

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Hause a prisoner at HMP Chelmsford on 13 January 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Joseph Hause died on 13 January 2018 after he was found hanged in his cell at HMP Chelmsford. He was 38 years old. I offer my condolences to his family and friends.

Prison staff were managing Mr Hause appropriately under suicide and self-harm prevention procedures at the time of his death. However, that evening, staff did not check him as frequently as they should have. There were also deficiencies with the emergency response which need to be addressed.

Chelmsford has previously accepted our recommendations to address failings in both these areas. The Prison Group Director for Hertfordshire, Essex and Suffolk will wish to satisfy himself that effective action is taken now to address these deficiencies.

I am also concerned that Mr Hause was able to contact the victim of his offence, which prison staff should not have allowed to happen.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

September 2018

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Summary

Events

1. On 29 December 2017, Mr Joseph Hause was arrested for assaulting his ex-partner and recalled to custody at HMP Chelmsford. This was just six days after he had been released from Chelmsford. He had a history of attempted suicide and self-harm. When Mr Hause arrived at Chelmsford with a suicide and self-harm warning form, staff opened suicide and self-harm prevention procedures (known as ACCT) and monitored him until his death.
2. Mr Hause had a long history of physical, mental and substance misuse problems. He had a long-standing mobility problem and needed a wheelchair. He had a heart condition and had had a pacemaker fitted. He was prescribed a significant amount of medication for his physical health.
3. After he was recalled to Chelmsford, Mr Hause told staff that he was frustrated about a number of issues. He believed that the social care and housing services had failed to offer him adequate support after he was released from prison and that this contributed to his recall. He was upset that he was unable to see his ex-partner because she was the victim of his offence and he missed his family.
4. At around 11.20pm on 12 January, the night patrol officer found Mr Hause hanged in his cell, but did not go into his cell for over three minutes. Staff were unable to resuscitate him and, at 00.15am on 13 January, paramedics recorded that Mr Hause had died.

Findings

ACCT procedures

5. We found that staff appropriately started ACCT procedures twice during Mr Hause's custody at Chelmsford. We are satisfied that it was reasonable for staff at Chelmsford to conclude that he was not at an increased risk of suicide or self-harm in the period leading up to his death and for the level of observations to have remained at one per hour. However, staff failed to check Mr Hause for two hours before he was found hanged in his cell. This was a missed opportunity to check on Mr Hause's wellbeing and, possibly, intervene. An officer has subsequently been suspended from duty and is subject to disciplinary proceedings.

Emergency response

6. There was a delay in staff entering Mr Hause's cell when he was found hanged. Although we cannot know whether this might have made a difference in Mr Hause's case, such delays can be critical.

Protecting victims from harassment

7. Because of the nature of his offence and by law, Mr Hause should not have been able to contact his ex-partner.

Clinical care

8. Although Mr Hause had been prescribed a significant amount of medication for his physical health, staff did not review the risk of his access to these prescribed substances.
9. Although Mr Hause needed to use a wheelchair, Chelmsford failed to provide him with one when he was released from prison in December 2017.

Recommendations

- The Governor should ensure that:
 - all staff undertake ACCT observations as directed and actively engage with prisoners being monitored; and
 - managers carry out checks to ensure that this happens.
- The Governor should ensure that all staff understand that when life is in danger, they should enter the cell as quickly as possible.
- The Prison Group Director for Hertfordshire, Essex and Suffolk should satisfy himself that effective action is taken to implement the two previous recommendations.
- The Governor should ensure that a system is in place to identify newly arrived prisoners whose offence is harassment or involves the fear of violence and that staff comply with the requirements of PSI 49/2011 so that prisoners are not able to contact the victims of their offences.
- The Head of Healthcare should establish a process for assessing prisoners who may require permanent equipment, including on their release from prison and ensure that they have access to such equipment.
- The Head of Healthcare should ensure that prison GPs review and manage prisoners' risk of access to medication, particularly when they have a history of substance misuse and/or multiple physical health problems.
- The Head of Healthcare should ensure effective implementation of the National Prison Pain Management Formulary at HMP Chelmsford.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Chelmsford, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Chelmsford on 17 January 2018. He obtained copies of relevant extracts from Mr Hause's prison and medical records and CCTV of the emergency response.
12. NHS England commissioned a clinical reviewer to review Mr Hause's clinical care at Chelmsford.
13. The investigator and clinical reviewer jointly interviewed nine members of staff and one prisoner.
14. We informed HM Coroner for Essex of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Hause's family to explain the investigation. Mr Hause's family raised the following concerns:
 - The family said that Mr Hause's ex-partner had contacted Chelmsford to raise concerns about his wellbeing after she received a suicide letter from him dated 30 December 2017. They asked whether prison staff had talked to Mr Hause about this letter.
 - They believed that Mr Hause had mental health problems and wanted to know if the prison mental health team had assessed him.
 - They wanted to know if Mr Hause was being monitored under Chelmsford's suicide and self-harm prevention procedures.
16. Mr Hause's ex-partner received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report.

