

**Investigation into the circumstances surrounding the death  
of a man at HMP Chelmsford on 20 March 2005**

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

**April 2006**

This is the report of an investigation into the death of a man who died in the segregation unit at HMP Chelmsford on 20 March 2005. The man cut himself with a razor blade that he had been given by staff when he had asked to be able to shave. When he was discovered bleeding, and although the timings are inexact, I conclude there was an unacceptable delay before his cell was opened.

I wish to offer my sincere condolences to the man's family for their loss. He was on remand at the time of his death. His mental health status, and the different views taken about it by clinical and non-clinical staff, is at the heart of this tragedy.

This investigation was conducted by one of my Senior Investigators. Both he and I are grateful to the Governor and his staff at Chelmsford for their help and co-operation during this investigation.

A clinical review was undertaken by the Chelmsford Primary Care Trust into the medical care that Mr Hampson received. I am grateful for their report. I was very disappointed that Chelmsford's Medical Officer, did not fully co-operate with my investigation.

This is a report that makes very uncomfortable reading. In an investigation that has revealed serious shortcomings in respect of F2052SH procedures, completion of the segregation safety algorithm, and other matters, one vision haunts me. It is of a F2052SH review being conducted in a cell with the prisoner actually hiding under his bed.

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**Prisons and Probation Ombudsman**

**April 2006**

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## Summary

1. The man was remanded into custody at HMP Chelmsford on 4 March 2005. He had cut himself whilst in police custody and was immediately placed on a F2052SH booklet and housed in the Healthcare unit.
2. He was started on a short (5 day) detoxification programme having tested positive for benzodiazepines. But he was unhappy that he was not given methadone.
3. During the afternoon of 8 March, a smashed TV was found hidden under the man's bed. He denied damaging it but was placed on disciplinary report. A few minutes later, the Medical Officer discharged him from the Healthcare unit.
4. The man transferred to B wing the following morning. Later that afternoon, he punched an officer in the face who had responded to his cell bell. He was moved to the segregation unit and made the subject of a 'three man unlock'.
5. The man's behaviour became more and more odd. Despite being on an open F2052SH, he was given 17 days cellular confinement for the two offences of breaking his television and assaulting a member of staff.
6. Staff became concerned about his mental state but knew that he was due to see the Consultant Psychiatrist. He began hiding under his bed with the mattress on top of him. He told officers that people were coming to get him and kill him.
7. The man was seen by the Consultant Psychiatrist on 18 March, but he found no evidence of current mental illness. He remained on the segregation unit and continued to display bizarre behaviour.
8. Just before lunchtime on 20 March, the man asked to be given a razor so that he could shave. An officer gave him a disposable razor with his lunch. At 12.24 pm, the man pressed his cell bell. When the officer attended, he saw him staggering around his cell having apparently cut his left wrist.
9. A number of other officers arrived outside the cell, including two nurses. The man was on the blood-covered floor and the cell was entered. The man was taken out of the cell and resuscitation was attempted. He was pronounced dead at 2.15 pm.
10. The investigation has revealed a number of serious failings. I make nine recommendations.

## **Investigation methodology**

- 11.** The investigation was opened at HMP Chelmsford on 23 March 2005. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were distributed around the prison notifying staff and prisoners of the investigation.
- 12.** A number of prison staff were formally interviewed along with a prisoner who was in the Segregation Unit at the time of the man's death.
- 13.** My investigator met with officers from Essex Police on 24 May to discuss the case.
- 14.** Her Majesty's Coroner was contacted to inform her of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in her enquiries into the man's death.
- 15.** My investigator arranged a meeting with the man's mother and step-father at their solicitors' office on 18 April 2005. Also at the meeting was a representative from the organisation INQUEST.
- 16.** My investigator summarised the events surrounding the man's period in custody and his death, as he had discovered them during his investigation so far. He was able to clarify a number of matters for the family and noted a number of concerns that they had. A more comprehensive list of questions was included in a letter from the solicitors the following day.
- 17.** With the agreement of Her Majesty's Coroner, a number of documents relating to the man's time at Chelmsford were disclosed to the family's solicitors in line with this office's disclosure policy,

### **The person this report relates to**

- 18.** The man was 32 years old when he died. He had two sisters and a brother. He excelled at sports, especially swimming, and had a love of art. He worked as a window fabricator for a short while before giving it up to concentrate on his art.
- 19.** In the early 1990s, the man was in a long term relationship from which he had a daughter.
- 20.** In 2000, one of the man's sisters died tragically. This had a profound effect on him as he was unable to come to terms with her death.
- 21.** The man had a drug dependency problem for over ten years. In the past, he had used heroin intravenously but more recently had been prescribed methadone. He also used cannabis and ecstasy. Prior to his death, the man's doctor was treating him for depression, alcoholism and drug addiction.

