

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP & YOI
Chelmsford in September 2012**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell at HMP Chelmsford in September 2012. He was 23 years old. I offer my condolences to his family and friends.

A review was conducted into the clinical care the man received at Chelmsford. The prison cooperated fully with the investigation. The investigation was suspended for some time for police inquiries. I am sorry for the consequent delay in the issue of this report.

The man was monitored under Prison Service suicide prevention measures as soon as he arrived at Chelmsford in June 2012, but monitoring stopped the next day. He received mental health support throughout his time at the prison and was prescribed antidepressants. In August, suicide prevention measures were started again when he was distressed after learning that his father was critically ill. In September, he was found hanging in his cell.

The investigation found that the man received some good support at the prison, including effective liaison with his family through the chaplaincy. However, a number of weaknesses were identified in healthcare, including poor medicine management which resulted in him receiving a lower dose of antidepressants than had been prescribed. We also have concerns over the management of suicide prevention measures. His first period of suicide prevention monitoring was stopped prematurely, less than 24 hours after he had arrived at the prison. Monitoring reviews did not involve multidisciplinary teams, as required by Prison Service guidance. There was also insufficient focus on identifying and addressing all risk factors, including the disproportionate risk of suicide among men from the Gypsy and Traveller community such as him. On the afternoon he was found hanging, it does not appear that observations were conducted as required.

It is not possible to know whether, if all procedures had been carried out effectively, the man's death would have been prevented, but it is important that efforts are made to improve suicide prevention procedures and medicine management at Chelmsford. It is disappointing to note that some of the issues identified, particularly relating to suicide prevention arrangements, have been found in investigations into previous deaths at Chelmsford.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

October 2013

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SUMMARY

1. On the 8 June 2012, the man was remanded in custody to HMP Chelmsford charged with burglary and driving offences. It was not his first time in prison.
2. At his initial health screen, the man said that he had recently taken an overdose. He gave vague responses to questions about his well-being and was described as unpredictable. The nurse could not establish whether he had any mental health issues. She started Prison Service suicide and self-harm prevention measures (known as ACCT) and referred him to see the prison doctor, who prescribed antidepressant medication which was to be taken under supervision by staff. He said he was worried about his father who was seriously ill. A number of actions to help keep him safe were identified when the ACCT plan was opened, but the plan was closed the day after he arrived and before they had been achieved.
3. On 12 June, a mental health nurse assessed the man and recorded that he suffered from anxiety and depression. The nurse referred him for an urgent psychiatric assessment which took place on 19 June. This identified that he had a history of self-harm, but said he had no thoughts of wanting to harm himself at that time. He was advised to continue to take his medication and he would be reviewed in about eight weeks.
4. The man settled into the prison regime and told staff he had no thoughts of self-harm, but said he was stressed about his relationship with his girlfriend and about his father's poor health. He continued to take his medication and received support from the mental health team.
5. On 29 August, an ACCT plan was started again after the man learnt that his father was critically ill and needed a serious operation which was due to take place on 3 September. He was required to be observed hourly during patrol state (when all prisoners are locked in their cells). Staff were also required to record three observations during the day. The prison chaplain facilitated telephone calls to his family. His father's operation was later postponed. While he was waiting for his family to let him know when his father's operation would be rescheduled, suicide prevention measures remained open.
6. On 1 September, the man told staff that he found it difficult being around other prisoners and wanted a job in the fresh air. Nothing was done to address these issues. A couple of weeks later he was locked in his cell after lunch. Although there is some doubt about the accuracy of the prison officer's observations, checks were recorded at 1.50pm and 2.50pm, and no problems were noted. Another prisoner said that he and the man had talked through their cell windows and said that he had seemed okay.
7. When the man's cell was unlocked at 4.18pm, an officer found him hanging from a bed sheet from the window bar in his cell. Despite resuscitation attempts by officers, healthcare staff and paramedics, he was pronounced dead at 5.00pm.

8. The man had a history of self-harm and was anxious throughout his time in prison. The investigation found that the operation of the suicide and self-harm (ACCT) procedures required improvement. We make recommendations about ACCT procedures, management of medications and emergency procedures.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 17 September 2012. The investigator issued notices to staff and prisoners at HMP Chelmsford to inform them of the investigation process and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited the prison on 24 September, met the Governor and collected the man's prison records.
11. Essex police conducted a criminal investigation into the suicide prevention monitoring on the afternoon of the man's death. The police shared relevant interview statements, but, in line with our agreement with the police, we suspended our investigation until the outcome of the criminal investigation. The Crown Prosecution Service decided that no criminal charges would be brought and he resumed this investigation on 25 April. We regret the consequent delay in issuing this report. After the investigation had resumed, he visited the prison and interviewed nine members of staff and two prisoners.
12. A clinical reviewer was appointed by the local PCT to review the clinical care the man received in custody.
13. One of the Ombudsman's family liaison officers contacted the man's family and explained the purpose and scope of the investigation. The family and family liaison officer met the man's sister and father, who had the following questions and concerns which they wished the investigation to consider:
 - How frequently was he observed on the day he died, and did he have a cellmate at that time?
 - Who found him hanging in his cell?
 - Had he been assaulted by another prisoner over trading tobacco?
 - His family acknowledged that he was depressed, but said that he had never said he would hurt himself. Although he was frustrated by his situation, he was looking forward to the future and seeing his baby.
 - His sister had received a letter from him three weeks after his death. There was no date or stamp on the letter, and the post mark was 4 October. She was upset to receive the letter so long after his death and wanted to know why it had been delayed. (The prison said all post was checked after his death to prevent such an occurrence. We understand the distress this caused but unfortunately it is not possible to establish whether the letter was delayed in the prison post system or whether the delay was with the Post Office.)
14. The family received a copy of the draft report. They did not raise any further issues or comment on the factual accuracy of this report.

