REPORT

ARTICLE TWO COMPLIANT INVESTIGATION

IN THE CASE OF 'TA'

JANUARY 2022

COMMISSION AND TERMS OF REFERENCE

I am commissioned by the Secretary of State for Justice to conduct an investigation with the following terms of reference:

- to examine the management of TA by HMP Chelmsford from the date of his reception on 20 June 2013 until his life-threatening self-harm on 1 July 2013, and in light of the policies and procedures applicable to TA at the relevant time

- to examine relevant health issues during the period spent in custody at HMP Chelmsford, from 20 June 2013 until 1 July 2013, including mental health assessments and TA's clinical care up to the point of his life-threatening self-harm on 1 July 2013

- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved

- to provide a draft and final report of my findings including the relevant supporting documents as annexes

- to provide my views, as part of the draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of the case. The Secretary of State will take my views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

The Interested Parties to the investigation are:

TA

The Ministry of Justice, through Deputy Director, Prison Safety and Drug Strategy Group, HM Prison and Probation Service

Practice Plus Group (PPG). Under their former name of Care UK, the company provided healthcare at HMP Chelmsford from March 2012 to April 2015. My report uses the former name of Care UK.

NHS England, through Head of Health and Justice (East of England). NHS England held the contract with Care UK (now Practice Plus Group) after the abolition of the Mid Essex Primary Care Trust on 31 March 2013 as a result of the Health and Social Care Act 2012.

NHS England is still responsible for commissioning healthcare at Chelmsford prison. The current provider of most healthcare services is Castle Rock Group (CRG Medical), who are contracted to provide healthcare at HMP Chelmsford from 1 April 2019 to 31 March 2024. In addition, Forward Trust are separately commissioned to provide a primary care mental health service.

The investigators are:

Barbara Stow, Lead Investigator
Will Thurbin, Assistant Investigator
Sandra Morgan. Clinical Reviewer

Barbara Stow
BA (Hons), MSt (Cantab) Applied Criminology and Management
January 2022

EXECUTIVE SUMMARY

A young man, called 'TA' for the purposes of this report, was sentenced to 12 months in prison and admitted to Chelmsford prison on 20 June 2013. He was 31 years old. It was his first time in prison. He hanged himself by a bedsheet attached to window bars in his cell 11 days later at about 9:30 am. He suffered severe cognitive and physical damage and requires full-time care in a nursing home.

When TA was admitted to prison, the Prison Escort and Custody Service recorded an instance of past self-harm but gave no details. On reception at Chelmsford, TA appears to have minimised the importance of it. The healthcare reception screen says TA said he had overdosed a few years ago but did not mean to kill himself. A local system for further enquiry was not properly followed up.

There was no second healthcare assessment within seven days of TA's admission to prison as required by the Prison Service Order on Continuity of Healthcare and now included in the National Institute for Health and Care Excellence (NICE) Standard for Prison Health. Recent national prison policies do not mention this requirement. We think they should.

TA was convicted of harassment, so his telephone calls were restricted. He was not authorised to use the telephone until his sixth day in prison. There is no evidence that TA's request for a first night telephone call, or for a friend to be contacted on his behalf, was acted on.

After the first night interview, little was recorded about TA's short time on the wings. He was not allocated a personal officer. After his self-harm, staff reported previous incidents that might have given cause for concern but they were not recorded or probed at the time. These were: that he was upset he

had no tobacco; it was said later he might have been in tobacco debt; he was said to be quiet and inclined not to come out of his cell; his cellmate complained in front of other prisoners about TA not taking a shower. Shortly before TA hanged himself, he was refusing to get up and go to work, and was known to have cut himself.

Officers and healthcare staff attended to TA when he was discovered. The lead nurse was not aware for seven minutes that TA had ligatured and thought he had had a seizure. Consequently, his neck was not immobilised. The clinical reviewer notes a lack of information for prison staff about the need to guard against injury to the spinal cord by supporting the neck.

The Control Room did not call an ambulance as soon as the emergency alarm was raised but only after a nurse requested it. Paramedics arrived swiftly and took over care.

Post-incident procedures were not followed correctly. The local serious incident review did not meet the requirements for a formal investigation. Serious incident report forms by staff were narrow in scope. There was no incident report from the officer who was first on scene or from the manager in charge. The reviews by the healthcare agencies and the review by the prison were carried out separately. Support for staff was patchy.

Our report examines procedures for preventing suicide and self-harm, at the time and now, both nationally and at Chelmsford. Chelmsford adopted new policies in 2018, following recommendations by the Prisons and Probation Ombudsman. We consider the changes in policies and practice on risk assessment, information sharing and supporting new prisoners.

We make recommendations to the Governor of Chelmsford, HMPPS and the healthcare agencies about healthcare screening, the need for guidance for the

process of ligature cut-down, support for first-time prisoners, visits and first night telephone calls for new prisoners, and the required procedures after a serious incident.

We invite the Governor of HMP Chelmsford, HMPPS, and the healthcare agencies to consider some further issues that have caused us concern.

Attentive risk assessment and support for new prisoners help to prevent suicide and self-harm, but there is a danger in relying too much on segmentation of the prison population into those identified as at risk, who receive special attention, and those who are less visible. Risk assessment will always be imperfect. The foundation of safer custody is a healthy prison culture, led by managers, in which staff engage constructively with all the prisoners in their care. Staff need the skills, the confidence, and the time, to engage with prisoners. Staffing levels need to be based on an appreciation of this crucial role of prison officers if prisons are to be safe, decent, and rehabilitative.

THE STRUCTURE OF THE REPORT

A full contents list signposting the sections of the report is provided at pages 9 to 17, but broadly the report is structured as follows

Executive Summary

Part One of the report contains:

A note on the reason for the investigation, the investigation process, and the requirement for public scrutiny.

Part Two contains

A summary of the investigation's findings and observations
The investigation's recommendations
Matters that we draw to the attention of the Governor of HMP Chelmsford, HMPPS, and the healthcare agencies.

The later parts of the report contain the evidence on which Part Two is based and each chapter concludes with the findings, observations and sometimes recommendations, which are repeated in Part Two for the convenience of readers.

Part Three of the report is about what happened. It contains an introduction to TA, a detailed account of the evidence we have considered about his time in prison and our commentary on the evidence.

Part Four contains the findings of the Clinical Review.

Part Five examines general issues emerging from the investigation in the light of HMPPS and Chelmsford prison's policies and procedures on preventing suicide and self-harm, supporting new prisoners during their first days in custody, and supporting staff after traumatic incidents.

Part Six is about the reviews and reports that were prepared shortly after TA's self-harm, by the prison and the healthcare agencies, and HMPPS policies at the time and now about investigating serious incidents of self-harm.

The Confidential Annexes

The confidential annexes have been made available to the Interested Parties but are not published with the report. They comprise:

a chronology based on the evidence obtained by the investigation

the clinical review in full by Sandra Morgan with a chronology of clinical events.

a list of the documents referred to by the investigation, which have been made available in confidence to the Interested Parties, where requested.

a list of documents seen but not relied on by the investigation or referred to in the report, so not disclosed to the Interested Parties.

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PART ONE:

THE INVESTIGATION

The reason for the investigation

A young man, TA, hanged himself in a cell at HMP Chelmsford on 1 July 2013 after 11 days in prison. His life was saved by the intervention of prison and healthcare staff but he suffered severe and life-changing cognitive and physical damage and since then has required 24-hour care in a nursing home.

Article 2 of the European Convention on Human Rights says that everyone has an absolute right to life. The European Convention has been incorporated into UK law through the Human Rights Act 1998. Case law has established that when someone who is in the custody of the State dies or suffers life-threatening or life-changing self-harm there must be an investigation that is impartial, independent and open to public scrutiny.

The purpose of an investigation of this kind is to ensure as far as possible:

- that the full facts are brought to light
- that any culpable and discreditable conduct is brought to light
- that suspicion of deliberate wrongdoing is allayed if it is unjustified
- that dangerous practices and procedures are changed
- and that lessons learned may save others.

This report examines the circumstances in which these events occurred, and whether there are lessons to be learned to prevent something similar happening in future.

The investigation

The events we have investigated took place in 2013. An independent investigation was commissioned in April 2016. The investigator interviewed prison staff witnesses in 2016 and 2017. Unfortunately, the investigator was unable to complete the investigation and was released from her commission. My investigation was commissioned in November 2019. It is regrettable that there has been further delay as a result of the Coronavirus pandemic.

TA is severely disabled but he is able to communicate by means of a computer. The investigator commissioned in 2016 met TA twice and he consented to disclosure of his medical records. TA and a relative have been invited to contribute to the present investigation but have made no response to several invitations. I was told by the nursing home where TA lives that he and his family no longer wanted to take any part in the investigation.

I have examined documentary evidence provided by HMPPS and others and interviewed two witnesses most centrally involved. Otherwise, because of the lapse of time since the events under investigation, for oral accounts from witnesses of fact I have relied largely on the evidence obtained by my predecessor.

I have also taken note of an internal inquiry conducted in the prison immediately after TA's self-harm, and reviews conducted by the healthcare agencies. These had the advantage of taking place shortly after the event but it will be evident from this report that in some respects, I found these inquiries too narrow in scope and not sufficiently searching.

The requirement for public scrutiny

My commission requires that I provide my views, as part of the draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of the case.

My objectives for the investigation have been:

- To bring to light as far as possible, all the relevant facts
- To discover any shortcomings that might have adversely affected TA's care
- To draw from what happened any lessons that might help to save others, in future from suicide or catastrophic self-harm.

The investigation leaves questions that we cannot answer. TA has declined to take part in the investigation so we do not know what account he would give of his experience in prison or the reasons for his actions. His reluctance is understandable given the passage of time. Some records have not been retained, and much of what we have learned about TA's 11 days in prison is in second-hand accounts or information provided after his self-harm. However, I have no reason to believe that evidence has been purposely withheld or that there is significant information that could now be discovered through any other process. I hope that this examination of TA's short time in prison may contribute some useful lessons for those responsible for the care of prisoners, so many of whom are potentially similarly vulnerable.

PART TWO:

SUMMARY OF FINDINGS, RECOMMENDATIONS AND MATTERS FOR CONSIDERATION

In this part of the report, we have extracted from the narrative of the evidence, the conclusions we have drawn in each chapter about what happened and our observations on those events.

We make seven recommendations and highlight some other matters for consideration by the Governor of HMP Chelmsford, HMPPS, and the healthcare agencies.

FINDINGS AND OBSERVATIONS

Part 3: What happened

Chapter 1: Who is TA?

1. In March 2013, TA pleaded guilty to offences committed between April and October 2012 of causing criminal damage, having an offensive weapon, and conduct amounting to harassment of his former girlfriend. He remained on bail until sentencing on 20 June 2013.

2. The pre-sentence report noted a troubled history in TA's birth family. As a child, he was taken into care, then moved to a foster family and remained close to them in adulthood.

3. TA's GP records, which were not available to the prison, recorded an overdose in 2008. TA used someone else's prescription medication and required hospital treatment. The GP records show that from time to time TA admitted to depression but said he wanted to deal with it himself.

4. The pre-sentence report recommended a community order, but TA was given a 12-month prison sentence and admitted to HMP Chelmsford. It was his first time in prison. He was aged 31.

5. Eleven days later, at about 9.30am on 1 July 2013, TA was found hanging in his cell. Prison staff gave first aid, paramedics attended, and TA was taken to hospital. He has suffered severe cognitive and physical impairment.

Chapter 2: TA's admission to HMP Chelmsford on 20 June 2013 - the Reception process

6. The Prison Service had no prior records about TA. A prison custody officer from the Escort and Custody Service wrote in the risk section of the Person Escort Record *'overdose 12 months ago'*. There were no further details, and the custody officer did not complete a Suicide and Self-Harm Warning Form.

7. This was the only indication of any history of suicide or self-harm that accompanied TA to the prison, but it was sufficient for the desk officer to enter the information on a Form 2050A Information of Special Importance. The complete form was not preserved so we do not know whether it was authorised by a manager, as required.

8. Consistent with a system in use at the prison at the time, the form was sent to the Safer Custody team, who in turn asked the induction wing manager to investigate and report back. The wing manager noted in TA's electronic record that he had received the request from Safer Custody but there is no further information.

9. The pre-sentence report and OASys form were not examined as part of the Reception process but, in any event, they did not indicate any risk of self-harm disclosed by TA or identified by the assessor. There were some references to depression.

10. The prison officer who interviewed TA in reception wrote down that he had no thoughts of self-harm. There is no record from Reception of the extent of any conversation about the historical overdose, for example whether the interviewing officer asked TA anything about the circumstances.

11. The report of the prison's serious incident review says that TA told the reception officer the overdose was more like two years ago and it was no longer an issue; that the officer found TA responsive and that he said he had no thoughts of suicide or self-harm. There is no statement or other evidence of the source of this information with my copy of the serious incident review.

12. The interviewing officer said he might interview as many as 22 new prisoners in the course of an evening and another officer said that interviews might vary between five minutes and an hour. Whilst we recognise that the needs of individual prisoners will vary, the reception interview is a critical stage in risk assessment. Staffing levels need to be sufficient to meet the requirements.

13. Care UK's Root Cause analysis and the NHS Serious Incident Closure Form say that TA disclosed an *'accidental'* overdose some three years previously. The reception nurse's entry in the medical record says that TA overdosed a few years ago but did not mean to kill himself. It seems likely that TA minimised the significance of the overdose during his reception into prison but the nurse's entry in SystmOne does not justify the conclusion in the NHS Review that the overdose was accidental. The nurse told us that TA called it a cry for help.

Chapter 3: The induction wing – Thursday 20 June to Monday 23 June 2013

14. It is known that prisoners may be vulnerable in their first days in prison, and especially so if they have not been in prison before. The First Night interviewing officer noted in the electronic case record that it was TA's first time in prison, but the forms in the induction pack do

not include anything to indicate the character, mood, disposition, or aspirations of the new prisoner.

15. There is no evidence that TA was permitted to make a phone call on admission to prison or that any call was made on his behalf. There is no indication in the induction pack or in the case note history in P-Nomis (electronic information system, also called C-Nomis) that any action was taken on his request for a friend to be contacted and asked to tell his mother he was in prison.

16. The First Night in Prison (FNIP) form says TA received a PIN phone allocation. TA was convicted of a charge of harassment so the numbers he wanted to phone had to be approved and he was not permitted to make phone calls until the following Wednesday 26 June after being admitted to prison on Thursday 20 June.

17. It is not clear from the induction record whether TA was considered to be eligible for a reception visiting order or whether one was issued. We say more about this in Part Five of this report in Chapter 12.

18. We have no evidence of the supervising officer's response to the notification of past self-harm from Safer Custody or that he made any entry in the observation book. The supervising officer recorded in the electronic case record only that the Safer Custody notification had been received.

19. The serious incident review was right to pursue the point – and its wording may simply be unfortunate - but the reason for recording more detailed information is not the defensive one of demonstrating that procedures are robust, as the review implied, but in order to

communicate useful information to colleagues who are responsible for the safety of the prisoner concerned.

Chapter 4: TA moves from the induction wing to C wing – Monday 24 June to Sunday 1 July 2013

20. We know little about the week that TA spent on C wing. It is unfortunate that the observation books were not available to the investigation, but the serious incident review makes no reference to any entries in them, and on balance it seems unlikely they contained any information about TA.

21. The evidence is sketchy but, drawing on the serious incident review, what my predecessor investigator was told, and security reports completed after his self-harm but no longer available, we note that TA was said to be protesting at one point that he needed tobacco, that it was suggested after his self-harm he might be in tobacco debt, and that on the evening before his self-harm his cellmate complained to an officer, in the presence of other prisoners, about TA's personal hygiene.

22. There were apparently no records made of these incidents at the time, or any attempt to probe what lay behind them. Whilst mindful of the benefit of hindsight, we consider that these incidents should have been recorded and followed up.

23. The incidents raise questions: about why TA was suddenly in need of tobacco – he might simply have used up his smokers' pack, but it might indicate bullying or debt; about relations with his cellmate; and about possible self-neglect – or avoidance of the showers for fear of bullying. Incidents like these may not raise alarm bells individually but they

should be followed up and recorded in wing logs and personal records, so that colleagues and senior staff are made aware.

24. An officer told us that TA was quiet and tended not to come out of his cell. Isolation may be a sign of vulnerability. TA was a young man in prison for the first time. He was not allocated a personal officer. We do not know why. His cellmate had a personal officer. A personal officer gets to know a prisoner, builds a relationship, and would have been an appropriate officer to follow up these incidents.

Chapter 5: Monday 1 July – the day of TA's self-harm

25. TA was found hanging at about 9:30am. Earlier that morning his cellmate, who was being discharged from the prison, told an officer he had seen blood and that TA appeared to have cut himself. Also that morning, when roused for work, TA, in bed, insisted to another officer that he would not go to work.

26. We have not been able to establish the precise sequence of events. There are discrepancies between the account of events given in the serious incident review and the account that emerged from the independent investigation's interviews with the officer who was alerted by the cellmate.

27. The review has the officer going only once to the cell, finding the observation panel blocked then finding TA hanging. The officer told the investigation that he went to the cell twice. The first time, after being alerted by the cellmate, he went into the cell, saw blood on a tissue and spoke to TA, who denied having cut himself but said he would not go to work. The officer said he planned to go back to speak with TA later, and at about 09:30, he went back to the cell intending to check on TA before he was allocated a new cellmate, who might be on

an ACCT plan. The observation panel was not covered, and through it he could see TA hanging.

28. The serious incident review did not present the evidence on which it relied for the report's account of these events. There is no serious incident report from the officer who discovered TA. He told us he did not write a report and that he was not asked for information for the review. Incident reports by other staff refer only to what happened after TA was found, not to any prior events.

29. We are satisfied that, having been prompted by the cellmate, the officer spoke to TA but we cannot be sure whether this was before or after another officer, unlocking prisoners for work, spoke with him.

30. At this time of day, the six wing officers and the senior officer were no doubt all focused on their particular duties, to lock and unlock cells, and check and count the prisoners, to start the day in accordance with the requirements of the regime. We must be careful not to judge from the comfort of hindsight. But it is a pity that the officer alerted by the cellmate apparently did not tell other officers on TA's landing, or the wing senior officer, about the cellmate's warning, that he had seen blood on a tissue, and that TA was resolved not to go to work and would remain alone in his cell.

31. None of these necessarily indicated an immediate emergency, but they were indicators that something was amiss. The officer was right that they needed investigating and it is hard to understand why, when seeing blood, he did not, for example, ask to see where TA had injured himself. When another officer spoke with TA and he refused to get up for work, she was apparently not aware of his cellmate's warning or

her colleague's conversation with TA, but we cannot say whether she spoke with TA before or after her colleague.

Chapter 6: What happened when TA's self-harm was discovered – evidence from the prison staff

32. Wing staff and healthcare staff responded quickly when the alarm was raised. The officer who discovered TA was able to cut the ligature with a 'fishknife' (anti-ligature tool) but with difficulty because of the thickness of the ligature. Other wing staff were on hand to support TA's weight and give assistance. They acted properly in distressing circumstances but in the confusion of the moment the wing staff who cut the ligature and placed TA in the recovery position did not explicitly tell the lead nurse that TA had ligatured and she was not aware of this for seven minutes. TA's neck was not immobilised to safeguard against injury to the spinal cord. (See Chapter 8 – the findings of the clinical review.)

33. An officer fetched the oxygen from the office then had to go back for the emergency bag. The Prisons Ombudsman had been told that the ambubag was kept inside the emergency bag. All emergency equipment should be brought to the scene immediately when a Code Blue[1] is called.

34. A 999 call was made only when requested by healthcare staff instead of immediately on receipt of the emergency call. A first paramedic arrived within a few minutes. A second paramedic arrived in the

[1] Prison Service policy PSI 03-2013, and the current policy at HMP Chelmsford distinguishes between Code Blue for severe breathing difficulties/chest pain/collapses and Code Red, for severe bleeding or burns. At the time, Chelmsford used the term Code One for all serious medical emergencies.

ambulance and went to the cell. The ambulance waited outside the prison gate on standby until admitted in order to take TA to hospital.

35. Not all the staff involved prepared serious incident reports. Neither the Duty Manager nor the officer who was first on the scene wrote reports.

36. The reports refer only to what happened when TA was discovered. One of the officers, as well as the officer who was first on scene, had had significant conversations with TA that morning, but there is no record of these except as reported in the serious incident review without evidence of the source.

37. Some of the reports appear to have been prepared jointly as they contain a common error about the time of the incident. Incident reports are important evidence and they should record the unvarnished recollection of the individual member of staff.

38. Records of actions taken after the event are not complete. According to TA's records his cell was released at 21:49 on 4 July but I have seen no information about who secured the cell, about the contents of the cell, who authorised its release and what became of the contents.

39. It is not clear who took overall responsibility. A formal investigation should have been commissioned. The serious incident review did not meet the requirements for a formal investigation, which should have been commissioned by a senior manager. We consider this further in Chapters 15 and 16.

Chapter 7: What happened when TA's self-harm was discovered – evidence from the healthcare staff and records

40. The 7- day report by Care UK says that the prison officers did not tell healthcare staff that TA had ligatured until a few minutes after Nurse 1 arrived and that consequently his neck was not immobilised. There is no reference to this in the prison's serious incident review.

41. We do not consider it sufficient for the prison and the healthcare provider to commission separate and parallel investigations into incidents of serious self-harm. Findings and recommendations should take account of both aspects considered jointly. We say more about this in Part Six of the report.

42. The question of care for people who have been cut down from ligature is examined in Chapter 8, the findings of the clinical review.

Part Four: The Clinical Review

Chapter 8: Outline medical history, areas of concern, key findings, and recommendations

43. The triangulation of direct questioning, self-harm assessment and the timely acquisition of community medical records enables the prison healthcare team to provide optimum safe custody. TA entered custody with many risk factors that attribute to potential self-harm but in his short time in custody his physical and mental health was not fully assessed. This was not equivalent to standards of best practice in the community setting.

44. TA had been diagnosed and treated for depression in the community and it is accepted that he did not disclose this information during his reception health screen. His GP summary record and sight of the pre-

sentence report would have provided written evidence of his past medical history.

45. Receipt of the community GP records was not straightforward at the time of this incident, as it relied upon direct contact with the GP practice. This has now been rectified by the ability for health professionals to access the electronic NHS Summary Care Record system.

46. TA should have received a second more in-depth physical health screen and a referral to the prison mental health team for further assessment of his self-harm risk factors.

47. Within the statement made by the lead nurse post-incident, and in the NHS 7- day report, it was documented that it was seven minutes before the prison officers told the nurse that TA had been cut down from a ligature. There is no reference to this important information in the clinical record.

48. It appears that TA was moved twice without neck immobilisation: on cutting down and then being placed into the recovery position. It appears that there is little guidance for prison officers and prison healthcare staff in the correct management of hanging/hanged patients especially when the patient is still alive and does not require resuscitation. The review of this case has indicated that specific HMPPS and NHSE/I guidance for the management of ligature cut down is required.

49. It also appears that emergency equipment accessed when Code Blue is called does not always include a soft cervical collar for neck

immobilisation, and if it does there is no consistent guidance of how to immobilise a neck correctly.

50. TA was not diagnosed with a cervical injury, caused by ligature. He suffered severe hypoxic brain injury from strangulation resulting in his current physical status.

51. There is evidence of an inadequate response by both the healthcare provider and the commissioners, at the time, to address the incident sufficiently. There is no evidence of shared learning from the incident.

52. The well-being of all staff after such an incident is paramount to decrease the potential of post-traumatic stress when it is not dealt with in a supportive manner at the time.

53. Clinicians must adhere to their professional code of conduct to ensure that all clinical notes are factual and contemporaneous.

54. It is accepted that this review refers to healthcare practice in 2013 but it would seem prudent that the current Head of Healthcare at HMP Chelmsford should ensure that health screening within early days of custody conforms to the current HMPPS and NHS guidance to ensure safe custody.

55. HMPPS and NHSE/I need to ensure that all prison and healthcare staff are aware of the measures to be taken to ensure optimum management of a patient who has ligatured. This includes the need to avoid unnecessary movement of the neck and access to appropriate protective equipment such as a soft cervical collar.

56. The Head of Healthcare at HMP Chelmsford should ensure that healthcare staff now receive good, structured support after any traumatic incident.