## HMP Chelmsford

22. HMP Chelmsford was built in 1828 as a county gaol. Since 1987, it has been used as a category B local prison and young offender institution.
23. Two new house blocks and a purpose-built sports facility were opened in 1996 to relieve overcrowding. During 2000, Chelmsford converted one of the wings to house more young people. The new Healthcare Centre was formally opened in July 2004.
24. In the introduction to her report on an unannounced inspection of Chelmsford in August 2004, HM Chief Inspector of Prisons says:

*'This report of Chelmsford prison and young offender institution records an establishment continuing to make progress. This is all the more impressive because Chelmsford has had a difficult history, both in terms of inadequacies in its care for prisoners and its troubled industrial relations.*

*Chelmsford remained a reasonably safe establishment. Various supporting procedures had been improved since our last inspection, including those for induction, anti-bullying, reducing drug supply into the prison, mandatory drug testing and detoxification.*

*However, we were concerned that there had been an increase in the use of force, segregation and special cells – the reasons for which were not entirely apparent. This concern was heightened because the segregation unit was badly in need of refurbishment, although we noted that staff prisoner relationships in the unit were constructive and reviews and care plans for difficult prisoners were excellent.'*

## Events prior to the man's death

25. The man's parents said that he was at their house on 3 March 2005. His behaviour caused them such concern that they called the local police. The officers who responded were about to leave when the man insisted that they take him to prison. He was told that he had not done anything to make that necessary. The man promptly punched one of the police officers in the face. He was arrested. Whilst in police custody, he attempted to cut his wrists and was placed on a self-harm watch.
26. On 4 March, the man was transferred from the police station to Southend Magistrates' Court to answer the charge of actual bodily harm on the police officer. He was handed over to the private escort company (Premier Custodial Group) who checked him every five or ten minutes.
27. At court, a suicide/self-harm warning form was completed based on information supplied by the Community Psychiatric Nurse (CPN) at the court. The Premier escort officer completing the form noted the following information: *'Believed to be withdrawing from illicit drugs (heroin/crack) Methadone user. Appears to be acutely psychotic, drug induced psychosis. Believes he is going to be abducted and killed.'* Checks every five minutes were indicated.
28. The man arrived at HMP Chelmsford at 4.30 pm, having been remanded in custody until 7 March. The committal warrant from the court had a hand written note on it stating, 'MDO CJMHT report attached. Risk self-harm.' The CPN at court, had written the report. He identified that the man had had three admissions to psychiatric hospitals since October 2004, the last being on 24 February 2005. He stated that the man presented as suffering from a drug induced psychosis, with clear paranoid delusions. He said that the man was a risk to both himself and others as a result of his delusional beliefs. He recommended that he be remanded into custody until 7 March when a further assessment could be made, adding that it would enable a decision to be taken as to whether the man would require hospital treatment in an environment with some degree of security.
29. During his First Reception Health Screen at Chelmsford, the man denied having any suicidal or self-harm thoughts when he was asked. He claimed to have been prescribed Cipramil (an anti-depressant), methadone and tablets for his drinking. He was referred to see the Detox nurse.
30. At 7.25 pm, a self harm at risk form F2052SH was opened in Reception. This form is designed to record the reasons why a prisoner is felt to be at risk, the proposed means of support during the crisis period and a place to record, at stipulated intervals, observations of the prisoner throughout the risk period.