Background Information

HMP Chelmsford

17. HMP Chelmsford is a local prison which takes prisoners directly from courts. It holds nearly 730 men over 18 years old. Essex Partnership University Trust provide healthcare.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Chelmsford was in May 2018 but has not yet been published.
19. At their previous inspection in April 2016, inspectors noted that four prisoners had taken their lives since the last inspection and there had been a considerable increase in incidents of self-harm to a level far higher than at similar prisons. Inspectors noted that Chelmsford was working to implement the recommendations of PPO investigation reports of these deaths. They found that the quality of most ACCT procedures was reasonable, with generally effective caremaps and mostly good monitoring and recording. However, they reported that there was often a lack of multidisciplinary case reviews. Inspectors noted that the weekly complex needs' meeting contributed well to the management of prisoners who needed both enhanced support and control.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to August 2017, the IMB remained very concerned that current staffing levels and the prison's general shortage of resources continued to make it difficult to ensure the safety of prisoners and staff.
21. The IMB noted the number of ACCT procedures that had been started during the reporting period fell by 12% compared to the previous year, although the total number of ACCTs remained high. The IMB reflected that prisoners subject to an ACCT require regular monitoring and review which required significant resources.

Previous deaths at HMP Chelmsford

22. Mr Hause's death was the eleventh at Chelmsford since January 2015 and the eighth apparently self-inflicted death. Our investigations into previous deaths also identified inadequacies in ACCT management and the emergency response. We repeat the recommendations in this report.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Integrated Drug Treatment Services (IDTS)

26. IDTS aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on early custody, improving the integration between clinical and substance misuse services and reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

Victim and public protection issues

27. As far as reasonably practicable, prisoners should not be permitted to contact their victim(s) (or the victim's family) or to harass them from prison. Prison Service Instruction (PSI) 49/2011 (which replaced PSO 4400) requires prisons to identify such prisoners. If they wish to contact their victim, they are required to apply to the Governor for permission, and permission may be withheld if it is considered that contact would add to the victim's distress.

Key Events

28. On 19 July 2017, Mr Joseph Hause was charged with assaulting his ex-partner. On 17 August, Mr Hause received a suspended sentence, but two days later he was charged with a further offence of assaulting his ex-partner. On 21 August, Mr Hause was remanded to HMP Chelmsford. It was not his first time in prison.
29. Prison staff noted no concerns during his reception screening and recorded that he had no thoughts of suicide or self-harm.
30. A mental health nurse completed Mr Hause's reception health screen. She recorded that he had depression and anxiety, and had used heroin four weeks earlier. Mr Hause said that he had taken an overdose of tablets five weeks earlier but denied thoughts of suicide or self-harm. He asked to be referred for bereavement counselling (because of the death of his two daughters in 2003 and 2014) and to the mental health team as he had anger management problems.
31. Mr Hause's medical records recorded a number of health concerns: he had a history of substance misuse, depression, self-harm, epilepsy, migraines, mobility issues, Brugada syndrome (a condition that causes disruption of the heart's normal rhythm) and had had a cardiac arrest a number of years earlier. As a result, he was at risk of a sudden cardiac arrest and had had a pacemaker fitted.
32. The mental health nurse noted that in the community, Mr Hause had been prescribed the following medication:
 - amitriptyline for his depression and migraines;
 - aspirin to reduce the risk of heart attack or stroke and to relieve mild migraine pain;
 - baclofen for muscle spasms, rigidity and pain;
 - bisoprolol used to treat high blood pressure and heart failure;
 - dihydrocodeine, an opioid analgesic used to relieve moderate to severe pain;
 - epilim chrono to treat his epilepsy;
 - fostair inhaler for asthma;
 - mirtazapine for his depression;
 - morphine sulphate as a strong painkiller;
 - paracetamol as a mild painkiller; and
 - salbutamol inhaler to relieve the symptoms of asthma such as coughing, wheezing and feeling breathless.
33. The mental health nurse referred Mr Hause to the prison GP and added his name for discussion at the healthcare team's next allocation and referral meeting. Healthcare staff arranged for Mr Hause to be prescribed his medication that night, and noted that he would not be allowed to keep his medication in his cell.
34. On 24 August, a substance misuse team nurse reviewed Mr Hause. He said that he had taken heroin and crack cocaine the week before he came to Chelmsford.