Part Five: Policies and procedures - preventing self-harm and supporting new prisoners

Chapter 9: Suicide and self-harm in prison - overview and national policies

57. Suicide and self-harm are more prevalent among male prisoners than in the male population as a whole. Most prisoners suffer from one or more mental illnesses. Vulnerability can be exacerbated by the physical conditions of the prison and features of prison life. Relationships are a significant factor. They may be protective or harmful.

58. The Prison Service has developed policy and practices to identify risk and to support prisoners identified as at risk of self-harm. But this is not an isolated category. A culture of curiosity and energetic engagement with all prisoners is necessary to identify those who may be at risk and to provide support as part of the routine practice of the prison.

59. The current PSI about self-harm contains much useful information but it is long, and broad in scope. Some, but not all, the information it contains is of immediate relevance to the everyday practice of wing staff in daily contact with prisoners. Some of the information may be better suited to training, though there is useful reference material for staff wanting to refresh their understanding, for example of mental illnesses, and the topics in the chapters are well signposted. We

understand that the PSI sets the framework for local policies and that local managers must ensure that local arrangements meet the national requirements. However, overall, it is not clear to us exactly how, when and by whom HMPPS expects the document to be used, and how the information it contains is delivered to the staff who have most contact with prisoners.

60. Unlike PSO 2700, which it replaced, PSI 64-2011 does not contain instructions about emergency assistance to be given by staff who are first on scene. We endorse the recommendation in the clinical review that HMPPS and NHSE/I consider how to ensure that all prison and prison healthcare staff are aware of the measures to be taken to ensure optimum care of a person who has ligatured, and that a soft cervical collar should be a standard items in emergency equipment in prisons.

61. There is insufficient recognition in PSI 64-2011 that it will not always be clear whether or not an act of serious self-harm will prove fatal, requiring the measures for preservation of evidence, critical de-brief, completion of incident reports, and support for staff and prisoners affected, to be activated. We refer in Chapter 16 to PSI 15-2014 which is about investigations and learning after an incident of serious self-harm or serious assault but there appears to be no signpost to this PSI in PSI 64-2011.

Chapter 10: Individual risk factors for suicide and self-harm - could TA have been seen to be at risk?

62. TA entered prison with some known risk factors. It was not unreasonable that reception and first night staff did not think it necessary immediately to open an ACCT plan, but there was reason for

vigilance and support. There is no record of what action was taken as a result of the self-harm warning. TA was not allocated a personal officer. A series of incidents occurred that raise questions about his welfare but they were not recorded or investigated at the time.

63. Chapter 5 of PSI 64-2011 is unequivocal that any member of staff who receives information or observes behaviour that may indicate self-harm risk must start a protection plan by completing a Concern and Keep Safe Form. Chapter 1 says that either the ACCT process must be started or a manager informed. We think it would be good practice to require that a supervising officer should be alerted immediately to evidence of self-harm in a prisoner not previously thought to be at risk.

64. Much has changed at Chelmsford prison since 2013. There is now an ambitious local policy on suicide and self-harm. It recognises the importance of rigorous risk assessment, of sharing information, of the staff taking an active interest in prisoners and modelling pro-social thinking and behaviour. Staff are being trained in the skills required to apply the new policies. In the next chapters we examine the changes in policy and practice on risk assessment, information sharing and supporting new prisoners during their first days in custody, and we make some recommendations for consideration by HMP Chelmsford and HMPPS.

Chapter 11: Safer custody at HMP Chelmsford - changes in policy and practice since 2013

65. The policy adopted in 2018 at HMP Chelmsford marks a substantial advance on the informal practices relied on in previous years. The aspirations and elements of the policy address many of the issues that have caused us concern in examining TA's short time in prison, and

which were also identified from time to time by the Prisons and Probation Ombudsman.

66. For example: the current policy requires systematic consideration of risk factors and documentation of the process; it recognises the special vulnerability of newly arrived prisoners and prisoners who are isolated; it provides for investigation of every instance of self-harm; it emphasises the importance of active staff-prisoner interaction; and commits to training to underpin the policies. The aspirations of the key worker policies and the five-minute intervention are promising, but they depend on staff having the time, the opportunity, and the support of managers, to put them into practice, and we note the concerns about the availability of key workers expressed at a Safer Custody Meeting in 2019.

67. It is beyond the scope of our investigation to examine how effectively these policies have been implemented, but we draw the attention of the Governor to the missed opportunities we have identified in paragraph 10.12 which might have diverted TA, and we invite him to consider whether these would be handled differently now.

Chapter 12: Supporting new prisoners - reception procedures, early days in custody and staff-prisoner relationships. Was TA given adequate facilities and support?

68. Prisoners are known to be vulnerable during early days in custody. The policies on preventing suicide and self-harm and supporting new prisoners are closely linked.

69. Someone experiencing prison for the first time is especially vulnerable. The First Night interviewing officer noted in C-Nomis that TA had not

been in prison before. That was good practice. But the local induction interview template at Chelmsford does not appear to contain a prompt to consider, at the first night interview, whether the newly admitted prisoner has been in prison before. We think it should.

70. TA was 31 years old when he first went to prison and may not have been expecting a custodial sentence. PSI 74-2011 and the current local policy point out that young prisoners may have particular vulnerabilities, but for someone whose adult life has not included significant exposure to the criminal justice system, the shock of admission to prison for the first time is a risk factor that ought to be taken into account, especially as the prison will have little if any knowledge of the person's risks and behaviours.

71. Policies on reception screening by both prison and healthcare staff identify a wide range of risk factors. Not all identified vulnerabilities will require a prisoner to be placed on an ACCT plan on immediate entry to prison but vigilance and practical help may be needed to recognise and allay emotional and mental deterioration during the transition into prison life.

72. Practical support could include, for example, teaming a prisoner with a buddy for a month or until they have learned the prison routine, giving extra calls/visits to keep in touch with family, or a one-month mental health review to see how they are coping, or an extra visit on the wing from a faith leader.

73. Positive interactions with staff are a crucial support for prisoners newly cut off from family and friends. In TA's case no personal officer was appointed during the 11 days he was in prison, and there are no informative records in P-Nomis about how TA was coping. One of the

officers described him as a quiet prisoner who did not come out of his cell. That in itself might suggest a need for investigation and support.

74. Since 2015 an offender supervisor has been required to meet a new prisoner within 72 hours of admission and to complete a Basic Custody Screening Form. That was not in force when TA was in prison and there is no indication that TA met an offender supervisor while he was in prison. The offender supervisor has access to more information than is available in reception, including the OASys assessment, and the opportunity to learn more about a new prisoner, and his state of mind and aspirations, so has a part to play in supporting the prisoner, assessing risk, and alerting colleagues.

75. **We recommend** that men in prison for the first time should be distinguished as a category of prisoners requiring extra vigilance and support for the first two to four weeks in custody and that HMPPS and the Governor of Chelmsford consider setting this out in policy guidance.

76. This could be combined with the key worker or personal officer scheme but we envisage it as the subject of a distinct policy, requiring recording of significant interactions at not less than prescribed minimum intervals, and review and sign-off by a wing manager when extra care is judged to be no longer necessary.

77. It appears that TA may not have been given some facilities to which he was entitled on admission to prison. There is no record that TA was given access to a telephone on his first day in prison or that a call was made on his behalf.

78. **We recommend** that the Governor of Chelmsford ensures that, in accordance with PSI 07-2015, a telephone call is offered consistently to

new prisoners in reception or on the first night location, including those subject to harassment measures, that the outcome is documented and that local policies include these requirements.

79. National and local policies indicate that newly convicted prisoners are entitled to a social visit within 72 hours of their admission to prison. **We recommend** that the facility of a social visit for newly convicted prisoners should apply equally to newly sentenced prisoners who have previously been at liberty on bail.

80. The first night interview is an important stage in the introduction to prison. The local policy makes clear that it requires significant time and resource. The duration of the reception interview is one indication of the extent of enquiry. The same applies to the First Night Interview. The needs of individual prisoners will vary but there may be a case for monitoring the duration of both these interviews, at least periodically. We would expect managers to set clear expectations and ensure they are met. Information about the duration of these interviews would also show whether staffing levels are sufficient to meet the requirements of reception and induction policies.

81. TA had no further medical assessment after the healthcare screening in reception. PSIs 74-2011 and 07-2015 say nothing about a second medical assessment within a new prisoner's first week though in the 2006 policy PSO 3050 this is stated to be a requirement and it is included in the current NICE Quality Standard and the current local policy at Chelmsford.

82. In response to the draft of this report, NHS England told us that healthcare contractors were required to comply with PSIs and that providers who had failed to undertake secondary screenings had been sanctioned for breach of the requirements of the Care Quality

Commission Therefore they saw no need for any further review of requirements by them as commissioners as they considered that secondary screenings were already mandatory. This was reassuring, but we remain concerned that the current PSI 07-2015 makes no stipulation about secondary healthcare screenings for newly arrived prisoners.

83. **We recommend** that HMPPS review their current instructions on healthcare assessments for new prisoners to ensure that there is no doubt that a second medical assessment within a prisoner's first week is a mandatory requirement.

84. There may be occasions when a prisoner's history of self-harm is known to prison staff but not to healthcare. **We draw to the attention** of HMPPS the presumption in the NICE guidance that prisoners with a history of self-harm should be referred for mental health assessment.

85. In this report we have examined the process of risk assessment to identify prisoners most likely to be at risk of suicidal distress, and we have suggested that special attention should be given to men who are in prison for the first time. These are appropriate processes for helping to prevent suicide and self-harm. But there is a danger in relying too much on segmentation of the prison population into those identified as being at risk, who receive special attention, and those who are less visible. Risk assessment will always be imperfect and the foundation of safer custody is a healthy prison culture, led by managers, in which staff have the skills, confidence and the time to engage constructively with all the prisoners in their care. Staffing levels need to be based on an appreciation of this crucial role of prison officers if prisons are to be safe, decent and rehabilitative.

Chapter 13: The impact of suicide and self-harm on prison staff

86. Some prison staff found that the Prison Service had been careless of the impact of distressing incidents. Staff told us that for the most part they relied on each other for support and that healthcare staff were just expected to be resilient.

87. It may well be that support for staff after distressing incidents is much improved since 2013 but **we draw to the attention of the Governor, HMPPS, and the healthcare agencies**, the sad experiences reported by the staff, and a manager's misconception that an incident of life-threatening self-harm required less rigorous follow-up than a death in custody. We also note the comments about reduced staffing levels.

Part Six: Other Reviews and Investigations

Chapter 14: Healthcare records and reviews

88. The 7-day report by the healthcare provider says that officers did not make clear to the responding nurses that TA had ligatured and consequently his neck was not initially immobilised.

89. There is no further reference to this in any of the other reports by the healthcare agencies or in the prison's serious incident review. There is no assessment as to whether it in any way compromised TA's care. Nor any consideration of whether the importance of briefing healthcare staff in an emergency should be drawn to the attention of prison staff.

90. We do not know on what evidence the Root Cause Analysis relied for its conclusion that the cause of TA's suicide attempt was inability to

cope with news that his girlfriend was seeing another man. Whilst there is reason to believe that relationship problems may well have been a factor, this is too simple a conclusion, which neglects consideration of whether there were other risk factors that could have been anticipated, or triggers related to TA's time in prison.

91. The nurse's entry in SystmOne says that in reception TA said that when he took an overdose a few years ago he did not intend to kill himself. That is not the same as *'accidental'*, as reported by the Root Cause Analysis and the Serious Incident Closure report.

92. In spite of the conclusion that the overdose was accidental, the Root Cause Analysis and the closure report both recommended that previous suicide attempts should be shared with all partners through C-Nomis and SystmOne. We do not know how that recommendation was taken forward and what the current method is for flagging past suicidal or self-harming behaviour in SystmOne.

93. The healthcare reviews and the Prison's internal investigation proceeded in parallel. There is no indication that the healthcare reviews obtained evidence from non-healthcare records or staff, or that the prison's investigation took account of any evidence from healthcare staff. We consider this further in Chapter 16.

Chapter 15: the Prison's investigation

94. The serious incident review did not meet the requirements of a formal investigation. It was immediately clear that TA's injuries were grave. A senior manager should have commissioned a systematic inquiry to examine the care and management of TA up to and including his self-harm, and to advise on any lessons to be learned. Prison Service Order 1300 requires that this should have been a formal investigation

registered with the Investigations Support Section at HMPPS Headquarters.

95. We have seen no record of how the investigating officer was instructed to conduct the investigation, or what terms of reference were set. My copy of the report is not dated. There is no evidence that the investigation was registered with the national investigations unit.

96. A note of an interview with TA's cellmate was attached to the report and I have seen serious incident reports prepared on the day of TA's self-harm by some of the first responders when TA was found hanging. But there was no record of any evidence from the officer who was first at the scene and who had spoken with TA earlier after being alerted by his cellmate. In the case of the death of a prisoner in custody, PSI 64-2011 (Chapter 12) requires that staff directly involved in the incident, particularly those who were first on scene, must complete incident report forms as soon as practicable. This should apply equally to incidents of serious self-harm.

97. The serious incident report by the lead nurse is dated 3 September 2013. This may be a mistake, but there is no reference to the nurse's report in the report of the Prison's review. We do not know whether it was available to the Prison's investigating officer when she conducted her review. The serious incident reports from staff are exclusively about what happened when the alarm was raised and the care given to TA in the cell until he was taken to hospital. Rightly, the focus of the review was wider than this. It included consideration of TA's admission to the prison and the time he spent on F wing and C wing. But I have seen no record of the evidence on which the investigating officer relied for this part of her report.

98. In her interview with my predecessor, the investigating officer mentioned speaking with Officer 7, who was first at the scene and a key witness. But I have seen no record of that conversation, nor the basis of the statements in the report about what TA said in reception. The evidence on which a serious incident review relies should be attached to the report. Notes of oral evidence given by staff should be dated and signed by the staff member concerned.

99. I would also expect to see a fuller account of what measures were taken after TA was taken to hospital, to secure the cell and to preserve evidence which might be required by the police or, if TA had died, by a Coroner. I have been unable to discover any inventory of the contents of the cell, of what happened to the contents, or when the cell was released. The observation book was not available to my predecessor's investigation and was apparently not preserved.

100. The serious incident review contained some useful insights, but the commissioning of the report and the absence of evidence supporting many of the statements in the report show a lack of the rigour that is necessary for a formal investigation of a serious incident.

101. This may also apply to the follow up to the review's conclusions. We note elsewhere (see paragraph 11.2) that, according to a report on a death at HMP Chelmsford some months after TA's self-harm, the system for following up self-harm warnings about new prisoners was still not working properly. At the time of our investigation, minutes of the Safer Custody Meetings from 2013 were no longer available so we do not know whether the review was considered there.

102. There are now more detailed national and local policies for investigating incidents of serious self-harm. We examine these in Chapter 16.

103. The healthcare reviews and the Prison's internal investigation proceeded in parallel. There is no indication that the healthcare reviews obtained evidence from non-healthcare records or staff, or that the prison's investigation took account of any evidence from healthcare staff. We say more about this in Chapter 16.

Chapter 16: Current policies on investigating serious incidents of self-harm

104. Since 2013, more detailed guidance has been issued on the procedures to be followed after an event of serious self-harm. This includes more oversight by the national Equality, Rights and Decency Group. It may be expected that the current policy helps to promote more consistency and quality assurance but it is our understanding that the new instructions in PSI 15-2014 supplement but do not replace the general requirements for investigations in PSO 1300 that we referred to in Chapter 15.

105. The Chelmsford local policy locates with the Safer Custody Management Team a responsibility to investigate incidents of serious self-harm so that lessons can be learned and shared appropriately. Minutes of the Safer Custody meeting show a commitment to learning lessons and applying them to practice. This is right and commendable but the delegation to the Safer Custody Team should not be at the expense of the overriding responsibility of the Governor to ensure that an appropriate level of investigation is conducted in line with PSO 1300. An incident of self-harm that is life-threatening or life-changing will usually require a formal investigation compliant with PSO 1300.

106. We note that the local policy refers to the questionnaire that has to be sent to the national Equality Rights and Decency Group within three days of a serious incident of self-harm. It does not refer to the more in-depth fact-finding investigation that must usually follow. The implication of the wording in the local policy is that the questionnaire completed within three days is sufficient. **We draw this to the attention of the Governor.**

107. **We recommend** that both HMPPS and the Governor of HMP Chelmsford review current policy and practice to ensure that it is clear that compliance with national and local policies following an incident of serious self-harm does not replace the general duty under PSO 1300 to commission a formal investigation of a serious incident.

108. The healthcare reviews and the Prison's internal investigation proceeded in parallel. There is no indication that the healthcare reviews obtained evidence from non-healthcare records or staff, or that the prison's investigation took account of evidence from healthcare staff. The care and management provided to prisoners by prison staff and healthcare staff is a joint endeavour. Investigation in silos gives an incomplete picture.

109. **We recommend** that an inquiry into an incident of life-threatening self-harm by a prisoner should include an examination of healthcare as well as the actions of the discipline staff and that findings and conclusions should take account of both aspects considered jointly.

110. In response to the draft of this report, CRG Medical, the current provider of healthcare at Chelmsford prison, said they were supportive in principle of the concept of joint investigations at a local level but that this would need protocols agreed with HMPPS which would need

to take account of patient confidentiality, and the potential of litigation and subsequent liabilities. CRG say that at present they are not allowed to take evidence from prison authorities or prison records for the healthcare investigation.

111. In response to a recommendation in another Article 2 investigation, HMPPS said that prisons are now asked to consult with their healthcare departments when conducting a fact-finding review and that in the longer term HMPPS would consider this recommendation when revising PSI 15-2014 so that the benefits of sharing relevant information between the prison and healthcare provider during the local investigation process are explained.

112. We understand that the healthcare agencies have their own structures and systems for reviewing adverse incidents quickly, but we hope that healthcare providers can be encouraged to enable staff to contribute to the investigation by prisons of incidents of serious self-harm, and that there can be arrangements at establishment level for joint consideration by HMPPS and healthcare staff of the findings, lessons, and recommendations of reports on serious incidents of self-harm.

SUMMARY OF RECOMMENDATIONS

Recommendation 1 - Consistency between healthcare standards and HMPPS policies (See Chapters 8 and 12).

The care of people in prison is a joint enterprise between prison staff and healthcare staff. There should be consistency between policies, to promote mutual understanding and so that each agency knows what to expect of the other.

Second healthcare assessment for new prisoners within seven days of admission

TA had no further medical assessment after the healthcare screening in reception. Local policy and practice at Chelmsford now provides for a second medical screening with the first few days in custody.

NHS England and Improvement told us that contracts for healthcare provision require compliance with NICE standards and Prison Service instructions. The current instructions PSIs 74-2011 and 07-2015 say nothing about a second medical assessment within a new prisoner's first week though this is stated in the 2006 order PSO 3050, to be a requirement and included in the current NICE Quality Standard.

We recommend that HMPPS reviews the current instructions on healthcare assessments for new prisoners to ensure that there is no doubt that a second medical assessment within a prisoner's first week is a mandatory requirement.

Mental health referral for prisoners with a history of self-harm

There may be occasions when a prisoner's history of self-harm is known to prison staff but not to healthcare.

We draw to the attention of HMPPS the NICE Quality Standard and guidance for the health of people in prison and, in particular, the presumption that prisoners with a history of self-harm should be referred for mental health assessment. It may be appropriate to take account of this in Prison Service Instructions.

Recommendation 2 - Emergency response to prisoners who have ligatured (See Chapters 8 and 9).

Guidance for the process of ligature cut-down

HMPPS and NHS England/Improvement need to ensure that all prison and healthcare staff are aware of the measures to be taken to ensure optimum management of a patient who has ligatured. This includes the need to avoid unnecessary movement of the neck, and access to appropriate protective equipment such as a soft cervical collar.

We recommend that HMPPS and NHSE/I consider specific guidance for the process of ligature cut down to ensure optimum management of the unconscious patient. This will include clarification of whether emergency bags should contain a soft cervical collar as a standard item.

We ask the Governor of Chelmsford and HMPPS what arrangements are in place to ensure that all prison staff who may be first on scene in a medical emergency are adequately trained to provide immediate care.

Recommendation 3 - Support for men in prison for the first time (See Chapter 12).

We recommend that men in prison for the first time should be distinguished as a category of prisoners requiring extra vigilance and support for the first two to

four weeks in custody and that HMPPS and the Governor of Chelmsford consider setting this out in policy guidance.

This could be combined with the key worker or personal officer scheme but we envisage it as the subject of a distinct policy, requiring recording of significant interactions at not less than prescribed minimum intervals, and review and sign-off by a wing manager when extra care is judged to be no longer necessary.

Recommendation 4 - Telephone calls for newly admitted prisoners (See Chapter 12)

We recommend that the Governor of Chelmsford ensures that, in accordance with PSI 07-2015, a telephone call is offered consistently in reception or on the first night location to all new prisoners, including those subject to harassment measures, that the outcome is documented, and that local policies include these requirements.

Recommendation 5 - Social visits for newly sentenced prisoners previously on bail (See Chapter 12)

National and local policies indicate that newly convicted prisoners are entitled to a social visit within 72 hours of their admission to prison.

We recommend that the facility of a social visit for newly convicted prisoners should apply equally to newly sentenced prisoners who have previously been at liberty on bail.

Recommendation 6 - Investigation of serious incidents of self-harm (See Chapters 15 and 16)

We recommend that HMPPS and the Governor of HMP Chelmsford review current policy and practice to ensure that it is clear that compliance with national and local policies following an incident of serious self-harm does not replace the general duty under PSO 1300 to commission a formal investigation of a serious incident.

We draw to the attention of the Governor of HMP Chelmsford deficiencies in the collection, recording and preservation of evidence that we have found in this case.

Recommendation 7 - Investigation of serious incidents of self-harm should draw on evidence from both healthcare and HMPPS (See Chapters 14, 15 and 16)

We recommend that an inquiry into an incident of life-threatening self-harm by a prisoner should include an examination of healthcare as well as the actions of the discipline staff and that findings and conclusions should take account of both aspects.

We understand that the healthcare agencies have their own structures and systems for reviewing adverse incidents quickly, but we hope that healthcare providers can be encouraged to enable staff to contribute to the investigation by prisons of incidents of serious self-harm, and that there should be arrangements at establishment level for joint consideration by HMPPS and healthcare staff of the findings, lessons and recommendations of reports on serious incidents of self-harm.

OTHER MATTERS FOR CONSIDERATION

FOR THE ATTENTION OF THE GOVERNOR, HMPPS, AND THE HEALTHCARE AGENCIES

Support for staff

Chapter 13 of this report considers support for staff after TA's self-harm. It may well be that support for staff after distressing incidents is much improved since 2013 but, we note the sad experiences reported by both prison and healthcare staff, and a manager's misconception that an incident of life-threatening self-harm required less concern for aftercare for staff because the incident was not a death in custody.

We draw to the attention of the Governor, HMPPS and the healthcare agencies the need for planned, structured support for both prison and healthcare staff after any traumatic incident.

FOR THE ATTENTION OF THE GOVERNOR OF HMP CHELMSFORD

Support for prisoners

Among the little we know about TA's time at Chelmsford, there were missed opportunities where a more proactive approach and sharing of information with colleagues might have made a difference.

We draw the attention of the Governor to the following missed opportunities that we identified in paragraph 10.12 and we invite him to consider whether these would be handled differently now:

- There is no information in the records or for the benefit of colleagues responsible for TA's management on C wing about how the senior officer

on the induction wing followed up the alert from Safer Custody or what TA told him about his state of mind.

- There is no indication that TA was allocated a personal officer.

- TA was apparently without tobacco soon after he moved to C wing. This might have indicated debt or bullying. There was no record of the incident.

- An officer told the investigation that TA was quiet and stayed in his cell.

- There is no record of the cellmate's complaint, made in front of other prisoners, about TA's personal hygiene. This indicated a poor relationship with the cellmate and might also have indicated a reluctance to use the showers, possibly through fear of other prisoners.

- An officer was made aware of possible self-harm by cutting not long before TA ligatured, He did not ask to see the injury that caused the bleeding, but intended to come back later. He did not share the information with colleagues or a senior officer.

- The same officer and others were aware that TA was refusing to go to work that morning.

PART THREE:

WHAT HAPPENED - THE EVIDENCE CONSIDERED BY THE INVESTIGATION, WITH FINDINGS AND OBSERVATIONS

Part Three of the report is about what happened. It contains an introduction to TA, a detailed account of the evidence we have considered about his time in prison, and our commentary on the evidence.

