

**Investigation into the circumstances surrounding the
death of a man at HMP Chelmsford
in September 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

February 2010

This is the report of an investigation into the circumstances surrounding the death of a man at HMP and YOI Chelmsford. His short and tragic life ended during the early hours of 20 September 2008, just four days after his reception at Chelmsford. It was the first time he had been in an adult prison. He was discovered hanging in his cell by staff at about 5.20am.

The man faced many painful events during his life, not least the death of one of his uncles and the difficulties experienced by his mother in her own life. In view of this, it must be particularly distressing for his mother, sister and other family members now to suffer the sorrow of his loss. I would like to add my condolences to those already expressed to his family by my investigators and by one of my Family Liaison Officers.

Two investigators carried out the investigation. I would like to thank the Governor of Chelmsford and his staff for their participation. Particular thanks go to Mr B for making all the practical arrangements. The Primary Care Trust commissioned a clinical reviewer to undertake a review of the man's clinical care and I also thank them for their assistance. I also appreciate the help the Youth Justice Board and members of the Youth Offending Team gave to my investigators.

I have found that procedures were not in place to ensure the transfer of key information between the Youth Offending Team and the prison at the time the man came into custody. Furthermore, if staff had acted on information received the day after his arrival it seems likely he would have been placed on self-harm monitoring. Of course, it is not possible to say that his subsequent actions would have been different, but the risks could well have been reduced. I do not believe that everything was done that could have been done to have prevented his death.

I make a total of ten recommendations. Of these, eight are directed to the Governor of Chelmsford. I also make one recommendation for the National Probation Service and Youth Justice Board relating to the transfer of information between the two services. Another recommendation is for the Prison Service and relates to entries on Prisoner Escort Records at court. Finally, I believe Sister C should be commended for her actions on the morning of 20 September. She went into the prison and spoke personally to all the prisoners on C wing following the man's death. I regard this as good practice. There has been no response to the recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

In August 2005, the man who is the subject of this report came into contact with a Youth Offending Team (YOT) for the first time. He volunteered to work with a member of the Resettlement and After Care Provision Team (RAPT) in November 2005.

On 29 November 2007, the man was sentenced to 18 months in custody under a Detention and Training Order (DTO). He was required to serve half the sentence in custody and the remainder on licence in the community. When he became 18 responsibility for the man remained with a YOT instead of being transferred to the Probation Service as he was still serving an 18 month DTO. He was released a month early from HMP and YOI Huntercombe on 28 June 2008 on Home Detention Curfew (HDC). HDC allows prisoners to serve part of their sentence in the community, subject to monitoring via an electronic tag.

The man appeared before a Magistrates Court on 16 September. A Prisoner Escort Record (PER) was completed shortly before he left police custody that day in which he was identified as a suicide/self-harm risk. A note added to the form stated that he had said he would smash his head open in custody.

As the Magistrates' Court is an adult court there was no official YOT presence. (A duty probation officer was present.) However a member of RAPT arrived at the court after the hearing and visited the man in the cells. She was concerned for him as she found him to be "hyper", laughing and joking and "too happy", which was different to his usual demeanour in these circumstances.

The man arrived at HMP and YOI Chelmsford during the evening of 16 September. Unfortunately, none of the staff who spoke to him in the reception area identified him as being at risk of self-harm.

Members of the YOT met during the morning on 17 September to discuss his safety. They then contacted the duty governor at Chelmsford to outline their concerns. A follow up email was sent but not received at the prison. An entry was made in the wing observation book that read, "SO D phoned and said the man's Youth Offending Team had called and said that they were worried about him and could staff watch him."

At about 5.23am on 20 September, Officer E carried out his early morning prisoner roll check on C wing. He looked in cell C3-027 and discovered the man hanging from a ligature attached to the cell window bars. As rigor mortis had set in, resuscitation was not attempted and paramedics pronounced his death shortly afterwards.

THE INVESTIGATION PROCESS

1. My investigator obtained the man's prison and medical records and made initial contact with the prison's liaison officer, Mr B on 23 September. The investigation was formally opened on 26 September 2008 when my investigator met the deputy governor. All other documents likely to be required for the investigation were requested at this time.
2. Notices were issued to staff and prisoners prior to the investigators initial visit to Chelmsford. They announced the investigation and invited anyone who had information about the man's death to make themselves known to my investigator. In the event, one prisoner came forward.
3. My investigator's colleague, Mr A, interviewed three members of the Youth Offending Team (YOT). Interviews relating to the man's time in custody were conducted by my investigator. A total of over 30 interviews took place. They were either recorded or notes taken. Copies are attached as an annex to this report.
4. My investigator considered the latest Independent Monitoring Board (IMB) report and spoke to the member of the IMB with responsibility for issues relating to safer custody. HM Chief Inspector of Prisons carried out an announced inspection in July 2007, and the report of that inspection was also considered.
5. An independent clinical review of the healthcare the man received whilst in custody was carried out by the local Primary Care Trust. The clinical reviewer was asked to consider all clinical issues. Her brief summary of the man's care is also attached as an annex.
6. My investigator contacted HM Coroner to inform her of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of this report will be sent to the Coroner to assist her enquiries.
7. Throughout the investigation process, my investigator provided the deputy governor with regular updates of emerging findings. As a result, several procedural changes were implemented by the prison before this report was published.
8. One of my family liaison officers contacted the man's next-of-kin to offer them the opportunity to participate in the investigation. My investigator and family liaison officer visited the family. Several concerns were raised about the care the man received whilst at Chelmsford. Where they were within my terms of reference, I have addressed them within this report. My investigator was also able to answer some of their questions during his visit with the family and in subsequent correspondence. I hope my report helps the family to better understand the events leading up to their son's death.

THE MANAGEMENT OF CHILDREN AND YOUNG PEOPLE

Youth Justice Board

9. The Youth Justice Board (YJB) is a public body whose purposes include monitoring the operation of the youth justice system and the commissioning of youth justice services. From April 2000, the YJB became the commissioning and purchasing body for all forms of secure accommodation for children and young people.

Youth Offending Teams

10. Under the Crime and Disorder Act 1998, local authorities with responsibilities for Social Services and education are required to establish Youth Offending Teams (YOTs). The teams work in partnership with Police, Probation Services, Health Authorities and Social Services. The role of the YOTs is to work with young offenders, and those at risk of offending, in order to turn them away from crime. The teams coordinate the delivery of a range of youth justice services including the supervision of community sentences and of young people released from custody.

Detention and Training Orders

11. The Detention and Training Order (DTO) was introduced as part of the Crime and Disorder Act in 1998 for young people aged under 18. The sentence was devised, in part, to make custody more effective in preventing re-offending.
12. There are seven DTO sentences available to the courts ranging from four months to 24 months. Half of the sentence is served in custody and the other half under supervision in the community.
13. There are three types of secure accommodation in which a young person serving a DTO can be placed. These are:
 - A Secure Training Centre (STC)
 - A Secure Children's Home (SCH)
 - A Young Offender Institution (YOI).
14. STCs are purpose built centres for young offenders up to the age of 17.
15. SCHs provide young children with support tailored to the individual's needs. They are generally small facilities with a high ratio of staff to young people. There are 14 such facilities in the country ranging in capacity from six to 40 beds.
16. YOIs are run by the Prison Service and can accommodate 15 to 21 year olds. These establishments normally have a lower ratio of staff to young people and they accommodate larger numbers.