The nurse referred him to be assessed by Phoenix Futures (an organisation that provided social care and psychology services for prisoners with substance misuse issues).

35. On 1 September, a Phoenix Futures worker discussed Mr Hause's social care needs with him. Mr Hause said that he had used crutches since 2005, was confident in moving around and had no problems carrying out his daily living tasks such as washing, cleaning and dressing. Mr Hause was located in a disabled cell on the ground floor.
36. On 11 September, staff started ACCT procedures after Mr Hause threatened to harm himself. The next day, an officer completed the ACCT assessment. Mr Hause said that he was unable to contact his ex-partner because of his offence and he missed her. He explained that he had attended the first session of a living with loss course the previous day and had found the session difficult. Although he had felt angry, he had not tried to harm himself and said that he had no intention to do so. He disclosed that he had tried to take his own life in the past as a cry for help. He told the officer that he would ask for help if he had any thoughts of harming himself.
37. Afterwards, a Supervising Officer (SO) chaired the ACCT review. An officer and a nurse attended. The SO noted that Mr Hause engaged well during the review. He had had a lot of bereavement in his life and found this and other life issues difficult sometimes. He was upset that he was not able to speak to his ex-partner but understood why he could not. Mr Hause said that he was looking forward to a future with his ex-partner. He reiterated that he had not self-harmed and had no intention of doing so. The SO assessed Mr Hause's risk of suicide and self-harm as low and stopped ACCT monitoring.
38. On 22 September, Mr Hause was sentenced to 36 weeks in prison.
39. On 28 September, at a healthcare multidisciplinary team (MDT) meeting, a consultant psychiatrist noted that staff had arranged for the prison psychiatrist to assess Mr Hause. The psychiatrist reviewed Mr Hause on 18 October and 15 November. He noted that Mr Hause did not display signs of a mental illness but had anger management issues and resentment towards others. The consultant psychiatrist subsequently prescribed him zopiclone (a sleeping aid).
40. On 18 October, an officer spoke to Mr Hause on the wing. Mr Hause was a little upset and talked about his two daughters who had both died. He denied thoughts of suicide or self-harm and said that he did not need to be supported under ACCT procedures. He said that he was looking forward to his release from prison in nine weeks' time.
41. On 3 November, a nurse saw Mr Hause, who said that he had difficulties moving with his crutches because of a hand injury. The nurse told Mr Hause to speak to the prison GP about applying for a wheelchair.
42. On 6 November, a prison GP saw Mr Hause and noted his hand injury and that he could not put his right leg on the floor. The GP said that he would speak to the Healthcare Administrative Manager but said that there was no process to assess whether a prisoner needed a wheelchair.