CHAPTER ONE: WHO IS TA?

1.1 As a result of his self-harm in Chelmsford prison, TA suffered severe cognitive and physical damage. He is paralysed from the neck down and requires 24-hour nursing care. He is able to communicate with the aid of a computer.

1.2 My predecessor investigator visited TA in the nursing home where he lives and met him and his brother. I have been unable to meet TA or any members of his family, who have chosen not to respond to invitations to take part in the investigation. Consequently, what I know of TA's identity and his history before prison comes from his police record, the pre-sentence report prepared for the court, the OASys assessment and his community medical records. (OASys is the abbreviated term for the Offender Assessment System used by the prison and probation services in England and Wales. It is a framework for analysing systematically the history, current circumstances, attitudes, capacities and aspirations of someone charged with a criminal offence, and of the risk they pose to others or themselves.)

Childhood

1.3 TA was born in 1982. The pre-sentence report records that he had a troubled childhood, including domestic violence in the family. He was taken into care and subsequently moved to a foster family whom he regarded as his family and who remained close to him in adulthood and after his self-harm. I understand that, sadly, TA's foster mother has died since TA's self-harm.

Criminal justice history

1.4 TA's first recorded contact with the police was at the age of 23 in 2006. He was cautioned twice for minor offences. Between 2008 and 2011, TA was convicted of failure to surrender to custody, resisting arrest, and being drunk and disorderly.

1.5 On 29 November 2012, TA was charged with offences of destroying or damaging property and carrying a knife, both on a date in October 2012, and pursuing a course of conduct amounting to harassment.

1.6 According to the pre-sentence report, there were four occasions in 2012 when TA's former partner called the police to complain that TA was in breach of a non-molestation order in which he was forbidden to use or threaten violence, or to intimidate, harass or pester her by phone, text, or email or by entering the street where she lived. On a day in October 2012, he was loitering outside the home of his former partner, and when he saw her new partner, he returned, holding a knife and kicked and punched at the door.

1.7 TA pleaded guilty to the offences. He remained on bail until 20 June 2013 when he was sentenced to 12 months for the offence of carrying a knife, with concurrent sentences of one month and a fine of £100 for the other offences. He was admitted to HMP Chelmsford. TA was 31 at the time and had not been in prison before.

Offender manager's assessment

1.8 In June 2013, before TA was sentenced, an offender manager conducted an 'OASys assessment' and, based on this, a pre-sentence report for the court.

The pre-sentence report

1.9 TA told the assessor that his relationship with his former partner ended in November 2012 and he was now in a new relationship.

1.10 TA reported that he had smoked cannabis and misused alcohol in the past but no longer used either. He told the assessor he had some mental health issues, being frequently impulsive, without thought for the consequences, and prone to emotional outbursts. Also that he had a longstanding problem with depression but had not sought medical help, preferring to deal with this '*in my own way*'.

1.11 The assessor identified that TA posed a risk to current or past partners but that he wanted to address his offending behaviour. He was said to be ashamed of his offences, though inclined to minimise their gravity, and said that he wanted to change. The assessor advised that the risk of reoffending could be reduced by structured interventions that were unlikely to be available in prison. Rather than a custodial sentence, he recommended a 25-month community order conditional on:

- supervision, including referral to community-based agencies, such as his GP, to address mental health issues and to identify changes in mood/depression brought on by drug/alcohol misuse;

- and an accredited programme, the Integrated Domestic Abuse Programme, which was an intensive group work programme of nine modules, to address his abusive behaviour towards the former partner, to assist him in managing feelings and emotions, including awareness of the effect of his actions on victims, and to develop skills in managing close relationships.

Additional information in the OASys assessment

1.12 The section about emotional well-being says that TA had some problems coping and had current psychological problems/depression but had not sought help from his GP and said he would deal with these in his own way. There was no identified history or risk of self-harm, attempted suicide, suicidal thoughts or feelings, and TA's state of emotional wellbeing was said not to indicate risk of serious harm to himself or others.

1.13 The analysis includes a section for self-assessment. TA identified problems of being bored, getting violent when annoyed, literacy and numeracy, getting qualifications and a good place to live, getting and keeping a job, managing money, getting on with his partner, feeling depressed and feeling stressed.

1.14 The assessor did not identify any concerns about TA coping in prison.

Mental health history – TA's community medical records

1.15 TA's community medical records contain some references to his mental health. They say that on 12 October 2008, TA took an overdose of risperidone, tegretol, and lamotrigine, medications that had been prescribed for a family member. He was admitted to hospital through Accident and Emergency and discharged from in-patient care on 15 October 2008.

1.16 In September 2009 TA was said to be using much cannabis, and is reported to have told the doctor his mother believed he had no self-esteem.

1.17 In January 2011, TA consulted his GP about a chest infection and also said he was sleeping badly and had experienced depression for three weeks. He scored quite highly on the depression assessment scale PHQ9 and was diagnosed with depressive disorder. He denied any thoughts of harm to himself or others. The GP prescribed antidepressant medication and a short course of night sedation. TA was given a form to complete for referral to psychotherapy and was asked to return to the GP for review but he did not do so.

1.18 TA had no further contact with his GP until November 2012 when he reported feeling dizzy. There was no further investigation or intervention for depression recorded in his community medical records.

1.19 When TA was admitted to prison, the records say that he could not remember the name of his GP and consequently his community medical records were not immediately available. We understand that patients' community medical records are now more readily accessible to prison healthcare services through the NHS digital Summary Care Records System.

CHAPTER TWO: TA'S ADMISSION TO HMP CHELMSFORD ON 20 JUNE 2013 - THE RECEPTION PROCESS

At the court

2.1 TA had been on bail before the sentencing hearing. The pre-sentence report recommended a conditional community sentence on the basis that the structured interventions that would enable TA to address his offending behaviour were unlikely to be available in prison. However, at Chelmsford Crown Court on Thursday 20 June, TA was sentenced to 12 months' imprisonment and at 12:20 pm he was taken into custody for transfer to HMP Chelmsford. He had not been in prison before.

2.2 TA was interviewed by a Prison Custody Officer from the Escort and Custody Service, who completed a Person Escort Record (PER). This form records the transfer of a person in custody from one agency to another and communicates essential information that each agency needs to know. It includes a section to indicate risks of which the agencies need to be aware.

2.3 On the risk indicator page in the PER, against risk of suicide/self-harm, the custody officer noted '*overdose 12 mths ago'*. This was the only reference to self-harm. No medical or mental health risks are recorded**.** No separate warning form was opened to indicate that TA was thought to be currently at risk.

2.4 TA left the court cells to be taken to the prison at 13:43.

The reception process at HMP Chelmsford

2.5 The prison 'Reception' is the gateway through which prisoners are admitted or discharged. Various administrative procedures take place, for example, to register new prisoners and record their property. This is also the first opportunity for the prison to identify new prisoners who have special needs or pose risks to themselves or others. Where any such risk is identified, the information should be recorded and passed on to the staff who will be responsible for their care and management. New prisoners are interviewed by a prison officer and by a member of the healthcare team.

2.6 We have a description of the reception arrangements and staffing and the typical numbers of prisoners admitted and discharged each day, based on a visit to the prison by my Assistant Investigator on 22 November 2016, information provided by HMP Chelmsford, and interviews with the reception officers on duty when TA was admitted.

2.7 In the week that TA was admitted, the prison reception received 194 prisoners, and discharged 177, on release, or to court, or transfer to another prison. TA was admitted on a Thursday. The prison received 29 prisoners that day. Numbers admitted on a Thursday from 24 May to 18 July 2013 ranged from 21 to 34.

2.8 We were told that all reception staff were trained through the national reception officers' course, which was delivered as a refresher every five years.

2.9 At the time of the investigator's visit in 2016, posters and information were available in sight of prisoners in reception. None of the posters or leaflets expressly encouraged disclosure of mental health issues.

Listeners and Insiders were available in reception. 'Insiders' are prisoners trained to offer information and support to other prisoners. Listeners are trained by the Samaritans and provide a confidential service.

2.10 Reception staff told us that there were usually seven officers working in reception, with two officers on the desk receiving prisoners when they arrived, three officers doing searches and logging property, and two officers interviewing new prisoners. We were told that five officers was the minimum required for safe working.

The reception process for TA

The account in the serious incident review that followed TA's self-harm

2.11 There is no evidence from any of the reception officers with my copy of the prison's internal investigation, the serious incident review. However, the report of the review says that when asked by a reception officer about the self-harm warning on the escort record (PER) that he had overdosed 12 months ago, TA disputed this, saying it was more like two years ago, it was an issue in the past, and he had now moved on. The report says the interviewing officer felt TA was very responsive throughout the interview and stated he had no thoughts of suicide or self-harm. I have not seen any statement or other evidence of the source for this and I do not know which officer gave this information.

2.12 The serious incident review describes a system in use at HMP Chelmsford at the time to alert the Safer Custody Team to prisoners who enter the prison with any past or present self-harm warnings.

Safer Custody would forward this information to the senior officer managing the prisoner's wing for the senior officer to speak to the individual concerned. The senior officer was expected to email Safer Custody with a summary of the conversation and update the wing observation books and P-Nomis (the electronic record for each prisoner, which is also called C-Nomis).

2.13 Healthcare Nurse 1 interviewed TA as part of the reception process. The report of the review says that TA was interviewed by a reception nurse where he repeated that he had no thoughts of self-harm or suicide and there were no apparent mental health concerns. The source of this information is not stated. Nurse 1 completed a serious incident report form which may have been available to the investigating officer but this refers only to events at the time of TA's self-harm. It does not include any information about TA's healthcare reception interview.

The account in the health care reviews

NHS East of England Health and Justice Team Serious Incident Closure Form

2.14 This says TA:

'…had disclosed a previous accidental overdose 3 years previously on arrival – this information had not been shared.'

and

'Upon review of the Reception Screen undertaken on 20/06/13 the prisoner stated no previous history of mental illness, no medication

other than asthma inhalers previously but not currently taking medication, and no thoughts of DSH. First time in prison with a low risk score for In Possession Medication. Previous overdose a number of years ago, however, claimed he did not do this to end his life. Had booked an appointment for mid-July to see the dentist. Prisoner stated when asked that they do not feel like self-harming or suicide.'

Care UK Root Cause Analysis

2.15 The Root Cause Analysis report says

' – the prisoner had presented as unremarkable during the reception screen, he had noted that he accidentally overdosed at least 3 years previously but raised no cause for concern.'

Evidence obtained by my predecessor's investigation

2.16 When TA arrived at the prison, the 'receiving officer' at 14:02 was Reception Officer 1. He noted on a form F2050A Information of Special Importance (1.58), '*overdose 12 mths ago*'. This was the information given on the Person Escort Record (the PER).

2.17 I do not know exactly what process followed from completion of this form but I infer that it was used to alert Safer Custody to self-harm risk indicators in accordance with the system referred to in the internal serious incident review (see paragraph 2.12 above).

2.18 Form 2050A says that entries should be made only with the authority of the security officer, medical officer or a governor grade. My copy is incomplete so I do not know whether it was endorsed by a manager.

The evidence of Reception Officer 1, the desk officer

2.19 Interviewed in 2016, Reception Officer 1 had no recollection of receiving TA but he described the process when a new prisoner arrived. Officer 1 thought he was probably on the front desk. The escort staff would bring in the prisoner with documents. Officer 1 said he would normally read only the front page. He would not look at confidential medical information. Sometimes there would be a suicide and self-harm warning form completed by the escort staff. As desk officer, he would check whether there was any prior prison record but TA had not been in prison before so there would have been no record.

2.20 Officer 1 said he assumed he would have got the reference to an overdose from the papers. He would ask the prisoner how they were and, if he had any concern, he would put the file into a red tray indicating risk of self-harm, so the prisoner would be given priority by the interviewing officer and nurse, who would both be alerted to the risk. Green trays were used for prisoners where they were substance misuse concerns, and blue trays for those for whom there were no issues.

2.21 Officer 1 was asked which documents accompanied the prisoner and what information was examined in reception. He said they would sometimes, but not always, have the package of information from the Crown Prosecution Service.

2.22 The desk officer would not significantly probe the information. The interviewing officer and nurse would go into more depth and would be alerted to a self-harm concern by the papers being in a red tray. After

the assessments in reception there would be the first night interview on the wing.

2.23 Officer 1 was aware of the system referred to in the serious incident review for sending an email to Safer Custody from reception for all prisoners with an 'ACCT' plan, or others without a plan but where there was a concern about self-harm. He said that, since then, the format had been updated with more tick boxes to indicate relevant factors giving cause for concern, for example, harassment, domestic violence etc.

2.24 ACCT stands for Assessment, Care in Custody and Teamwork. It is a key part of the Prison Service strategy to prevent self-harm. For prisoners identified as posing a current risk of self-harm an assessment and care plan is opened which is usually referred to as an ACCT. In Chapters 12 and 13 we examine the current national and local policies for preventing self-harm.

The evidence of Reception Officer 2

2.25 Reception Officer 2 was also interviewed by my predecessor's investigation. He signed to confirm the cell sharing risk assessment by Reception Officer 3 – see below.

2.26 Officer 2 was a reception officer at the time but had no recollection of TA or the particular day. He described the processes in reception and also the induction process. He said there were assessments in each of the three days of the induction process, with tick boxes on standard templates. There might be 10 or 12 prisoners arriving each day or it could be as many as 24 or 25. They might all be arriving together late

in the day. Interviews could take five minutes or an hour or more depending on the circumstances.

2.27 Officer 2 was asked about the paperwork available to the reception officers. He said the Person Escort Record and the warrant were the main ones. The reception officer would check the details on the warrant against the PER to be sure they were consistent. The PER contained personal details, the offence, and any risk factors, all on the front page.

2.28 If there was an indicator for suicide or self-harm the file would go in a red tray and the officer would put a marker on the computer record. Officer 2 said he would also look to see if there was any information from a doctor or the mental health team from the court. If there was a self-harm warning from the mental health team, he would open an ACCT straightaway. He would err on the side of opening an ACCT if he had any concerns from the prisoners' presentation but sometimes he would refer to the mental health nurse if he felt a prisoner needed more care and attention than he could give. In such a case he would put on to the P-Nomis case notes that he thought the prisoner vulnerable and had referred him to the duty mental health nurse. In such a case the prisoner would be fast-tracked to the nurse in reception even if that meant jumping the queue.

2.29 At one time the reception officers had a lot of paperwork including the Police National Computer record but with so many documents things started to get missed so it was narrowed down.

2.30 Occasionally, there would be a pre-sentence report but it could be 12 pages long. Officer 2 suggested there could be a tick box on the front for risk of self-harm.

Healthcare screening in reception

2.31 At 14:44 TA saw Healthcare Nurse 1, who was a Clinical Team Leader, for initial healthcare screening. I understand that the healthcare screening interview is recorded electronically in the SystmOne electronic clinical record and that it follows a structure of prompts within the electronic system. These cover various aspects of the new prisoner's medical and social circumstances and history. All the questions are mandatory. The page on mental health asks whether the prisoner has received medication, care, or treatment in the past, for details of any history of self-harm, and whether the prisoner currently feels like harming himself.

2.32 Nurse 1's record in SystmOne say that TA had a history of asthma and used inhalers. He had no concerns about his physical health and made good eye contact. He was said to have no mental health history or history of self-harm within the last five years. He said he had overdosed a few years previously but had not meant to kill himself. He was assessed as suitable to hold medication in possession. There was said to be no reason for him to see the doctor. He had a history of cannabis misuse. He had not consumed alcohol within the last week. He had not received treatment for mental health problems. He did not feel like self-harming and the nurse's impression of his behaviour and mental state indicated no thoughts of deliberate self-harm.

2.33 The record says that TA could not recall details of his GP, so the prison was not immediately able to access his community medical records. We understand that patients' community medical records are now more readily accessible to prison healthcare services through the NHS digital Summary Care Records System.

2.34 Nurse 1 left HMP Chelmsford in 2016 and was not interviewed as part of my predecessor's investigation. We were able to speak with her in 2021. She recalled that TA had said that when he took an overdose, he had not meant to kill himself but had meant it as '*a cry for help'.*

Interview with Reception Officer 3, the interviewing officer

2.35 An entry at 15:02 on the electronic case note history notes TA's interview with Reception Officer 3. The entry says TA had no thoughts of self-harm, that he was a smoker, it was his first time in prison, and he had no cash.

2.36 Officer 3 also completed the initial entries on a hard copy Form 2050 Core Record for TA. This contains personal details, identifying particulars, next of kin and the like. There is a place for the prisoner to sign to say he does or does not consent to notification of next of kin if he is transferred to another prison or in an emergency. TA has signed the note but neither 'do' nor 'do not' has been deleted.

The evidence of Reception Officer 3

2.37 Interviewed in 2016, Officer 3 told the investigation he had no specific recollection of seeing TA in reception, but he assumed he was the interviewing officer. Officer 3 said that he would generally see about 22 people in an evening. At the time of the interview, he no longer worked in reception.

2.38 Officer 3 told the investigation that if he received the file in a red tray he imagined he would have considered the prisoner's body language, demeanour, eye contact and responsiveness, as well as the PER and any suicide and self-harm warning form. If he had any concerns, he

would have opened an ACCT or passed his concerns on, maybe to a manager or to healthcare. There might be a record of an interview with the police if it was relevant but the Police National Computer (PNC) records would not usually be available in reception.

Cell-Sharing Risk Assessment

2.39 Officer 3 and Nurse 1 completed their appropriate sections of a cell-sharing risk assessment (CSRA). The template does not refer to risk of self-harm, which is not of itself considered to be an impediment to cell-sharing, although two prisoners on ACCT plans would not be placed in the same cell. Neither the officer nor the nurse recorded any impediments to cell-sharing but Officer 3 was required to record high risk, as TA's PNC record had not yet been examined. Although the body of the form was completed by Officer 3, Officer 2 signed the first day assessment that TA was to be treated as high risk.

2.40 We were told that PNC records are examined by the night staff during a new prisoner's first night. Accordingly, the CSRA was checked the next day by the induction wing senior officer who recorded standard risk.

Summary and observations

2.41 TA was on bail before the court hearing on 20 June. The pre-sentence report recommended a non-custodial sentence but TA was sentenced to 12 months and taken into custody. He had not been in prison before so neither the Escort and Custody Service nor the Prison Service had any prior records about him. The reception officers and healthcare staff at Chelmsford did not have access to TA's previous

medical records from his GP. They had only the information on the PER, the warrant and what TA told them.

2.42 A prison custody officer from the Escort and Custody Service wrote in the risk section of the Person Escort Record *'overdose 12 months ago'*. There were no further details, and the prison custody officer did not complete a Suicide and Self-Harm Warning Form.

2.43 This was the only indication of any specific risk of suicide or self-harm that accompanied TA to the prison, but it was sufficient for the desk officer to enter the information on a Form 2050A Information of Special Importance. The complete form was not preserved so we do not know whether it was authorised by a manager, as required.

2.44 The pre-sentence report and OASys form were not examined as part of the Reception process but, in any event, they did not indicate any risk of self-harm disclosed by TA or identified by the assessor.

2.45 The prison officer who interviewed TA in reception wrote down that he had no thoughts of self-harm. We do not know the extent of the conversation about the historical overdose, for example whether he asked TA anything about the circumstances. The report of the serious incident review says TA told the reception officer the overdose was more like two years ago and it was no longer an issue, and that the interviewing officer found TA responsive and that he said he had no thoughts of suicide or self-harm. There is no statement or other evidence of the source of this information with my copy of the serious incident review, which is accompanied only by statements made on the day of TA's self-harm by some of the people who were directly involved in events on that day.

2.46 The interviewing officer says that he might interview as many as 22 new prisoners in the course of an evening and another officer said that interviews might vary between five minutes and an hour. Whilst we recognise that the needs of individual prisoners will vary, the reception interview is a critical stage in risk assessment. Staffing levels need to be sufficient to meet the requirements.

2.47 Care UK's Root Cause analysis and the NHS Serious Incident Closure Form say that TA disclosed an *'accidental'* overdose some three years previously. The reception nurse's entry in the medical record says that TA overdosed a few years ago but did not mean to kill himself. It seems likely that TA minimised the significance of the overdose during his reception into prison but the nurse's entry in SystmOne does not justify the conclusion in the NHS Review that the overdose was accidental. Nurse 1 told us that TA called it '*a cry for help'*.

2.48 In Part Five of this report, we examine processes for assessing and recording risk at the time of TA's self-harm and now.

CHAPTER THREE: THE INDUCTION WING – THURSDAY 20 JUNE TO MONDAY 23 JUNE 2013

3.1 From Reception, TA was taken to F wing, for initial induction into prison, where he was interviewed by Officer 4. Officer 4 was not interviewed as part of my predecessor's investigation. Her entry in TA's electronic case note history at 15:49 on 20 June notes:

'FNIP [First Night in Prison] interview carried out. Smokers pack issued, PIN not issued as Harassment charge. This is TA's first time in prison, however he has no issues at present.'

The induction process

3.2 A prisoner induction pack forms a record of a prisoner's first days in Chelmsford prison. The structure of the pack is that the officer, or in some cases the prisoner, indicates by tick box or signature that a wide range of topics have been covered. The entries in the induction pack for TA are sketchy and are not always easy to interpret. Signatures or initials are not legible and it is not always clear whether they are by TA or an officer.

3.3 The pack has several sections.

- The custody compact sets out expectations of the prisoner, for example, to follow rules and instructions, address offending behaviour and not to use drugs, and what he can expect from staff, for example, to be treated with respect and supported to address offending behaviour.

- The section on First Night in Prison records any special needs, and the prisoner signs to confirm for example, that he has received various information, reception letter, and a PIN phone allocation. This is a personal code issued to a prisoner to enable him to make telephone calls. No special needs were recorded for TA.

- The box for PIN phone allocation has been ticked, which is in conflict with the entry in P-Nomis. The interviewing officer says in her entry in P-Nomis case notes that a PIN was not issued because TA had been convicted of harassment. TA was not allowed to make telephone calls until later (see paragraph 3.6 to 3.12 below).

- The box has been ticked for '*Reception Visiting Order (if applicable)*' (see paragraph 3.26 below).

- There is no reference to any risk of self-harm. The only prompt relating to self-harm risk in the induction template is a box to indicate whether there has been any previous ACCT (suicide and self-harm care plan). This was – correctly – left blank. The form also asks opposite this box whether the possible need to open an ACCT has been considered. This box is blank along with similar ones in this section of the report. The implication is that the question does not have to be answered unless there has been a previous ACCT.

3.4 The First Night Information section has been signed, apparently by TA, on 20 June.

3.5 Later pages of the pack deal with other aspects of prison life, including the availability of the Insiders scheme – a prisoner peer support service – and are signed on Friday 21 June, and also after the Day 2 Induction on Monday 24 June.

Telephone calls and visits

3.6 All prisoners are required to sign a communications compact confirming that they are aware that letters and telephone calls may be monitored and the terms and conditions of the 'PIN phone' system**.** Each prisoner is given a personal Identity number (PIN) to use to access the telephone, and calls may be made only to authorised numbers listed on each prisoner's personal account at their request. The Communications compact sets out the conditions of the PIN phone system and arrangements for letters.

3.7 TA appears to have signed agreement to the compact. The document is also signed by Reception Officer 3, but neither signature is dated.

3.8 Because TA had been convicted of a charge of harassment, he was subject to extra controls on whom he could write to and telephone. He would therefore not be allowed to make phone calls until all his requested numbers were checked and authorised. At the time, the policies were set out in Prison Service Order PSO 4400.

3.9 A form on page 19 of the induction pack instructs prison staff, in accordance with paragraph 6.1 of Prison Service Instruction PSI 49-2011 Prisoner Communication Services, that they should make a call on the prisoner's behalf, checking first that the recipient is willing to take the call. There is a space for a reply to the prisoner's request and an instruction that the call should be noted on P-Nomis. PSI 49-2011

paragraph 6.2 makes clear that the facility to have an early phone call on first reception into prison applies to all prisoners, including those who may be subject to special controls because of the nature of their offence.

3.10 In the form on page 19 of the induction pack, TA asked for a woman friend to be contacted. He wanted her to be asked to book a visit and to bring joggers and trainers; also for the friend to tell his mother he was in prison. He gave his mother's phone number.