Placement of young people

17. The YJB is responsible for allocating young people to the most appropriate custodial establishment. Specific needs of the individual, bed spaces, location and the age of the individual are considered. The placement is decided after a vulnerability assessment is completed by the YOT, known as an Asset. The Asset is a structured assessment that aims to identify the key factors contributing to offending:
 - to provide a prediction of reconviction
 - to help identify young people who may present a risk of serious harm to others
 - to identify situations in which a young person is vulnerable to being harmed
 - to identify issues where more in-depth assessment is required.
18. Ideally, a young person sentenced to a DTO will be placed close to his family home in an environment that suits his needs. In general, if an individual is not identified as vulnerable, and is aged between 15 and 18 years, they will be sent to a YOI.

Transfer of responsibility to the Probation Service

19. When a child reaches the age of 18 they are classed as a young adult and responsibility passes from the YJB to the Probation Service. The YOT has no further responsibility for the individual unless they are still serving the community part of their DTO sentence.

YOUTH OFFENDING TEAM

20. The man who died first came to the attention of the Youth Offending Team (YOT) in 2005 when he was placed on an Intensive Supervision and Surveillance Programme.
21. In May 2008, Ms F took over case management responsibility for the man. Ms F manages the whole range of youth community and custody orders from first time offenders through custodial sentences, including orders requiring intensive supervision. When the man was released from Huntercombe he was required to have contact with the YOT team twice weekly. He usually had between two and four contacts per week. Ms F met him at least once each week.
22. A specialist substance misuse/mental health worker also met the man on a weekly basis. He provided a transitional substance misuse service from the Child and Adolescent Mental Health Service (to whom the man was previously known) to adult services for those who had turned 18. Ms F told my investigator that he was resistant to these sessions as they were “opening up old wounds”.
23. A member of the Resettlement and After Care Provision Team (RAPT), began working with the man in 2005. She is a counsellor specialising in cases of substance misuse. She provides advocacy and counselling services for young people in the community and in custody who present complex needs. These needs include “dual diagnosis” (substance misuse and mental health problems) and “hidden harm”. The RAPT within the YOT provides a voluntary service in addition to statutory enforceable appointments. The member of RAPT maintained very regular contact with the man and usually met him once and often twice each week.
24. Mr G was a YOT team manager in September 2008. He did not directly have line management responsibility for any of the man’s YOT workers who were managed by a senior practitioner. However, he was responsible for managing a team with between 160 to 200 cases. In addition he had special responsibility for court work. Mr G left the YOT on 20 September 2008.

HMP & YOI CHELMSFORD

25. HMP Chelmsford is a category B local prison built in 1830. It is located within walking distance of the city centre. Originally built as a county jail with four wings, the prison has been extended twice and currently has an operational capacity of 695. The prison's function is to serve the courts. Prisoners are held on six main wings. There is a small healthcare centre that has 12 in-patient beds.
26. Until recently, the prison induction unit was located on E wing and held approximately 120 prisoners. The introduction of an Integrated Drug Treatment System (IDTS) on E wing has resulted in a gradual reduction in the number of spaces available for prisoners undergoing Induction. Induction has now been moved to a new location. (The IDTS programme includes maintaining prisoners on methadone instead of placing them on a detoxification programme. Detoxification was the only option prior to the introduction of IDTS.)
27. More than one third of the prison population is made up of young people under the age of 21. At Chelmsford, they are distributed throughout the prison. The prison no longer holds juvenile prisoners (those under the age of 18).
28. The man's death in September 2008 was the sixth self-inflicted death in custody at Chelmsford in a ten month period commencing in November 2007. In each case the method used was hanging. Since 2004, this is the 11th death I have investigated at Chelmsford.
29. The IMB member with responsibility for monitoring safer custody, told my investigator that the safer custody team had considered in some depth possible links between the recent deaths. No pattern had emerged. He commented that the safer custody committee had recently been reconstituted under the leadership of the deputy governor. Future plans included moving responsibility for safer custody to the psychology department. The IMB member welcomed this move.
30. HM Chief Inspector of Prison's report in July 2007 found that induction appeared efficient and appropriate, although it only lasted one day. Her report goes on to say that, although the personal officer scheme had been re-launched, it had not yet become embedded. Many entries on wing history sheets focused on prisoners' compliance and did not suggest general engagement between staff and prisoners.
31. HM Chief Inspector of Prison's also found few entries to demonstrate quality engagement with prisoners who were subject to an Assessment, Care in Custody and Teamwork (ACCT) document. (The ACCT procedure provides additional monitoring and personalised support for prisoners considered to be at risk of self-harm or suicide.)

KEY EVENTS

Prior to the man's arrival at Chelmsford

32. In August 2005, the man who is the subject of this report received a referral order after being found guilty of possessing an offensive weapon. It brought him into contact with the YOT for the first time. He volunteered to work with a member of RAPT after receiving an Intensive Supervision and Surveillance order at a Youth Court. Regular notes were made relating to the man on the Young Offenders Information System (YOIS). Over the next two years, the member of RAPT developed an in-depth knowledge of the man. In particular, he had problems with alcohol, drugs and self-harm. It was believed that these issues may have been linked to his relationship with his mother and other family members. He lived with his older sister throughout the majority of this period, and she was a great support to him.
33. In August 2007, the man was arrested for burglary and remanded into custody at HMYOI Feltham. This was his first experience of prison custody. The member of RAPT told my investigator that, whilst he was at a Crown Court in late October, he was discovered cutting himself with a badge. There were also reports that he had been banging his head. When he arrived at Feltham he was placed on self-harm monitoring but no further incidents were reported.
34. On 29 November 2007, the man was sentenced to 18 months under a Detention and Training Order (DTO). He was required to serve half the sentence in custody and half on licence in the community. He transferred from Feltham to HMYOI Huntercombe to serve the custodial part of the order. He progressed well during his time at Huntercombe. He attained an educational qualification and attended church services, and there were no further acts of self-harm. The member of RAPT attended most case review meetings whilst he was at Huntercombe due to his high needs and vulnerability. The reviews were normally held fortnightly and, whenever possible, his sister accompanied the member of RAPT and visited the man.
35. The man's 18th birthday was in April. As he was still serving an 18 month DTO, responsibility for him remained with the YOT instead of being transferred to the Probation Service. Ms F became the man's case manager in May 2008. She confirmed that responsibility for him would remain with the YOT until the full DTO had been completed in April 2009.
36. On 28 June, the man was released a month early from Huntercombe on Home Detention Curfew (HDC). One of the conditions of release was that he should live with his sister. He attended regular meetings with YOT workers. The member of RAPT told my investigator that he appeared well, healthy and happy when he was released. Although he admitted to drinking heavily during the weekend of release, he stopped drinking excessively for about two months. During this period, he was seen up to four times a week by a variety of youth workers. He did not miss any appointments and often popped in to the YOT offices to chat with staff.