43. On 9 November, a healthcare support worker recorded that she would try to source a wheelchair for Mr Hause from the prison reception area or the healthcare team. Healthcare staff discussed this at their MDT meetings on 11 and 23 November but there is no evidence that the issue was resolved and Mr Hause remained without a wheelchair.
44. On 24 November, staff suspected Mr Hause of being under the influence of a psychoactive substance (PS) and downgraded his incentives and earned privileges (IEP) level to basic. A member of the substance misuse team saw Mr Hause on 28 November and discussed his recent use of PS. Mr Hause refused support from the substance misuse team and said that he had no intention of taking PS again.
45. On 7 December, a prison GP noted that he had reviewed Mr Hause after he had allegedly fallen out of a wheelchair. Although nothing was recorded in Mr Hause's medical record, staff had managed to source a temporary wheelchair for him from the healthcare unit. However, nothing was recorded about sourcing a permanent wheelchair for Mr Hause. At the review, Mr Hause complained of severe pain and was sent to hospital, where it was noted that he had not seriously injured himself. The GP discussed pain relief options with him.
46. On 18 December, Mr Hause told an officer that he was concerned about his imminent release from prison, that he would be homeless and did not have a wheelchair to use after his release. Staff made an appointment the next day for Mr Hause to see a worker from the National Association for the Care and Resettlement of Offenders (NACRO, a charity organisation that advises on housing and education for prisoners). Mr Hause failed to attend the appointment.
47. On 22 December, Mr Hause was released from Chelmsford with no wheelchair. He returned to his ex-partner's home address and allegedly assaulted her shortly afterwards. On 27 December, the police arrested Mr Hause. In police custody, Mr Hause threatened to take his own life and repeatedly hit himself on his head.
48. On 29 December, Mr Hause appeared in court. A mental health nurse assessed him and noted that he needed a wheelchair and was homeless. During this review, Mr Hause said he wanted to die because he had tried without success to get help with housing services but found it difficult because of his disability. He said that returning to prison meant that he would at least have a roof over his head and three meals a day. He said that he had recently misused drugs (heroin and crack) and alcohol. The nurse noted that despite Mr Hause's low mood, he was also making plans for the future.

Mr Hause's return to HMP Chelmsford

49. The court remanded Mr Hause to Chelmsford. His person escort record (PER) noted that he had recently punched himself in the face, had tied clothing around his neck and said that he would kill himself when he was returned to prison. The PER said that Mr Hause had taken an overdose of medication in 2006, was wheelchair-dependent and had had a number of physical and mental health problems, for which he was taking medication. The escort contractor had

- completed a suicide and self-harm warning form as Mr Hause was very upset and said he had thoughts of suicide and self-harm.
50. When he arrived at Chelmsford, staff noted that Mr Hause had his own wheelchair that he said he had bought when he was released.
 51. An officer spoke to Mr Hause and, having reviewed the PER, started ACCT procedures. He set observations at every 30 minutes until the ACCT assessment was completed. Mr Hause said that he was upset and felt abandoned by the system. He believed that when he was released from prison again, he would face an identical situation to his present circumstances and would have to commit a further offence to get the help he needed. He doubted that he would be at Chelmsford long enough on this occasion to get anything organised for his release.
 52. A mental health nurse completed Mr Hause's reception health screen. She noted Mr Hause's current medication and added that he had had a pacemaker fitted. Mr Hause tested positive for drugs as part of his reception screening. He said he had misused drugs (crack and benzodiazepam) as recently as 22 December. He said that he had stopped taking his mirtazapine as it made him feel drowsy. He also said he had pain when he moved his lower limbs. She referred Mr Hause to the prison GP, the substance misuse team and Phoenix Futures.
 53. An officer completed Mr Hause's first night screen interview. Mr Hause said his partner had left him, he was homeless and therefore had no reason to live. As part of his reception screening, staff informed Mr Hause that because his offence was related to domestic violence, he would be subject to Prison Service Order 4400 (Prisoner Communications, The Protection from Harassment Act 1997). This meant that Mr Hause was not able to contact his ex-partner, the victim of his alleged offence.
 54. A prison GP examined Mr Hause. He noted Mr Hause was anxious but engaged well. He prescribed all the medications that Mr Hause had been prescribed in the community.
 55. Mr Hause lived in a disabled cell on the ground floor on F Wing.
 56. On 30 December, as part of the ACCT assessment, an officer interviewed Mr Hause. He was concerned about Mr Hause and so a Supervising Officer (SO) and a mental health nurse also attended the assessment. Mr Hause said he was anxious, depressed and was disabled. He felt helpless and had had no help from social services when he was released. He was homeless and had to live on the streets. He wanted to be dead and said he had tried to choke himself the previous night. He said that he had previously tried to hang himself and that he had taken an overdose. Mr Hause complained that he was in constant pain and was unable to contact his ex-partner because of his offence. He wanted to complete bereavement and anger management courses.
 57. Afterwards a custodial manager chaired the first ACCT case review. A SO, nurse and an officer attended. A mental health nurse also attended to assess Mr Hause after concerns raised during the ACCT assessment. Mr Hause said that he wanted support with his personal care. He was upset that he had not been

given a wheelchair on release from Chelmsford a week earlier and he had had to buy one. He was also unhappy about his medication. The nurse said she would arrange for Phoenix Futures to see him and review his medication. Mr Hause said that his mood would be lifted if he saw a tangible indication by 2 January that progress had been made to help him. The mental health nurse recorded that Mr Hause was initially tearful during the review but became calmer. She saw no evidence that he lacked the capacity to make informed decisions. She noted that Mr Hause did not intend to act on his suicidal thoughts.