3.11 There was no entry in the reply box and no case note on P-Nomis, so there is no indication that the call was made. TA appears to have been authorised to make phone calls on Wednesday 26 June and made some phone calls to his mother's telephone number in the following days.

3.12 There is no record of TA receiving any visits while he was in prison, or of any visits being cancelled.

Notification from safer custody

3.13 An entry in TA's electronic case note by the induction wing manager on Friday 21 June at 13:27 says *'Safer Custody Self-Harm Warning received'*. There are no further details.

3.14 The induction wing manager no longer works at the prison and was not interviewed during the investigation.

3.15 According to the serious incident review that followed TA's self-harm, Safer Custody sent a self-harm warning to the induction wing manager on 21 June, informing him of the entry in the PER about a past

overdose and asking him to speak to TA to assess for potential risk; then to reply to Safer Custody with an update and to document the outcome in the wing observation book and on P-Nomis. The incident review says the manager replied (presumably to Safer Custody) to say this had been completed but that the details of his conversation with TA was not evidenced on P-Nomis or in the Observation Book.

3.16 The source of this information is not included in my copy of the serious incident review or elsewhere. I have not seen any statement by the wing manager or any record of an interview with him. The wing observation book was not provided to my predecessor's investigation and I understand it has not been preserved. Nor have I seen any record of his wing manager's reply to Safer Custody.

3.17 According to the review, the system for notifying Safer Custody of prisoners received with self-harm warnings was that:

'reception staff email Safer Custody with details….Safer Custody then forward this to the relevant wing SO the following day for the SO to speak with the individual and then email Safer Custody with a summary of the conversation and update the wing Observations books and C-Nomis'

3.18 The serious incident review found that, although this was generally being completed, the documentation was not always sufficient *'…to evidence that our procedures are robust'*. The review recommended that all Senior Officers should be reminded of the importance of responding to self-harm warnings in accordance with the system and that this continue to be highlighted in SOs' refresher training.

3.19 After the wing manager's entry on 21 June there was no further entry in the case notes for TA until his self-harm on 1 July.

Healthcare records

3.20 The SystmOne Patient record notes an application received from TA and that on 23 June he was added to a waiting list. The reason is not specified but the Care UK's Root Cause Analysis report after TA's self-harm says he had been added to the dental waiting list.

3.21 At the time, there was no provision for a routine second health screening interview for new prisoners. We say more about this in Chapters 8 and 12 below.

Summary and observations

3.22 It is known that prisoners may be vulnerable in the first days they are in prison, and especially so if this is their first time in prison.

3.23 The forms in the induction pack may not do justice to the quality of the first night interview but they do not include anything to indicate the character, mood, disposition, or aspirations of the new prisoner. The impression given is of a tick box exercise. There is nothing suggestive of this being the first stage in building relationships with officers or finding out anything about the prisoners' individuality, though the First Night interviewing officer, rightly, noted in the electronic case record that it was TA's first time in prison.

3.24 The First Night in Prison Form says TA received a PIN phone allocation. I do not know whether this was accurate. TA was not permitted to

make phone calls until the following Wednesday 26 June after being admitted to prison on Thursday 20 June.

3.25 Because TA had been convicted of a charge of harassment, he was subject to certain restrictions on whom he could phone. The numbers he requested had to be checked, but he should not have been denied access to the phone for so long. The delay is especially concerning as there is no evidence that TA was permitted to make a phone call on admission to prison. There is no indication in the induction pack or in P-Nomis that any action was taken on his request for a friend to be contacted and asked to tell his mother he was in prison.

3.26 It is not clear from the induction record whether TA was considered to be eligible for a reception visiting order or whether one was issued. We say more about this in Chapter 12 (see paragraph 12.43).

3.27 We have no evidence of the induction wing manager's reply to the notification from Safer Custody or any entry in the observation book. The entry in TA's electronic case record is not informative and not helpful. We do not know whether anyone on the wing spoke with TA about the warning or whether any other action was taken.

3.28 The serious incident review was right to pursue the need for informative recording – and its wording may simply be unfortunate - but the reason for recording more detailed information is not the defensive one of demonstrating that procedures are robust, as the review implied, but in order to communicate useful information to colleagues who are responsible for the safety of the prisoner concerned.

CHAPTER FOUR: TA MOVES FROM THE INDUCTION WING TO C WING – MONDAY 24 JUNE TO SUNDAY 1 JULY 2013

4.1 On Monday morning 24 June, TA was moved from the induction wing to C wing, one of the main residential wings in the prison. C Wing Officer 5 told the investigation that when prisoners move from the induction wing there is an oral handover rather than any consideration of documents or the electronic record.

4.2 We have only sketchy knowledge of events affecting TA during the week he spent on C Wing, There are no informative entries in TA's electronic case notes until after his act of self-harm a week later, on 1 July. We cannot be certain whether there was any reference to TA in the wing observation book, as this had apparently not been preserved when my predecessor investigator asked for it in 2016. But the serious incident review conducted by the prison says nothing about any record in the observation book, so it seems unlikely. Some of the accounts included in this chapter are consequently based on information obtained only after TA's self-harm and some of it is second-hand reporting without any evidence of the source.

4.3 We do know for a fact that TA was placed in cell C2-16, which he shared with another prisoner, Prisoner A. The records for Prisoner A name his allocated personal officer as Officer 6, one of the officers who worked on C wing. No personal officer is recorded for TA.

4.4 A report prepared for consideration of release on temporary licence when TA was in hospital after his self-harm, says he engaged with induction and completed an employability assessment before being allocated to a plumbing course, which he attended from Thursday 27 June.

Telephone calls, letters and visits

4.5 According to the serious incident review, on Wednesday 26 June a form was sent to the wing for TA to sign so he could be issued with a PIN to make telephone calls. Telephone records show that TA made four calls to his mother's telephone number on Thursday 27 June, each lasting a few minutes. He appears to have phoned again in the morning of Friday 28 June, the afternoon of Saturday 29 June, and the morning of Sunday 30 June but each time hung up almost immediately after dialling. We do not know why.

4.6 TA did not send or receive any letters during his week on C wing. We have not seen his property cards and do not know whether anything was brought into the prison for him.

4.7 We do not know whether any visiting orders were issued, but there is no record that TA received any visits, or of any visits being cancelled.

The serious incident review – tobacco incident

4.8 The report of the serious incident review says that on arrival on C wing, TA told C Wing Officer 7 he had no tobacco and threatened to '*smash up'*. Officer 7 is said to have arranged for him to have tobacco the following day as it could not be arranged that night. The review says there is nothing documented about this incident on C-Nomis or in the Observation book.

4.9 I have seen no evidence of the source of this information. Interviewed by the independent investigation some three years later, Officer 7 had no recollection of any such incident and believed his shift pattern at

the time meant that he would not have been at work on the Monday when TA arrived on C wing.

4.10 However, I have been told that a security report, dated 1 July 2013, referred to irrational behaviour by TA about a smokers' pack, not on Monday, when he arrived on C wing, but on Wednesday, 26 June. I do not know whether the security report named the officer involved. I am told that another report, dated 5 July 2013, said that intelligence suggested that TA might have been in debt for tobacco and did not have enough to pay everyone. These two reports were noted by my predecessor's investigation but I have not seen them, I have no further information about them, and I am told that they have now been destroyed in accordance with the protocols on destruction of records.

4.11 The serious incident review says that, apart from the tobacco incident, staff had no further issues with TA and he did not come to their attention for any other reason. There is a recommendation in the serious incident review to commend staff for acting sensitively in response to the request for tobacco.

4.12 The current induction pack says that canteen sheets are given out on Sunday, for return the same day, for delivery the following Friday. I do not know whether that was the case at the time, or how much tobacco is issued to prisoners in a smokers' pack, or whether TA had ordered more tobacco on Sunday 23 June.

The evidence of C Wing Officer 7

4.13 Interviewed by the independent investigation in 2016, Officer 7 said he believed he had worked long shifts until 21:00 on Saturday and Sunday 29/30 June. From 17:00, the wing would have been in 'patrol state'

with prisoners locked in their cells. He believed he would have worked the previous Wednesday and Friday but not otherwise that week. He was working only for 21 hours a week at the time. When we spoke to Officer 7 recently, he commented that this was not a good shift pattern to get to know the prisoners on the wing.

4.14 Officer 7 told my predecessor's investigation he had no memory of TA coming to his attention at all until an incident that occurred at the weekend. He remembered TA as quite a quiet chap who did not come out of his cell. He said it took time to get to know the quieter prisoners. The more noisy or disruptive ones would tend to require attention. He said he would not have been aware of TA except that during association, at the weekend, his cellmate, whom the officer remembered as being a rather unpleasant chap, asked Officer 7, in front of other people, to have a word with TA about taking a shower, which Officer 1 thought was rather a nasty thing to do.

The serious incident review – case notes and personal officers

4.15 The serious incident review draws attention to the absence of case note entries and personal officer entries in TA's records. It recommends:

'Managers to brief staff on the importance of documenting key issues that affect the individual prisoner. All such issues relating to their behaviour and safety must be logged in the wing observation books and on C-Nomis.

In addition, staff will be reminded of the expectation for a personal officer entry every 14 days.'

Summary and observations

4.16 We know little about the week that TA spent on C wing. It is unfortunate that the observation books were not available to the investigation, but the serious incident review undertaken at the time makes no reference to any entries in them, and on balance it seems unlikely they contained any information about TA.

4.17 The evidence is sketchy but, drawing on the serious incident review, what my predecessor investigator was told, and security reports completed after TA's self-harm, but that are no longer available, we note that TA was said to be protesting at one point that he needed tobacco, that it was suggested he might be in tobacco debt, and that on the evening before his self-harm his cellmate complained to an officer, in the presence of other prisoners, about TA's personal hygiene.

4.18 There were apparently no records made of these incidents at the time, or any attempt to probe what lay behind them. Whilst mindful of the benefit of hindsight, we consider that these incidents should have been recorded and followed up.

4.19 The incidents raise questions: about why TA was suddenly in need of tobacco – he might simply have used up his smokers' pack, but it might indicate bullying or debt; about relations with his cellmate; and about possible self-neglect – or avoidance of the showers for fear of bullying. Incidents like these may not raise alarm bells individually but we agree with the serious incident review that they should be followed up and recorded in wing logs and personal records, so that colleagues and senior staff are made aware.

4.20 Officer 7 noted that TA was quiet and tended not to come out of his cell. Isolation may be a sign of vulnerability. TA was a young man in prison for the first time. He was not allocated a personal officer. We do not know why. His cellmate had a personal officer. A personal officer gets to know a prisoner, builds a relationship, and would have been an appropriate officer to follow up these incidents.

CHAPTER FIVE: MONDAY 1 JULY – THE DAY OF TA'S SELF-HARM

5.1 At about 09:30 on Monday 1 July TA was found hanging in his cell. This chapter is about events earlier that morning.

C Wing regime

5.2 C wing consisted of three landings with 30 prisoners on each landing. According to the Incident Log there were five prison officers and two senior officers on duty from 07:30 that morning. One of the senior officers was acting as a prison officer.

5.3 According to the C wing regime at the time, on Monday mornings cells were unlocked at 07:45 for prisoners to go about 'domestic' activities, such as collecting breakfast, handing in applications or requests, making phone calls, or taking showers. By 08:45, prisoners were locked in their cells and the wing roll (the register of prisoners) was checked. The period 08:50 to 09:00 was for 'mass move'. Prisoners who were leaving the wing for activities elsewhere were let out of their cells and supervised by staff as they moved to other parts of the prison.

Evidence of Senior Officer 8

5.4 At her interview with my predecessor's investigation in 2016, the wing senior officer, SO 8 said that she had been on leave and started back at the prison at 07:30 on Monday 1 July. She said she would always check the observation book after being on leave and at the start of a shift. She was not aware that any concerns had been handed over from the weekend staff.

5.5 For movement to work, there was a 'free flow' system, with officers supervising from fixed positions and prisoners moving to wherever they had to go for work or education etc. There would be two officers on each landing and the supervising officer would be at the bottom with the list of where each prisoner was to go. After this, prisoners who remained on the wing would be locked in their cells again. The staff would check the roll and the senior officer would brief staff.

5.6 TA's cellmate, Prisoner A, was to be released from prison that morning. Senior Officer 8 said that reception staff would probably have collected Prisoner A for release at about 09:00. At that time SO 8 was on the 1s (the first level) in the wing office with Officers 5 and 6.

The evidence of TA's cellmate

5.7 After TA was found hanging, a governor in the Safer Custody office asked a colleague, Officer 9, to interview Prisoner A before he was released. This was shortly after 09:45 when Prisoner A was in the interview room in reception, receiving his discharge papers.

5.8 According to the officer's note of the interview, Prisoner A said that when he woke in the morning, he noticed what looked like blood, on the side of the milk carton. He thought nothing of it at the time but went to use the lighter and saw blood on this too. He asked TA what he was playing at and where the blood had come from.

5.9 TA was still in bed under the covers. Prisoner A pulled the covers back and saw blood in the bed and that TA had made a cut to his arm. He asked TA why he had done this, saying, '*What are you doing, you've only got six months inside.*' TA replied that he had been told he was not allowed to contact his partner as he was on a harassment order.

He said that when he got out, that was the first place he would go, then he would be back in jail anyway.

5.10 Prisoner A said that when he was unlocked, he told staff. He was not sure whether they took him seriously. We do not know what time this all took place. After the interview, Prisoner A was released from the prison at 10:22.

5.11 The investigation team for the first independent investigation was able to contact Prisoner A but he was unwilling to provide any information.

C Wing Officer 7

The account of events in the serious incident review

5.12 The review says that it was as Prisoner A was leaving the wing that he told Officer 7 he had seen specks of blood on the soap and the floor and that, as a result of Prisoner A's warning, Officer 7 immediately went to speak to TA to check he was OK and why he had not gone to work, and found him hanging. The report says that when Officer 7 arrived at the cell, he found the observation panel covered and, on entering, found TA suspended from the window bars by a twisted sheet. He shouted for assistance from staff, re-entered the cell, and cut through the sheet with a 'fish knife' (an anti-ligature tool carried by prison staff).

5.13 I do not know the source of this account. There is no evidence from Officer 7 with my copy of the internal review. The account in the incident review is not consistent with the sequence of events as described by Officer 7 in his interview for the independent investigation in July 2016, in which he describes going to the cell twice,

on the first occasion speaking to TA, and the second time finding him hanging.

Officer 7's interview in 2016

5.14 In his interview for the first independent investigation, Officer 7 said that, when Prisoner A came out of the cell, he said to Officer 7 something like that he had better go and check on TA as he thought he might have cut himself. Officer 7 went into the cell and could see some blood on a tissue. TA was sitting up in the top bunk. Officer 7 asked him if he had cut himself and TA said no. Officer 7 said OK and he would be back in a little while as TA would be going to work. TA said he was not going to work. Officer 7 said he was on the list for work and told him there would be ramifications, like losing his television, if he refused to go. TA insisted he didn't want to go to work. Officer 7 asked him what the matter was. TA said, '*You'll see*.' Officer 7 shut the door and left, reflecting that TA might well have cut himself and obviously had issues, so he intended to come back later to explore what was wrong.

5.15 Officer 7 then went down to the wing office, where there was a discussion going on about cell allocations. Someone suggested locating a prisoner who was on an ACCT in the space vacated by Prisoner A in the cell occupied by TA. (ACCT is Assessment, Care in Custody and Teamwork – the self-harm and suicide prevention plan.) Officer 7 was mindful that if TA had cut himself they might be opening an ACCT for him, too, and it was not appropriate for two prisoners on ACCT to share a cell. He also thought that TA might be uneasy about a new cellmate immediately after the unpleasant incident with Prisoner A complaining about him not taking a shower.

5.16 Officer A therefore went back to the cell, with the intention of talking with TA. It was then that he looked through the observation glass and saw him hanging.

5.17 Officer 7 told my predecessor's investigation that he believed it would have been about 07:45 or 08:00 when Prisoner A spoke to him about TA. He thought he would have talked to a few people before going downstairs to the meeting in the office and estimated there would have been about a half-hour gap between him speaking to TA in the cell and going back to the cell and finding him hanging. He said the CCTV records might show the times. These were no longer available at the time of the investigation.

5.18 Officer 7 said that at the start of a shift the wing senior officer would look at the observation book and brief staff accordingly but that didn't alert to the personal needs of prisoners. There were 30 prisoners on each landing. There was no time for officers to go to P-Nomis and read personal officer entries etc – *'You'd be there till lunchtime and get no work done.'*

5.19 Officer 7 said staff didn't get to know the prisoners instantly at that time and it was still less so now as staffing ratios had been reduced. There was no longer a senior officer for each wing. Instead, the SOs would 'roam'. Without engagement with prisoners, it was harder to exercise control.

C Wing Officer 6

The account of events in the serious incident review

5.20 The serious incident review says that in the morning of 1 July C Wing Officer 6 unlocked TA for work. (According to the timetable for the regime, this would have been about 08:50.) TA was still in bed and said he didn't want to go to work. When asked if he was OK, he nodded his head. After repeatedly trying to cajole him into attending, Officer 6 said she would speak to him later and continued to unlock other cells for mass move.

5.21 Officer 6's serious incident report does not refer to her conversation with TA that morning before he was discovered hanging and I do not know on what information the review relied.

Officer 6's interview in 2016

5.22 At her interview with my predecessor's investigation in August 2016, Officer 6 said the officers would usually go round in pairs, with one carrying the board with the list and one to unlock. She was not sure who she was working with on the day but thought it might have been Officer 5.

5.23 Officer 6 said she had not really known TA. He had moved to C wing on Monday 24 June. He would have gone to the plumbing course on Thursday and Friday. Officer 6 had been off at the weekend and she believed her conversation with TA on Monday morning was her first interaction with him.

5.24 Cell 2-16 was at the far end of the landing on the left. Officer 6 recalled that TA was in bed and that she said that he had to get up and go to work. He said he was not going. The usual pattern was to encourage, to say, for example, that he didn't want a red entry (a negative entry in the Incentives and Earned Privileges Scheme), but TA wouldn't get out of bed so the officers locked the door and carried on unlocking the wing, as there was only a limited amount of time you could spend with one person.

5.25 They then went down to the office to sort out what spaces they had for new prisoners allocated to the wing. The senior officer and Officers 5 and 6 and were there when one of the cleaners shouted that Officer 7 needed help, and the three of them all ran to the cell.

5.26 Officer 6 said TA's cellmate had not spoken to her about TA that morning. Officer 6 was recorded as Prisoner A's personal officer.

Officer 7's interview in 2021

5.27 From the evidence obtained by my predecessor's investigation, it was difficult to understand the precise sequence of events, and the present investigation spoke with Officer 7 again in February 2021. Officer 7 confirmed that he had not completed a serious incident report at the time. He said that after TA's elf-harm he had attended a hot debrief, was asked if he was OK and had then gone directly back to continue his shift on the wing. He told us that he had not been asked to provide any information for the serious incident review and he had not seen the serious incident review report until we showed it to him. He understood from Officer 6 that when she and Officer 5 spoke to TA in his cell it was just to warn the prisoners they were required for work.

5.28 At the time of this interview, it was more than seven years from the date of TA's self-harm and we were not surprised to find that so long after the event we have not been able to establish the precise sequence of events. In particular, we have not been able to establish with certainty whether Officer 6 spoke with TA before or after Officer 7 was alerted by his cellmate, or the interval between Officer 7's first conversation with TA and his going back to the cell. We do not know when Prisoner A left the wing. The senior officer said that prisoners for discharge probably left the wing at about 09:00. Officer 7 said that the time could vary widely from day to day according to numbers. Prisoners going to court were discharged first, then prisoners transferring to other prisons, and then prisoners being released. Officer 7 was also puzzled that he had apparently not been responsible for unlocking prisoners on the 2s for work, as he normally worked on the 2s landing. On balance, it seems that Officer 7 may have been mistaken in saying at his interview in 2016 that he thought it was as early as 0745 or 0800 when the cellmate spoke to him and he went to check on TA the first time.

5.29 We asked Officer 7 to tell us more about the basis of his decisions that morning. Officer 7 recalled that he opened the cell and let Prisoner A out. Prisoner A said to Officer 7 that he might want to go in and check TA as he *'might have cut himself*'. Having walked a few steps with Prisoner A and directed him to the officer who would take him to reception, Officer 7 went back and asked TA if he had cut himself. TA told him no. Officer 7 said that, at that point, he could have made a choice to pull back the sheets, but he didn't. He could see a small amount of blood on a tissue. TA denied there was an issue.

5.30 Officer 7 told us that, before leaving the cell, he said to TA, '*I'll come back and have a chat in a minute as you have to go to work*'. TA said

'*I'm not going to work'* but did not give a reason why. Officer 7 explained the consequences of not going and TA said he '*didn't care if he loses his telly*.' Officer 7 asked '*why*', and TA said, '*You'll see*'.

5.31 Officer 7 said he then shut the cell door and went downstairs to the office. At the meeting there he was told that space needed to be made for two prisoners who were on their way over from F Wing, both were on ACCTs and one had to go in the cell with TA now Prisoner A had left.

5.32 Officer 7 said he was not sure if TA had cut himself but it was in his mind that TA hadn't been particularly happy and they might need to open an ACCT. He went downstairs and raised concerns, then went back up and found him. The prisoners with ACCTs were on their way from the induction wing, so he went back directly to check TA. He opened the flap, which wasn't covered, looked in the cell and could see TA hanging.

5.33 We asked Officer 7 if the possibility of self-harm had crossed his mind. Officer 7 said it had, and that was why he went to the cell when prompted by the cellmate. TA had denied there was an issue. Officer 7 said his judgment at the time was that it would not have been appropriate to rip the sheets off forcibly to examine TA. That might have escalated to a control and restraint incident. He resolved to go back to see him later and said he would do so. If he had been sure that TA had self-harmed there would have been no option but to open an ACCT. Officer 7 commented that if he had gone off to do ACCT paperwork and an Action Plan that would have occupied an hour and TA would be dead. Instead, he wanted to speak to him. Officer 7 said that even in hindsight he did not think TA had met the criteria for risk of self-harm.

Summary and observations

5.34 We have not been able to establish the precise sequence of events. There are discrepancies between the account of events given in the serious incident review and the account that emerged from the independent investigation's interviews with staff.

5.35 The review has Officer 7 going only once to the cell, finding the observation panel blocked then finding TA hanging. Officer 7 told the investigation that he went to the cell twice. The first time was after being alerted by the cellmate. He went into the cell, saw blood on a tissue and spoke to TA, who denied having cut himself but said he would not go to work. Officer 7 said that he went back to the cell a second time, intending to speak with TA before he was allocated a new cellmate who might be on an ACCT plan. The observation panel was not covered and through it he could see TA hanging.

5.36 The serious incident review did not present the evidence on which it relied for the report's account of these events. Officer 7 told us that he did not write a report and was not asked for information for the incident review. Incident reports by other staff refer only to what happened after TA was found, not to any prior events.

5.37 We are satisfied that, having been prompted by the departing cellmate, Officer 7 spoke to TA but we cannot be sure whether this was before or after Officer 6 spoke with him.

5.38 At this time of day, the six officers and the senior officer on the wing were no doubt all focused on their particular duties, to lock and unlock cells, and check and count the prisoners, to start the day in accordance with the requirements of the regime. As we have said before, we must

be careful not to judge from the comfort of hindsight. But it is a pity that Officer 7 apparently did not alert other officers on TA's landing, or the senior officer, to Prisoner A's warning, that he had seen blood on a tissue, and that TA was resolved not to go to work and would remain alone in his cell.

5.39 None of these necessarily indicated an immediate emergency, but they were indicators that something was amiss. Officer 7 was right that they needed investigating and it is hard to understand why, when seeing blood, Officer 7 did not, for example, ask to see where TA had injured himself. When Officer 6 spoke with TA and he refused to get up for work, she was apparently not aware of his cellmate's warning or Officer 7's conversation with TA, but we cannot say whether she spoke with TA before or after Officer 7.

CHAPTER SIX: WHAT HAPPENED WHEN TA'S SELF-HARM WAS DISCOVERED – EVIDENCE FROM THE PRISON STAFF

Officer 7's interview in 2016

6.1 In his interview for the investigation in 2016, Officer 7 said that as soon as he opened the flap in the door he could see TA hanging. He shouted for assistance and heard the cleaners alerting staff. When he entered the cell, he did not know whether TA was alive. Officer 6 was the first officer to arrive.