37. The man moved into his own bed-sit accommodation at the end of August. This was provided by the Homeless Persons Unit. He acquired a puppy, Charlie, which he felt gave him some responsibility. He also attended a local church. The member of RAPT told my investigator that the man was happy to have his own home as it meant giving his sister a well earned break. Ms F told my investigator that he felt he was a burden on his sister who had been looking after him since she was 18 years old.
38. At about the same time that he moved home, he had a serious argument with his mother. He began drinking again and missed two YOT appointments. The YOT case diary indicates that two unsuccessful attempts were made to contact him on 3 and 8 September. On 10 September, Ms F met him to discuss his case. He told her that he had been arrested for assault the previous week when he had gone to help a member of the public who was being attacked. In the process he had lost his phone. He said he had been released without charge. A further meeting was set for 17 September.
39. On 15 September, the man told his sister that a few days earlier he had gone into town with the intention of throwing himself into the Thames from a London bridge. His sister took him to see his general practitioner (GP) who prescribed Amitriptyline in 10 milligram doses. (This medication is used to treat depression and anxiety.)
40. The man was arrested later the same day. His sister telephoned the member of RAPT to inform her that he would be appearing in court the following day. The member of RAPT relayed this information by email to Ms F and Mr G, the YOT team manager.
41. A Prisoner Escort Record (PER) was completed shortly before the man left police custody on 16 September. The PER is in two parts. Part A was completed at a police station and outlined the possible risks surrounding the man. Violence was identified as a risk. He was also identified as a suicide/self-harm risk and a note added on the form said that he had stated he would smash his head open in custody. The section is signed by Officer H at 12.55pm on 16 September. Part B of the form is a record of events whilst in the custody of court and escort staff. This record shows that the man arrived at the Magistrates Court at about 1.10pm.
42. The Magistrates Court is an adult court with no official YOT presence although a duty probation officer is normally present. Unfortunately, the Probation Service had no information relating to the man. Whilst he was still at the court his sister telephoned the member of RAPT. She told the member of RAPT that three of the man's uncles were there, and that they were drunk and were being abusive to her. She asked if the member of RAPT would attend in her place. She agreed and the man's sister left the court.
43. The man appeared before the Magistrates at about 3.30pm. He was remanded in custody to await trial at Inner London Crown Court in November.

44. The member of RAPT arrived at the court after the hearing and visited the man in the cells. She told my investigator that she was quite concerned about him as she found him to be “hyper”, laughing and joking and “too happy”. This was not how he would normally appear in this situation. The member of RAPT expressed her concern to him who told her he was all right. He suggested his medication might have made him “bouncy”. She believed that the police doctor had given him some sleeping medication. She told my investigator that before she left the court she spoke to the court custody officers to express her concerns about him. She added that they assured her that they knew the man and were keeping an eye on him. She updated his case diary and, when she returned to the YOT office later that afternoon, emailed Mr G and Ms F to outline her concerns. She then passed several messages to his sister from the man. He left the court buildings at about 5.30pm.

After the man’s arrival at Chelmsford

45. The man arrived at Chelmsford at about 6.45pm on 16 September. The PER was signed by Officer I to confirm the man had been received into prison custody. The committal warrant from the Magistrates Court was checked. The man went through the normal reception process. The first page of his prison record was completed. This included details of his home address and that of his next of kin. His sister was named as his next of kin. A record of his possessions was recorded on the appropriate form.
46. A Cell Sharing Risk Assessment (CSRA) was completed. This form is used to assess the risk a prisoner poses to a cellmate if they are required to share. Officer J completed sections one and two of the form. He confirmed in section one that the PER and warrant had been received. Part of the section requires a description of concerns or observations by the officer. Officer J wrote, “States doesn’t want to share with anyone as he has violent outbursts and is trying to get his head around his offence.” In section two, Officer J answered a variety of questions with tick box answers. Two related to confirming that there was no evidence of either current or previous self-harm monitoring. All the information in section two appears to have been provided by the man himself. Officer J assessed him as a medium risk and signed the form. He did not identify any self-harm issues.
47. Nurse K, a qualified mental health nurse, completed section three of the CSRA. He assessed the man as being a low risk of harming a cell mate and ticked a box to confirm that no concerns had been raised following the self-harm assessment. Nurse K wrote on the form “no concerns fit for ordinary location” and signed it. Officer L completed the final section of the CSRA and signed the completed form. The man was not assessed as high risk and so the “locate as normal” box was ticked.
48. Nurse K also completed the first reception health screen. This is an eight page document that predominantly comprises tick boxes. As with the CSRA, answers are generally obtained from the patient. The man confirmed that he had been in custody before at Huntercombe. He said he was an occasional drinker but that drink was not a problem, and that he had not used drugs in the

past month. Questions eight to ten of the screening form ask questions relating to mental health issues and self-harm. It appears that he told the nurse that he had never received treatment from a psychiatrist and had never tried to harm himself. Question 11 specifically asks if the patient feels like harming themselves. he replied “no”. However, he told Nurse K that he was taking medication and therefore he referred him to the prison doctor.

49. Officer L completed a First Night In Prison (FNIP) form with the man as the first part of the induction process. This is a fairly basic form mainly used to confirm that the prisoner has received appropriate prison information and that he agrees to behave in accordance with the rules. The man signed the compact to confirm that he had received the information and agreed to abide by the rules. Officer L opened a history sheet and entered a comment that the man had been seen by the FNIP officer. The entry also referred staff to his CSRA relating to the assessment of him as a medium risk. Having completed all the requirements of the reception process, he moved from Reception to E wing, the induction unit, at about 8.30pm. He was placed in a shared cell, E1-039.
50. During the morning of 17 September, Dr M, the prison medical officer, spoke at some length with the man. The man told him he had urinary problems. Dr M believed this to be a side effect of taking Amitriptyline and changed his medication to Mirtazapine, a mild anti-depressant. At interview, Dr M said that the man told him he had been mildly depressed in the past but had no thoughts of suicide or self-harm at that time. He added that the man appeared to be in a good mood, had normal speech, good eye contact, and showed no signs of any mental health issues.
51. The member of RAPT spoke to Mr G the same morning, as he was due to attend a risk management meeting later that day. She believed his case should be discussed at the meeting. Mr G met the member of RAPT and Ms F after the meeting. He thought it was appropriate that he became involved in the case as the senior practitioner responsible was not available. They discussed their concerns for the man's safety. They believed he was a significant suicide risk and needed a mental health assessment. They also concluded that he had issues with substance misuse. An immediate action plan was necessary to help reduce the risk. They confirmed that the YOT juvenile court worker had not seen him as he had appeared in an adult court. They concluded that Mr G should contact the duty governor at the prison to outline their concerns. The member of RAPT agreed to contact the prison healthcare centre and Ms F agreed to book a legal visit to see the man to offer support.
52. Mr G decided to contact the duty governor immediately using a conference call facility. The member of RAPT and Ms F were both present when he made the call. Mr O was the duty governor. He made a note of the concerns and agreed to pass the information to the Induction Unit staff. After confirming his cell location, Mr O contacted the Safer Custody SO D. He handed her the note he had made during the telephone conversation. SO D telephoned the Induction Unit on E wing and spoke to Officer N. Officer N made an entry in the wing observation book that read, “SO D phoned and said the man's Youth Offending

Team had called and said that they were worried about him and could staff watch him.”