31. The nurse who opened the form decided to admit him to the healthcare centre within the prison, noting that he should be in single accommodation and requesting Mental Health Team input. The level of supervision was set as 'regular'. Chelmsford's Suicide Awareness Policy – Operational Instruction 'Annex B' states: '*At risk prisoners in a single cell, or on their own in a double cell, should be seen by staff at irregular intervals of no more than one hour.*' The supervision recorded on the F2052SH was frequently more than an hour apart, sometimes several hours.
32. A Samaritans telephone was to be made available to the man upon request.
33. The man was urine tested for drugs on 5 March. He tested positive for benzodiazepines but not for methadone or opiates. He was put onto a short detoxification program, consisting of lofexidine and a nine day course of diazepam. He was assessed by the Detox nurse and given a second urine test. That test proved positive for opiates. No satisfactory explanation for the discrepancy between the two tests has been presented.
34. A psychiatrist saw the man on 6 March when it was noted on the F2052SH that the man was not suicidal and there was no evidence of acute mental illness. A review of the F2052SH was planned for later in the week.
35. At 5.26 am on the morning of 7 March, the man called out to the night officer who came to check on him. He said there would be dramas at 7 am as people were coming to get him, calling him a 'nonce'. He was rocking on his feet but claimed to be feeling alright. He went to court later that morning without incident. The man was remanded into custody until 21 March and returned to healthcare.
36. At 3.15 pm on 8 March, a smashed TV was found in the man's cell under his bed. He denied being responsible. The security report of the incident says that a shard of glass wrapped in a towel was found under the bed. The shard of glass is referred to as a weapon. There is no mention of the fact that the man was on an open F2052SH. The report of the incident in his medical record refers to the man being somewhat annoyed that he did not get his methadone detox. There is no mention of the shard of glass in either the medical record or the F2052SH.
37. The man was seen by Chelmsford's Medical Officer, at 3.30 pm. His written F2052SH discharge report states in the summary of in-patient stay, '*Settled, No mental illness. No s/harm ideation. On a brief detox at present.*' In the recommendation section, the doctor wrote, '*Normal management plan. May become upset when detox ends though.*'
38. At 9 am on 9 March, the man was moved to B wing. An entry in the F2052SH booklet at 3 pm reads, '*Threats to cut up. MO adamant not*

*coming back to HCC at present. Insists detoxing methadone.  
Rationalised manipulation – cited by Lyn Booth MHT.'*

39. At 5 pm, an officer answered a cell bell at the man's cell. When the officer opened the door, the man punched him in the face. As a result, he was moved to the segregation unit on A wing. A case conference, attended by a senior manager, should have been held immediately in order to take account of events leading up to the decision to segregate and to develop a specific care plan for the man whilst in segregation. There is no evidence that this was done, contrary to Chelmsford's Suicide Awareness Policy Statement.
40. A Segregation Safety Algorithm form is a document that has to be completed whenever a prisoner is to be moved into segregation. It consists of five sections. Part A is a yes/no flow chart designed to show any healthcare reasons against segregation. That part is completed by a registered nurse or doctor within two hours of the prisoner being placed in segregation or before a punishment of cellular confinement at adjudication. Part B records the name of the duty governor informed and the time. Part C shows the decision made by the duty governor/adjudicator. Part D has a short list of actions to be taken if the prisoner is to be segregated, and part E has space for the name of the duty governor, the signature and the date and time. The process is referred to as 'being fitted' i.e whether the prisoner is 'fit' for segregation mentally and physically. An algorithm form was initiated by a nurse and she completed part A of the form. The remainder of the form was not completed.
41. On 10 March, the man was made the subject of a three man unlock because he apparently continued to threaten violence toward staff. (Three man unlock meant that three officers needed to be present before his cell could be unlocked.)
42. A F2052SH review was held with the man present. It was noted that he was completely pre-occupied with the need to get more drugs whilst detoxing. He stated that he would 'lose it' without treatment. He also said that he had no thoughts of self-harm and that he would never get through the detox. The support plan was to discuss the detox issues with healthcare staff and the doctor, offer support from the chaplaincy and use of the Samaritans phone. The review team did not set an observation interval, but as the man was being held in the segregation unit he should have been observed every hour as a minimum. A further review was scheduled for 17 March.
43. Later that morning, a governor grade officer held the adjudication for the man's two offences of smashing his TV and assaulting an officer. She was unaware that the man was on an open F2052SH. During the adjudication hearing, the man became verbally abusive and when he moved towards the governor he was restrained and removed from the adjudication room. The hearing continued in his absence.