HMP CHELMSFORD

15. HMP Chelmsford is a local prison which takes prisoners directly from courts mainly in Essex and London. It holds up to 710 adult and young adult men.

Accommodation is in four residential wings (A, B, C and D) in the older Victorian part of the prison and in three separate new units (E, F and G).

Her Majesty's Inspectorate of Prisons

16. The most recent report inspection of Chelmsford by HM Inspectorate of Prisons was in May 2011. In relation to suicide prevention, the Inspectorate found:

“A comprehensive strategy set out procedures to minimise the risk of self-harm. Protocols were well known to staff and prisoners. The multidisciplinary suicide prevention committee met monthly to monitor and ensure consistent implementation of the policy. There were good links with the mental health in-reach team. The Listeners' scheme was well supported, their role was properly advertised and prisoner had good access to them. Despite solid structures, the quality of self-harm monitoring forms was inconsistent. Care mapping required some further development, attendance at case reviews was sometimes irregular and written entries on HMP/YOI Chelmsford observation forms were sometimes cursory. The attitude of staff to prisoners at risk was particularly good throughout the prison and the level of care was generally high.”

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their 2012 annual report the IMB noted:

“The importance of Safer Custody, Violence Reduction and the ACCT process is continually apparent throughout all areas of the prison...”

Violence Reduction

18. The prison's violence reduction team investigates acts of antisocial behaviour by interviewing prisoners. Part of the team's work is to oversee the SAFE process (Safe and Free Environment). The purpose of SAFE is to identify, monitor and manage prisoners who display antisocial behaviour. There is a SAFE prisoner representative on every wing.

Assessment Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan

should not be closed until all the actions of the caremap have been completed.

Previous deaths at Chelmsford prison

20. In the last year, there has been one other self-inflicted death at Chelmsford. In that investigation, we were critical of the ACCT process and made a related recommendation. This investigation has found that there are still fundamental problems with the ACCT process at Chelmsford.

KEY EVENTS

21. The man was born in November 1988. He had a history of mental illness and was described by his community GP as having an unstable personality. In January 2011, his GP prescribed mirtazapine (an antidepressant). He used cocaine and cannabis frequently and had been referred for help with his substance misuse problems but did not always engage with his treatment. In 2011, he injured his leg in an accident and used crutches as a result.
22. On 5 April 2012, the man was remanded to HMP Brixton. He was prescribed mirtazapine in line with his GP's prescription, but was not regarded as a risk of suicide and self-harm and did not receive any mental health support while he was there. He was released from Brixton on 25 April. On 19 May, he took an overdose of drugs and was taken to hospital. He told a psychiatrist that he had taken the overdose because his girlfriend had left him and taken their child. He said he was no longer suicidal and he returned home the same day.

HMP Chelmsford

23. On 6 June 2012, the man was arrested and held in police custody charged with burglary and driving offences. Police custody records noted that he suffered from anxiety and depression and had previously taken an overdose, cut his arms and jumped in front of a bus. He had no medication with him.
24. The man remained in police custody until the morning of 8 June when he attended Magistrates' Court. The Person Escort Record (PER), a document that accompanies detained persons, recorded that he "bites his arms in custody". He was checked every ten minutes while he was waiting at court. The court adjourned his case and he was remanded to HMP Chelmsford.
25. The man told officers in reception that he had no thoughts of suicide or self-harm. An officer reviewed his court warrant and PER and carried out a cell sharing risk assessment (CSRA¹) which concluded that he was an "interim high risk" to other prisoners if he shared a cell, because of his mental health history. The officer referred him to the mental health team.
26. At his initial health screen, the man told the mental health nurse that he had recently taken an overdose of medication and had been admitted to hospital. He said he had no current thoughts of suicide or self-harm, but he reported suffering from a mental illness and said he had problems remembering things. He asked for medication. The nurse assessed his mental health and described him as agitated and unpredictable, but concluded that he had no psychotic symptoms. The nurse faxed his GP surgery for his medical records, which were received on 19 June.
27. The nurse started suicide and self-harm prevention procedures (ACCT) because of the man's recent history of self-harm and his presentation. After consulting a colleague in the healthcare team, he recorded on the cell sharing

¹ The CSRA process is designed to assess the risks posed by an individual to other prisoners.

risk assessment that although he had no immediate health risks, he was not suitable to share a cell.