53. Although they had informed the duty governor, the YOT team still had concerns for the man. They also realised that they had no evidence of the action they had taken. They decided to send an email to Mr O confirm the concerns outlined on the telephone. This was sent at about 12.20pm. The member of RAPT told my investigator that she also contacted the prison healthcare centre sometime between 1.00pm and 1.30pm and spoke to a female member of staff. She added that she had passed on similar information to that in the call made to the duty governor. She was told that when he arrived in prison he would have been assessed by a qualified mental health nurse. The member of RAPT said she now regretted that she did not confirm the details by either fax or email. She could not recollect to whom she spoke. Two staff were detailed to be in the healthcare centre at the time, Nurse K and Ms P. Ms P told my investigator that she did not remember taking a telephone call relating to the man. Nurse K said that he had not been made aware of any call relating to the man. There is no record of the call, or any action as a result of the call, in his medical record.
54. The man attended the remainder of the induction process during the day on 17 September. It comprised a number of group sessions in the morning including bail information, employment, legal services and the chaplaincy. (Some of these sessions are followed up with individual talks with prisoners.) A member of the chaplaincy team, spoke to the man. He told my investigator that the man had asked for a bible. He took one to his cell and left it there as he was not present at the time. During the afternoon the man was required to watch a PowerPoint presentation which was the final part of the induction process.
55. At about 7.15pm on 17 September, the man spoke to his sister using the prison pinphone system. (This is a telephone service for prisoners. All calls must be made to a pre-approved number and are timed and recorded. It is possible to monitor a call as it takes place but this is not normally done without good cause.) He spoke to his sister and her partner. The conversation lasted just under five minutes and was not monitored. His sister’s number was the only number that he had asked to be on his approved list. The conversation appeared to be quite normal and he did not seem to be distressed. He was moved from cell E1-039 to E1-042 shortly before 8.00pm that evening. He shared this cell with another prisoner. His cell mate told my investigator that he did not remember him very well. He added that there was nothing that he could recall that was unusual or out of the ordinary about him.
56. The man remained on E wing during the day on 18 September. He made nine attempts to telephone his sister between 3.45pm and 4.30pm that afternoon but there was no reply. The following morning he attempted to contact his sister at about 8.40am; again there was no reply. That was the last time he used the pinphone system.
57. At about 10.30am on 19 September, the man was moved from E wing to C wing. C wing accommodates a mixture of young adult prisoners and adults.

He was initially placed in cell C1-021 with another prisoner. This prisoner apparently objected to sharing his cell and therefore he was moved, at about 12.30pm, to another double cell C3-027 where he was the only occupant. My investigator interviewed the prisoner who was identified as briefly sharing a cell with him. He told my investigator that he did not know the man and had not shared a cell with him.

58. Officer E carried out an early morning prisoner roll check on C wing at about 5.23am on 20 September. (This is a brief visual check through the observation panel of the cell door to provide the number of prisoners for staff coming onto the day shift.) When he looked through the observation panel in cell C3-027, he saw the man hanging from a ligature attached to the cell window bars. Officer E used his prison radio to alert other staff. He then waited for the Night Orderly Officer to arrive at the cell. The assistant to the Night Orderly Officer arrived at about the same time as the Night Orderly Officer. When they went into the cell, they discovered that the man was cold to the touch and that his arm was stiff. He was fully clothed and his bed was made. They cut the ligature and laid him on the floor of the cell. They did not attempt resuscitation.
59. The Night Orderly Officer sent Officer E to collect Nurse T from the healthcare centre. She examined the man but found no signs of life and that rigor mortis had set in. An ambulance was called, and when the paramedics arrived they examined him again. They pronounced him dead and completed a Recognition of Life Extinct (ROLE) form at 5.43am.
60. Several messages had been written on the cell wall, some of which may have been written by the man. He did not leave a formal note. He wrote "give this to my mum" and "to mum love xxxxx" on a religious passage entitled "Footprints". Another passage entitled "Thinking of you" was on the reverse side of this document. The man wrote "give my bits to X and my dog" on a different piece of note paper.
61. Death in custody contingency plans were put in place. The Governor and duty governor were informed. The duty governor attended the prison and was responsible for managing the follow up action after the man's death. All staff involved completed the appropriate paperwork before they went off duty. A member of the prison care team, Sister C, visited the prison during the morning. She spoke to staff involved and prisoners in every cell on C wing. The deputy governor arrived at the prison at about 11.30am.
62. Essex police attempted to inform the man's sister that he had died early during the morning on 20 September. They eventually made contact with her in the early afternoon. She was visited at about 7.30pm the same day by Mr O and Mr S, the coordinating chaplain at Chelmsford.
63. The Duty Governor carried out a "hot" debrief for staff who had been on duty at the time the man was discovered. This took place in the evening of 20 September when staff returned to work for their night shift. (Hot debriefs are primarily carried out to ensure staff have an early opportunity to discuss issues following serious events such as deaths in custody.)

64. A post mortem was carried out on 22 September by Dr U. He concluded that the man's death had been due to suspension. A toxicology report was carried out by Dr V, a forensic scientist, on 28 October. Dr V found traces of cannabis and a larger than normal amount of paracetamol in his system.
65. Senior Officer W was appointed as a Family Liaison Officer (FLO) on 25 September. She made contact with the man's sister on 26 September, and family concerns were identified, in particular relating to funeral costs. The family believed the prison would pay all funeral costs. SO W subsequently made and received several telephone calls, several related to funeral costs. The prison eventually agreed to pay an amount in line with PSO guidelines. The funeral took place on Monday 6 October 2008.
66. On Thursday 15 October, the man's sister visited the prison accompanied by his other sister. They visited his cell, said a prayer and met with an officer who had been present when the man was discovered. After the visit, they collected his property and left the prison. His sister told my investigator that he wore a religious cross that she expected to be returned with his property. My investigator was unable to discover the whereabouts of the item. There is no record on his property card to confirm that he had the cross with him when he arrived at the prison.