44. A healthcare nurse who happened to be on A wing, was given a set of algorithm forms to complete at 10.35 am by the adjudicating governor before she gave her punishment. The nurse knew that the man had been on a F2052SH but did not know if he still was. The man was not present when she completed the form. She answered 'no' to the question asking if the prisoner was on an open F2052SH. The governor was subsequently unable to correctly complete section C of that form.
45. The man was punished for smashing the TV with seven days cellular confinement and another ten days for the assault on the officer, making 17 days in total.
46. An un-timed entry later that day in the man's medical record states, 'Spoke to on A wing appears quite hyper. Rude and abusive, decision by medical officer and myself (detox nurse) to curtail treatment as it is enhancing his anxiety.'
47. Just before 1 am on 11 March, the man began pacing his cell and banging the door. When spoken to, he said he was OK. At 1 am, an entry in the F2052SH states, 'Smashing up cell. Informed Oscar 1 via comms phone.' The 1.10 am entry in the A wing staff observation book states, 'banging and pacing around his cell, smashed vanity board. Oscar 1 informed and came over and calmed him down.'
48. At 6.30 am, the man began to bang his cell door with the vanity board. He was again calmed down. At 6.45 am, he began shouting. He was spoken to by an officer and said that people were ringing the jail and saying that they wanted to kill him. The officer assured him that was not the case. The man appeared to accept that and sat on his bed.
49. At 8.00 am, when he was asked why he had declined hot water and exercise, the man said that people were looking at him through binoculars. The officer concludes an entry in the F2052SH with 'Very strange'. At 10 am, the man rang his cell bell - for no reason, he said.
50. At 8.45 pm that evening, the man asked to be let out of his cell and seemed very confused. At 9.25 pm, he was seen lying under his bed. He came out and told the officer that an armed response unit was outside intending to get him out.
51. A governor's entry for 12 March states, 'Still displaying strange paranoid behaviour although a little more coherent today.' When the governor did his rounds the following morning, the man told him that a particular officer and he were going to be shot.
52. The next entries of significance begin at 3.15 pm on 13 March when the man was abusive to a nurse who had come to see him. At 7.30 pm, he rang his cell bell and told the officer that the prison was surrounded by armed police. There are then numerous entries throughout the night

with the man distressed and lying under his mattress on the floor and continuing to shout about armed forces coming.

53. The Governor's rounds entry for 14 March states, 'Displaying strange behaviour traits, writing on mattress. To be seen by psychiatrist.' The entry for 15 March states, 'Found under bed. I have concerns with this prisoner's state of health and will discuss this with healthcare staff.' My investigator found no record of any subsequent discussion.
54. An entry in the A wing staff observation book dated 16 March reads, 'still displaying bizarre behaviour. Psychiatrist coming to see him on Friday. Currently prisoner refusing to wear clothing. Staff are continuing to try and work with him but uncooperative.'
55. At 6.10 am on 17 March, the man rang his cell bell. The records say that he asked for all nine prison officers hiding in the office to get him a 'burn' (cigarette) before he was shot in the head. Later that morning, the man was seen by a governor in the segregation unit. He was acting bizarrely and told the governor that all the staff were going to Broadmoor.
56. At 11 am, the man was hiding under his bed and refused to come out of his cell for his F2052SH review. A Senior Officer decided to hold the review in his cell with the man still under the bed. The man said that he was praying. The review noted that he was due to see the psychiatrist the next day and that he had another 17 days on cellular confinement (CC). (In fact, he only had another ten days of his punishment left.) The review team persuaded the man to have a shower. The support plan was for A wing staff to support the man to complete his punishment, referral to the psychiatrist, and use of the Samaritans phone.
57. At 3 pm, the man's mother and his stepfather visited him. It was a closed visit, meaning that he and his visitors were separated by a glass partition. The man was dressed, but looked dishevelled and distressed. At times, he talked loudly about people going to shoot him. A governor was passing through the segregation unit and saw the visit taking place. He noted how distressed the man's parents were by the visit. The governor arranged for the man's parents to meet with him after the visit. They were very concerned about the state that the man appeared to be in. The governor reassured them that the man was now in the best place to be taken care of. He advised them that he was to see a psychiatrist the next day. His parents also believed that he told them that the man was being checked every 30 minutes and was on a three man watch.
58. The governor denies saying the man was on a 30 minute watch and believes that the family misheard him when he mentioned that he was on a three man unlock. The governor was told of the circumstances of the man's arrest. No information from that conversation was written down or passed on to others. Later that night, the man was in his cell sitting on the floor with a blanket over his head.

- 59.** The following day, 18 March, the man was seen by a Consultant Psychiatrist. In his report, he notes that the man was initially quite uncooperative and guarded. The man admitted to being distressed as he had thought his mother and stepfather were dead, so he was shocked to see them. The man denied that he had behaved in any odd manner, for example having his hair standing on end or lying under his bed. He admitted to using heroin and methadone outside of prison. The man stated that he was causing havoc in the prison because he wanted to stay in healthcare, but that he was now going to behave well in A wing.
- 60.** The psychiatrist noted that he elicited no abnormal beliefs or thoughts and that the man denied having an abnormal mood. He decided that the man had no current ideas of self-harm or suicide nor could he detect any feature suggestive of any current mental illness.
- 61.** During his interview with my investigators, the psychiatrist agreed that, prior to his meeting with the man, he had been able to read the notes and comments on his Medical Record and F2052SH. He had also read the report written by the CPN from the Criminal Justice Mental Health Team at court. Unfortunately, the CPN had dated the letter incorrectly as 4 March 2004 and not 2005. Even though the text in the letter makes it clear that the events mentioned took place in 2005, the psychiatrist disregarded the information as he believed it referred to events over a year earlier.
- 62.** The psychiatrist's report in the man's Medical Record gave no diagnosis or plan for his continued care. During interview, he told my investigators that maybe the man had a 'borderline personality disorder' and that, even if he was suffering from a drug induced psychosis, he would have expected the effects to have worn off by time he saw him.
- 63.** The man went back to his cell in the segregation unit and continued to display unusual behaviour, sitting on the end of his bed praying, lying under his bed with the mattress on top of him, and talking about angels. The observation book notes that he was awake all night, talking rubbish and making a lot of noise. The man continued to talk to himself, pace his cell etc until about 11.20 pm on 19 March, when he appeared to be asleep.