Officer 7's interview in 2021

6.2 Officer 7 said that he cut the ligature above TA's head. It was made of twisted bed sheets. It was very thick and he had difficulty cutting it with his standard 'fish knife'. We told Officer 7 that the lead nurse did not know at first that TA had ligatured and she thought he had had a seizure. Officer 7 said he did not understand why healthcare staff would not have been aware. He had left the cell when healthcare staff took over but the ligature was still in the cell. Afterwards, he had attended the hot debrief, was asked if he was OK, then went directly back to work the rest of his shift on the wing.

Officer 6's incident report

6.3 Officer 6's incident report, completed at 12:30 on 1 July, says that at about 09:13 (not 09:33) a prisoner was shouting for staff to help Officer 7. Entering Cell C2-16, Officer 6 saw Officer 7 supporting TA, who was in a standing position but slumped. They lowered TA to the floor and placed him in the recovery position. Officer 6 felt a faint

pulse. TA's colour was grey-green, his pupils were dilated, his eyes bulging and he had urinated.

6.4 Officer 6 constantly called his name and pinched his ear but could not see or feel any breathing. Senior Officer 8 checked and confirmed there was a pulse. Officer 6 noted a cut to TA's right forearm.

6.5 When Healthcare arrived, the nurse asked the officers to lay TA on his back. They then left the room to allow the nurse room to work.

6.6 Officer 6 was aware of a ripped sheet used as a ligature but did not know what happened to it afterwards. A razor blade was placed in the sharps bin.

Officer 6's interview in 2016

6.7 At her interview with the investigation in August 2016, Officer 6 said that she and SO 8 and Officer 5 were in the office sorting out what cell spaces they had for new prisoners transferring from induction. She recalled one of the cleaners shouting that an officer needed some help.

6.8 The three officers ran up, with Officer 6 arriving first. Officer 7 was cutting the ligature, so Officer 6 went to support TA's weight. When the ligature severed, TA fell on top of her. She recalled also that there was quite a lot of blood as TA had cut one or both of his wrists.

6.9 The officers got TA on the floor and started working on him. They were not sure if he was alive but SO 8 found a pulse and he made one or two gasps but was not breathing properly. They put him in the recovery position and about that time the healthcare staff arrived.

Someone brought the bag of oxygen and the officers withdrew to make space for the medical staff. They did not know what condition TA was in.

C Wing Officer 5

Officer 5's serious incident report

6.10 Officer 5's incident report was completed at 12:40 on 1 July. The time of the incident as recorded at the head of the report form has been changed, apparently from 09:13 to 09:33. The body of the report retains 09:13 as the time the incident began.

6.11 It says that at about 09:13 Officer 5 was in the office on the 1s when she heard a prisoner shouting that Officer 7 needed help on the 2s. She made her way up the stairs. She found that Officer 7 had cut TA down as Officer 6 arrived at the cell. When Officer 5 arrived, TA was on the floor lying on his right side parallel to the bed, with Officer 5 crouched on his left and SO 8 on his right. Officer 7 was walking towards the door. Officer 6 was having trouble finding a pulse so Officer 5 felt and could feel a faint pulse.

6.12 Officer 5 at first stood at TA's head then at some point swapped with SO 8, so was then down on the floor on TA's left side. She and Officer 6 were trying to rouse TA by calling his name. Before Healthcare arrived, TA took a couple of deep breaths. Under Healthcare instructions the officers turned TA on to his back then Officer 5 left the cell.

6.13 Officer 5 noted that TA had a cut to his forearm and signs of hanging in that he had grey-green colour to his face and had urinated.

6.14 Officer 5 was aware of seeing a ligature made from a bed sheet but did not know its whereabouts after the event.

Officer 5's interview in 2016

6.15 Interviewed in August 2016, Officer 5 told the investigation she now had little recollection of the events. She believed she would have come on duty at 07:30 and that it was her first day back after being on leave. She thought she was assigned to the 3s (the third level of cells. TA was on the second level, the 2s.)

6.16 Officer 5 was with Officer 6 and the SO in the office on the 1s when they heard a prisoner shout that Officer 7 needed help on the 2s. The three of them ran to help but she was last as she locked the doors. At cell 2-16 she saw TA on the floor. Officer 6 was trying to feel for a pulse but was having difficulty so Officer 5 tried. She felt a pulse. TA was not breathing but then took two deep, heavy breaths.

6.17 Officer 5 recalled the senior officer asking people to get equipment, then the Healthcare staff arrived, first Nurse 1, then a few others, and the officers left the cell.

6.18 The investigator did not ask Officer 5 whether she had any recollection of Officer 6's conversation with TA when she was unlocking prisoners to go to work.

6.19 Officer 5 said she had not had anything to do with TA previously and she did not remember him. Usually, they got a simple oral handover from the induction wing.

Senior Officer 8's serious incident report

6.20 The C wing senior officer, SO 8, completed a serious incident report form at 18:00 on 1 July 2013. SO 8 said she was working in the office on the 1s on C wing when a prisoner came to the office shouting that officers on the 2s needed help. SO 8 ran up the stairs to Cell 2-16, arriving at about 09:30. Officer 7 was lowering TA to the floor after cutting a bed sheet from which he had been suspended. SO 8 used her radio to call Code One (the emergency code used at the time at Chelmsford).

6.21 Officer 6 was present and checked for TA's pulse and breathing. SO 8 asked an officer who was at the cell door to collect the oxygen and green medical equipment bag from the SO's office. Officer 7 was at TA's head. Officer 6 at his right side, Officer 5 at his left side, and Nurse 1 at TA's head. Officer 7 left the cell and Officer 5 came in to assist. Officer 6 was talking to TA to try to rouse him.

6.22 Nurse 1 arrived at the same time as the equipment and took over care. The nurse asked for TA to be turned on to his back for oxygen to be administered and confirmed by radio to Comms that an ambulance was required. At this point, SO 8 left the cell to make more room for the nursing staff.

6.23 SO 8 was aware of a cut to TA's right arm, that he had changed colour, his eyes were protruding and he had urinated.

6.24 She was aware of part of a razor blade, the ligature and the knot attached to the window. She did not know if anything was removed from the cell.

Senior Officer 8's interview in 2017

6.25 Senior Officer 8 recalled a cleaner on the 1s coming and shouting that Officer 7 needed help upstairs and they ran to the cell where Officer 7 was holding TA up.

6.26 She had called Code One (for emergency assistance). Nursing staff arrived quickly. SO 8 recalled sending someone to bring the big medical bag. Once the nursing staff arrived, SO 8 moved out of the cell. 'Victor 1' had arrived in response to the SO's emergency call and she left the incident in his hands. (Victor 1 is the radio call sign for the duty governor in charge of the prison at the time. However, it was a Custodial Manager who came to the cell. It is not clear whether he was Victor 1 or Victor 2.)

Senior Officer 10's serious incident report

6.27 Senior Officer 10 completed a serious incident report form at 17:30 on 1 July 2013. The report gives the time of the incident as 09:33 both on the front cover and in the text but in both instances the time seems to have been altered, possibly from 09:13.

6.28 The report says that at about 09:33 SO 10 was working on the 1s landing when a prisoner told him that staff needed assistance on the 2s. SO 10 ran upstairs and found Officers 5, 6, and 7 and SO 8 in the cell where TA was on the floor, apparently unconscious. Staff were putting him in the recovery position. They told SO 10 that they had found TA suspended from a ligature tied to the bars of the cell window, they had called a Code One, and Hotel 5 (the emergency response nurse) was on her way. As TA was having difficulty

breathing, SO 10 ran to the 1s office and took the emergency oxygen tank back to the cell.

6.29 Nurse 1 arrived and took over care. She asked for the other emergency bag from the 1s office, which SO 10 got for her. Nurse 1 and other healthcare staff were attending to TA when the paramedics arrived and SO 10 then, at their request, collected a large red medical bag from the paramedics' car.

6.30 SO 10 thought that at this point he had left the cell to find the staff who had found TA and to check on their well-being. He left the area and took no further part in the incident.

6.31 SO 10 noticed a cut to TA's right arm, that his skin had changed colour, he had urinated, and his eyes were protruding. He was aware of the ligature tied to the window bars and part of a razor. To the best of his knowledge these were left in the cell, which was unlocked by the prison security department.

6.32 SO 10 was not interviewed during the independent investigation.

Healthcare

6.33 In the next chapter we consider in detail the evidence from healthcare staff and records. But we should note here that Nurse 1, the lead nurse, reported that when she arrived at the cell officers were putting TA into the recovery position, she understood he had suffered some sort of seizure, and she was not aware for seven minutes that he had been cut down from a ligature. Consequently, his neck was not immobilised. The clinical reviewer considers the issue further in Chapter 8.

P-NOMIS Case Note History

6.34 An entry in the electronic case note history by SO 10 at 10:45 on 1 July says that at approximately 09:33 Officers 7 and 6 found TA suspended by a ligature from the bars of his cell. They called a Code One and cut TA down, then placed him in the recovery position. Healthcare staff arrived and commenced CPR until the paramedics took over and TA was subsequently taken to hospital. (This is not quite accurate. The healthcare records indicate that CPR was not indicated and not used.)

The Control Room Incident Log

6.35 An incident log was started by an officer in the Control Room at 09:33 as a result of the Code One call signal from SO 8. The log says that the Head of Healthcare and Nurse 1, respectively on call signals Hotel 4 and Hotel 5, attended at 09:34 along with a Custodial Manager who at 09:35 informed a governor. The reference to the Custodial Manager seems to have been changed. It is not clear whether he was Victor 1 or Victor 2 (Victor 1 is normally a duty governor in charge of the prison at the time and Victor 2 is a duty custodial manager).

6.36 The log records at 09:36 that an ambulance had been called and was on the way. A paramedic entered the prison at 09:40. A second paramedic arrived and entered the prison at 09:52. At 09:53 an ambulance arrived and waited outside the prison, entering the gate at 09:59. There are no further entries recorded until the log says the ambulance left the prison with TA at 10:44.

6.37 Ambulance records say that the first paramedic was at the prison at 09:37 and with the patient at 09:43. A second paramedic arrived in the ambulance and went to the cell to assist, whilst the ambulance

initially remained outside the gate on standby, before entering the prison in order to take TA to hospital.

6.38 The log says the Chaplaincy were informed at 09:37. At 09:41 the Care Team were contacted and a member of the team was on route to C wing.

Interview with the Custodial Manager in 2016

6.39 There was no incident report form from the Custodial Manager. He was interviewed for the investigation in July 2016.

6.40 The Custodial Manager said that he was the Duty Manager at the time of the incident, and attended C wing as Victor 1. He explained that there would always be a designated Duty Governor who was Band 7 or above in rank and a Duty Manager, who was a Band 5 Custodial Manager or might be more junior.

6.41 The Custodial Manager had little recollection of the particular event. He vaguely recalled that the nursing staff were already at the cell when he arrived, and that TA was alive.

6.42 The Custodial Manager said that, as Victor 1, it was his responsibility to see what was happening, isolate the area, arrange for staffing to accompany TA to hospital, liaise with security, and do the necessary paperwork. He said that if it had been a death in custody, he would have arranged for the Care Team to support the staff but that as it wasn't a death it wasn't necessary.

The serious incident review

6.43 As we have noted above, the serious incident review reported that Officer 7 went to TA's cell only once, and on entering the cell found him hanging. The serious incident review says that, on leaving the wing to be released, Prisoner A mentioned to Officer 7 to keep an eye on TA as he had seen specks of blood on the floor and the soap, that Officer 7 immediately went to speak to TA to check he was OK and why he had not gone to work, that Officer 7 arrived at the cell at about 09:30 to find the observation panel covered, and, on entering the cell, found TA suspended from the bars of his window by a twisted sheet with his feet off the floor.

6.44 The review says, at about 09:33, SO 8 radioed Code One to Comms, who radioed for Hotel 4 and 5 and Victor 1 to attend, also informing Victor 2. Healthcare arrived at about 09:34. The review says that Healthcare staff arrived at about 09:34 and requested an ambulance, that paramedics arrived at 09:40 and left the prison with TA for Broomfield hospital at 10:44.

6.45 The review says that after the event;

- An ACCT plan was opened for TA for the vigilance of staff who accompanied him to hospital.

- TA's next of kin were informed and supported through a designated family liaison officer.

- a hot debrief was held with staff and support offered.

I do not know who convened the hot debrief or what instructions were given to staff about writing reports.

6.46 In addition, the serious incident review says that: all ACCTs on the wing were reviewed; TA's cell was padlocked to preserve evidence; Listeners were briefed and offered support; a security report and a record of injury to a prisoner were completed; the observation book and P-Nomis were updated.

6.47 I have no information about the contents of the cell or who was responsible for its securing and release. I have not seen the record of injury (Form 213SH), the entry in the observation book, or the security report.

Observations

6.48 Some of the incident reports place the alarm as being raised at 09:13 and others at 09:33. The incident log started by the Control Room records a Code One alarm called at 09:33 and, on balance, the references to 09:13 seem to be a mistake in the confusion which will often follow an emergency. But the fact that a number of staff seem to have made the same error suggests some conferring over incident reports. It may be understandable that staff involved in a traumatic incident will talk over the events as part of mutual support, but the instructions on the serious incident report form state that it is to be used for recording an officer's personal recollection of incidents. The report may be significant evidence. There should be no collusion.

6.49 The Control Room Log and the serious incident review indicate that the Control Room officer did not call 999 immediately on receipt of the Code One alarm but only when requested by Healthcare. This caused

only two minutes' delay and paramedics were at the scene quickly, but good practice, and current policy, is for an ambulance to be called immediately on receipt of a Code One alarm (now called Code Blue for severe breathing difficulties/chest pain/collapses or Code Red for severe bleeding or burns).

6.50 In reports on the deaths of Chelmsford prisoners that occurred in March and September 2015, the Prisons and Probation Ombudsman expressed concern that in those cases an ambulance had not been called immediately.[1]

6.51 In TA's case, a paramedic was at the prison within four minutes of the Code One (two minutes of the 999 call), and at the scene six minutes later. A second paramedic arrived at the prison Gate in an ambulance 15 minutes after the 999 call and was at the scene two minutes later. The paramedics attended TA with the help of prison healthcare staff.

6.52 National policy on medical emergencies at the time was in PSI 03-2013 Medical Emergency Response Codes. It made clear that in response to a Code Blue or Code Red indicating a serious medical emergency (or Code One, as it was then called at Chelmsford) the communication/control room should automatically call an ambulance and access to the patient should not be delayed. Each action is to be logged as completed.

6.53 The current local policy at Chelmsford on Medical Emergency Response Codes follows the national instruction. Mandatory actions include requiring the Control Room to call for an ambulance

[1] Fatal incident investigation reports by the Prisons and Probation Ombudsman are available on the Ombudsman's website at Fatal Incident reports | Document Types | Prisons & Probation Ombudsman (ppo.gov.uk)

immediately on hearing a Code Blue (for breathing/collapses) or Red (used for blood or burns), and to inform the Gate to prepare for an emergency vehicle, giving them details of the vehicle and crew so that there will be no delay in giving access to the patient.

6.54 SO 10 said in his report that he ran to the 1s office and took the emergency oxygen tank back to the cell. At the request of the nurse, he then went to get another emergency bag from the 1s office. In a report published in February 2013 following the death of a prisoner at Chelmsford in July 2011, the Prisons and Probation Ombudsman noted that the ambubag should have been velcroed to the emergency bag and was now said to be kept inside the emergency bag. The Ombudsman recommended that the Governor satisfy him/herself that all emergency equipment was checked regularly.

6.55 It was disappointing to see no incident report or other record from Officer 7, who was first at the scene, or from the Duty Manager or Duty Governor. Indeed, the Duty Governor has not been identified, other than a reference to a named governor in the Control Room Log. There appears to have been confusion about who was Victor 1, who should have taken charge. A Custodial Manager said that as Duty Manager he was Victor 1. A more senior member of staff ought to have taken overall responsibility for the incident and the required steps to be taken after it.

6.56 We have seen no record of what was in the cell at the time of TA's self-harm, or what became of the contents of the cell, including the ligature. It appears that a razor blade was disposed of in the sharps bin.

6.57 We have not seen any record of the formal commissioning or terms of reference of the serious incident review or what consideration was given to the scope of the review. The review was too narrow, and insufficiently rigorous, to constitute a sufficient investigation.

6.58 The serious incident review says that staff were offered support after the event and we were told that a member of the Care Team came to the wing. We do not agree with the Duty Manager that there is any less need for staff to be supported after an event of this kind than after the death of a prisoner.

6.59 We say more in Chapter 16 about what investigation should take place after a serious incident of self-harm.

Summary

6.60 Wing staff and healthcare staff responded quickly when the alarm was raised. Officer 7 was able to cut the ligature with a 'fishknife' (anti-ligature tool) but with difficulty because of the thickness of the ligature. Other wing staff were on hand to support TA's weight and give assistance. They acted properly in distressing circumstances but in the confusion of the moment the wing staff who cut the ligature and placed TA in the recovery position did not tell the lead nurse TA had ligatured and she was not aware of this for seven minutes. TA's neck was not immobilised to safeguard against cervical spinal injury. (See Chapter 8 – the findings of the clinical review.)

6.61 An officer fetched the oxygen from the office then had to go back for the emergency bag. The Prisons Ombudsman had been told that the ambubag was kept inside the emergency bag. All emergency

equipment should be brought to the scene immediately once a Code Blue is called.

6.62 A 999 call was made only when requested by healthcare staff instead of immediately on receipt of the emergency call.

6.63 A first paramedic arrived within a few minutes. A second paramedic arrived in the ambulance and went to the cell. The ambulance waited outside the prison gate on standby until admitted in order to take TA to hospital.

6.64 Not all the staff involved prepared serious incident reports. Neither the Duty Manager nor the officer who was first on the scene wrote reports.

6.65 The reports refer only to what happened when TA was discovered. One of the officers, as well as the officer who was first on scene, had had significant conversations with TA that morning, but there is no record of these except as reported in the serious incident review without evidence of the source.

6.66 Some of the reports appear to have been prepared jointly as they contain a common error about the time of the incident. Incident reports are important evidence and they should record the unvarnished recollection of the individual member of staff.

6.67 Records of actions taken after the event are not complete. According to TA's records his cell was released at 9:49pm on 4 July but I have seen no information about who secured the cell, about the contents of the cell, who authorised its release and what became of the contents.

6.68 It is not clear who took overall responsibility. A formal investigation should have been commissioned. The serious incident review did not meet the requirements for a formal investigation, which should have been commissioned by a senior manager. We consider this further in Chapters 15 and 16.

CHAPTER SEVEN: WHAT HAPPENED WHEN TA'S SELF-HARM WAS DISCOVERED – EVIDENCE FROM THE HEALTHCARE STAFF AND RECORDS

Healthcare Nurse 1

7.1 Healthcare Nurse 1 was a clinical team leader, employed by Care UK (now called Practice Plus Group), who was the healthcare provider at HMP Chelmsford from March 2012 to April 2015. Nurse 1 was the lead nurse attending to TA after his self-harm on 1 July 2013. Nurse 1 left the prison in 2016 and was not interviewed during my predecessor's investigation. However, because of her central role in attending to TA we interviewed Nurse 1 for the present investigation in 2021.

SystmOne

7.2 Nurse 1's entry in the SystmOne patient record at 11:26 on 1 July 2013 says that TA was found to be hanging from the windows with a ligature made of bed sheets, and that paramedics arrived at 09:40 and requested an ambulance. The entry records TA's condition, that he was cannulated and treated with saline, diazemuls and oxygen, and that at 10:10 the paramedics applied a cervical collar. At one point, TA appeared to be choking and there was some evidence of seizures or cerebral irritation.

Nurse 1's serious incident report

7.3 The SystmOne record says that TA was found to be hanging from the windows with a ligature made of bed sheets. However, in her serious incident report Nurse 1 says that she was not initially aware that TA had been found hanging.

7.4 The report gives the time of the incident as 09:33. It says that when Nurse 1 arrived at the cell TA had just been rolled into the recovery position on the cell floor and that she was not advised for seven minutes that he had just been cut down from hanging. She suspected a seizure as TA was unconscious and incontinent of urine. They turned him on to his back to assess his condition. Nurse 1 felt he had taken an opiate overdose and asked for the drugs box from the centre treatment room. Only then was she informed he had been cut down. Emergency care continued until paramedics arrived and assumed responsibility. TA was dispatched to A & E at 1100. Nurse 1 noted a superficial laceration on TA's right forearm which did not require immediate treatment. All healthcare equipment was removed from the room as clinical waste.

7.5 Nurse 1's serious incident report is dated 3 September 2013. When we spoke to Nurse 1 in 2021, she could not understand why that was. She said that incident reports were always done on the day and was inclined to think the date was a mistake. It was the prison who asked her to write a report. She recalled that on the day of TA's self-harm she had attended the prison staff hot debrief. She told us that healthcare staff were not invited but she had '*invited herself*'. She recalled that two female officers became tearful during the debrief and were sent home. Nurse 1 said she had found the incident very disturbing and asked to go home but her request was refused. There was not a strong healthcare team on the day. Staff were thin on the ground.

7.6 Nurse 1 was also aware that the SO held a debrief in the staff office, to which healthcare were not invited, and she held a debrief with her staff to make sure they were OK. This was attended by the Care UK

Service Manager, who advised her not to include in the SystmOne report that she had not been aware for seven minutes that TA had ligatured, as it sounded accusatory against the officers.

7.7 The clinical reviewer says more in Chapter 8 about the importance of knowing when someone has ligatured so that his/her neck is protected to prevent cervical spinal injury, and for SystmOne records to be complete.

Other healthcare staff

7.8 We have not seen incident reports from any other members of the healthcare staff, but two members of the healthcare team were interviewed during my predecessor's investigation.

Interview with Healthcare Assistant 1 - 2016

7.9 Interviewed in 2016, Healthcare Assistant 1 said she recalled the incident but not in detail. When there is a Code One '*they would normally all run at the same time.'* (Code One was the call for emergency medical response.) She recalled that there were several healthcare staff present. TA was on the floor, unconscious but breathing, and the defibrillator was in place. Her role was inscribing – taking notes – of TA's blood pressure etc.

Interview with Head of Healthcare, Nurse 2 - 2016

7.10 Interviewed in August 2016, Nurse 2, who was the Head of Healthcare, said she did not recall the incident well and had not looked at the notes. She remembered that she and Nurse 1 attended the Code One (emergency call) and she thought Healthcare Assistant 1 was also

there. Nurse 1 assessed TA and asked for an airway. She had the choice of a couple. She chose a good airway and got it inserted and they had a defibrillator. This showed output so they didn't start CPR (cardio-pulmonary resuscitation) but just maintained the airway with oxygen.

The serious incident review by HMP Chelmsford

7.11 In addition to information from the incident reports by prison staff, the incident review notes that the radioed Code One was at approximately 09:33 and that SO 8 asked SO 10 to collect the emergency bags from the office to be ready for the healthcare staff.

7.12 The serious incident review says that healthcare staff arrived at about 09:34 and requested an ambulance. Nurse 1 asked the officers to turn TA on his back. Officers then left the cell to make way for healthcare staff.

7.13 There is no reference to any information obtained from healthcare staff. My copy of the report is not dated.

The healthcare reviews

7.14 There were three healthcare reviews, which we consider further in Chapter 14. The first was a Serious Incident – 7-day report by the Service Manager, Care UK, NHS Mid Essex, dated 24 July. This notes that the officers responding to TA did not make it clear to the responding nurses that the prisoner had hanged himself, and they had placed him in the recovery position. Therefore, his neck had not been immobilised. The report does not say whether this had any adverse effect.

Aftercare for TA

7.15 Entries in the SystmOne record show that Nurse 1 visited TA in hospital a number of times until his release from custody on 20 December 2013 and liaised closely with the hospital and sympathetically with both TA and his mother.

7.16 TA remained in Broomfield Hospital Medium High Dependency Unit until he transferred to Northwick Park Hospital neurological rehabilitation unit on 17 September. In October, he learned to use an eye gaze machine (an E TRAN board) which enabled him to use his eyes to point a mouse to aim at words for communication. On 16 December 2013, TA was transferred to the nursing home where he still lives.