28. The man went to the prison's induction unit, where an officer completed a first night assessment. He recorded that the man was a member of the Traveller community and was on an open ACCT document. The officer noted in the ACCT observation log that his mood was "quite upbeat, states he does not want to kill himself".
29. A healthcare assistant recorded the man's basic observations, including his weight, blood pressure and pulse, all of which were within the normal range. She noted that he had a history of depression, anxiety disorder, psychotic disorder and depression. A prison doctor prescribed him 30mg mirtazapine to be taken daily, supervised by staff.
30. No concerns were noted about the man's first night at the prison. The next morning an Operational Support Grade (OSG) carried out an ACCT assessment. He recorded that he was slightly anxious and wanted to move off the induction wing and share a cell. He was worried about his father who he said was seriously ill. He talked about the support he had from his girlfriend and their two-year-old son. The OSG noted that his arms were scarred. He said he had no suicidal thoughts but said that he had attempted take his own life two weeks earlier by taking an overdose of tablets because of family issues. He said that he had also previously attempted suicide by jumping in front of a vehicle. The OSG recorded that he should be referred for bereavement counselling (because of his mother's death three years previously), to the mental health team and to the chaplaincy. He also wrote that he should share a cell. He was encouraged to arrange family visits and to apply for a job in the prison.
31. A Senior Officer (SO) chaired an ACCT case review straight after the man's assessment. The SO said that he had given her his views and she read through the assessment notes, but the SO conducted the review on her own, with no other member of staff present. She told the investigator that she would have contacted someone from the healthcare team to attend if she had had any concerns about his health, but she had none. She told the SO that he had no intention of harming himself and just wanted to be moved. The SO opened a caremap for him, highlighting two issues: to share a cell and to move to C wing with a need for a cell sharing risk assessment as the action identified to address the two issues. She telephoned C wing to confirm that a space would be available for him. She recorded on the ACCT action plan that a move would be arranged once he had completed his induction. She recorded that his risk of self-harm was low and closed the ACCT. None of the issues and actions identified by the OSG were addressed and neither of the actions on the caremap had been completed when the ACCT was closed. The SO updated the cell sharing risk assessment form by completing the "Day 2 Assessment" section noting that he was now a standard risk and there was no indication of a risk to cell mate.

32. On 12 June, the nurse assessed the man's mental health. He recorded that he suffered from depression and anxiety and had received treatment for his mental health in the past. He said he could not remember when he had received treatment because he had a poor memory. He said he had cried himself to sleep since his mother's death. He explained that he was worried about how long his father, who was ill, had left to live. He was anxious about his trial which was scheduled to begin in about ten weeks. The nurse recorded that he had been prescribed mirtazapine and said he had no thoughts of suicide or self-harm. He said he felt claustrophobic in his cell and wanted to move wings. The nurse referred him for an urgent psychiatric assessment and obtained assurances from officers that he would be moved as soon as there was an available cell.
33. On 15 June, the man moved from the induction unit to a standard prison wing where he shared a cell with another prisoner. The prisoners' equality representative was informed that he was a Traveller and his name was added to a list of prisoners to be included in any forthcoming forums or support from Travellers in the community.
34. On 19 June, a psychiatrist and a nurse carried out a psychiatric assessment. The psychiatrist recorded the man's family medical history and his previous self-harm. He said that he was on a plumbing course and had applied to learn bricklaying, painting and decorating. He said that he had no thoughts of suicide or self-harm. The psychiatrist recorded that he would be reviewed in about eight weeks, or earlier if needed, and was to continue to take mirtazapine. Atrium (a counselling services agency working in the prison) confirmed that he was on their waiting list to receive bereavement counselling.
35. On the same day, an officer carried out an ACCT post-closure interview. The man said he was settled at Chelmsford and described staff as very supportive. He was still concerned about his father being unwell and talked about his mother. He said he had telephone credit and got supported from his sister and his girlfriend. He had a job in the prison and planned to use the gym. The ACCT remained closed.
36. On 26 June, the man told a nurse that he had ongoing family issues and wanted to see the prison chaplain. There is no record that he saw a member of the chaplaincy. That evening, officers found him and another prisoner fighting. A nurse treated him for bruising, lacerations to his face and head, and a neck injury. For his part in the incident, he was to be monitored by staff under the prison's violence reduction procedures (SAFE), until a review on 4 July. The other prisoner was moved to a different landing. He was told to stay away from him. It was noted that he was reminded of the services of the Listeners' scheme. (Listeners are prisoners trained by the Samaritans to support other prisoners in distress.)
37. On 28 June, a bereavement counsellor came to his wing to assess the man but he was at the plumbing workshop. The senior officer on the wing told the counsellor that they had no immediate concerns about him and the counsellor agreed that the assessment would be rescheduled for a week later.

July 2013

38. On 3 and 4 July, the man did not attend the plumbing workshop. He told an officer that he was depressed because his girlfriend had told him that she was moving to Manchester with his son. He said he thought his relationship was over, although he would be out of prison in a month and said he might try to sort things out with his girlfriend then. He said he had no thoughts of self-harm and agreed to talk to prison staff if he needed any support. A few hours later, he told the officer that he felt better because he had learned that his girlfriend was planning a visit in the next two weeks.
39. On 5 July, as there had been no further concerns raised about the man's behaviour after the fight on 26 June, the monitoring under violence reduction procedures ended. The nurse checked him later that afternoon. He was continuing to take his medication, but said that he was stressed, not sleeping well and was worried about his father and his son. He said he was trying to stay out for trouble so that nothing would affect his court appearance on 24 August. Officers told the nurse that he did not mix with other prisoners and only really talked to his cell mate. She recorded on his medical record that he had already been referred for counselling, had no thoughts of self-harm and would continue to receive mental health support. Shortly after his meeting with the nurse, he attended a session with a counsellor from Atrium.
40. On the 10 July, the man moved to another wing. There is no recorded explanation for the move. Four days later, he said he wanted a move to a different wing because another prisoner was bullying him for his medication and 'canteen' (items such as tobacco, toiletries and confectionary bought from the prison shop). It was recorded in the wing observation book that a Security Incident Report was made relating to this matter and all staff were to be vigilant, but he was not moved. There is no record that any other anti-bullying procedures were started or that there was an investigation by the violence reduction team.
41. On 19 July, a nurse recorded that the man was calm and settled. He said that he felt fit and well and the nurse recorded that he made good eye contact during conversation. He had no psychotic symptoms and no thoughts of self-harm. He was eating and sleeping well and said it was possible that he would be released from prison after his court appearance in August. The nurse encouraged him to keep himself busy and find work on the wing to avoid boredom.
42. In a personal officer entry on 22 July, an officer recorded that the man was polite and followed the wing regime without any problems. The officer noted he had a shared cell.