## Events surrounding the man's death

64. At 11.17 am on the morning of 20 March, the man pressed his cell bell. When Officer One and two other officers responded, the man asked to be given a razor as he wanted to have a shave. He was unshaven, and had been for some time. Despite knowing that the man was on an open F2052SH, originally opened because he had superficially cut his wrists whilst in police custody, and being aware that he had been exhibiting bizarre behaviour for some time, the man was promised a razor with his lunchtime meal. The officers were also aware that he had been seen two days before by the psychiatrist, although no report of that consultation was available to the Segregation staff as it was only documented in his 'confidential' Medical Record. Healthcare staff had not passed relevant information on to those caring for the man in the segregation unit.
65. The man's cell was unlocked about 11.50 am and the three officers gave him his lunch and a plastic disposable razor. The issue of the razor was not documented. During his interview, Officer One told my investigators that he had given the man the razor. He knew that he was on a F2052SH and that it was for 'cutting' but said that the form did not say not to give him a razor.
66. At 12.24 pm, the man pressed his cell bell again. Officer One responded within seconds and immediately shouted the alarm when he looked into the cell. He saw the man staggering around the cell, a bloody handprint on the wall and a lot of blood on the cell floor. The man was apparently naked from the waist down.
67. Other officers arrived at the cell. A Senior Officer saw the man moving around the cell and grunting. He called to the man a number of times to ask where the blade was and for him to pass it out. The SO said in interview that he was assuming it was a razor blade at that time. At some point, the man apparently said, "I don't know where it is." My investigators believe that the man's reputation for violence and unpredictability was the major reason the cell was not entered immediately.
68. Other officers were arriving, including two nurses from healthcare. By this time the man was writhing on the floor of the cell. Some of the officers were in the process of putting on protective clothing (overshoes and white paper suits) to protect themselves from the blood.
69. In the absence of any exact evidence, my investigators have had to rely on the timings provided by staff who were present. Within a few minutes of the man pressing his cell bell, a governor grade, a Principal Officer, a Senior Officer, three A wing officers, an officer who had gone onto the wing at lunchtime and two nurses from Healthcare were at the cell. The estimates of the time taken to enter the cell vary from three to fifteen minutes. An officer was tasked with keeping a log and he recorded entry

at 12.35 pm, nine minutes after the man pressed his cell bell. It should be noted that the officer also records the time of responding to the man's cell bell as 12.30 pm, which was incorrect.

70. The SO and Officer One said during interview that, when they looked into the cell, the man was on his feet. The other officers said they saw him on the floor. The first Healthcare nurse, who arrived at the cell a few minutes later, saw the man on the blood-covered floor. She saw that no blood was coming from the wound on his wrist and no movement. The second nurse said that an ambulance would be required as soon as possible and the PO contacted the control room at 12.29 pm to request one. In interview, the first nurse admitted that when she told the governor that they should go in she believed that the man was dead.
71. The second nurse opened the cell door and then she and two officers entered the cell. They brought the man out into the corridor to give them more room to work. He was placed on a blanket and the second nurse and an officer performed Cardio Pulmonary Resuscitation (CPR). They had just administered a shock from the defibrillator when the ambulance crew arrived at 12.50 pm. A paramedic arrived five minutes later. The ambulance crew and the paramedic took over CPR from the prison staff but without success. The man was pronounced dead at 2.15 pm.