58. Although the review panel initially considered placing Mr Hause on constant observations, after discussion, they agreed that observation every 30 minutes was appropriate and staff were required to have two conversations with him each day. The next ACCT review was scheduled for 2 January 2018. The mental health nurse said she would speak to the prison GP to consider prescribing mirtazapine at night.
59. The custodial manager noted on the ACCT caremap that: (1) Staff were to check if the prison had received Mr Hause's birth certificate as he needed it to claim benefits; (2) wing staff would facilitate Mr Hause's attendance at an appointment with the resettlement team to assist with his housing needs; and (3) Phoenix Futures should assess Mr Hause's physical and social needs. The mental health nurse agreed to manage this action.

Events in January 2018

60. On 2 January 2018, two nurses (Integrated Drug Treatment Service) discussed Mr Hause at the Referral and Allocation meeting. It was noted that Mr Hause would remain under the care of the prison GP and be offered support from Phoenix Futures.
61. On the same day, a SO chaired an interim ACCT review to check on Mr Hause's wellbeing after an unrelated incident on A Wing. Mr Hause said that he had no thoughts of suicide or self-harm. The SO told Mr Hause that that a full review would take place the next day.
62. On 3 January, the SO chaired an ACCT review, which a nurse, a member of Phoenix Futures, the Social Care Manager and a SO attended. Mr Hause reiterated that he was upset that he had not received any help from the Probation Service, social care or housing services in the community. He asked to be referred for self-help courses, including bereavement counselling, making better relationships and anger management. The nurse noted that Mr Hause had no thoughts of self-harm and was making plans for the future. The review panel agreed to address all of Mr Hause's concerns while he was in prison. They agreed that the healthcare team would discuss his medical needs at their MDT meeting the next day, and arrangements would be made for a member of the occupational therapy team to attend the prison to complete an assessment of his needs. Mr Hause was happy with the review team's responses to his needs. The SO reduced the ACCT observations to irregular hourly checks and scheduled the next ACCT review for 5 January.
63. On 4 January, Mr Hause refused to attend the prison's NACRO induction session.

64. That day, a substance misuse interventions worker reviewed Mr Hause. He discussed Mr Hause's recent drug use and how to minimise the harm caused by his use of illicit drugs such as PS, including the risk of overdosing. Later, the healthcare MDT, which included staff from IDTS and the prison GP, reviewed Mr Hause's situation. They noted that an occupational therapist would assess his care needs by 22 January.
65. That day, Mr Hause's ex-partner phoned the prison. She said that she had received a letter from Mr Hause dated 30 December 2017 and posted on 2 January 2018. In it, Mr Hause stated that he intended to hang himself. This information was passed to a SO, who spoke to Mr Hause that afternoon. Mr Hause told the SO that he had written the letter out of frustration when he had first arrived at Chelmsford. However, this was before speaking to staff and other agencies about his needs, which were now being addressed. He said that he now felt settled in prison, was happy on F Wing and had no thoughts of suicide or self-harm.
66. On 5 January, a SO chaired an ACCT review, which a nurse attended. Mr Hause said that although he was not happy to have returned to prison, he hoped that support in the community would be arranged for his release this time. He said that he had no thoughts of suicide or self-harm and intended to keep himself busy by helping other prisoners with their educational needs. In terms of his mobility, Mr Hause said he was no longer able to stand at all and, although he said he struggled to carry out his daily living activities, he said he did not want any help. The nurse noted that Mr Hause had an appointment with the prison GP on 22 January and was due to see the occupational therapist. The SO did not change the ACCT observation level and scheduled the next review for 12 January.
67. At the healthcare team's Referrals and Allocations meeting on 8 January, they noted that Mr Hause did not need support from the mental health team.
68. On 9 January, a case manager from Phoenix Futures assessed Mr Hause, who agreed to address his lapse with illicit substances while in custody. He was tearful at times but agreed to participate in group work on drugs, relapse prevention and managing anxiety.
69. Security intelligence intercepted a letter in the internal post from Mr Hause to his ex-partner dated 10 January. In it, Mr Hause stated that he missed his partner and felt guilty about his offence against her. He said that he was not coping in prison but would not let others know this. He hoped that his ex-partner would wait for him to be released from prison. He explained that he had a prison job, helping other prisoners with their educational needs. There is no record that staff spoke to Mr Hause about his wellbeing or to address the fact that he was not complying with the restrictions not to contact his ex-partner.
70. On the night of 10 and 11 January, the night duty officer noted in Mr Hause's ACCT record that he had complained that he had received his medication late on both evenings.