ISSUES

Information available before the man entered custody

67. The man who died became an adult in April 2008. Responsibility for his supervision would normally have transferred from the YOT to the Probation Service. A sample case transfer protocol was issued by the National Probation Service in consultation with the YJB in December 2005. The protocol outlines arrangements for transferring responsibility for offenders from YOTs to the Probation Service. The protocol indicates that, when an individual who is in custody or on licence under YOT supervision reaches 18, responsibility should remain with the YOT until the period on licence has expired. As he was still serving the custodial part of a DTO at the time, he would remain under the supervision of the YOT until he completed both the custodial part of his order and the period on licence. This meant that his case would not be transferred to the Probation Service until April 2009.
68. If he had still been under 18 on 16 September, he would have appeared at the youth court. He would then have been referred to the YJB before being sent to an appropriate juvenile establishment. All the information relating to him would have been available both at the court and to the establishment to which he was sent at the time he was received into custody. It is highly likely that he would have been identified as at risk of self-harm and would have been closely monitored. It is clear from his YOT records that members of the YOT knew him very well. They had worked with him for over three years and had a good knowledge of his issues and those relating to his family. It is unfortunate that this information was not available to the Probation Service at court, or to prison staff when he arrived in custody on 16 September.
69. The case transfer protocol does not include advice on transferring key information from YOTs to the Probation Service or prisons when a young person over 18, but still under YOT supervision, is remanded in custody by an adult court. This is clearly unacceptable.

The National Probation Service and Youth Justice Board should develop a system to ensure that key information relating to young persons who are over 18 but still under the supervision of Youth Offender Teams is available to receiving prisons on the day the young person is received into custody.

70. Part A of the PER was completed at about 1.10pm on 16 September by Police Officer H, before the man left police custody. It clearly identified him as being at risk of self-harm or suicide. There is, however, no evidence that a formal police self-harm warning form was opened at this time. Nor is there any acknowledgement of the self-harm risk in the record events section on part B of the PER completed by court staff. The member of RAPT visited him at court on September 16. She noticed that he was not behaving as he normally would in those circumstances and this concerned her. She told my investigator that, after she visited the man, she spoke to the court staff about her concerns and they told her that they knew him and would keep an eye on him. The PER part

B does not mention the RAPT member's visit to the man or any conversation between her and court staff. I could find no evidence that the man was placed on self-harm monitoring. However, part B of the PER records that he was checked over 30 times before he was handed over to prison custody. It was fortunate that the member of RAPT attended the court even though there was no formal requirement for her to do so. It is unfortunate that the details of her meeting with him and an outline of her concerns were not documented on his PER. If they had been, and if the document had been checked at Chelmsford, he might have been placed on monitoring to prevent self-harm. It is possible that court staff thought he was attempting to avoid being remanded in custody by threatening to self-harm. It is also possible that, when spoken to, he appeared upbeat and showed no outward signs that he was in distress. Part two of the PER contains brief one line entries that do not give any details about the individual's mood or offer any insight into how they might be feeling. I believe they should, as a minimum, include a brief summary of the individual and an outline of concerns raised by anyone they have contact with.

HM Courts Service should remind staff that they should write a summary of a prisoner's time whilst in their custody on part two of the PER before they leave the court. This summary should include details of any concerns raised by staff or visitors to the prisoner.

The reception process

71. Officer I signed the PER to accept the man into custody at Chelmsford on 16 September. At interview, he told my investigator that he did not recollect the man but did remember the comment on the PER relating to him smashing his head when in prison custody. Officer I told my investigator he believed he had discussed this with the escort staff. He went on to say that, if the escort staff were concerned about him, a formal self-harm warning form should have been opened by them and accompanied him into custody.
72. Officer J was the second member of staff to see the man. He completed the first two sections of the CSRA. He did not specifically remember him and does not recollect seeing the PER. Officer J had no prior knowledge of the man, and relied on him to provide the answers to questions on the CSRA. The man told Officer J that he had never abused alcohol or drugs and that he had no history of self-harm. He asked to be located in a cell on his own, saying he did not want to share as he had violent outbursts and was "trying to get his head round his offence".
73. Shortly afterwards, the man met Officer L. He told my investigator he did not know the man nor could he remember interviewing him. He told my investigator that the man gave no clue as to any of the issues surrounding his life at that time. Officer L completed part of the CSRA and carried out the FNIP procedures. I consider that process below.
74. Nurse K was the last person to formally meet the man in the reception area. He completed the first reception health screen and section three of the CSRA. Nurse K did remember the man and described him as being quite cheerful,

pleasant and appropriate. He assessed him for self-harm issues and questioned him about his medication. He told him that he was feeling a bit anxious and that his doctor had prescribed him ten milligram doses of Amitriptyline. Nurse K did not recollect seeing the self-harm warning on the PER, nor could he be certain that he actually saw the document. However, he added that he would have identified any self-harm issues if they had been present.

75. It is clear from the basic information gleaned during the reception process that the man did not tell prison staff a great deal about his history. It would appear that he might have been able to convince even the most experienced staff and a trained mental health nurse that he was not at risk of self-harm. It is disappointing that the staff in reception seem to have had difficulty remembering him. It is likely that this was due to a combination of the speed at which the reception process was completed and his apparent desire to provide limited information about himself. Under such circumstances it is essential that information provided by police and escort staff is not ignored. It is arguable that a formal police warning that the man was a suicide/self-harm risk should have accompanied him into custody. Court and escort staff could have opened a self-harm form to start the monitoring process before he was escorted to the prison.
76. Staff at Chelmsford had no prior knowledge of the man. He arrived with limited documentation and they did not recognise that they were dealing with a very vulnerable young person. In fact, the only real information they received related to his risk of self-harm. There is no documentary evidence to confirm that any of the staff had actually considered the comments made on the PER. It is possible that staff saw the documentation relating to the risk and, having spoken to him, decided he did not need monitoring. In retrospect this was clearly mistaken. Given what was said on the PER, and his tender age, I believe an Assessment, Care in Custody and Teamwork (ACCT) plan should have been opened in reception. (The Prison Service's monitoring and support arrangements for those at risk of suicide and self-harm, ACCT, is a prisoner-centred assessment and care planning system. It aims to identify the individual needs of prisoners at risk of self-harm and offer personalised care and support.)

The Governor should ensure that, when a prisoner's PER states he is at risk of self-harm and the prisoner is not already known to staff, an ACCT document must be opened on reception in all cases.

The Governor should ensure that, when a prisoner's PER states he is at risk of self-harm and the prisoner is known to staff, an ACCT must be opened on reception unless there is evidence to demonstrate that it is not necessary. In such cases the reasons why an ACCT was not opened should be documented in both the medical record and history sheet.