August 2013

43. On Wednesday 8 August, the man's prescription of antidepressant medication was repeated. On 13 August, he had his next counselling session. The

purpose of the counselling was to help him deal with the death of his mother, but he also spoke about his relationship problems. At a healthcare multidisciplinary meeting on 16 August, the Atrium counsellor suggested that he should see a doctor. The records do not indicate why the counsellor was concerned and no appointment was made.

44. The Head of Healthcare told the investigator that on 16 August when the man was given his prescription of mirtazapine, it was dispensed as in possession medication, therefore allowing him to keep the medication in his cell. It does not appear that there was any risk assessment for this.
45. The man did not go to a counselling session on 23 August because he said he was too tired to get out of bed. On 24 August, he attended Crown Court but was further remanded in custody for his trial at a later date. When he returned to Chelmsford, a nurse assessed him in reception and recorded that he was calm. No concerns were raised about his mood or behaviour and he said he had no thoughts of self-harm or suicide.
46. A nurse carried out a mental health review on 25 August. The man was said to be polite and calm throughout the review. He said that he had taken antidepressant medication since his mother's death. However, he felt that his current medication, mirtazapine, had no effect. He said that he could not sleep, felt restless and was unable to concentrate for any length of time. He said he was stressed about his court case and because he had not seen his son. He had stopped attending the plumbing course because of his low mood but had applied to work in the gardens and recycling area. He said he had no thoughts of self-harm or suicide and got on well with his cell mate. A nurse noted that he would continue to receive mental health support and would be reviewed by the psychiatrist at the earliest opportunity.
47. On 28 August, the man's cell mate was discharged from prison and he became the sole occupant of a double cell. Later that day, he told the psychiatrist and a nurse that he was stressed in prison and did not think his medication was effective. The psychiatrist's assessment reported he agreed to increase his mirtazapine from 30mg to 45mg daily, but this change was not reflected on his medical record or prescription chart. He also recorded that he had no thoughts of suicide or self-harm. The psychiatrist said that he would be reviewed in eight to ten weeks, or earlier if needed.
48. On 29 August, the prison chaplain visited the man on the wing as he had been reported to be upset after a telephone call. He told the chaplain that his sister had told him that their father was extremely ill and was due to have a potentially life threatening operation for a serious illness on 3 September. He had used all of his telephone credit speaking to his sister but wanted to speak to his sister again. The chaplain used the wing office telephone to allow him to speak to his sister. The chaplain agreed to stay in touch with the man's family and keep him up to date about his father's condition. Although he said he had no thoughts of self-harm after the telephone call, because he was upset, the prison chaplain opened an ACCT document.

49. During an ACCT assessment that afternoon, an officer recorded that the man was tearful but he said that he had no thoughts of suicide or self-harm. He talked about trying to take his own life three months before coming into prison, and said he had mental health problems. He said he wanted to visit his father in hospital.
50. The officer held an ACCT case review shortly after the man's assessment. No other member of staff was present. He said that he had no thoughts of self-harm. An officer noted that the chaplain would provide him with updates on his father's condition. His caremap was changed to reflect this. He was to be referred to the counselling service. The officer assessed him as a low risk to himself and set ACCT observations at three daily staff recorded interactions and hourly checks during patrol state². The next ACCT review was scheduled for 4 September. It was noted that the counsellor and the chaplain would be invited to attend.
51. The man attended a counselling session the next day. The counsellor recorded that he appeared 'spaced out', possibly because of an increase in his medication. However, his prescription chart did not reflect that his dose had increased. He said he was still very concerned about his father's operation on Monday 3 September.

September 2013

52. On 1 September, an officer, who normally worked on another wing, was helping out on the man's wing over the lunch period. She recorded in the ACCT log that he had told her that he had not been out on in the exercise yard to spend time in the open air for some time, because he could not cope with being around other people. He said he wanted a job outside to get some fresh air and to get him out of his cell and stop him thinking about his father's serious illness. After his death, she told the police that she took no action about this herself, but noted it in the ACCT log on the assumption that it would be picked up by wing officers or through ACCT management checks. A manager checked the ACCT log later that day but did not refer to the officer's entry and no action was taken about his request.
53. The chaplain arranged for a member of the chaplaincy team to speak to the man's sister each day and keep him up to date about his father's condition. On 2 September, the day before his father's operation was scheduled to take place, it was postponed.
54. At an ACCT review on 4 September, chaired by a SO and attended by the chaplain, the man said that he was still worried about his father. He said that he would get more telephone credit the next day and he could contact his sister without the help of the chaplaincy from then on. The chaplain reminded him that he would still be offered ongoing support and the SO reflected this in the ACCT caremap. He noted that his level of risk had increased to raised but his ACCT observation level was to remain the same (three daily

² Patrol state is when all prisoners are locked in their cell.

interactions and hourly checks during patrol state). There was no reference to the officer's entry in the ACCT document on 1 September, about his request for a job in the open air. The next ACCT review was scheduled for 18 September, two weeks later.