12 January

71. On 12 January, an officer was on duty on F Wing. She recorded no concerns about Mr Hause that morning and observed him talking to other prisoners on the wing. Mr Hause collected his lunch at around midday.
72. In the absence of previous ACCT review chairs due to operational pressures, a SO chaired Mr Hause's ACCT review at 4.30pm, and another SO attended. A nurse from the healthcare team had initially planned to attend the review but could not because there was an emergency in another part of the prison. The SO deemed this an interim review and told Mr Hause that a full review would be rescheduled for the next day (13 January) with a member of healthcare present. The SO said Mr Hause's mood was positive. Mr Hause said that Phoenix Futures were dealing with a lot of his issues. He said that he had no thoughts of suicide or self-harm.
73. Afterwards, CCTV shows Mr Hause sitting in his wheelchair in the doorway of his cell at 4.51pm during association. He collected his evening meal at 5.13pm and returned to his cell.
74. Staff completed ACCT checks on Mr Hause at 6.05pm and 7.20pm and noted no concerns. When checked at 8.30pm, Mr Hause was seen writing a letter on his bed.
75. At 9.03pm, CCTV shows an officer and a nurse unlock Mr Hause's cell door to dispense his evening medication. The nurse told the investigator that Mr Hause was lying on his bed, said he was okay and just wanted his medication. The nurse went into the cell and gave Mr Hause a glass of water to take with his medication. He said he had no concerns about Mr Hause during this short interaction.
76. CCTV shows the officer on night duty that day check on Mr Hause at 9.16pm during a roll check of the wing. She raised no concerns.
77. The prisoner who lived in the cell next door to Mr Hause told the investigator that he spoke to Mr Hause at around 9.30pm through the interconnecting pipes of their cells. He said that he had no concerns about Mr Hause.
78. The officer noted in the ACCT record at 9.30pm that Mr Hause was still waiting for his evening medication. This was contrary to her police statement, in which she said that he had been given his medication earlier.
79. The officer recorded in the ACCT record that she checked Mr Hause at 10.22pm when he was sitting on his bed, writing a letter. However, CCTV evidence contradicts this and although it shows her patrolling the landing at 10.01pm, 10.35pm, 10.45pm and 10.48pm, it does not show that she checked Mr Hause's cell.

Emergency response

80. CCTV shows that the officer checked Mr Hause at 11.18pm. She said that she saw Mr Hause sitting on the floor, with a ligature made from torn bed sheets tied around his neck. Mr Hause did not respond when she called his name. She

radioed a Code 1 emergency (indicating that a prisoner was unconscious or not breathing). The control room alerted other staff to attend F Wing and called an ambulance (recorded as at 11.20pm). She left the wing landing and returned to the wing office.

81. At 11.23pm, CCTV shows the custodial manager (CM), who was in charge of the prison, arriving on F wing, followed by two officers and a healthcare assistant and a nurse. The CM said that he was surprised that the officer was in the office writing something, and not waiting at the cell to indicate to others where the emergency incident was. He asked her the location of the emergency and was directed to Mr Hause's cell.
82. The CM went into the cell and saw Mr Hause suspended by a ligature, sitting on the floor. An officer cut the ligature and the nurse supported Mr Hause's body weight to lay him flat on the floor. The nurse checked Mr Hause for signs of life. He found none, though Mr Hause's body was still warm. The officer started cardiopulmonary resuscitation (CPR) by doing chest compressions.
83. At 11.24pm, the officer who had collected the medical emergency bags brought them into Mr Hause's cell. The nurse started to administer oxygen to Mr Hause and set up the defibrillator (a machine that monitors heart activity) which instructed to continue CPR. Another nurse arrived at 11.27pm. She brought further medical equipment and assisted with CPR.
84. Two paramedics arrived at Mr Hause's cell at 11.33pm and 11.45pm. They took over the care of Mr Hause and at 12.15am (on 13 January) pronounced that he had died. The police arrived shortly afterwards.
85. A note written by Mr Hause was found on his bed after he died. Mr Hause apologised to his ex-partner stating that he loved her, was sorry for what he had done and was unable to live with the guilt any more. He also said that he had written lots of suicide notes before but had not gone through with it.