## **Events after the man's death**

- 72.** The governor remained on A wing and continued to supervise events and facilitate the police response. The other officers involved were told to go and wait in the command suite. They found the suite locked, however, and they ended up waiting in the boardroom. All of the officers interviewed spoke of the length of time, by some estimates almost two hours, before a debrief took place. During the time they were in the boardroom, they had no idea what was happening although they were provided with refreshments.
- 73.** The officers were complimentary of the care team's response. The possible impact of the man's death on the other A wing prisoners was not overlooked. A member of staff was instructed by the governor to patrol the wing to keep an eye on the other prisoners. A general review of other prisoners on F2052SHs was conducted as is standard practice. Each prisoner on A wing was spoken to, in order to gauge any reaction to the death.
- 74.** Chelmsford has a Governor's Order which outlines the procedures to be followed after a death in custody. My investigators were content that the staff actions following the man's death were in accordance with that policy.
- 75.** After some trouble identifying the man's mother's address, the governor who had been at the cell went and informed her personally of her son's death. When he was interviewed, my investigators noted how deeply the man's death had apparently affected him.
- 76.** When my investigator met with the man's parents, his mother was unhappy with some of governor's answers to her questions.
- 77.** As part of the investigation, my investigators wanted to interview Chelmsford's Medical Officer, as he had made a number of decisions and documented entries relating to the man's care. He refused to co-operate with my investigation despite a personal request to do so by the prison Governor. His main reason for not co-operating appeared to be the mistaken belief that my investigators, and by implication, the Ombudsman's office, were not entitled to have access to the man's Medical Record. (Prisoners' Medical Records are one of the documents that are required - and always made available - at the start of an investigation into a death.) Chelmsford's Medical Officer is employed by a private company, which in turn is contracted by the local Primary Care Trust to provide the services of a Medical Officer at Chelmsford. The doctor also declined to co-operate with the person who was preparing the clinical review for the Primary Care Trust.
- 78.** As the result of my investigators giving feedback on the investigation to the Governor, a Governor's Order was issued on 1 April 2005. It stated, amongst other things, that prisoners in the segregation unit on F2052SH

booklets should only be allowed supervised shaves.

## **Clinical Review**

- 79.** The clinical review of the man's medical care whilst he was at Chelmsford was undertaken by the Chelmsford Primary Care Trust. The reviewer was able to take part in the interviews with staff and had access to a copy of the documentation supplied by the prison, including the man's Medical Record.
- 80.** In her report the reviewer makes a number of recommendations, most of which are reflected in my own recommendations at the end of this report. She has included recommendations about the requirement for accurate and contemporaneous record keeping by Healthcare staff, F2052SH observation levels, and a medical emergency coding system, amongst others.
- 81.** The reviewer also asked the Section Head for Substance Misuse at Prison Health, for an opinion. She specifically wanted his views on the clinical management of the man's substance misuse. He makes two recommendations with which I concur and have included amongst my own.

## Findings and Conclusions

### *F2052SH and the man's behaviour*

82. There were concerns about the man's mental condition before he arrived at Chelmsford, and his behaviour once there only added to them. Every officer interviewed commented on his bizarre behaviour in one form or another. He was placed on the F2052SH booklet upon arrival and admitted to Healthcare. It was known at that time that he had recently self-harmed by cutting himself and had lately (and not for the first time) been a patient at the local mental hospital.
83. No specific observation intervals were set in the F2052SH, only 'regular' supervision. That is contrary to Chelmsford's own Suicide Awareness Policy which stipulates 'irregular observations intervals of not more than an hour' for a prisoner on a F2052SH alone in a cell. On 9 March 2005, there was an interval of six hours between entries on the F2052SH and several other large gaps on other days.
84. From the evidence of the written records, the man appears to have been seen as manipulative, disruptive and possibly dangerous, rather than unwell and a potential self-harmer. An example is the smashed TV incident on 8 March. There was no mention of the shard of glass wrapped in a piece of towel, either in his Medical Record or the F2052SH. As the man was on the self-harm watch for cutting himself, I am concerned that the glass shard was only seen as a potential weapon rather than as a possible means of self harm. I also note that the fact he was on a F2052SH booklet was not included in the Security Information Report. Within 15 minutes of the smashed TV being discovered, the medical officer had decided that the man should leave Healthcare and go onto normal location. I question the appropriateness of this decision given the man's history of mental instability.
85. The man continued to exhibit behaviour recognised by staff as strange and bizarre. The F2052SH review on 17 March was actually held in his cell as the man was hiding under his bed and refusing to come out. Although he was eventually persuaded out and later agreed to take a shower, I do not believe that holding a F2052SH review in those circumstances was decent or acceptable.
86. The impression gained from reading the documentation and the staff interviews is that the prison and the man were in a 'holding pattern', waiting for the Consultant Psychiatrist to make his assessment and tell the prison what to do with the man. However, the psychiatrist ended his report by stating that he could detect no feature suggestive of any current mental illness. I am in no position to make my own clinical assessment and must defer to his professional judgement. I simply note that it was at odds with the observations being made on a daily basis by non-clinical staff.