Summary and observations

7.17 The 7-day report by Care UK says that the prison officers did not tell healthcare staff that TA had ligatured until a few minutes after Nurse 1 arrived and that consequently his neck was not immobilised. There is no reference to this in the prison's serious incident review.

7.18 We do not consider it sufficient for the prison and the healthcare provider to commission separate and parallel investigations into incidents of serious self-harm. Findings and recommendations should take account of both aspects considered jointly. We say more about this in Part Six of the report.

7.19 The question of care for people who have been cut down from ligature is examined in Chapter 8 and Chapter 9.

PART FOUR:

THE CLINICAL REVIEW

Independent clinical advice to the investigation was commissioned from, Sandra Morgan MMed Sci, BSc, RGN. Ms Morgan's clinical review and clinical chronology were made available to the Interested Parties in full at Confidential Annex 3 to the draft report.

An outline medical history, areas of concern, key findings, and recommendations, taken from the Clinical Review, are set out in Chapter 8.

CHAPTER EIGHT: OUTLINE MEDICAL HISTORY, AREAS OF CONCERN, KEY FINDINGS, AND RECOMMENDATIONS

Outline medical history - 2008 to 2013

8.1 TA was a prisoner at HMP Chelmsford from 20 June 2013 until 1 July 2013. TA survived an attempt to take his life by ligature and now resides in a care home due to resultant brain injury. TA was born in June 1982. In July 2013 he was 31 years old.

8.2 A summary of his contact with healthcare services as from 2008 is as follows:

8.3 In October 2008, when TA was 26 years old, he took a drug overdose. The GP record states that TA took a mixture of risperidone, tegretol and lamotrigine that had been prescribed for a relative, for epilepsy. TA was admitted to hospital for two days but no further information or follow up to this event is recorded.

8.4 The GP record highlighted that TA had spent much of his childhood in foster care and indicated that during this time he displayed behavioural problems.

8.5 In September 2009, the GP recorded that, during a consultation regarding a gastric problem, TA disclosed that he smoked a lot of cannabis and stated that his mother had told him he had no self-esteem.

8.6 In January 2011, TA attended the GP for a chest infection but also said he had felt depressed for the previous three weeks and that he had poor sleep. He denied any suicidal thoughts or wanting to harm

anyone else. It was noted by the GP that TA had previously taken a drug overdose.

8.7 TA scored quite high on the depression assessment scale, known as PHQ9, and was diagnosed with a depressive disorder. The GP prescribed an antidepressant plus a short course of night sedation. TA was given a depression information leaflet and was asked to return for a review in one week. He was also given a form for the psychotherapy service.

8.8 TA did not make contact with GP services again until November 2012 when he attended due to feeling dizzy. The GP noted that he had been previously diagnosed with depression but no further intervention or investigation was recorded.

8.9 On 10 June 2013, TA's pre-sentence report states that TA disclosed that he had a long-standing problem with depression but that he had not sought help from his GP. The probation service recommended a two-year community order that included supervision to address his mental health issues.

8.10 TA entered custody at HMP Chelmsford on 20 June 2013 sentenced to one year for criminal damage and having a knife in a public place. His victims were his former partner and her new partner. TA was 31 years old and had not been in prison before.

8.11 TA received a reception health screen on arrival at HMP Chelmsford conducted by Nurse 1, a clinical team manager. It was noted that his person escort record indicated that TA had taken an overdose a year ago. On enquiry, TA confirmed that he had taken an overdose but it was a few years ago and stated that he did not mean to kill himself.

8.12 TA stated that he had been diagnosed with asthma but denied any history of mental illness. Nurse 1 recorded that he maintained good eye contact, was orientated and denied any thoughts of self-harm or suicide. He disclosed previous cannabis use but said he had not used any drugs in the last month and had not taken any alcohol in the last week. He was deemed fit for normal location, work, and any cell occupancy.

8.13 He could not recall his GP details at this first health screen.

8.14 On 23 June 2013, TA made an application to be seen by the healthcare team and was told he would be added to the waiting list. There is no further information in the clinical record to indicate what this appointment was for or the clinician he was requesting to see, however this may have been for a dental appointment.

8.15 TA had no further contact with healthcare until 09:33 on 1 July 2013 when he was found hanging in his cell. TA had made a ligature from his bed sheets using the cell window. TA was cut down by wing staff. Nurse 1, who was the emergency response nurse that day and responded to the emergency code alarm, found him to be unconscious but with a pulse and laboured breathing.

8.16 Oxygen was immediately administered and a defibrillator attached. The paramedics arrived at 09.40hrs and once TA was stabilised, they were able to transfer him by ambulance to Broomfield Hospital.

8.17 TA was admitted to the intensive care unit and placed initially into a medically induced coma for four days to rest his brain. However, he was diagnosed with post-hanging severe hypoxic brain injury. The intensive care unit also noted that he had a fresh incision wound to his

left forearm that indicated that he had self-harmed prior to his hanging attempt.

8.18 TA was placed onto a medium dependency care unit on 8 July 2013, with severe cognitive, communicative and physical problems. He had weakness in all limbs and required full care.

8.19 On 17 September 2013, TA was transferred to a neurological rehabilitation unit and then onto a care home on 16 December 2013. TA was released from custody at this point in time.

Key findings and issues of concern:

Mental health

8.20 TA took a drug overdose in 2008 when he was 26 years old, five years before he entered custody at HMP Chelmsford. This incident was documented in the GP notes but there is little information to understand the cause of him wanting to self-harm. There appeared to be no formal follow up to this incident to check his well-being.

8.21 TA was formally diagnosed with a depressive order by his GP in January 2011, when he was 28 years old. The GP prescribed medication to treat his depression, gave written information, made a direct referral to the psychotherapy service and asked TA to return for review in one week. TA chose not to engage with the GP again and his depression was not actively followed up in the community.

8.22 Prior to TA's appearance in court the probation service recorded in his pre-sentence report that he disclosed a long-standing problem with depression.

8.23 During TA's first reception screen on entering HMP Chelmsford, aged 31 years old, in June 2013, it was noted from his person escort record (PER) form that TA had taken an overdose *'12 months ago'*. The PER contains information from the court custody and escort staff about risk.

8.24 The reception nurse saw this information and on further enquiry TA reassured her that this occurred a few years ago and he did not intend to kill himself. As there is no other information available it is presumed that he was referring to the incident in 2008.

8.25 On enquiry about his mental health, TA denied any history of mental illness. He could not remember his GP details during the first health screen so the reception nurse was unable to request his community medical summary. The reception nurse did not make reference to information contained within the pre-sentence report regarding his mental health issues and probably was unlikely to have had sight of this information.

8.26 At Interview, Nurse 1 confirmed that her initial meeting with TA was unremarkable and no immediate concerns were raised. Nurse 1 stated that her understanding at the time was that TA had not intended to harm himself in 2008 and that the overdose was '*a cry for help'* but she didn't know why.

Health screening and risk assessment

8.27 When he arrived at HMP Chelmsford, TA received an initial health screen to identify immediate health needs and to ensure first night safe custody. He did not have a further in-depth health assessment during the following 10 days that he was in custody. It is recorded in

the notes that TA requested a healthcare appointment three days after he arrived at HMP Chelmsford but there is no information in the clinical record to support the reason for this request. It is thought that this relates to a dental appointment.

8.28 In 2013 the national guidance for prison health screening was included in Prison Service Instruction PSI 74-2011 'Early Days in Custody'. This guidance covered from December 2011 to December 2015 and states that immediate health needs are dealt with to ensure first night safe custody. The PSI also includes reference to PS0 3050 (issue 245 in 2006) *'Continuity of healthcare for prisoners'* and in section 2.12 it highlights that a prisoner should receive a second more in depth health screen within the first week. The National Institute for Clinical Excellence (NICE) has now produced quality standards for physical health of people in prisons in September 2017 - second health screen within the first week is quality standard 2.

8.29 PSI 74-2011 also highlights the importance of good risk assessment that is based on medical history and social circumstances as well as the person's presentation. Even though TA denied any thoughts of self-harm when asked during his reception screen he had significant risk factors of self-harm which appeared not to be fully addressed or followed up. These risk factors being:

- History of mental disorder
- History of self-harm
- Crime against a partner
- First time in prison

8.30 The triangulation of direct questioning, self-harm assessment and the timely acquisition of community medical records enables the prison

healthcare team to provide optimum safe custody. Receipt of the community GP records was not straightforward at the time of this incident, as it relied upon direct contact with the GP practice. This has now been rectified by the ability for health professionals to access the electronic NHS Summary Care Record system.

8.31 Nurse 1 confirmed at interview that HMP Chelmsford did not routinely perform second health screens in 2013.

Self-harm

8.32 It was reported within the hospital discharge letter that TA had a fresh incision wound to his left forearm that was thought to have happened prior to his attempt to ligature. There is no reference to this incident within the prison medical records.

8.33 Nurse 1 confirmed at interview that she did not recall seeing any lacerations on TA's arms and did not remember why this was not recorded in the clinical record. She assumed they must have been superficial lacerations. (Nurse 1's serious incident report says TA had a superficial laceration to his right forearm.)

Emergency response

8.34 Code One (Blue) was called at 09.33 which Nurse 1 documents in the clinical record of her attendance. Within the statement made by Nurse 1 post-incident and in the NHS 7-day report, it was documented that it was seven minutes before the prison officers told Nurse 1 that TA had been cut down from a ligature. There is no reference to this important information in the clinical record.

8.35 Nurse 1 documented that she administered oxygen and inserted a breathing tube to maintain airway patency before the paramedics arrived. TA's blood oxygen levels were recorded at the normal value of 98%.

8.36 Nurse 1 documented that the paramedics arrived at 09.40 and applied a cervical collar at 10:10 to TA to immobilise his neck; that at 10:15 the paramedics used a manual suction device as TA was choking; and that there was some evidence of possible seizures or cerebral irritation.

8.37 It appears that TA was moved twice without neck immobilisation: on cutting down and then being placed into the recovery position.

8.38 At interview, Nurse 1 confirmed that she and another nurse responded to the Code One emergency call for TA and requested that the prison staff picked up the emergency bag from the Senior Officer's wing office. Nurse 1 explained that every wing had an emergency bag which contained basic emergency equipment including a defibrillator and oxygen but did not include a cervical collar.

8.39 Nurse 1 stated, at interview, that when she arrived at TA's cell the prison officers had placed TA into the recovery position and told her that they thought he had had a 'fit'. She confirmed that she was eventually told, in a passing comment by the officers, that they had in fact cut TA down from a ligature.

8.40 Nurse 1 said that she had not seen any marks around TA's neck indicating ligature and it was not obvious that he had hung himself. She said she had been involved in similar incidents and had seen such marks caused by ligature.

8.41 Nurse 1 stated that had she known when she went into TA's cell that he had hung himself she would have ensured that his neck was immobilised until the ambulance crew took over. She confirmed that in this situation the recovery position should be avoided if at all possible, to maintain immobilisation of the neck. However, if this is required to maintain the airway, when a patient vomits, then it must be done in a controlled way with correct and supportive head tilt.

8.42 In discussion, it was agreed that the use of a rigid cervical collar is not recommended, as the correct fitting of a rigid collar is vital not to cause more damage, but a soft collar, blocks, or manual techniques, should be used.

8.43 Nurse 1 stated that she had not documented the seven-minute delay of not knowing that TA had been cut down from ligature, on the advice of a senior non-clinical healthcare manager. The reason she was told was for it not to sound accusatory against the prison officers. Nurse 1 could not recall if she had told her senior clinical manager that she had been asked to do this but said that she felt she had to do this even though she knew it was not right to miss out such important information in the clinical record.

East of England Ambulance Service patient care record

8.44 It is documented that the initial call from the prison was received by the ambulance service at 09:35. The patient status was recorded as 'unconscious' and given a RED1 category which is the most urgent.

8.45 A solo paramedic was first to arrive at the prison at 09.37 and was with TA within eight minutes of the initial call to the ambulance service, at 09.43.

8.46 The paramedic notes indicate that on arrival the paramedic was informed by staff that TA had been cut down from a ligature. The paramedic notes state the following observations:

- TA had 'marks around the neck'.
- TA cervical spine (neck) had to be compromised to allow TA to vomit at one point but no loss of sensation was observed
- TA was severely combative and agitated cerebrally

8.47 A second ambulance crew arrived at the scene at 09:45 and were with TA at 09:51 to transport him to hospital. Other standby ambulance crews were at scene at 09:38 and 09:50 but did not enter the prison.

Best practice guidance for the management of ligature

8.48 PSO 2700 Suicide and Self-harm Prevention, published in 2003, lists guidance for cutting down ligatures in Annex C. This does not indicate that the patient's neck should be immobilised and does say to put the patient into the recovery position if breathing. However, Annex D states that a hard cervical collar should be part of the emergency equipment bag. PSI 64-2011 replaced this PSO from April 2012 to January 2016 but does not appear to include such guidance.

8.49 Evidence indicates that most non-judicial hangings do not cause cervical spine injury (c.2%). Gubbins 2016[1] recommends that pre-hospital care of the unconscious hanging victim should be:

- *Reduce patients weight from the neck if possible (by supporting manually)*

[1] Gubbins, K, MSc, PGCert, BSc, FHEA (2016) The Hanging/Hanged Patient and Relevance to Pre-Hospital Care, *Journal of Paramedic Practice,* Vol. 8 Issue 6, pp290-293

- *Maintain cervical spine stability and consider the use of a cervical collar to support head if available quickly (to avoid creating a cervical spine injury by loss of head control)*
- *Cut off the ligature or suspending cord*
- *Maintain head control and lower the patient to the floor or trolley*
- *Consider the needs for cervical spine immobilisation – is the patient likely to have damaged the cervical spine based upon the circumstances (i.e. a patient who has hanged themselves by dropping from a loft hatch is much more likely than one who has tied the ligature to a curtain rail and then knelt down).*
- *Check and manage airway, breathing and circulation – consider early use of intubation in case of airway swelling due to trauma*
- *Supply ventilations and cardiac compressions as necessary (apply current life support guidelines)*
- *Consider if the use of a cervical collar could aggravate any raised intracranial pressure.*
- *If cervical spine injury is likely, consider the use of sandbags/head blocks without the use of a collar*

8.50 It appears that there is little guidance for prison officers and prison healthcare staff in the correct management of hanging/hanged patients especially when the patient is still alive and does not require resuscitation.

8.51 It also appears that emergency equipment accessed when Code Blue is called does not always include a soft cervical collar for neck immobilisation, and, if it does, there is no consistent guidance of how to immobilise a neck correctly.

Serious Incident process

8.52 There is evidence of an inadequate response by both the healthcare provider and the commissioners, at the time, to address the incident sufficiently. There is no evidence of shared learning from the incident.

8.53 Nurse 1 completed a serious incident statement which is dated two months after the incident. Nurse 1 did not document in the SystmOne record that there had been a seven-minute delay after her arrival on the scene before she was told that TA had been cut down.

8.54 At interview, Nurse 1 stated that she was puzzled by the date of the statement and could not recall why it was dated 3 September 2013 as incident reports were always done on the same day. She remembered that the statement she supplied was requested by the prison. Nurse 1 confirmed that her statement contained her knowledge of the seven-minute delay and, as requested by the non-clinical healthcare manager, this was not in the clinical record.

8.55 Nurse 1 confirmed that despite being the emergency response nurse, she had not been involved in the Root Cause Analysis.

Diagnosis for TA

8.56 TA was not diagnosed with a cervical injury, caused by ligature, but did suffer severe hypoxic brain injury from strangulation resulting in his current physical status.

8.57 A study in 2015[1] included the following:

[1] Heinz, U.E., Rollnik, J.D. Outcome and prognosis of hypoxic brain damage patients undergoing neurological early rehabilitation. *BMC Res Notes* 8, 243 (2015).

'Hypoxic brain damage, also called hypoxic–ischemic encephalopathy, is a severe consequence of global cerebral ischemia of hanging. Due to improvement of pre-hospital emergency care, the prevalence of patients surviving resuscitation and suffering from severe hypoxic brain damage is increasing.

Results:

- *75.3% had a poor outcome*
- *40.9% patients were discharged to a nursing care facility*
- *22.6% to subsequent rehabilitation'*

8.58 As with other studies that focus on neurological rehabilitation, functional status on admission turned out to be a strong predictor of outcome from hypoxic brain damage.

8.59 At interview, Nurse 1 explained that the incident had been a very upsetting case within her career as she thought that by not immobilising TA's neck from the point of cut down, she had exacerbated his injury. The clinical reviewer was able to reassure her, after all this time, that this was not the case.

8.60 Nurse 1 explained that she kept in contact with TA and his family until she was told by a healthcare manager that she had got too involved and she needed to back off. Nurse 1 found this difficult as it compromised her as a caring professional.

Conclusion

8.61 TA entered custody with many risk factors that attribute to potential self-harm but in his short time in custody his physical and mental

health was not fully assessed. This was not equivalent to standards of best practice in the community setting.

8.62 TA had been diagnosed and treated for depression in the community and it is accepted that he did not disclose this information during his reception health screen. However, the obtaining of his GP summary record and sight of the pre-sentence report would have provided written evidence of his past medical history.

8.63 Receipt of the community GP records was not straightforward at the time of this incident, as it relied upon direct contact with the GP practice. This has now been rectified by the ability for health professionals to access the electronic NHS Summary Care Record system.

8.64 TA should have received a second more in-depth physical health screen and a referral to the prison mental health team for further assessment of his self-harm risk factors.

8.65 The review of this case has indicated that specific HMPPS and NHSE/I guidance for the management of ligature cut down is required.

8.66 The well-being of all staff after such an incident is paramount to decrease the potential of post-traumatic stress when it is not dealt with in a supportive manner at the time.

8.67 Clinicians must adhere to their professional code of conduct to ensure that all clinical notes are factual and contemporaneous.

Recommendations:

Second healthcare screening

8.68 It is accepted that this review refers to healthcare practice in 2013 but it would seem prudent that the current Head of Healthcare at HMP Chelmsford should ensure that health screening within early days of custody conforms to the current HMPPS and NHS guidance to ensure safe custody. (Chapter 12 of this report outlines current policies. In response to the draft of this report, CRG Medical have confirmed that secondary healthcare screening takes place, normally on a newly arrived prisoner's second day at the prison.)

Post-incident support

8.69 The Head of Healthcare at HMP Chelmsford should ensure that healthcare staff now receive good, structured support after any traumatic incident.

Guidance and equipment for ligature cutdown

8.70 HMPPS and NHSE/I need to consider specific guidance for the process of ligature cut down to ensure optimum management of the unconscious patient. This will include clarification of whether emergency bags should contain a cervical collar as a standard item.

PART FIVE:

POLICIES AND PROCEDURES - PREVENTING SELF-HARM AND SUPPORTING NEW PRISONERS

I am asked to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved.

TA was not identified as being currently at risk of suicide or self-harm when he was admitted to HMP Chelmsford, or at any time in the 11 days until the morning that he tried to hang himself.

This part of the report explores whether there are lessons to be learned about recognising risk, sharing information, and preventing suicidal distress, especially among new prisoners during their first days in custody. We also consider the training and instructions given to prison staff about first aid to a prisoner who has ligatured.

We examine national and local policies at the time and how they have changed since then, with particular reference to what we know of TA's time in prison. National policies set out mandatory requirements and guidance. Local policies may incorporate national policies but may include additional instructions about how the policy is to be applied in the particular local establishment.

CHAPTER NINE: SUICIDE AND SELF-HARM IN PRISON - OVERVIEW AND NATIONAL POLICIES

Vulnerability of the prison population

9.1. A study covering the years 2008 to 2016 found that adult male prisoners are 3.7 times more likely to die by suicide than adult men in the general population (Office for National Statistics: *Drug Related deaths and suicide in prison custody in England and Wales*: 2008 to 2016).

9.2. The disparity might be less stark if the cohort of prisoners was compared with a cohort of men in the community with similar characteristics. Prisoners are disproportionately drawn from a vulnerable section of the population. For example, Prison Service Instruction PSI 64-2011 says that the majority of prisoners have one or more mental illnesses (paragraph 17). Prison Service policies and operations must take account of the vulnerability of the prison population.

Powerlessness

9.3. As well as vulnerabilities originating in prisoners' lives or clinical conditions, there are factors particular to the experience of being in prison. Prisoners' autonomy and choice is severely curtailed, they may feel unsafe, and they are deprived of access to family, friends and other sources of distraction or support that they might rely on in the community. Feelings of powerlessness can exacerbate despair. Seemingly trivial issues may acquire exaggerated importance where there is no escape.

The prison environment

9.4. The physical environment of the prison may impact on a prisoner's sense of hope and well-being. In HMIP's inspection of HMP Chelmsford in 2016, C wing is mentioned especially as having poor and overcrowded accommodation:

'The quality of accommodation varied widely, from some sub-standard cells on the old Victorian wings (especially C wing) to the excellent accommodation provided on G wing. While most of the cells were reasonably clean and well equipped, some, even on the newer wings (E and F), were dirty, ill equipped, lacking lockers and cabinets, and contained extensive and offensive graffiti.

Many cells that were designed for one continued to be used to house two prisoners and were cramped. This was exacerbated by poorly screened toilets located close to the bunk beds. The offensive display policy was well publicised but there was little adherence to it on any of the wings and breaches went unchallenged by wing staff.

Communal showers on most of the older wings were constantly damp, in poor condition and lacked privacy screening.'

9.5. HMIP's report of an inspection in 2019 says that the prison had made progress in improving living conditions. Major investment in refurbishments on some of the older wings had delivered much needed improvement to the conditions of many showers, toilets and cells. The prison was less overcrowded but this was because of refurbishment works and the population was expected to increase again, which in the Inspectorate's view would undermine the prison's efforts to provide safe and decent living conditions.

9.6. In the 2019-20 Annual Report based on inspections across the prison estate, HMIP speaks of the importance of the regime: of time out of cell, purposeful activity, and opportunities to progression to rehabilitation, for prisoners' mental health and well-being. HMIP also urges systematic and energetic enquiry into the reasons for self-harm among prisoners, saying that it is *'often measured but not really understood.'* (HM Chief Inspector of Prisons, *Annual Report 2019-2020*).

Relationships with other prisoners

9.7. Relationships with other prisoners may affect a prisoner's state of mind. The cell-sharing risk assessment is designed to reduce the most significant risk from cellmates, but staff need to be vigilant, and sensitive to signs of fear or distress. The peer support provided by prisoners who act as Insiders and Listeners is valuable. It is right that the Safer Custody function in prison encompasses violence reduction as well as prevention of suicide and self-harm.

Relationships with staff

9.8. Incarceration places a special responsibility on the authorities to identify and mitigate the distress that can lead to despair and self-destructive behaviour. Constructive relationships between staff and prisoners are a key protective factor. This requires a culture among staff of active curiosity and energetic engagement. Prison Service policies and the current local policy at Chelmsford emphasise the importance of positive staff-prisoner relationships.

9.9. Prison Service Order PSO 2700 said:

'Prisoners emphasise the value of having a member of staff listen to them and take their problems seriously. Interviews with suicidal prisoners confirm that staff who take time to help them are greatly appreciated. In particular, several prisoners who had attempted suicide talked about how they wanted staff to talk to them and engage with them, not just to observe them. This is one of the areas of work that the key worker or personal officer are so important ...' (paragraph 2.2.1, 2007 edition)

This Prison Service Order is no longer in force but the advice remains good.

National policies

9.10. Over many years, the Prison Service has developed strategies to prevent suicide and self-harm, drawing on the work of, among others, the Inspectorate of Prisons, the Independent Advisory Panel on Deaths in Custody, coroners' recommendations, the reports and recommendations of the Prisons and Probation Ombudsman, academic research, internal inquiries, the experience of Prison Service staff, and research reports by third sector bodies, including the Samaritans, Inquest and the Prison Reform Trust.

Prison Service Instruction PSI 64-2011 – Management of prisoners at risk of harm to self, to others, and from others

9.11. Prison Service Instruction PSI 64-2011 sets out at length the current Prison Service strategy relating to self-harm and violence in prisons. It is a public document available on the Prison Service website.

9.12. The PSI is 70 pages long. It aims to:

- Identify, manage and support prisoners who are at risk of harm to self, others, and from others.
- Reduce incidents of self-harm and deaths in custody.
- Manage and reduce violence, deal effectively with perpetrators and support victims.
- Support effective multi-disciplinary case management and sharing of information to reduce incidents of harm.
- Ensure staff, prisoners and visitors affected by incidents of harm are supported appropriately.
- Ensure appropriate responses and investigations to incidents, which promote learning to prevent future occurrences and improve local delivery of safer custody services.