Support for prisoners and staff

86. After the incident the duty manager debriefed the staff involved in the emergency response. He reminded staff how to access the prison's care team. Members of the care team subsequently contacted the staff involved to offer support.
87. The prison posted notices informing other prisoners of Mr Hause's death and offering support. Staff reviewed all prisoners assessed as a risk of suicide and self-harm in case they had been adversely affected by Mr Hause's death.

Contact with Mr Hause's family

88. The police noted that Mr Hause had listed his ex-partner as his next of kin despite her being the victim of his offence. They therefore took the decision to check whether Mr Hause had any other known and more appropriate relatives before allowing Chelmsford to break the news to his ex-partner. The police's search proved unsuccessful and they updated Chelmsford about this in the early hours of 13 January. At 8.30am on 13 January, the duty manager and one of the prison family liaison officers visited Mr Hause's ex-partner and broke the news of

his death. The prison contributed towards the costs of Mr Hause's funeral in line with national guidance.

Post-mortem report

89. The post-mortem examination concluded that Mr Hause died as a result of suspension.
90. The toxicology report noted the presence of a number of prescribed drugs in Mr Hause's bloodstream. Of these, only amitriptyline was detected at a concentration level higher than the expected therapeutic dosage. The toxicology report suggested that Mr Hause might have hoarded amitriptyline tablets, which he took as a single dose in the hours before he died. The toxicology report also noted the presence of galantamine (used for the treatment of mild to moderate Alzheimer's disease) which Mr Hause had not been prescribed,

Findings

Management of risk of suicide and self-harm

91. Mr Hause had a range of risk factors for suicide and self-harm, including previous attempted suicide, poor physical and mental health, substance misuse and family relationship breakdown. In line with Prison Service Instructions (PSI) 64/2011 on safer custody, staff appropriately started ACCT procedures for Mr Hause twice at Chelmsford. The first occasion was when he told staff that he would harm himself on 11 September 2017, and he was monitored until the next day. The second time was on 29 December when Mr Hause was recalled to prison, having only been released six days earlier. Mr Hause arrived with a suicide and self-harm warning form which stated that he had recently threatened to take his own life. This period of ACCT monitoring continued up until his death.
92. Mr Hause's last period at Chelmsford was just 15 days. During this time, he had significant contact with prison, healthcare, substance misuse and social care staff. ACCT reviews were well attended by staff who contributed to his care, the level of observations set was reasonable and reflected his circumstances. While his mood was initially low when he arrived at Chelmsford, he gave staff no indication that he was at risk of suicide in the days before he died. We do not consider that staff at Chelmsford could have predicted that Mr Hause intended to take his own life imminently.

ACCT check

93. Mr Hause's ACCT observations were set at irregular hourly intervals. CCTV confirmed that on the evening that Mr Hause died, an officer checked Mr Hause at 9.16pm. However, although she noted in the ACCT record that she checked Mr Hause at 10.22pm, CCTV footage showed that she did not do so, and that she did not check him again until 11.18pm (two hours after her previous check). She has subsequently been suspended from duty and is subject to disciplinary proceedings. Although we cannot know whether Mr Hause's death might have been prevented if staff had checked on him in line with agreed observation levels, it is that likely they would have discovered him earlier than they did.
94. ACCT observations are intended to ensure the well-being of prisoners and offer them support as needed. It is therefore vitally important that staff adhere to instructions agreed at ACCT reviews. We make the following recommendation:

The Governor should ensure that:

- **all staff undertake ACCT observations as directed and actively engage with prisoners being monitored; and**
- **managers carry out checks to ensure that this happens.**

Delay entering Mr Hause's cell

95. Chelmsford's local instructions for unlocking a prisoner during the night state:

"Under normal circumstances, no cell will be opened unless a minimum of three members of staff are present, one of whom should be the Orderly

Officer ... Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer... Where there is, or appears to be immediate danger to life, cells may be unlocked with one member of staff.”

The instruction continues:

“You should use your judgement to decide if it is safe to open a cell in an emergency... However, preservation of life supersedes security and it is down to the individual on patrol to make the assessment and decision... Staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence.”