- 87.** Whatever the man's exact mental condition, the fact is that staff were looking for guidance on how best to deal with a prisoner they found difficult and who was exhibiting bizarre and challenging behaviour. The doctor's assessments on 6 March and 8 March, and that of the Consultant Psychiatrist, on 18 March, all concluded that the man did not have a current mental illness. However, the Consultant Psychiatrist could not have taken full account of the man's medical history in coming to this view, as he believed that the contents of the report by the CPN referred to events over a year previously instead of less than a month before.

### ***Segregation and Adjudication***

- 88.** Rightly, Prison Service policy is that prisoners on open F2052SH booklets should only be placed in a segregation unit in exceptional circumstances. I am all too conscious of the number of deaths to have occurred in segregation since I started investigating all deaths in prison custody some 18 months ago. That said, I do understand why some such prisoners end up in segregation and the pressures on prison staff who are required to care for prisoners who, for a variety of reasons, cannot be located within the general prison environment.
- 89.** In the man's case, there was no case conference before he was placed in the segregation unit, contrary to the prison's Suicide Awareness Policy. That policy also states that the decision to locate at-risk prisoners in the segregation unit must be for as short a time as possible, and the temporary nature of the segregation should be reflected in the care plan. Again, that was not done. In addition, adjudicators should consider, for prisoners on an open F2052SH, the implications of imposing punishments such as cellular confinement. But in this case, the adjudicating governor was unaware of the man's self-harm status and gave a total of 17 days cellular confinement. Clearly, it is vital that the adjudicator should be in possession of all the facts and circumstances relating to a prisoner and the alleged offence. Only then can a proper assessment be made and suitable punishment given.
- 90.** The Segregation Safety Algorithm form was not properly completed on 9 March when the man first entered the segregation unit. On 10 March, the nurse incorrectly completed the algorithm form required by the adjudicating governor, by ticking the box stating that he was not on a F2052SH. That error led to the governor completing the remainder of the form incorrectly. There is no evidence, therefore, that the man was properly fitted for the segregation unit, either initially or at the adjudication stage.

### ***Issuing a razor***

- 91.** My investigators discovered that, at the time of the man's death, it was policy in the Healthcare unit only to allow supervised shaving for

prisoners on open F2052SH booklets. However, that policy did not apply in the segregation unit. The Governor has since implemented such a policy for the segregation unit. It is for consideration whether the policy should apply throughout the prison, and whether other jails should be made aware of it. I acknowledge that the universal adoption of supervised shaving for all prisoners on open F2052SH's would not be feasible or justified. My concern is focused especially on those with a known history of cutting as a form of self-harm. The decision to give the man a razor over the lunch period on 20 March was not risk-assessed in any way.

92. Within minutes of the man pressing his cell bell at 12.24 pm on 20 March, there were nine members of staff outside the cell. Too much emphasis was placed on him using the blade from the razor as a weapon and on protection from blood contamination. Much of the time that officers were looking at the man through the cell door window, he was writhing on the floor. His loss of blood was obvious, leading to one of the nurses believing that he was already dead when the cell was finally entered. The log records the time of entry as 12.35 pm, nine minutes after the man alerted staff. Whilst acknowledging the concerns for staff safety, the number one priority should be the preservation of life. It was apparent that he had seriously self-harmed and I believe there was an unacceptable delay before entering the cell.

## Recommendations

- 93. The Governor should ensure that staff receive any necessary training in relation to Chelmsford's Suicide Awareness Policy and the requirements of any self-harm documents.**

*Accepted – 1. All staff are currently being trained in the new Assessment, Care in Custody and Training (ACCT) procedures. This is mandatory training which, forms part of their SPDR objectives.*

*2. The establishments Suicide Awareness Policy is available and displayed in all areas for guidance to staff.*

*Target Completion Dates: 1. Currently on going with a target date of May 2006. This will be included in staff SPDRs for 2006 / 07. 2. Immediate*

- 94. The Governor should remind staff of the priority to preserve life and consider further training for wing staff, on actions to be taken on the discovery of apparent death or serious self-injury, as per PSO 2710.**

*Accepted - The Governor will publish a Governors Information Notice (GIN) in line with PSO 2710. This will form part of all staff SPDR's for 2006/07 as a generic objective. All staff must sign to say that they have both read and understood the notice.*