The induction process

77. The induction process at Chelmsford is currently undertaken in two parts. The first part is the FNIP process which takes place in the reception area with a member of staff from the reception group. When all of the reception process has been completed, the prisoner moves to the induction unit. Officer L carried out the FNIP interview with the man on 16 September. He told my investigator he too could not recollect him. Officer L made an entry on his history sheet relating to procedural issues. He was then moved to E wing and placed in a shared cell.
78. On 17 September, the man completed the remainder of his induction. In the morning, he attended sessions led by a variety of departments from the prison. During the afternoon, he watched a generic induction video with other prisoners who had been received the previous day. At some stage during the day he saw the prison doctor. By the end of his second day in custody, and less than 24 hours after arriving in the prison, his induction was complete. He was moved to C wing during the morning of Friday 19 September. Prisoners are moved from the induction unit shortly after they complete the process in order to create space for new prisoners.
79. The induction process at Chelmsford complies with the requirements of the Prison Service Order on induction. However, most elements are delivered within the first 24 hours after a prisoner is received. Interviews with the FNIP officer and doctor, if required, appear to be the only "one to one" interviews that take place. There are no formal "one to one" interviews with any member of staff from the induction unit team.
80. The man's history sheet contains no entries after his FNIP interview. In similar cases, I have concluded that this was merely a matter of failing to record interactions. I do not think that is likely in this case. None of the induction unit staff interviewed by my investigator had a clear recollection of the man. There is no requirement for induction unit staff to have any formal interactions with prisoners. I believe this is unacceptable.
81. A personal officer is appointed to each prisoner when they arrive on the induction unit. Personal officers are normally the first point of contact for a prisoner. The system at Chelmsford is based on allocating an officer to a group of cells, with a second officer appointed as cover in case the personal officer is not available. Officer X was the designated personal officer for both cells the man occupied whilst on E wing. He told my investigator that he did not remember the man and did not have any formal contact with him. Officer Y, who moved the man from E to C wing, was designated as relief personal officer. He told my investigator that he had no real knowledge of the man. Officer Y added that he had not seen him in his role as his personal officer. He believed that personal officer time was rarely used to see prisoners on the wing. The personal officer scheme clearly did not work in this case. I have doubts that it is effective at all on the induction unit as most prisoners leave the unit within two days.

82. I do not believe induction should simply be a bureaucratic process that complies with PSO requirements. It should take into account the needs of the individual and, where necessary, allow a familiarisation and assessment period. Some prisoners who go onto the induction unit will have been in custody at Chelmsford before. They may only need a brief period of induction. Many prisoners will be returning from court and are likely to need only a brief assessment in case of any change of circumstances. In contrast, the man was only 18 years old when he arrived at Chelmsford and had never been in an adult prison before. I could find no evidence that any member of staff from the induction unit, including the personal officer, actually sat down with him and discussed how he was feeling and coping with imprisonment. This is unacceptable. I believe hours allocated for personal officer work on the induction unit could be better utilised working with vulnerable individuals such as the man. Time spent on the induction unit should be flexible and apportioned according to individual needs. Any prisoner who has not been in Chelmsford before should not leave the unit until a written assessment of them has been completed by a member of the induction staff.

The Governor should review the induction process to ensure that it meets the needs of individual prisoners. In particular, prisoners who have not been in Chelmsford before should be assessed by a member of the induction team before they leave the unit. A summary of the assessment should be entered in the individual's history sheet.

Information received from Newham YOT on 17 September

83. Staff from the YOT were clearly concerned about the man's safety. They believed that information they had at the time of his imprisonment needed to be made available to the prison authorities. Ms F and the member of RAPT were present when Mr G spoke to Mr O on 17 September. All three recollect the main details of the conversation. They all told my investigator that a clear emphasis was placed on their concerns that he was a suicide risk. However, the note of the conversation written by Mr O places no emphasis on any suicide risk. Furthermore, his first point related to alcohol issues. Mr O did not request faxed or emailed confirmation of the information provided. Mr G followed up the telephone call by emailing Mr O at 12.20pm. The first sentence of the email reads, "He is a serious risk of suicide having made a recent attempt and is also a self harmer". Unfortunately, the email was not sent to the correct email address and therefore was not received by Mr O. Mr G could not remember where he had got Mr O's contact details. When my investigator attempted to contact Mr O using the same contact details, a message was returned confirming the account did not exist at the address it had been sent to.
84. The member of RAPT told my investigator that she rang the prison healthcare centre between 1.00pm and 1.30pm on 17 September. If her recollection of the response she received to the telephone call is accurate, that is that he would have already undergone a mental health assessment, it unlikely that any further action would have been taken.

85. It is possible that neither Mr G nor the member of RAPT emphasised their concerns sufficiently on the telephone. It is also possible that Mr O, or the person who spoke to the member of RAPT in healthcare, did not take sufficient notice of the possible suicide risk the man posed. An individual's perception of the emphasis placed on a particular point made during a telephone call may differ. It would therefore be unfair to be critical of any one individual on this matter. Had the information available to the YOT been received at the prison by either fax or email, I believe appropriate action would have been taken. I believe the information should have been sent by fax and that the duty governor is the appropriate person to receive such information.

The Governor should ensure that when information is received by telephone relating to a prisoner's self-harm risk, the call should be directed to the duty governor. The duty governor should provide specific contact details and, wherever possible, request a faxed or emailed confirmation of the information provided.

86. When information is received from any concerned individual it should be acted on appropriately. In this case, there is little formal documentation to record what actions were taken by prison staff. Mr O made a note of four points, in bullet form, on a piece of paper. He told my investigator that he tried to contact E wing by telephone to pass on the information but there was no reply. He handed the note to SO D and asked her to speak to staff on the wing. SO D told my investigator she telephoned the wing and passed on the information from the note to Officer N who made a note of the conversation in the observation book on the wing. I could not find any evidence that staff acted on the information in the observation book or that anyone spoke to the man about the matter. There is no evidence that the duty governor checked to see whether his instructions had been carried out. This is clearly unacceptable. A simple check list should help ensure any required actions are carried out.

The Governor should ensure that, when information has been received outlining concerns about a prisoner, details of the concerns, expected actions by individuals, and expected outcomes and follow up actions, should be clearly documented in the individuals records.

87. It is apparent from the interviews that none of the staff involved in the man's case would automatically have opened an ACCT document based solely on information received from an external source. SO D is the safer custody coordinator at Chelmsford and is also an ACCT assessor and trainer. She told my investigator that she would not have considered opening an ACCT as wing based staff would have more knowledge about an individual. She added they would make an assessment after they spoke to him and decide whether an ACCT document was appropriate. I believe this may be appropriate when a prisoner is known to the staff. However, in the man's case, it was his first time in the prison and he had been there for less than a day. There is no documentary evidence that staff on E wing spoke to him. If staff did speak to him it is possible that he told them he was fine, therefore it is unlikely that they would have opened an ACCT. Had the staff known him as well as members of the YOT, they might well have come to a different conclusion. I believe that in

this case an ACCT should have been opened.

The Governor should ensure that when information is received from an external source that states a prisoner is at risk of self-harm and the prisoner is not already known to staff an ACCT document must be opened.

The Governor should ensure that when information is received from an external source that states a prisoner is at risk of self-harm and the prisoner is known to staff an ACCT must be opened unless there is evidence to demonstrate that it is not necessary. In such cases the reasons why an ACCT was not opened should be documented in the medical record and on the history sheet.