96. The officer looked into Mr Hause’s cell at 11.18pm, but did not enter the cell or wait for staff support near the cell. While we understand the need to assess risk dynamically to ensure that staff do not put themselves in danger or risk the security of the prison, she could see Mr Hause had a ligature tied around his neck and was unresponsive. In these circumstances, we would have expected her to have gone into the cell to try to save Mr Hause’s life. At the very least, and as the manager in charge said, he expected that she would have remained at Mr Hause’s cell door to unlock it quickly when responding staff arrived. As we noted above, she has been suspended from duty and is facing disciplinary proceedings.
97. Although earlier intervention may not have made a difference in Mr Hause’s case, it might have done, and it is critical that staff act quickly where there is immediate danger to life. We make the following recommendation:

The Governor should ensure that all staff understand that when life is in danger, they should enter the cell as quickly as possible.

98. This is not the first time that we have made recommendations to Chelmsford about the management of those at risk of suicide and self-harm and emergency response procedures. We therefore make the following recommendation:

The Prison Group Director for Hertfordshire, Essex and Suffolk should satisfy himself that effective action is taken to implement the above recommendations.

Victim and public protection issues

99. Mr Hause was charged with a domestic offence against his ex-partner, and when Mr Hause arrived at prison, staff noted that under Prison Service Order 4400 (which is no longer in operation), he should not have been allowed to contact her. Although PSO 4400 has been replaced by PSI 49/2011, the same principles apply. Mr Hause should first have applied to the Governor for permission to contact his ex-partner. This application would have been considered and could have been refused if it was believed that it would add to his ex-partner’s distress.
100. Contrary to these requirements, Mr Hause contacted his ex-partner by letter on 2 January, shortly after he arrived and without the prison’s knowledge. This was despite reception staff notifying the Offender Management Unit (OMU) of his restriction when he returned to Chelmsford on 29 December. We do not know

why OMU did not action this information, though the investigator was told that the limited staff resources over the Christmas period might have played a part. Although we recognise that the restrictions of PSI 49/2011 were in force by 10 January, we are concerned that Mr Hause was able to contact his ex-partner before this time. This should not have happened. We make the following recommendation:

The Governor should ensure that a system is in place to identify newly arrived prisoners whose offence is harassment or involves the fear of violence and that staff comply with the requirements of PSI 49/2011 so that prisoners are not able to contact the victims of their offences.

Clinical care

101. The clinical reviewer concluded that the standard of healthcare that Mr Hause received was generally equivalent to that which he could have expected to receive in the community. However, she had two concerns.

Access to a wheelchair

102. Mr Hause used a wheelchair. When he was released from custody on 22 December, Chelmsford did not obtain a wheelchair for him to use in the community. While a wheelchair had been provided for Mr Hause's use in prison, it had to be returned when he was released. This caused him significant stress and anxiety. We make the following recommendation:

The Head of Healthcare should establish a process for assessing prisoners who may require permanent equipment, including on their release from prison, and ensure that they have access to such equipment.

Medication

103. Mr Hause had been prescribed a number of medications, including amitriptyline (an anti-depressant) and pain relief for a number of years, and prison staff recorded that he could become upset or demanding if his medication was not dispensed on time. The clinical reviewer noted that Mr Hause appeared to depend on pain relief to manage his complex physical health issues but that Chelmsford did not to have had a comprehensive plan in place to manage and monitor his pain and treatment.
104. The toxicology report found that Mr Hause had higher level of amitriptyline in his bloodstream when he died than would have been expected and from his prescription. This suggested that Mr Hause had hoarded amitriptyline tablets and taken them as a single dose in the hours before he died. We cannot know why he did so or what part the amitriptyline played in his death. It is possible that he took the tablets, alongside the ligature, to ensure that he died. It is also possible that he intended to take his life by means of an overdose and only resorted to a ligature when the tablets did not have the desired effect. Or there may be some other explanation.
105. We are concerned that there was no recorded risk assessment to monitor and manage Mr Hause's multiple medications or to consider if he had misused his

medications, particularly given his history of substance misuse. We make the following recommendations:

The Head of Healthcare should ensure that prison GPs review and manage prisoners' risk of access to medication, particularly when they have a history of substance misuse and/or multiple physical health problems.

**Prisons &
Probation**

Ombudsman
Independent Investigations