55. The chaplain continued to visit the man each day. On 6 September, he told the chaplain that his father's operation had been postponed for at least a month.
56. All prison telephone calls are recorded but most are not listened to unless there are security reasons to do so. The investigator obtained transcripts of telephone calls made by the man on 6, 8 and 9 September 2012. Prison staff had not monitored the calls at the time he made them.
57. On 6 September, the man made two telephone calls to his girlfriend. He said he had tried to hang himself the previous Tuesday because he had had enough and was stressed. There is no evidence of this in his prison records. They spoke about their son and their relationship. He also telephoned his sister. He said he was depressed and was not sure if he would be able to cope if he was found guilty at his trial. He told his sister that he was having problems with his girlfriend, but did not mention that he had tried to hang himself. In telephone calls to his sister on 8 and 9 September, he did not talk about harming himself but asked his sister to send him some money and stamps.
58. On 10 September, the man attended a counselling session which focused on his anxiety and concern about his father. A member of the chaplaincy team continued to visit him daily to offer him support until Thursday 13 September. On each occasion, he said he was okay and that there was no further news from his family about his father.
59. A prisoner who lived in the cell below the man's told the investigator that the man's mood was up and down. He said that the man was concerned about his father being ill and he often complained that he did not have enough money to buy tobacco. He said that on one occasion the man had swapped some trainers in exchange for tobacco. He thought that he was also anxious about the length of sentence he might receive. He did not believe that he was ever the victim of bullying and he saw no indication that he would harm himself. He said the man sometimes bought medication from other prisoners to help him sleep.

Day of the incident

60. On the day of the incident, at about 9.00am, an officer unlocked the cells on the man's landing. After the cells were unlocked, prisoners were allowed outside for fresh air. He did not go to the chapel as he normally did. An officer recorded in his ACCT observation log that he refused to go outside, but came out of his cell onto the landing and said he was okay. He collected his medication from the dispensing hatch on the wing.

61. The prisoners' lunch was served between 11.30am and 12.00pm. After collecting his lunch, the man was locked in his cell. It was recorded in his ACCT observation log at 12.15pm (shown on CCTV as happening at 12.06pm) that prison staff went to a number of cells giving out extra food and that he had accepted some more food.
62. At 12.50pm, an officer recorded in the ACCT observation log (12.39pm on CCTV), that he had checked the man through the cell observation panel. The officer said he remembered that he was standing on his bed talking to another prisoner through his cell window and that he waved to acknowledge him. In his police statement, the officer said that he closed the observation panel after he had checked him.
63. Between 12.15pm and 1.40pm, prisoners were locked in their cells and the prison was in patrol state for staff to have lunch. A prisoner shared a cell with the man on the landing below. He told the investigator that he often talked to him through the window. Before he went to the gym that day, at 2.00pm, he said he passed him some sauce and tobacco out of the window.
64. An officer recorded in the ACCT ongoing record at 1.50pm that the man was sitting in his cell watching TV. The investigator reviewed CCTV footage for the afternoon of 15 September. The CCTV shows the officer walking past the cell at 1.46pm and glancing in its direction. Another officer said he had closed the observation panel when he conducted the earlier check and the other officer was not close enough to open the panel. The investigator was told that observation panels are normally closed but could be left opened by staff if they had concerns. Prisoners also sometimes opened observation panels from inside or when they were passing a cell.
65. Between 2.00pm and 3.00pm, a prisoner said he spoke to the man on and off through his cell window. He passed him some cigarette papers. He had no concerns about him.
66. An officer recorded in the man's ACCT log at 2.50pm (2.41pm on CCTV) that the man was lying on his bed on his left hand side watching television. On the CCTV footage at 2.38pm and between 2.40pm and 2.58pm, the officer was standing outside his cell with his back against the cell door. Due to the location of the CCTV camera and the obstruction of a prisoners' phone, next to his cell, it is not possible to see whether or not he looked into the cell. In his police statement, the officer said that, as far as he could remember, he carried out checks on him which he recorded at 1.50pm and 2.50pm in the ACCT on-going record. He said that he made both entries retrospectively at the same time before the last meal of the day was served just before 4.00pm. The matter of whether the officer properly conducted and recorded the ACCT observations that afternoon was subject to a police investigation. No action was taken.
67. Around 4.18pm, officers began unlocking prisoners on the man's landing for their dinner. When the officer unlocked his cell he saw him facing the back wall. Bed sheets were tied around his neck and attached to the window bars.

The officer immediately shouted for staff assistance and made a Code 1 emergency radio call, which indicated a life-threatening situation. The prison incident log records that at 4.18pm, the prison communication room contacted the orderly officer in charge of prison that day and the nurse the emergency response nurse. An ambulance was called at the same time.

68. The officer quickly went into the cell and used his anti-ligature knife to cut the sheet. A prisoner was nearby when he heard the officer shout for help. He went into the cell and assisted the officer by supporting the man's body. When a SO, who was on the wing, heard the officer's shout, he pressed the general alarm button. He said he got to the cell in 15 seconds with an officer and helped to lower the man to the floor. The prisoner left the cell.
69. The SO, who was first-aid trained, removed the ligature from around the man's neck. A deep cut was visible, his body was cold and his arms and forearms were purple. An officer, who had previously had first-aid training, said he appeared to be dead, but she said they should start cardiopulmonary resuscitation³ (CPR). The officer passed a mouth shield to her and another officer gave him two rescue breaths, which were ineffective as there was no movement in his chest. The officer said she was unsure of the advised ratio of rescue breaths to chest compressions, but she then started chest compressions. The SO also helped by doing chest compressions. An officer left the cell to collect the first aid equipment from the wing office but another officer had already brought it. Another SO then arrived at the cell.
70. Two nurses responded to the emergency call and arrived at the cell at 4.20pm when a SO was carrying out CPR. One nurse immediately assessed the man for signs of life, but there were none. He was pale, not breathing and had no pulse, and there was a deep ligature mark around his neck. She managed to insert an airway in his mouth, although this was difficult because his jaw was stiff. Resuscitation continued, and a defibrillator⁴ was attached, which indicated that there was no detectable heart rhythm so no shock should be administered.
71. A doctor arrived at 4.27pm and assisted the healthcare staff with CPR. The prison staff continued resuscitation attempts until an ambulance crew arrived at 4.28pm and took over. A second paramedic crew arrived at 4.32pm. As the cell was cramped, the man was moved to the wing landing where CPR continued. The ambulance crew, the doctor and the nurses then agreed that resuscitation was not going to be possible. His death was confirmed at 5.00pm.