The events of 20 September

88. Officer E did not immediately enter the cell when he discovered the man hanging on 20 September. Staff on night duty carry a sealed packet containing a cell key. They have the authority to break the seal and enter a cell if they feel it is safe to do so. Officer E told my investigator that he had been advised not to enter cells alone at night during his initial training course and by more experienced staff at the prison. It is unlikely in this case that an immediate entry into the cell would have helped to save his life. Nevertheless, in other circumstances a swift response to a prisoner who has seriously harmed himself might well save a life. A delay of just a few minutes whilst waiting for support to arrive could mean that all subsequent efforts, no matter how professionally undertaken, might fail. It is difficult to say when staff should use their discretion to enter a cell. However, if prison staff lack confidence to enter a single occupancy cell when a prisoner is clearly hanging, it is difficult to imagine any circumstances when they would feel safe to go inside. Some staff might be reluctant to use their discretion in the belief that some prisoners might feign incidents in an attempt to overpower them if they enter a cell alone. I believe such instances to be extremely rare. Indeed, if staff were provided with the facts and figures relating to such incidents, it might reassure them of the low level of risk and a more balanced and informed judgement could be made about entering a single occupancy cell in these circumstances. This is an issue that might be common in many prisons. I recently made a recommendation to the Prison Service on this matter and therefore I do not repeat a formal recommendation here. However, the Governor might wish to consider ways to make staff aware of the actual level of risk at Chelmsford.
89. The only member of staff at Chelmsford who carries a full set of keys at night is the night orderly officer. Staff based on residential units are locked in the unit and have no means of responding independently to any incident. The orderly officer must either unlock a wing to release staff or deploy an assistant to do so. This causes an obvious delay. I am aware that the Governor is reviewing the policy relating to the issue of keys at night and therefore I do not make a formal recommendation on this point.

90. The actions of staff when they entered the cell appear to have been appropriate. It is clear that any attempts at resuscitation would have been unsuccessful. The man was cold and rigor mortis was present. When Nurse T arrived at the scene she assessed his condition. Ambulance staff pronounced his death and the cell was sealed until his body was removed.
91. The duty governor attended the prison when he was informed that the man had died. He put into place appropriate contingency plans and ensured that most actions were carried out. Staff who had been involved completed the appropriate incident report forms. A hot debrief was carried the following evening when staff attended for their night duty. (It is more normal for hot debriefs to take place before staff go off duty directly after an incident. This enables staff to discuss issues before they travel home.) In this case, it is possible that staff would have become more distressed by being asked to stay in order to attend a debrief. However, they were offered the services of a care team member before they went off duty, so I make no recommendation on this matter.
92. Sister C visited the prison during the morning and spoke to staff involved. She told my investigator that she visited each cell on C wing and spoke to every prisoner. I believe this should happen in every case and her actions are an example of good practice. I feel Sister C's actions should be commended.

Speaking to every prisoner located in a wing where a death in custody has occurred is an example of good practice. Sister C should be commended for doing so on 20 September 2008.

93. The local police informed the man's sister that he had died during the afternoon of 20 September. Mr O and Mr S visited his sister during the evening of 20 September. My investigator could not find any documentary evidence relating to the decision as to who informed the family and to send these staff to visit the family. Prison Service Order 2710 - Follow up to deaths in custody, states that the next of kin should be informed in a suitable manner. Family Liaison Officer guidance notes provide further information. Paragraph 4.9. says, "The family should be told face to face as soon as possible after the death. Wherever possible, this should be done by a FLO working alongside a chaplain, or the prison Governor or the most senior person available together with the chaplain."
94. In many cases when a death in custody occurs, the duty governor, or another governor in their place, is the appropriate person to visit and inform the next of kin. If the individual is only 18 years old, and dies under the circumstances described in this report, the news might be difficult to bear and, for that reason, the way it is conveyed to the family is even more important. Prison FLOs are trained to work with individuals who have suffered bereavement. I believe a FLO should have been appointed at the time of the man's death and accompanied the manager designated to carry out the visit.
95. Principal Officer Z was a prison FLO at the time of the man's death. She told my investigator that she had been informed of his death some time during the

afternoon of 20 September. She rang the prison and offered to attend but the duty governor told her it was not necessary. I could not find any evidence that a FLO or senior member of staff was formally appointed as a contact point for the family until 25 September.

96. Given the man's young age, his short time in custody, and the manner of his death, I believe the Governor would have been a more appropriate person to inform his next of kin. There may have been good reasons why this did not happen and therefore I do not make a formal recommendation. However, there should have been evidence of the risk assessment that concluded it was unsafe for prison staff to visit to inform the family. I believe there should also have been written evidence to support the decision to send Mr O and Mr S.

The Governor should ensure that full consideration is given to all the circumstances surrounding a death in custody before deciding how, and by whom, the next of kin should be informed. A summary of discussions on the matter should be recorded on the prisoner's history sheet.

Information from prisoners

97. Mr C was a Listener on C wing and also worked in the prison reception. (Listeners are trained by Samaritans to give emotional support to fellow prisoners in distress.) Mr C was there when the man came into custody. He told my investigator that he sees all prisoners when they come into the prison. He could not remember the man, but believed that if he had appeared distressed he would have noticed and therefore would have remembered him. Mr C added that he would normally see prisoners when they arrive on C wing, but he did not see the man as he was still in reception when the man reached the wing.
98. Mr D and Mr E were both prison Insiders on E wing when the man came into custody. (Insiders are appointed by prison staff to work specifically on the induction unit. They normally work as cleaners and provide fellow prisoners with information, guidance and support during their early days in custody.) Mr D told my investigator that he remembered the man who died. He said that he appeared depressed and it should have been obvious to anyone who saw him that he needed help. He added that he told staff but they did nothing. He could not remember exactly who he had told. Mr E told my investigator that he did not think that the man asked to see an Insider when he was on the wing. However, he felt that he looked worried when he saw him informally, but this was not unusual.
99. It is possible that the man appeared worried and distressed to some prisoners on E wing including prison Insiders. It is also possible that he tried to appear 'normal' when approached by staff during routine activities on the wing, in an attempt to hide his real anxieties. My investigator found no evidence that either prisoners or staff had raised any concerns about him during his time on E wing.
100. Mr H and Mr I shared cell C3 - 26 the night before the man was discovered. This cell is next door to the one occupied by the man. Mr H told my investigator

that he did not meet the man. He said that he heard a noise coming from his cell at about 7.00pm. He thought the man was banging his head on the cell wall. Mr H told my investigator that he asked him if he was alright and then spent about an hour chatting with him about ways to commit suicide. He added that he himself had tried it in the past and had told him hanging was the best method to use. Mr I told my investigator that he had spoken to him briefly through the window and he seemed okay. The man told him it was his first time inside. Mr I said that his cellmate did not talk to the man at all that evening about suicide. He added that if he had he "would have strangled him as it was not right".

