records are merged by an administrator some days after the reception screen.
116. Had the nurse been able to access Mr Weighman's previous medical records, she would have seen his history of mental health issues and two previous suicide attempts when Mr Weighman had tried to hang himself. The reception nurse said that had she seen these records, she would have referred Mr Weighman to the mental health team. However, this did not happen, and we make the following recommendation:

**The Head of Healthcare must ensure that staff access prisoners' SystemOne medical record before undertaking their initial health screen.**

117. The clinical reviewer reported that the secondary health screen, which was not completed within the required seven days, was completed by a healthcare administrator and not a clinician due to staff shortages. At the secondary health screen, Mr Weighman was referred to the mental health team. Despite a referral being made to the mental health lead, Mr Weighman was not assessed as he should have been. The mental health lead said that due to overwhelming work pressures at the time, she did not process the referral and subsequently Mr Weighman was not seen by the mental health team.
118. After Mr Weighman harmed himself on 3 January, the wing SO emailed the mental health lead's personal work email account to say that Mr Weighman was hearing voices and asked if he was under the care of the mental health team. The email was not picked up until after Mr Weighman's death. The clinical reviewer reported that this again highlighted the lack of a formal mental health referral process and a lack of awareness by officers about how to make mental health referrals.
119. It is not the first time that we have identified issues with the mental health referral system in place, and we most recently made a recommendation to address this concern in November 2023. The Head of Healthcare and the mental health lead confirmed that there is now a more robust referral system to the mental health team in place. We therefore make the following recommendation:
- The Head of Healthcare should write to the Ombudsman to set out how she has assured herself that the new referral system to the mental health team is robust and responsive and that there are timely mental health assessments following referrals to the mental health team.**
120. The clinical reviewer was concerned about the missed opportunities for Mr Weighman to access the mental health team at Chelmsford. However, the clinical reviewer concluded that this might not have prevented Mr Weighman's death.

## Head of Healthcare to note

121. On 4 November, a healthcare administrator, who was not medically qualified, completed Mr Weighman's secondary healthcare screen. This should have been completed by a qualified clinician.

## Governor to note

### Postvention

122. Postvention procedures, used to support staff and prisoners following a sudden death, which should be implemented after all self-inflicted deaths or serious incidents of self-harm, did not take place following the incident.

### Good practice

123. We identified three areas of good and compassionate practice:

- Prison staff allowed Mr Weighman and his brother to meet frequently, despite living on different spurs. This was a particularly important protective factor when Mr Weighman was being monitored under ACCT procedures;
- they planned for Mr Weighman to move to his brother's wing after he harmed himself; and
- they allowed his brother to visit him in hospital before he died.

## **Inquest Verdict**

124. The inquest hearing into the death of Mr Weighman was held on 17 April 2024. It confirmed that the medical cause of Mr Weighman's death was suspension by ligature. It concluded in a narrative verdict, that Mr Weighman deliberately deployed a ligature in his cell on 3 January 2023, but that the evidence did not fully explain whether or not he intended that the outcome would be fatal and reported on a number of probabilities that might have contributed to Mr Weighman's death.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100