Medication found in the man's cell

72. The following medication was found when the man's cell was searched after his death:

³ Cardiopulmonary resuscitation is an emergency procedure which is performed in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person in cardiac arrest.

⁴ A defibrillator is a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest.

- Unopened mirtazapine 30mg dispensed to him
- Paracetamol tablets dispensed to him
- 22 capsules of amoxicillin (antibiotic) not dispensed to him
- Two empty sleeves of 400mg tegretol (an anticonvulsant and mood stabiliser) dispensed to his former cell mate who had been released from custody on 28 August

Bullying allegations

73. After the man's death, a prisoner alleged that a prisoner from the cell below had bullied him. On 17 September, the Violence Reduction Team interviewed this prisoner and his cell mate, after this prisoner had been found with a pair of the man's trainers in his cell. The team concluded that the man had swapped his trainers with this prisoner in exchange for tobacco. The investigator interviewed this prisoner, who said that the man had agreed to give him his shoes in exchange for tobacco and had not been bullied for them.

Support for prisoners

74. Notices were displayed in the prison to let prisoners know of the man's death and the support that was available to them. All prisoners subject to suicide and self-harm monitoring procedures were reviewed in case they had been adversely affected by his death. His cellmate received some individual support. The next weekend, prayers were said for him during the prison church service.

Support for staff

75. After the man's death an operational manager held a hot debrief to support all the staff who had been involved in the incident. The staff care team visited the wing and offered their services for further support.

Family Liaison

76. A SO and a member of chaplaincy were appointed as the family liaison officers, along with an officer. They visited the man's sister at her home that evening to break the news of his death. The man's father and two brothers were also present. The SO and chaplaincy member gave them their contact details and offered financial assistance towards funeral costs in line with Prison Service guidance. The funeral was held on 26 September.

Post-mortem report

77. The post-mortem report concluded that death was caused by suspension.

ISSUES

Clinical care

78. The clinical reviewer considers that the clinical care received by the man while he was in HMP Chelmsford was generally comparable with the care he could have expected to receive in the community. However, some improvements were needed to deal with urgent mental health referrals and management of prescriptions and dispensing which are set out below.

Mental Health

79. When the man arrived at Chelmsford a nurse in reception had some concerns about his mental health. He opened an ACCT and referred him to the mental health team. Four days later, on 12 June, a mental health nurse assessed him. The nurse referred him for an urgent psychiatric assessment, but he did not see a psychiatrist until seven days after that, on 19 June.
80. The prison told the investigator that there are no clear timescales for an urgent psychiatric assessment to take place after a referral. Psychiatric assessments can take place three times a week (Monday, Tuesday and Fridays). However, we agree with the clinical reviewer that an urgent referral should have been dealt with as soon as possible, no more than three days after the referral. We make the following recommendation:

The Head of Healthcare should ensure that psychiatric assessments are completed within three days of an urgent referral.

Antidepressant prescription

81. The clinical reviewer considers that the man was appropriately prescribed mirtazapine 30mg when he first arrived at the prison on 8 June 2012. On 28 August, the psychiatrist agreed to increase his dose to 45 mg because he was stressed and did not think his medication was working. However, his prescription chart was not updated to reflect this increase and it does not appear that he ever received the increased dose which the doctor had specified. On 30 August, the Atrium counsellor described him as 'spaced out' which she attributed to an increase in his medication, but there is no evidence that him received the increased dose. At the time of his death, 30mg of mirtazapine prescribed for him was found in his cell.
82. The Head of Healthcare said that it is the responsibility of the nurse who assists the doctor during assessments to ensure that all prescription charts are kept up to date and acted upon. The man's increase in medication was intended to improve his mental health yet this was not done. It is important for patient safety that prescription charts accurately reflect the treatment that doctors have specified. We make the following recommendation:

The Head of Healthcare should ensure that any changes in medication are entered promptly and accurately on the prescription record and medication is dispensed as directed by the doctor.

Medication management

83. Chelmsford's local policy, "Medication In-Possession of Prisoners", requires that a multidisciplinary risk assessment is completed if staff are concerned about a prisoner's ability to manage his own medication and keep it in his cell. The risk assessment takes into account the risk of self-harm, history of overdose, mental health, recent adverse events, among other factors. If the risk to the prisoner is too great, the prisoner will collect his medication from the wing every day and staff will watch him taking his medication. There was no such risk assessment in his record. Chelmsford's policy requires that no prisoner on an open ACCT should be given a supply of medication to keep in their cell.
84. A doctor prescribed the man mirtazapine when he first arrived at Chelmsford to be taken under staff supervision. His medication record was entitled "not in possession prescription chart", and recorded that he was given 30mg mirtazapine daily under staff supervision, in line with the doctor's direction. On 16 August, a locum GP changed his prescription to "in possession" which meant he would no longer be required to take it supervised and could keep it in his cell. This explains why some mirtazapine was found in his cell after his death. No reason was documented for this change and there is no evidence that a medication risk assessment was completed. Although he was no longer on an ACCT at the time, he had taken a drug overdose not long before.
85. We agree with the clinical reviewer that Chelmsford's own policy was not followed in this case. There should have been a risk assessment in June and August, which was revisited each time the man's situation changed, at least when his ACCT was closed, and another opened. When a prisoner has been considered too high a risk to manage his own medication, he should not be able to store that medication in his cell. We make the following recommendation:

The Governor and Head of Healthcare should ensure that medication is dispensed to prisoners safely and with appropriate risk assessments in line with the prison's policy for in-possession medication.