101. Mr J and his relative, Mr K, shared cell C3 - 28, the other cell adjoining the man's. Mr K told my investigator that the man seemed okay when he came on the wing. He did not recollect hearing anything of note until about 5.20am when he was discovered hanging in his cell. Mr J told my investigator that he saw the man in the afternoon and he looked upset. He added he had been on the prison pinphone talking to his girlfriend that afternoon. Mr J said that he had heard a noise coming from the man's cell, like a chair falling over, at about 8.30pm on 19 September. It is possible that Mr J might have mistaken him for another prisoner. The man did not use the prison telephone system after he left E wing that morning.
102. The man's sister informed my investigator that a man she knew as "Mr X" had approached one of her friends after her brother's death. He told the friend that he had spoken to the man whilst he was on C wing and that he had been very upset and crying. He also told her that staff had not given support to him when he approached them. My investigator tried to identify this man. Only one man that matched the description provided by his sister had been discharged from Chelmsford within the relevant time frame. My investigator made several attempts to contact the number he had given the prison when he was discharged but there was no reply. Eventually, my investigator was contacted by a man calling from a different telephone number. He informed me that "Mr X" was his friend. He said he was aware of the man's death and that he would ask his friend to contact my investigator if he recollected anything. No further contact has been made.
103. My investigator could not find any evidence that the man who died appeared distressed during his brief time on C wing. There was no official 'time out of cell' period during either the afternoon or evening of 19 September. Therefore the only time he is likely to have come into contact with anyone after lunchtime that day is if he collected his tea meal at about 5.00pm. It is possible that he did speak to some prisoners about his distress and that he appeared normal and relatively happy to others. I found no evidence that staff on C wing mistreated him. There is also no evidence to suggest any prisoner spoke to staff about their concerns for him, or to complain about his treatment.

Other Issues

104. SO W was appointed as a FLO on 25 September. She immediately opened a FLO log. A number of entries are recorded from that date for a period of several weeks. They include notes of an attempt to inform the man's brother, who was serving a sentence at Highpoint prison, about his death which he had already been made aware of. Issues arose relating to the collection of his property, visiting his cell, and more significantly about funeral costs. It is clear from the FLO log that his family believed that the prison would pay all the costs towards his funeral. This was not the case. If the FLO had been appointed at the time of his death any misunderstanding might have been avoided. I have referred to this matter elsewhere in this report and a recommendation is not required. However, the Governor should be aware that the delay in appointing a FLO may have added to the distress felt by his family.
105. The toxicology report prepared by Dr V indicated that normal quantities of the medications prescribed for depression were found in the man's system. However, the quantity of paracetamol discovered indicated that he had taken more than the advised dose. Dr V added that this excess would not have been sufficient to cause his death. Dr V considers that the quantity of cannabis in his system indicated that cannabis may have been used, or inhaled passively, a few hours before his death. It is unlikely that he inhaled it passively as he was in a single occupancy cell and prisoners are not allowed to smoke on the prison landings.
106. In her review of the man's clinical care, the clinical reviewer found that it was very difficult to draw any significant conclusions from the medical records. The man received health contact on only three occasions during his short time at the prison. No concerns had been identified relating to his self-harming or having suicidal thoughts in either the screening assessment or supplementary review by the medical officer, Dr M. Staff responding to the emergency call on C wing found no pulse. Pupils were fixed and dilated and rigor mortis present. The clinical reviewer concludes that there is nothing within the medical record that would suggest that the man's death was linked to the healthcare treatment he received.

CONCLUSION

107. The information provided by the man's sister, relating to a possible suicide attempt prior to his arrest, indicates that he may have had suicidal thoughts before he entered prison custody. The way he presented when he spoke to the member of RAPT at court led her to believe that he might have been suicidal.
108. Some of the information provided to reception staff by the man was inaccurate. He had not been in an adult prison before but he had been in two juvenile prisons. He had been placed on self-harm monitoring whilst at Feltham the previous year. I believe it is reasonable to assume that he would have known what to say, and more importantly, what not to say, to avoid being identified as a suicide risk during the reception process. Reception staff might have seen the brief note on the PER relating to self-harm. Unfortunately, possibly due to the absence of any quality background information, none of the staff who saw him in the reception area identified him as being at risk of self-harm.
109. The man may have told staff in the reception area that he would be a risk to any cellmate in order to avoid sharing a cell. He was in shared accommodation from the time he arrived at Chelmsford until his move to C wing when he was placed in a cell as the only occupant. He died sometime during his first night alone.
110. If all the information available to the YOT had been received at the prison, and effectively acted upon at the time, it is likely that he would have been placed on an ACCT document during the reception process. The support that would then have been provided might well have been of help to him and could possibly have saved his life.
111. I conclude that appropriate procedures were not in place to ensure the transfer of key information between the YOT and the prison at the time the man arrived in custody. Furthermore, if staff had acted on the information received after his reception and placed him on self-harm monitoring, it is possible he would not have been placed in a cell alone and he might not have taken the actions he did.

RECOMMENDATIONS AND GOOD PRACTICE

1. The National Probation Service and Youth Justice Board should develop a system to ensure that key information relating to young persons who are over 18 but still under the supervision of Youth Offender Teams is available to receiving prisons on the day the young person is received into custody.
2. HM Courts Service should remind staff that they should write a summary of a prisoner's time whilst in their custody on part two of the PER before they leave the court. This summary should include details of any concerns raised by staff or visitors to the prisoner.
3. The Governor should ensure that, when a prisoner's PER states he is at risk of self-harm and the prisoner is not already known to staff, an ACCT document must be opened on reception in all cases.
4. The Governor should ensure that, when a prisoner's PER states he is at risk of self-harm and the prisoner is known to staff, an ACCT must be opened on reception unless there is evidence to demonstrate that it is not necessary. In such cases the reasons why an ACCT was not opened should be documented in the medical record and on the history sheet.
5. The Governor should review the induction process to ensure that it meets the needs of individual prisoners. In particular, prisoners who have not been in Chelmsford before should be assessed by a member of the induction team before they leave the unit. A summary of the assessment should be entered in the individual's history sheet.
6. The Governor should ensure that when information is received by telephone relating to a prisoner's self-harm risk, the call should be directed to the duty governor. The duty governor should provide specific contact details and, wherever possible, request a faxed or emailed confirmation of the information provided.
7. The Governor should ensure that, when information has been received outlining concerns about a prisoner, details of the concerns, expected actions by individuals, and expected outcomes and follow up actions, should be clearly documented in the individuals records.
8. The Governor should ensure that when information is received from an external source that states a prisoner is at risk of self-harm and the prisoner is not already known to staff an ACCT document must be opened.
9. The Governor should ensure that when information is received from an external source that states a prisoner is at risk of self - harm and the prisoner is known to staff an ACCT must be opened unless there is evidence to demonstrate that it is not necessary. In such cases the reasons why an ACCT was not opened should be documented in the medical record and on the history sheet.
10. The Governor should ensure that full consideration is given to all the circumstances surrounding a death in custody before deciding how, and by whom,

the next of kin should be informed. A summary of discussions on the matter should be recorded on the prisoner's history sheet.

GOOD PRACTICE

Speaking to every prisoner located in a wing where a death in custody has occurred is an example of good practice. Sister C should be commended for doing so on 20 September 2008.

Response to recommendations

There has been no formal response to the recommendations. At the request of NOMS, in an interim response, the words "probably due to the circumstances relating to his offence" have been removed from paragraph 48.