*TCD: GIN 067/05 published December 2005.*

*GIN 067/05 will also be included in all staff SPDRs for 2006 / 07 as a generic objective. Target May 2006.*

- 95. The Governor should ensure that provisions are in place so that any Adjudicator is fully briefed on the circumstances relating to the alleged offence and any other factors likely to have an impact on the punishment decision, including whether there is an open F2052SH.**

*Accepted - Adjudication paperwork now stamped to indicate an open F2052SH. The Adjudicating Governor receives the information regarding the circumstances of the offence as part of the enquiry process. The Wing conduct report also indicates an open F2052SH. This is verbally read out to ensure all present are aware.*

*Governors Order 068/05 re: Adjudication Daily Report Log (ADRL) now published inline with recommendation. The ADRL will provide the adjudicator with the following information i.e. name, number, status, charge, F2052SH, any other concerns prior to an adjudication taking place. The purpose of this is to ensure that the adjudicator is aware of prisoner's circumstances before conducting the adjudication.*

*TCD: Completed*

- 96. The Governor should consider whether his Order 008/05, relating to the issue of razor blades to prisoners on open F2052SH on the segregation unit, should be made policy throughout the prison.**

*Considered but not accepted - Each individual should be risk assessed separately based on their individual needs and situation. This recommendation was discussed at our local Safer Custody Meeting*

(21/12/05). It was considered to be unrealistic to monitor this policy effectively across the prison due to the high number of prisoners moving through the establishment, and also due to the fact that razors are currently issued to prisoners daily, twice as required, as part of the prisons decency agenda. A blanket policy restricting access to razor blades would be a disproportionate response in relation to both risk and resource cost. Individual case management is the right approach and is likely to be more effective and defensible.

TCD: ongoing

- 97. The NOMS Safer Custody Group should consider whether further advice should be offered to all prisons on the issuing of razor blades in light of this report.**

*Partially accepted - SCG has no plans to highlight this issue in isolation although the revised PSO 2700 will seek to strengthen the current policy on items in possession by cross referencing to ACCT plans and individualised care.*

*All cases should be treated individually, this is a key part of ACCT.*

- 98. The Governor and Primary Care Trust should consider whether the contract with the Medical Officer should be discontinued in light of his decision not to cooperate fully with this investigation.**

*Following discussions with PCT, Care UK, the Health Care Manager and the Governor the decision has been made not to terminate the doctor's contract*

- 99. Any specialist advisors giving a medical opinion on a prisoner should be encouraged also to propose a plan to deal with challenging behavioural problems, even if there is no diagnosed mental illness.**

*A multi disciplinary approach is required when managing prisoners who are displaying behavioural and discipline problems.*

*The Prison Lead GP would liaise with the assessing psychiatrist in the case of a prisoner displaying challenging behaviour as part of a team approach towards the overall care of such a patient. Any specialist opinion expressed by the Prison Lead GP or psychiatrist should be used as part of a team orientated multidisciplinary approach in caring for such prisoners.*

*TCD – immediate and ongoing.*

- 100. Patients with co-existent mental health and drug problems should be considered for longer term detoxification to limit the potential for exacerbation of their psychiatric symptoms in accordance with local community policies.**

*Accepted - Detoxification for patients is based on the Government Publication "Drug and Misuse Dependence, Guidelines on Clinical Management". Patients with any dual diagnoses are seen and reviewed regularly at present to formulate individualised plans towards achieving successful detoxification and treatment of any mental health issues. This*

*is currently done in conjunction with the mental health team and visiting psychiatrist. This will formally be adopted into the Local Drug Strategy and Protocols currently being updated.*

**101. Prisoners arriving at Chelmsford with a declared drug problem should normally be offered urine testing and a specialist substance misuse assessment the same evening.**

*Partially accepted - Prisoners at present are currently 'scored' using a formalised system which allows nurses in reception to clinically and objectively assess their need for immediate intervention with any detoxification, medication or symptomatic relief. As many prisoners have been treated with detoxification in police custody immediately prior to coming into prison they often do not present signs of withdrawal. We therefore adopt a broader approach to this through the system we currently employ as outlined above. This allows a more accurate assessment on a more individualised basis for each prisoner and is safe and effective. At present we do not have sufficient resources in place in the evenings in reception to achieve the testing of urine on reception. New Staff profiles will be introduced on 8 January 2006 and a new staff rota introduced. Once the new profiles have settled we will undertake a 'pilot' programme for urine testing in reception based on existing staffing levels. Pilot programme will commence 13 February 2006 and will be reviewed one month after.*