Assessment and management of risk of suicide and self-harm

86. When the man arrived at Chelmsford on 8 June we consider that an appropriate decision was taken to monitor and support him through ACCT procedures. He was suffering from anxiety and depression and had previously self-harmed including taking a drug overdose just weeks before. However, we have a number of concerns about the management of the ACCT procedures after that.

ACCT reviews

87. The man's first ACCT review was held on 9 June, immediately after his ACCT assessment, which had been carried out by a manager. Prison Service Instruction (PSI) 64/2011- Safer Custody says that the first case review should be attended by 'the Residential Manager, or equivalent and/or the Case Manager (if different), the Assessor, whenever possible, a member of staff who knows the prisoner e.g. wing officer, the person who raised the initial concern, healthcare, and any other member of staff who will has or will have contact with the at-risk prisoner and who can contribute to their support and care.' It is evident that it is not envisaged that reviews will take place with just one member of staff, yet the SO went ahead with the review on her own.
88. The PSI outlines some of the purposes of the first case review which includes identifying the prisoner's most pressing needs and how to address them, the level of risk taking into account all sources of information, agree how the prisoner will be supported, identify whether referrals such as for mental health care are needed and complete a caremap. At this review, the SO decided to close the ACCT, less than 24 hours after it had been opened, apparently simply on the basis that he told her that he did not intend to harm himself. Caremap actions (which we discuss in more detail below) could not have been completed.
89. The first case review after the man's second ACCT was opened on 29 August, was again held only with one member of staff. Despite mental health being highlighted as an area of risk for him, none of his case reviews were attended by a member of the healthcare team, nor is there any evidence that their views were sought. The case review held on 29 August noted that the counsellor and chaplain would be invited to attend the next review on 4 September. The counsellor did not attend.
90. On 1 September, an officer recorded in the ACCT ongoing record that the man had told her that he found it difficult to mix with other prisoners and stayed in his cell a lot. He asked for a prison job outside so he could get some fresh air. He said this would also stop him thinking about his seriously ill father. There was no reference to this at his subsequent ACCT review on 4 September and little evidence that the reviews actively considered the risks involved. He came from the Traveller community but there is no evidence that his cultural heritage and how it might impact on his risk in prison was considered, although suicide rates among young men from the Traveller community are much higher than comparable groups. As well as no healthcare representation at the reviews there was no diversity representative.
91. PSI 64/2011- Safer Custody requires that ACCT case reviews are held by a multidisciplinary team and states that "the ACCT process will operate more effectively if there is continuity in the attendance of staff from relevant departments/services". We do not consider that his risk was effectively managed by multidisciplinary case reviews. The case reviews were poorly attended and failed to take into account all of the information available in the ACCT document and all the risk factors. It is particularly unacceptable that

his first ACCT should have been closed after only one day and by a single member of staff acting on their own when the foundations of the ACCT process, is based on teamwork. We make the following recommendation:

The Governor should ensure there is a multidisciplinary approach to managing prisoners subject to ACCT procedures. At each case review staff should record, review and fully take into account all information and indicators, including from the ACCT ongoing record and any diversity issues, when assessing the risk of suicide and self-harm.

ACCT caremaps

92. PSI 64/2011 requires that ACCT caremaps reflect the prisoner's needs, triggers for self-harm and their level of risk. It says that the caremap must aim to address the issues identified in the ACCT assessment interview and give consideration to a range of issues including mental health intervention, family contact, peer support, time out of cell and other regime and diversionary activities. The ACCT assessment completed on 9 June identified that the man should be referred for bereavement counselling, referred to the mental healthcare team, see a member of the chaplaincy team and that he should share a cell. It was suggested that he should move to a different wing and apply for employment.
93. However, the subsequent ACCT caremap completed on 9 June had only two actions – to move to C wing and to share a cell. None of the other issues identified at his assessment interview were included in his caremap which appears a significant omission. Nor were any of the other issues suggested in the PSI covered. PSI 64/2011 requires that an ACCT can be closed only when all the actions of the caremap have been completed. Despite the limited targets in the caremap, the first ACCT was closed on 9 June before these had been achieved.
94. On 29 August, an officer drew up the man's second caremap and identified only one measure of support which was ongoing contact with the chaplaincy. This action was updated when the ACCT was reviewed to reflect that it was still ongoing. Although he was receiving bereavement counselling there was no reference to this in the caremap. Family contact was an important issue for him at the time but there was no caremap action. Nor was there a reference to his request to get a job in the open air, which might have helped to reduce his risk. We make the following recommendation:

The Governor should ensure that ACCT caremaps address the cause of the prisoner's distress, that realistic goals are set that meet identified needs and that these are reviewed and fully updated at each ACCT review. ACCTs should not be closed until all caremap actions have been completed.

ACCT checks

95. The man's agreed level of ACCT observations required that he should be checked at least once an hour when he was locked in his cell during the prison's patrol state. The investigator reviewed the CCTV footage and shares the police's initial concerns that it does not appear that an officer carried out the ACCT observations as required and as he recorded on the afternoon that the man died. (The officer has subsequently retired from the Prison Service.) Even if the checks had been done as recorded, an hour and 28 minutes elapsed between the last recorded check and the officer finding him hanging, although checks were supposed to have been completed at least hourly.
96. ACCT observations are intended to ensure the well-being of prisoners and offer them support as needed. The level of observation is agreed at a case review according to a prisoner's level of risk. They should not be at predictable intervals as appeared to be the case with the man. The PSI guidance about day to day management of ACCT plans says that that conversations and observations "must be recorded immediately or as soon as practicable thereafter" yet the officer said that he made entries for observations made at 1.50pm and 2.50pm retrospectively just before 4.00pm. We are concerned that there is too little management oversight to ensure that ACCT observations are carried out as expected. We make the following recommendation:

The Governor should ensure that all staff undertake ACCT observations as directed and actively engage with prisoners being monitored. Managers should carry out random checks of CCTV footage to help ensure this happens.