9.13. The PSI includes, among other topics, information about common mental illnesses and learning disabilities, management of prisoners who are terminally or seriously ill, management of prisoners who refuse food or fluids, family engagement to support prisoners at risk of self-harm, actions following a death in custody, including the requirements of the police and the Coroner, liaising with families following a death in custody, payment of funeral expenses, inquest procedures.

9.14. PSI 64-2011 emphasises the importance of positive staff-prisoner relationships:

'The identification and management of prisoners at risk of suicide and/or self-harm is everyone's responsibility. Good staff/prisoner relationships are fundamental to the management of safe and decent

prisons. They are integral to the reduction and management of self-harm and violence.' (Paragraph 25 page 8).

9.15. Chapter 1 on Roles and Responsibilities provides, as mandatory requirements, that all staff in contact with prisoners must be trained in safer custody requirements. The content and frequency of refresher training is for local discretion.

9.16. Chapter 1, page 10, says that all staff who receive information, or observe behaviour, that indicates a change in risk must communicate their concerns immediately to a manager *'and/or consider opening an ACCT plan and make a record in an appropriate source.'*

ACCT - Assessment, Care in Custody and Teamwork

9.17. Where prisoners are identified as at particular risk of suicide or self-harm, a key element in the national policy for reducing suicide and self-harm is the ACCT process. ACCT stands for Assessment, Care in Custody and Teamwork. The process starts with being alert to signs of risk:

'Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form.' (Chapter 5 page 26)

9.18. The Concern and Keep Safe Form requires the staff member to indicate the reason for concern, such as recent events, behaviour or information received, and what the person themselves says about their situation. An immediate action plan must be completed by the unit manager within an hour of the form being raised. This is followed

by an interview with a trained assessor and a multi-disciplinary case review. Unless it is concluded that there is no continuing risk, the review leads to a care plan with *'multi-disciplinary case management and sharing of information to reduce incidents of harm'*.

9.19. Staff at Chelmsford did not consider it necessary to open an ACCT plan for TA. In the following chapters we examine the local guidance to staff at Chelmsford, at the time, and now, for assessing whether prisoners are at risk of suicide/self-harm, for supporting prisoners especially during early days in custody, and for sharing information.

Care of prisoners who have ligatured

9.20. PSI 64-2011 replaced and cancelled PSO 2700 on Suicide and Self-Harm, PSO 2710 Follow up to Deaths in Custody and PSO 2750 on Violence Reduction. We note that the original version of PSO 2700 published in 2003 contained guidance on cutting down ligatures (at Annex C). It does not indicate that the patient's neck should be immobilised and it does say to put the patient in the recovery position. Annex D lists emergency equipment to be held in residential areas and in the healthcare centre. The specialist equipment to be held in healthcare included rigid collars.

9.21. PSO 2710 on follow-up to deaths in custody gave guidance on what staff should do in the case of an apparent death. It emphasises the need for prompt assistance and refers to the emergency first aid procedures described in Annex C to PSO 2700.

9.22. PSI 64-2011, which replaced PSO 2700, does not contain advice for first on scene officers finding a prisoner hanging. The PSI requires

emergency response kits to be available but content is to be determined locally in consultation with the local healthcare provider.

9.23. Our clinical review has recommended that HMPPS and NHSE/I consider specific guidance for the process of ligature cutdown to ensure optimum management of the unconscious patient and that this should include clarification of whether emergency bags should contain a cervical collar as a standard item.

9.24. In response to the draft of this report NHS England say that they acknowledge the finding but do not think it appropriate for them to issue instructions or guidance about the contents of emergency bags, and that it is for the local healthcare team to satisfy themselves that the contents of emergency bags are appropriate for them to deliver the services they are commissioned to provide. They point to guidance from the Resuscitation Council that says that organisations must undertake a risk assessment to determine what resources are required given their local circumstances.

9.25. In respect of the care to be given when people are discovered having attempted to ligature, NHS England says the priority is to preserve life and restart breathing and circulation. The application of a cervical collar would be appropriate after breathing and circulation has been established and following completion of attempts to resuscitate.

9.26. It is for NHS, as commissioner, to say whether the professional judgment of local providers is sufficient safeguard to ensure that healthcare equipment and training guarantees optimum care to prisoners who have ligatured. But it remains our firm view that in the particular circumstances of a prison, all prison and healthcare staff who may be called on as first on scene or to give assistance where a prisoner has ligatured need to be aware of the need to protect the

patient's neck, moving it as little as possible consistent with the priority of resuscitation, and it seems to us unarguable that emergency bags should contain protective equipment to facilitate this.

9.27. One of the officers interviewed was asked what training he had received in first aid and what to do on finding a prisoner who had ligatured. The officer told us that that first aid was part of his initial training some 20 years ago but he had not received any refresher training since then. He was aware that refresher courses were put on but he did not know which staff attended. He said he had not received any training in what to do if first on scene in an emergency. He thought that would be valuable, and should include Officer Support Grade staff, who were often on duty overnight.

Summary and observations

9.28. Suicide and self-harm are more prevalent among male prisoners than in the male population as a whole. Most prisoners suffer from one or more mental illnesses. Vulnerability can be exacerbated by prison conditions and features of prison life. Relationships are a significant factor. They may be protective or harmful.

9.29. The Prison Service has developed policy and practices to identify risk and support prisoners identified as at risk of self-harm. But this is not an isolated category. A culture of curiosity and energetic engagement with all prisoners is necessary both to identify those who may be at risk and to provide support as part of the routine practice of the prison.

9.30. The current PSI about self-harm contains much useful information but it is long, and broad in scope. Some, but not all, the information it

contains is of immediate relevance to the everyday practice of wing staff in daily contact with prisoners. Some of the information may be better suited to training, though there is useful reference material for staff wanting to refresh their understanding, for example of mental illnesses, and the topics in each chapter are well signposted. We understand that the PSI sets the framework for local policies and that local managers must ensure that local arrangements deliver the national requirements. However, overall, it is not clear to us exactly how, when, and by whom, HMPPS expects the document to be used, and how the information it contains is delivered to the staff who have most contact with prisoners.

113. Unlike PSO 2700, which it replaced, PSI 64-2011 does not contain instructions about emergency assistance to be given for staff who are first on scene. We ask the Governor of HMP Chelmsford and HMPPS what arrangements are in place to ensure that all prison staff who may be first on scene in a medical emergency are adequately trained to provide immediate care. We endorse the recommendation in the clinical review that HMPPS and NHSE/I consider how to ensure that all prison and prison healthcare staff are aware of the measures to be taken to ensure optimum care of a person who has ligatured, and that a soft cervical collar should be a standard item in emergency equipment in prisons.

9.31. There is insufficient recognition in PSI 64-2011 that it will not always be clear whether or not an act of serious self-harm will prove fatal, so the measures for preservation of evidence, critical de-brief, completion of incident reports, and support for staff and prisoners affected, should be activated. We refer in Chapter 16 of this report to PSI 15-2014 which is about investigations and learning after an

incident of serious self-harm or serious assault but there appears to be no signpost to this PSI in PSI 64-2011.

CHAPTER TEN: INDIVIDUAL RISK FACTORS FOR SUICIDE AND SELF-HARM: COULD TA HAVE BEEN SEEN TO BE AT RISK?

Identifying prisoners at risk: risk factors for suicide and self-harm

10.1 The Prison Service policy on safer custody, PSI 64-2011, recognises that suicide and self-harm are linked to a combination of multiple factors, some related to the individual, their history, their mental health and well-being, and some related to their immediate circumstances and feelings.

10.2 Chapter 3 of PSI 64-2011 gives an analysis of risk and triggers that may increase a prisoner's likelihood of self-harm. It distinguishes between static factors that are unchangeable and relate to a person's life experiences, dynamic factors that change over time, which may be chronic and subject to change only slowly, and acute factors (triggers) that may change rapidly.

10.3 Risk factors for suicide are listed as follows:

Demographic factors

- Low socioeconomic status
- Unmarried, separated, widowed, recently divorced

Background history

- Deliberate self-harm (especially with high suicide intent)
- Childhood adversity
- Family history of suicide
- Family history of mental illness
- Spouse/partner with terminal illness

Clinical history

- Mental illness diagnosis (eg depression, bipolar disorder, schizophrenia)
- Mental health in-reach
- Personality disorder diagnosis
- Physical illness, especially chronic conditions and/or those associated with pain and functional impairment
- Recent contact with psychiatric services
- Recent discharge from psychiatric in-patient facility

Psychological and psychosocial factors

- Hopelessness
- Impulsiveness
- Low self-esteem
- Life event
- Relationship instability
- Lack of social support

Current 'context'

- Early days in custody and following each transfer
- Suicidal ideation
- Suicide plans
- Availability of means
- Lethality of means
- Offence - particularly those charged with violence against another person, especially against family members or partners, and arson

Triggers that may increase risk are identified as:

- Change in status

- Further charges
- Anniversaries and Key Dates
- Court Appearances, especially start of trial and sentencing
- Bereavement of family or close friends, including exposure to suicide
- Substance Misuse or Detoxification, including alcohol
- Segregation
- Family/Relationship Breakdown
- Transfers between prisons, even progressive moves may increase risk in the early days of a new prison
- Foreign National Prisoners, who are, or are about to be, detained under immigration powers and those close to deportation
- Licence Recall

Could TA have been seen to be at risk?

10.4 There were risk factors that prison staff could reasonably have known about in TA's first days at Chelmsford: he was newly sentenced; he was subject to harassment procedures for an offence associated with relationship breakdown with a former intimate partner; he disclosed an overdose but from some years ago and is said to have minimised the significance of it; he disclosed some history of depression but had not sought psychiatric help. The OASys assessment indicated childhood adversity but this would not have been seen by staff in reception or at his first night interview. There was little that would clearly mark TA out as significantly more at risk than many other prisoners, but there was some cause for concern.

First time in prison

10.5 In addition to the factors listed in PSI 64-2011, the Reception and First Night checklist in PSI 74-2011 Early Days in Custody includes first time in prison as a risk factor for suicide. TA had not been in prison before and the offender manager had recommended a non-custodial sentence. It was seven months since TA had been charged. He had been at liberty on bail. According to the pre-sentence report, he claimed to have moved on and to be in a new relationship. The prison sentence and his first experience of prison may well have been a shock.

10.6 To the prison staff, TA was an unknown quantity. Because it was his first time in prison and he disclosed that he had self-harmed in the past, it would not be unreasonable to consider TA to be at increased risk, until a proper understanding could be built up over time about TA as an individual and his needs.

10.7 It cannot be assumed that a new prisoner, let alone a first-timer, will immediately speak frankly about their feelings or their history on admission to prison. A new prisoner is likely to be stressed, wary and unsure how prison will affect them. They may not be confident to disclose full details of past self-harming behaviour and may minimize it or give a distorted view. There is a case to be made that any adult in prison for the first time who discloses that they have self-harmed in the past should have some higher degree of attention for a period. We say more about this in Chapter 12 about supporting prisoners during early days in custody.

Risk assessment is a dynamic process

10.8 Whilst there was some cause for concern from TA's circumstances and what he disclosed, lessons to be learned from TA's self-harm may relate to general practices and the culture of the prison, more than to the care of prisoners who have been identified as at special risk, and hence to the importance of staff vigilance and positive engagement, including with prisoners who remain withdrawn, and do not readily attract the attention of staff.

10.9 PSI 75-2011, about Residential Services, emphasises the importance of good staff-prisoner relationships to the successful management of a decent prison, including the reduction of self-harm and violence (paragraph 2.1). It states, at paragraph 2.3, that residential staff play a key role in spotting signs of distress, anxiety or anger which might lead to self-harm.

10.10 Risk assessment is not a one-off event completed through reception screening. It must be a dynamic process, informed by staff observations of a prisoner's behaviour and interactions during daily activities so that the best information is available to build up an understanding. Significant incidents should be noted and shared with colleagues.

Warning signs

10.11 We do not know what triggered TA's self-harm. It is likely that there were multiple factors, at least some of which were extraneous to the prison. The interview with TA's cellmate indicates that he continued to be distressed about the relationship with his former partner.

10.12 However, among the little we know about TA's time at Chelmsford, there were missed opportunities where a more proactive approach and/or sharing of information with colleagues might have made a difference:

- There is no information in the records or for the benefit of colleagues responsible for his management on C wing about how the senior officer on the induction wing followed up the alert from Safer Custody or what TA told him about his state of mind.

- There was no second healthcare assessment as should have occurred during TA's first week in prison (see paragraphs 8.27 to 8.28 and 12.14 to 12.19)

- There is no indication that TA was allocated a personal officer.

- TA was apparently without tobacco soon after he moved to C wing. This might have indicated debt or bullying. There was no record of the incident.

- An officer told the investigation that TA was quiet and stayed in his cell.

- There is no record of the cellmate's complaint, made in front of other prisoners, about TA's personal hygiene. This indicated a poor relationship with the cellmate and might also have indicated a reluctance to use the showers, possibly through fear of other prisoners.

- An officer was made aware of possible self-harm by cutting not long before TA ligatured but he did not ask to see the injury that

caused the bleeding and intended to come back later. He did not immediately share the information with colleagues.

- The same officer and others were aware that TA was refusing to go to work that morning.

Summary and observations

10.13 TA entered prison with some known risk factors. It was not unreasonable that reception and first night staff did not think it was necessary immediately to open an ACCT, but there was reason for vigilance and support. There is no record of what action was taken as a result of the self-harm warning. TA was not allocated a personal officer. A series of incidents occurred that raise questions about his welfare but they were not recorded or investigated at the time.

10.14 Chapter 5 of PSI 64-2011 is unequivocal that any member of staff who receives information or observes behaviour that may indicate self-harm risk must start a protection plan by completing a Concern and Keep Safe Form. Chapter 1 of PSI 64-2011 says that *either* the ACCT process must be started *or* a manager informed. This appears to be an inconsistency. We think it would be good practice to require that a supervising officer should be alerted immediately to evidence indicating the possibility of self-harm in a prisoner not previously thought to be at risk. Among other benefits, this would enable the supervisor to deploy the staff on the wing so as to release the reporting officer from other duties to follow up the immediate concern.

10.15 Much has changed at Chelmsford prison since 2013. There is now an ambitious local policy on suicide and self-harm. It recognises the

importance of rigorous risk assessment, of sharing information, of the staff taking an active interest in prisoners and modelling pro-social thinking and behaviour. Staff are being trained in the skills required to apply the new policies. In the next chapters we examine the changes in policy and practice on risk assessment, information sharing and supporting new prisoners during their first days in custody, and we make some recommendations for consideration by HMP Chelmsford and HMPPS.

CHAPTER ELEVEN: SAFER CUSTODY AT HMP CHELMSFORD: CHANGES IN POLICY AND PRACTICE SINCE 2013

Local policies from 2013 – recommendations by the Prisons and Probation Ombudsman (PPO)

11.1 A report by the Prisons Ombudsman on a prisoner's death in November 2013, says that Chelmsford did not have a current local safer custody policy but followed the national instruction in PSI 64-2011 (Safer Custody).[1] In addition, there were some local processes which were treated as 'accepted practice' but they were not encapsulated in any local safer custody guidance. One such 'unwritten' practice was the process described in the serious incident review in the case of TA of reception officers notifying Safer Custody of any indications that new prisoners might be at risk.

11.2 The serious incident review said that where any warning of risk of suicide or self-harm was received for a new prisoner, reception staff should notify Safer Custody, who would ask the wing manager to see the prisoner, to report back and to record the outcome of the conversation in the wing observation book and P-NOMIS (the electronic information system in prisons). The review found that in TA's case the procedure did not work properly: all that was recorded in TA's case notes about the warning was an entry by the induction wing manager on TA's second day in prison that a Safer Custody Self-Harm Warning had been received. The review recommended that senior officers be reminded of the requirements. However, the Ombudsman found that in November 2013, in the case of a prisoner who, like TA,

[1] Fatal incident investigation reports by the Prisons and Probation Ombudsman are available on the Ombudsman's website at Fatal Incident reports | Document Types | Prisons & Probation Ombudsman (ppo.gov.uk)

disclosed past self-harm which was noted on his escort record, an inexperienced reception officer was not aware of the requirement to complete a risk assessment form for Safer Custody.

11.3 The Ombudsman recommended that the Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular to ensure that reception and first night staff:

- have a clear understanding of their responsibilities and the need to share all relevant information about risk

- consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs

- open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

11.4 In several subsequent reports, the Ombudsman continued to find the system of risk assessment at Chelmsford unreliable and unsatisfactory. In the report of a death in July 2018 the Ombudsman found a failure to identify risk factors when a prisoner who had a history of suicide attempts and mental illness was moved to a smaller quieter wing having presented as withdrawn, overwhelmed and vulnerable. The Governor was asked to produce clear guidance on procedures to identify and support prisoners at risk of suicide or self-harm. In particular:

- First night procedures should recognise the additional vulnerabilities of newly arrived prisoners.
- Reception, Healthcare and First Night should have a clear understanding of their responsibilities and the need to share relevant information about risk. They should consider and record all known risk factors of newly arrived prisoners when determining risk, including from the Person Escort Record. They should document the information considered and the reasons for decision and start an ACCT whenever there were significant risk factors, irrespective of stated intentions.

The recommendation formed part of the prison's action plan for PPO recommendations.[1]

Current policy at HMP Chelmsford to prevent suicide and self-harm

11.5 HMP Chelmsford now has a comprehensive local policy on preventing suicide and self-harm. In this chapter we consider the outline and general principles of the policy. In the next chapter we examine related policies and procedures about reception procedures and early days in custody.

11.6 The introduction to the 2019/20 policy says the aims are:

- to reduce the incidence of suicide and self-harm by providing support to prisoners through a more supportive environment
- upskilling staff to identify prisoners at risk and to provide the necessary support

[1] Fatal incident investigation reports by the Prisons and Probation Ombudsman, and actions plans as a result, are available on the Ombudsman's website at Fatal Incident reports | Document Types | Prisons & Probation Ombudsman (ppo.gov.uk)

- to improve the interactions and recording of interactions between staff and prisoners
- to develop staff's understanding of mental health
- and to monitor and maintain compliance and adherence to accepted recommendations.

11.7 When assessing whether to open an ACCT, staff are required to identify and consider all the relevant risk factors, and the decision made should be fully documented on P-Nomis with a full description of the reason for decision, quoting relevant risk factors.

11.8 The policy stresses that it is important to recognise that those in their first few days in custody can be particularly vulnerable, so reception and First Night staff should pay close attention to risk factors when assessing whether there is a need for an ACCT.

11.9 The Safer Custody Team is required to investigate every act of self-harm. Investigations will test compliance with local systems and explore reasons, and will tie into the individual's key worker to enable further support.

11.10 The policy notes that isolated prisoners may be vulnerable. Staff should highlight isolating prisoners to the Safer Custody team, who will investigate and implement repeating welfare checks weekly.

Interaction and information sharing

11.11 The current local policy on preventing self-harm sets as one of its aims, improving interaction and recording of interactions between staff and prisoners.

11.12 Under PSI 75-2011 about Residential Services, which was in force at the time of TA's self-harm, it was left largely to the discretion of the Governor of each prison to decide how to cultivate positive interaction between staff and prisoners. Paragraph 1.3 says that the specification for residential services and PSI 75-2011:

'highlight the particular importance of staff in residential units building good relationships with prisoners, interacting with them regularly and providing positive role models. It is for Governors to decide the best way of achieving this locally.'

11.13 It was not mandatory to have a personal officer scheme, but HMP Chelmsford apparently did have a scheme in 2013. The records for TA's cellmate name a personal officer, but there is no personal officer named in TA's records. HMIP's report of an inspection at Chelmsford in 2016 says the personal officer scheme was not universally applied but prisoners said they had someone to turn to for help and support. The inspectors found that electronic case notes were mostly regular and showed good knowledge of prisoners by wing staff.

11.14 The serious incident review says that personal officers were required to make an entry in the records of their allocated prisoners every 14 days. It may be that no personal officer had yet been identified for TA but it is known that prisoners are especially vulnerable in their early days in prison and introducing a personal officer should have been a priority as soon as he moved from the induction wing to C wing.

TA – information sharing

11.15 After the entry on 21 June that a self-harm warning had been received there was no further entry in the case notes for TA until his self-harm on 1 July.

Key workers

11.16 The White Paper, *Prison Safety and Reform*, published in 2017 included proposals to give every prisoner a dedicated officer who can engage with them one-to-one. The keyworker role is intended to include assisting prisoners to settle into prisons and providing support.

11.17 National guidance on the key worker role was issued in July 2018. The aim is to promote rehabilitative and constructive staff-prisoner relationships, in order to foster positive behaviour through staff example, dynamic security, building trust and confidence, giving hope, listening and building commitment to change.

11.18 Key workers are allocated an average of 45 minutes each week for each prisoner on their caseload. This includes time for preparation, follow-up and recording as well as one-to-one contact with the prisoner. Key workers aim to form a trusting working relationship to encourage and enable their allocated prisoners to complete any plans they are working towards, including support in achieving sentence plan targets.

11.19 The goals of the scheme include for everyone to receive individual support, to build healthy relationships with the prisoner, to empower the individual to make the right choices for their progression and development, and to improve the prison environment by reducing

violence and self-harm. Key workers are encouraged to use listening skills to develop an understanding of what the individual wants to achieve through the process.

11.20 Chelmsford's suicide prevention policy says that all operational staff will receive key worker training.

11.21 The Safer Custody meeting in July 2019 highlighted the potential of key workers to help to develop constructive staff/prisoner relationships. However, there were reservations. At that time only 70% of prisoners had been allocated key workers. Prisoner representatives at the meeting on 13 September 2019 said that prisoners did not see their key workers often and it was noted that because key workers were allocated to prisoners randomly they were not usually working on the same wing as the prisoners on their caseload.

Five-minute intervention

11.22 Chelmsford's suicide prevention policy says that all operational staff will receive training in the *Five-Minute Intervention* (FMI) which is intended to give officers the skills to turn everyday conversations into opportunities for rehabilitation, using skills such as active listening, motivational interviewing and 'Socratic questioning' which is a method of questioning designed to challenge an individual's habitual understandings and perceptions. The aim is that with these FMI skills staff can take every opportunity to encourage the people in their care to strengthen their decision-making skills and build a stronger sense of self-efficacy while working with hope toward positive change.

The role of prison officers on the wings

11.23 In his interview for the investigation in 2021, Officer 7 was eloquent in his description of the dilemmas faced by officers on the wings in balancing the demands of paperwork – completing records in compliance with policies – and actively engaging with prisoners to address the cause of their frustrations, such as chasing up a missing parcel, or reading a letter for a prisoner unable to read. In his view, there was a danger that resource allocation and staffing levels were determined on the basis of inappropriate assumptions about minimum levels required for security, and that policies were inclined to be process-driven, emphasizing 'defensible' decision-making. Officer 7 said that it was important for officers to understand, and be supported in, practical engagement with prisoners. He commented that for a period during the Covid pandemic some officers had been allocated to duties additional to the basic staffing complement to act as welfare officers. This was a distinct role, and the title made it clear to the officers what was expected of them.

Summary and observations

11.24 The policy adopted in 2018 at HMP Chelmsford marks a substantial advance on the informal practices relied on in previous years. The aspirations and elements of the policy address many of the issues that have caused us concern in examining TA's short time in prison, and which were also identified from time to time by the Prisons and Probation Ombudsman.

11.25 For example: the current policy requires systematic consideration of risk factors on admission; it recognises the special vulnerability of newly arrived prisoners and prisoners who are isolated; it provides for

investigation of every instance of self-harm; it emphasises the importance of active staff-prisoner interaction; and commits to training to underpin the policies. The aspirations of the key worker policies and the five-minute intervention are promising, but they depend on staff having the skills, the time, the opportunity, and the support of managers, to put them into practice, and we note the concerns about the availability of key workers expressed at a Safer Custody Meeting in 2019.

11.26 It is beyond the scope of our investigation to examine how effectively these policies have been implemented, but we draw the attention of the Governor to the missed opportunities we have identified in paragraph 10.12 which might have diverted TA, and we invite him to consider whether these would be handled differently now.