Emergency response

97. CPR was started as soon as the man was found hanging in his cell, but with no success. The prison officers, healthcare staff and paramedics worked together in their efforts to revive him but were unable to do so.
98. The nurses who attended the man's cell were unable to open his mouth to introduce an airway. The emergency bag taken to the cell contained a tube to obtain an airway through the nasal passage for situations when it is difficult to establish an artificial airway through the mouth, but the tube was not used. The clinical reviewer notes that, while it seems the use of such a tube (known as a nasopharyngeal tube) might not have altered the outcome in this case, its use should be considered in an emergency when an airway cannot be established through the mouth. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use a nasopharyngeal tube when necessary in an emergency situation.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that psychiatric assessments are completed within three days of an urgent referral.
2. The Head of Healthcare should ensure that any changes in medication are entered promptly and accurately on the prescription record and medication is dispensed as directed by the doctor.
3. The Governor and Head of Healthcare should ensure that medication is dispensed to prisoners safely and with appropriate risk assessments in line with the prison's policy for in-possession medication.
4. The Governor should ensure there is a multidisciplinary approach to managing prisoners subject to ACCT procedures. At each case review staff should record, review and fully take into account all information and indicators, including from the ACCT ongoing record and any diversity issues, when assessing the risk of suicide and self-harm.
5. The Governor should ensure that ACCT caremaps address the cause of the prisoner's distress, that realistic goals are set that meet identified needs and that these are reviewed and fully updated at each ACCT review. ACCTs should not be closed until all caremap actions have been completed.
6. The Governor should ensure that all staff undertake ACCT observations as directed and actively engage with prisoners being monitored. Managers should carry out random checks of CCTV footage to help ensure this happens.
7. The Head of Healthcare should ensure that healthcare staff use a nasopharyngeal tube when necessary in an emergency situation.

ACTION PLAN: The man - HMP & YOI Chelmsford

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that psychiatric assessments are completed within three days of an urgent referral.	Accepted	We now facilitate seven Psychiatric Consultancy sessions per week, Monday to Friday. Any urgent referrals which require a Psychiatric input will be seen within the three recommended days.	06/08/2013	
2	The Head of Healthcare should ensure that any changes in medication are entered promptly and accurately on the prescription record	Accepted	SystemOne is now being utilised to prescribe and dispense, this was not in place September 2012 for all prescriptions. The Psychiatrists now also prescribe off of SystemOne.	31/08/13	

	and medication is dispensed as directed by the doctor.				
3	The Governor and Head of Healthcare should ensure that medication is dispensed to prisoners safely and with appropriate risk assessments in line with the prison's policy for in-possession medication.	Accepted	All prisoners receive an agreed risk assessment for their suitability for In-Possession Medication. Prisoners on E,F and G on both see to take and in possession medication collect their medication from hatches during the prison core day. On Centre all IP meds are dispensed from the Centre Med Hatch. All See to Takes are currently administered by Nursing staff with the support of an officer on the wings when prisoners are out. We are currently installing Medical hatches to both C & D Wings	31/08/13	

4	<p>The Governor should ensure there is a multidisciplinary approach to managing prisoners subject to ACCT procedures. At each case review staff should record, review and fully take into account all information and indicators, including from the ACCT ongoing record and any diversity issues, when assessing the risk of suicide and self-harm.</p>	Accepted	<p>All reviews are discussed at the morning operational meeting and departments are requested to confirm their attendance to the reviews. The dedicated Custodial Manager carries out compliance checks ensuring that the reviews are carried out timely and with the appropriate attendance and that this is recorded accordingly.</p>	31/08/13	
5	<p>The Governor should ensure that ACCT caremaps address the cause of the prisoner's distress, that realistic goals are</p>	Accepted	<p>Care maps will have realistic and achievable outcomes, caremap actions will be completed prior to closure of the ACCT and HCC will be consulted prior to closure. This requirement is included in both National and local policies. We are delivering training to all individuals who are involved in the ACCT process. This training is being overseen by the dedicated Custodial manager</p>	31/08/13	

	<p>set that meet identified needs and that these are reviewed and fully updated at each ACCT review. ACCTs should not be closed until all caremap actions have been completed.</p>				
6	<p>The Governor should ensure that all staff undertake ACCT observations as directed and actively engage with prisoners being monitored. Managers should carry out random checks of CCTV footage to help ensure this happens.</p>	Accepted	<p>Management checks of CCTV will be carried out if there was a cause for concern or following any incident deemed appropriate. We are currently looking into using the cell bell button outside the cell as another form of registering the attendance of staff and the logging of the time, A trial period has proved positive and subsequently. This system will be fully introduced by 08/09/13</p>	08/09/13	

7	The Head of Healthcare should ensure that healthcare staff use a nasopharyngeal tube when necessary in an emergency situation.	Accepted	All staff are trained to use all airways, including Nasopharyngeal. The airway of first choice should be IGEL, as this does not require stabilising and allows the response nurse to continue assessment and CPR if alone. However if a jaw is fixed, and not papable then a naso airway will be inserted.	31/08/13	
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