CHAPTER TWELVE: SUPPORTING NEW PRISONERS: RECEPTION PROCEDURES, EARLY DAYS IN CUSTODY AND STAFF-PRISONER RELATIONSHIPS: WAS TA GIVEN ADEQUATE FACILITIES AND SUPPORT?

Early days in custody

12.1 Prison Service policies recognise that prisoners may be especially in need of support during their first days in prison. Policies on early days in custody include provisions on induction to prison and supporting new prisoners. This chapter examines national and local policy and practice at the time, and now, with particular relevance to TA. We consider whether the requirements in force at the time were met, and whether any lessons can be drawn. We make some recommendations to the Governor of HMP Chelmsford and to HMPPS.

National policy in 2013

PSI 74-2011 Early days in custody

12.2 This was the national policy in force in 2013 for reception into prison, first night in custody, and induction into custody. It was subsequently replaced by PSI 07-2015.

Telephones calls

12.3 PSI 74-2011 states that newly arrived prisoners must be given access to a telephone on their first night in custody, either in reception, or in their first night location, to contact their legal adviser, or to address urgent domestic issues, or to advise a family member where they are being held (paragraph 2.39).

12.4 If the prisoner is subject to public protection measures a member of staff should make the call on the prisoner's behalf, checking in the first instance that the recipient is willing to receive the call (paragraph 2.42).

TA – telephone access

12.5 Contrary to PSI 74-2011 there is no evidence that TA was allowed a phone call on his first night in prison, or that his message to a friend was passed on as requested.

Visits

12.6 PSI 74-2011 says that all '*newly convicted*' prisoners must be advised that they are entitled to a social visit within 72 hours of their conviction (paragraph 3.38). This follows PSI 16-2011, about Managing Prison Visits, which says, as a key output, that, in addition to the statutory entitlement to visits, every prisoner is to be given the opportunity of receiving a social visit within 72 hours of reception *'upon conviction'* (section 3, page 7).

TA - visits

12.7 There is no indication that TA was offered an early visiting order as required for newly convicted prisoners. TA was not *newly convicted* but *newly sentenced*, and had been on bail ever since he was charged. It seems that the provision for an immediate visiting order for a newly convicted prisoner does not apply to those who have previously been on bail and are newly sentenced. In our view it should. Coming into prison for the first time is a vulnerable time for prisoners, regardless of

the circumstances. Early contact with family and friends may provide crucial support.

First-time prisoners

12.8 PSI 74-2011 says that every prisoner's knowledge and previous experience of custody should be explored during the reception and first night stages. Prisoners are referred either to a full induction programme comprising two phases, or only to Phase Two if they have already completed Phase One recently.

Preventing suicide and self-harm

12.9 PSI 74-2011 on Early days in custody says:

'First Night in Custody, when family and community links are broken and the future is uncertain, is one of the most stressful times for prisoners. Many self-inflicted deaths and self-harm incidents occur within the first 24 hours, the first week, and the first month, particularly among younger prisoners.

Extra emphasis placed on tackling safer custody issues during the first 24 hours and beyond is likely to produce most benefit in this early period. Listeners or other peer supporters may offer additional help to prisoners, particularly during the first night.' (Paragraph 3.2)

12.10 Certain categories of prisoners are identified as at enhanced risk of suicide. These include people who - like TA - are in prison for the first time, or whose status has recently changed (eg from remand to convicted or sentenced), or were subject to harassment measures, or with a history of self-harm or attempted suicide (Annex D).

12.11 Other factors said to indicate enhanced risk include transfer from another establishment, especially to more restrictive conditions or further from family, those accused or convicted of particularly violent offences, especially against a family member, potential category A prisoners, those sentenced to life or other indeterminate sentences, those with mental health problems or drug/alcohol dependency, recalled prisoners, those facing possible deportation (Annex D).

Current national policy on early days in custody - PSI 07-2015

12.12 The policy in force in 2020 is broadly similar to PSI 74-2011 but was updated in 2015 to take account of new resettlement policies. For all new prisoners, an offender supervisor must complete a resettlement needs screening within the first 72 hours. The offender supervisor will have access to the OASys assessment so will be aware of more information about a new prisoner than when he was first admitted to reception. A Community Rehabilitation Company must complete a resettlement plan within five days of reception of the basic screening.

Current local policy at HMP Chelmsford

Reception procedures (undated) – risk assessment and preventing self-harm

12.13 The Reception procedure requires that all prisoners are risk assessed for potential harm to themselves, to others and from others. Staff are asked to be alert to enhanced risk of suicide/self-harm posed by certain categories of prisoners. The policy repeats the list of risk factors from PSI 74-2011, which includes those in prison for the first time, those with a history of self-harm or attempted suicide, and those

subject to harassment measures. Any prisoner who has a self-harm warning is prioritised and his paperwork placed in a red tray.

12.14 The policy requires that during the interview process the prisoner should be asked about self-harm. It says that staff should not base a decision not to open an ACCT solely on how the prisoner presents during an interview. All documentation should be considered, and guidance on identifying risk, which is located in the interview room, should be consulted. The Operations Supervising Officer is available for consultation to ensure that those who need support are placed on an ACCT immediately.

12.15 A Reception Self-Harm Risk assessment should be completed for all prisoners who have been placed on an ACCT and for all prisoners who have a self-harm warning but have not been placed on an ACCT. Before this form is sent to Safer Custody it should be discussed with the Operations Supervising Officer.

HMP Chelmsford Prisoner Induction Policy (May 2018)

12.16 (The cover of the policy refers to PSI 06-2015. I think that should be 07-2015. PSI 06-2015 is the reference for Community Rehabilitation Companies; for prisons it is 07-2015.)

12.17 The Statement of Purpose says that the aim of the policy is:

'to alleviate prisoners' fear and apprehension about being in custody and to provide them with relevant information that they will need in order to maintain links with family and friends.'

12.18 In respect of telephone calls, visits and prevention of suicide and self-harm, the policy closely follows the wording of the national instructions. For example, it includes in full the statement from paragraph 3.2 of PSI 74-2011 about first night in custody being one of the most stressful times for prisoners and that many self-inflicted deaths and self-harm occur during the first night, the first week and the first month, particularly among younger prisoners.

12.19 In assessing risk of suicide or self-harm, staff are required to take into account risk factors and any warnings from outside agencies, any alerts from a previous sentence, any case notes generated by reception or from a previous sentence and from the Police National Computer if available. After speaking to the prisoner, staff are asked to use their judgment in combination with all available evidence to decide the best course of action, consulting a manager if in doubt.

12.20 First Night in Prison (FNIP) interviewing staff are required to complete a First Night in Prison Introduction to Custody Interview to identify any immediate issues. The policy says that:

'this information must be recorded on C-NOMIS case notes for each offender.'

and

'During this initial FNIP interview, staff must take time to listen to prisoners and offer them help and support in resolving or managing their most urgent issues….Time and resources must be available to resolve issues that cannot be left unresolved overnight and to provide personal help and support to prisoners as needed.'

12.21 Sections 1 and 2 of the template for the First Night in Prison Introduction to Custody Interview are about past episodes or current

thoughts of suicide and self-harm, with prompts for staff to consider factors affecting risk. Staff are instructed to document the outcome of the conversation, but it is not clear from the template how or where that is to be done. There is a non-exhaustive list of factors, as follows, for the interviewer to consider, namely:

- Age
- Previous self-harm/suicide episodes
- Previous ACCT document in prison
- Family history of self-harm/suicide
- Current situation
- Sentence/offence
- Lack of social/family support
- Relationship issues/status
- History of violence
- Alcohol/drug misuse
- Mental health issues
- Physical illness

There is no prompt in the template to consider whether the prisoner has been in prison before. However, Annex D to the policy, which is about healthcare screening, suicide and self-harm and disability, follows PSI 75-2011 in listing categories of prisoners at enhanced risk as including those in prison for the first time, and those subject to harassment measures.

12.22 Section 3 asks whether the prisoner wishes the prison to inform anyone he is in prison. It is not clear whether this is in addition to prisoners being offered a first night phone call.

12.23 Other sections deal with urgent domestic issues, first night meal packs, toiletries and a shower, access to a Listener or Insider, the incentives and earned privileges scheme, smokers and non-smokers packs, television compact.

12.24 A First Night in Prison Leaflet is given to all new prisoners. This explains what will happen in the first 72 hours. Among other things, in the afternoon of Day 2 the new prisoner will be interviewed by a member of staff from the Offender Management Unit (OMU) to complete Part 1 of the Basic Screening Tool, and then a secondary health screen by the medical team. There was no secondary health screen at the time of TA's admission to Chelmsford.

12.25 On Day 3, the Community Rehabilitation Company staff will complete Part 2 of the Basic Screening Tool and develop a resettlement plan in conjunction with the offender supervisor from OMU.

12.26 Prisoners should be offered a private meeting with a member of the chaplaincy team within the first 72 hours.

12.27 Canteen is issued on Friday afternoon. Canteen sheets are given out on Sunday morning and need to be returned by 1700 the same day for delivery the following Friday. PIN credit for telephone calls is ordered on the canteen sheet and added to phone accounts the following Wednesday.

12.28 The leaflet gives the time and booking number for social visits. It does not say that a newly convicted prisoner is entitled to a visit within 72 hours. However, a prompt sheet for staff delivering induction says 'Reception visiting orders are issued in Reception on conviction; they

may be left at the gate so visitors can make a visit within the next 72 hours providing they telephone and book a table.'

12.29 There is a leaflet about the Insiders scheme.

Healthcare

12.30 NHS England say that contracts for healthcare provision in prison require compliance with Prison Service Instructions and NICE[1] standards.

Healthcare screening of new prisoners (PSIs 74-2011 and 07-2015)

12.31 PSI 74-2011 say that all newly arrived prisoners must be assessed as part of the reception health screen process to determine whether they are at risk of suicide or self-harm, and an Assessment Care in Custody and Teamwork (ACCT) Plan opened, or an existing ACCT continued, as appropriate.

12.32 In addition to the requirement for assessment of risk of self-harm, further provisions for the healthcare screening of new prisoners are set out in Annex D to PSI 74-2011 and the successor instruction PSI 07-2015. The PSIs state as a mandatory requirement that prisoners' immediate medical needs must be assessed by a member of the healthcare team on first entry to an establishment, and any identified clinical concerns must be appropriately followed up. Efforts should be made to retrieve any information required from the prisoner's GP.

[1] NICE stands for National Institute for Health and Care Excellence

12.33 There is no reference in the PSIs to a further health assessment being required for new prisoners. However, the list of associated documents for both instructions refer readers to PSO 3050 on Continuity of Healthcare which was issued in 2006.

12.34 Paragraph 2.12 of the 2006 document, PSO 3050, says that in the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community and should act as an opportunity for gathering further medical information, checking how the prisoner is settling in, health education and health promotion.

12.35 TA did not have a further medical assessment at Chelmsford in 2015 and there appears to have been no provision for a second healthcare assessment for new prisoners there at the time.

NICE Standards for Prison Health

12.36 In September 2017 the National Institute of Clinical Excellence (NICE) produced quality standards for physical health of people in prisons. Paragraph 1.1.13 states that a healthcare professional should carry out a second stage health assessment for every person in the prison within seven days of the first health assessment.[1]

12.37 The NICE guideline on the mental health of adults in contact with the criminal justice system advises that any person who has ever tried to harm themselves should be referred for a mental health assessment.

[1] www.nice.org.uk/guidance/qs156

See question 20 in Table 1, the template for first stage prison health assessment.[1]

12.38 NHS England says that a healthcare practitioner would need to record their rationale for not referring someone who self-harmed for mental health assessment, and assessment would seem appropriate if self-harm was recently present and for which no treatment had been accessed. An up to date summary of the patient's clinical record, if available, would provide the context for a decision about whether to refer to mental health and practitioners would need to use their professional judgment.

Current provision at Chelmsford

12.39 CRG Medical, the current main provider of healthcare services at Chelmsford, told us that they use the national secure assessment tool templates in use across prisons for reception and secondary health screenings. The templates contain prompts which initiate referrals to mental health teams for individuals who self-harm or who have previous mental health issues. Secondary health assessments are normally completed on the day after a prisoner arrives in custody. The secondary assessment includes a 'mini mental health assessment' which allows a second chance for a prisoner to be referred to mental heath. Even if a referral has already been completed the night before, it will be done again, with a task sent to the mental health team to alert them to the referral.

New mental health care initiative for young prisoners

[1] www.nice.org.uk/guidance/ng66

12.40 In response to the draft of this report, NHS England told us of a new mental health initiative at Chelmsford prison. In addition to the services provided by CRG Medical, Forward Trust are now separately commissioned to provide a primary care mental health service at the prison, including a brief contact with all prisoners aged 30 or under for whom this is their first time in prison, whether or not they have been referred for mental health assessment. NHS England say this requirement has been included because Chelmsford is a remand prison and it aims to ensure that all prisoners in the cohort are aware of the mental healthcare service should they need to access it in future. The intention is to communicate with this cohort of prisoners, who are noted as being more likely to struggle with mental health issues and to seek to end their own lives, so that they are proactively contacted as early as possible after reception into prison, to inform that that help is available, should they need it. An independent valuation of the initiative will be commissioned in 2022.

Observations and recommendations

12.41 Prisoners are known to be vulnerable during early days in custody. The policies on preventing suicide and self-harm and supporting new prisoners are closely linked.

12.42 Someone experiencing prison for the first time is especially vulnerable. The First Night interviewing officer noted in C-Nomis that TA had not been in prison before. That was good practice. But the local induction interview template at Chelmsford does not appear to contain a prompt to consider, at the first night interview, whether the newly admitted prisoner has ever been in prison before. We think it should.

12.43 TA was 31 years old when he first went to prison and may not have been expecting a custodial sentence. PSI 74-2011 and the current local

policy point out that young prisoners may have particular vulnerabilities, but for someone whose adult life has not included significant exposure to the criminal justice system, the shock of admission to prison for the first time is a risk factor that ought to be taken into account, especially as the prison will have little if any knowledge of the person's risks and behaviours.

12.44 Policies on reception screening by both prison and healthcare staff identify a wide range of risk factors. Not all identified vulnerabilities will require a prisoner to be placed on an ACCT plan on immediate entry to prison but vigilance and practical help may be needed to recognise and allay emotional and mental deterioration during the transition into prison life.

12.45 Practical support could include, for example, teaming a prisoner with a buddy for a month or until they have learned the prison routine, giving extra calls/visits to keep in touch with family, or a one-month mental health review to see how they are coping, or an extra visit on the wing from a faith leader.

12.46 Positive interactions with staff are a crucial support for prisoners newly cut off from family and friends. In TA's case no personal officer was appointed during the 11 days he was in prison, and there are no informative records in P-Nomis about how TA was coping. One of the officers described him as a quiet prisoner who did not come out of his cell. That in itself might suggest a need for investigation and support.

12.47 Since 2015 an offender supervisor has been required to meet a new prisoner within 72 hours of admission and to complete a Basic Custody Screening Form. That was not in force when TA was in prison and there is no indication that TA met his offender supervisor while he was in prison. The offender supervisor has access to more information

than is available in reception, including the OASys assessment, and the opportunity to learn more about a new prisoner, and his state of mind and aspirations, so has a part to play in supporting the prisoner, assessing risk, and alerting colleagues.

12.48 **We recommend** that men in prison for the first time should be distinguished as a category of prisoners requiring extra vigilance and support for the first two to four weeks in custody and that HMPPS and the Governor of Chelmsford consider setting this out in policy guidance.

12.49 This could be combined with the key worker or personal officer scheme but we envisage it as the subject of a distinct policy, requiring recording of significant interactions at not less than prescribed minimum intervals, review and sign-off by a wing manager when extra care is judged to be no longer necessary.

12.50 It appears that TA may not have been given some facilities to which he was entitled on admission to prison. There is no record that TA was given access to a telephone on his first day in prison or that a call was made on his behalf.

12.51 **We recommend** that in accordance with PSI 07-2015 the Governor of Chelmsford ensures that a telephone call is offered consistently to new prisoners in reception or on the first night location including those subject to harassment measures, that the outcome is documented and that local policies include these requirements.

12.52 National and local policies indicate that newly convicted prisoners are entitled to a social visit within 72 hours of their admission to prison. **We recommend** that the facility of a social visit for newly convicted

prisoners should apply equally to newly sentenced prisoners who have previously been at liberty on bail.

12.53 The first night interview is an important stage in the introduction to prison. The local policy makes clear that it requires significant time and resource. The duration of the reception interview is one indication of the extent of enquiry. The same applies to the First Night Interview. The needs of individual prisoners will vary but there may be a case for monitoring the duration of both these interviews, at least periodically. We would expect managers to set clear expectations and ensure they are met. Information about the duration of these interviews would also show whether staffing levels are sufficient to meet the requirements of reception and induction policies.

12.54 TA had no further medical assessment after the healthcare screening in reception. PSIs 74-2011 and 07-2015 say nothing about a second medical assessment within a new prisoner's first week though this is stated in the 2006 policy PSO 3050 to be a requirement and it is included in the current NICE Quality Standard and the current local policy at Chelmsford.

12.55 In response to the draft of this report, NHS England told us that healthcare contractors were required to comply with PSIs and that providers who had failed to undertake secondary screenings had been sanctioned for breach of the requirements of the Care Quality Commission. Therefore they saw no need for any further review of requirements by them as commissioners as they considered that secondary screenings were already mandatory.

12.56 This was reassuring, but we remain concerned that the current PSI 07-2015 makes no stipulation about secondary healthcare screenings for newly arrived prisoners. **We recommend** that HMPPS review their

current instructions on healthcare assessments for new prisoners to ensure that there is no doubt that a second medical assessment within a prisoner's first week is a mandatory requirement.

12.57 **We also draw to the attention** of HMPPS the presumption in the NICE guidance that prisoners with a history of self-harm should be referred for mental health assessment.

12.58 In this report we have examined the process of risk assessment to identify prisoners most likely to be at risk of suicidal distress, and we have suggested that special attention should be given to men who are in prison for the first time. We suggest that these are appropriate processes for helping to prevent suicide and self-harm. But there is a danger in relying too much on segmentation of the prison population into those identified as being at risk, who receive special attention, and those who are less visible. Risk assessment will always be imperfect and the foundation of safer custody is a healthy prison culture, led by managers, in which staff have the skills, confidence and the time to engage constructively with all the prisoners in their care. Staffing levels need to be based on an appreciation of this crucial role of prison officers if prisons are to be safe, decent and rehabilitative.

CHAPTER THIRTEEN: THE IMPACT OF SUICIDE AND SELF-HARM ON PRISON STAFF

PSI 64-2011 Management of prisoners at risk of harm

13.1. One of the aims of PSI 64-2011, the policy on preventing suicide and self-harm, is to ensure that staff affected by distressing or traumatic incidents are supported appropriately. Chapter 12 of the PSI, on actions to be taken after a death in custody says that, in line with PSI 08-2010 Post incident Care, a Hot Debrief must be held immediately after all deaths in custody. A senior member of staff must act as debriefer and a member of the care team must attend. All staff directly involved in the incident *'including healthcare staff'* should be invited (PSI 64-2011 page 56).

PSI 08-2010 Post incident Care

13.2. PSI 08-2010 (paragraph 2.11) says the purpose of the 'Hot' debrief is to acknowledge what happened and the role of the staff involved, to *'normalise'* the situation and ensure that the immediate needs of the staff have been met.

13.3. Within five to ten days of a potentially traumatic incident involving more than two members of staff, a 'Critical Incident' de-brief must be held by an Employee Support Officer. Attendance by staff is voluntary but the purpose is to give staff an opportunity to discuss the personal impact of the incident with others involved, to encourage and enhance mutual support, provide information on the effects of post trauma stress, normalise post trauma stress reactions and to encourage coping strategies and support networks (PSI 08-2010 paragraph 2.17).

PSI 02-2018 Post incident Care

13.4. PSI 02-2018 contains the current guidance about Post-Incident Care. It lists actions to be followed after serious incidents which may be distressing or traumatic for staff. The manager in charge of the incident and/or a line manager should:

- Provide practical and emotional support and information - talk to staff to determine whether they need a break, or should go home, and provide a Trauma Information leaflet and details of the local Care Team. Social support should be put into context and match individual needs, which may vary over time.

- Gather details of all staff who have been affected and acknowledge the role of the staff involved – collect and record name and contact details.

- Ensure that the local Care Team is informed of a serious incident and that they are provided with the names/contact details of the staff involved.

- Identify any staff who are exhibiting signs of extreme distress, are in a shocked state or are withdrawn.

- Agree with staff how they will be followed up – this could include for example arranging to speak with them personally, or by arranging for a Care Team member to contact them if prison based, by telephone, and/or on their next shift on duty, to find out how they are doing.

- Must ensure that the staff involved are aware of the peer support available from the establishment's Care Team and how to contact them.

- Must ensure that each member of staff involved in the serious incident is aware of the trauma support available from HMPPS's contracted Employee Assistance provider.

13.5. PSI 02-2018 lists certain incidents which should always prompt these measures. They include deaths in custody and certain other violent incidents. The instruction says that the list is not exhaustive, but it does not explicitly mention incidents of serious self-harm.

13.6. The serious incident review noted that a member of the Care Team had been called to the wing whilst staff were attending to TA, and that a hot debrief was held and support offered. However, the duty manager told us it was not necessary to arrange support for staff as it was not a case of a death in custody.

What staff told us

13.7. In interviews, staff who assisted when TA's self-harm was discovered spoke of the impact on them of what were sometimes repeated occasions when they had been involved in attending to prisoners who had self-harmed.

13.8. One officer said he had counselling after a similar incident a couple of years before and someone suggested he do so again. He had issues looking through cell doors because of what he had seen. He said there was a macho culture in prisons that led people to mask their feelings and not be open about them.

13.9. One officer with 20 years' service told us she had also worked in a women's prison where there was much more self-harm than at Chelmsford. After her involvement with TA, she said she read the serious incident report but was not asked for any more information. She did not recall being offered any counselling. A year after the incident she had an email asking why she had been absent without leave on the date in question. She worked out that it was the day she had been sent home after TA's self-harm. She felt a bit angry she was being threatened with loss of pay.

13.10. The same officer was involved in another incident a few days after TA's self-harm when a prisoner set himself on fire. She was still upset a month or so after and recalled bringing it up at a meeting with someone from Headquarters and asking for support but said she never got any. The only support was from fellow officers who had shared the experience.

13.11. When she was interviewed in 2016, this officer had recently transferred to Officer Support Grade for a less stressful time.

13.12. Another officer recalled that the staff involved were taken away from the wing for a cup of tea. A member of the Care Team was present. Then they had to go and do incident reports and then she went home. The officer told us she had cut another prisoner down from a ligature only six weeks earlier and she felt '*awful*'. The staff from the scene supported each other and she didn't ask for anything else as she wanted to forget what had happened and not to talk about it. Not long before her interview with my predecessor in 2016, this officer had been involved in a similar incident when a prisoner died.

13.13. The C wing senior officer recalled that Victor 1 arrived and they left the scene. She thought she had probably gone back to the office. She recalled that a member of the Care Team was present and also a Chaplain.

13.14. This officer had changed her job in 2015 and was working in Learning and Skills. She said that, in the past, staffing was consistent, so staff would get to know the prisoners, for example by chatting in association. Working on the wings had changed with the introduction of New Ways of Working (a personnel strategy using benchmarking with the aim of improving efficiency). Lower staffing levels meant the SO was virtually doing an officer's job. The SO had found it harder.

13.15. A healthcare assistant said that there wasn't really any aftercare support. As healthcare staff they were just expected to be resilient. There was more support before 2012 when they were employed by the Prison Service.

13.16. A nurse said there was an assumption that healthcare staff were '*bullet proof*' and not affected by these sorts of incidents. She said that healthcare staff should be given the same ongoing care as prison staff. It was not enough just to check in that people were OK at the end of their shift. This nurse said that, when she was working in another prison, she went to every debrief and the Care Team contacted everyone involved, signposting them to support via the employees' assistance programme and access to counselling. They were better at asking if the person was OK after the incident. In the case of TA, she said she had not been invited to the hot debrief but she had *'invited herself*.'

13.17. The officer who attended from the Care Team was a prison officer who was one of 14 volunteers on a rota. He said he might have gone to C wing on his own initiative when he heard the radio call and bell. It was now more difficult to leave other duties since staffing levels had been reduced. He said the Care Team was now led by the chaplaincy and a lot of the Team were chaplains. The officer said he was not confident you could separate the chaplaincy function and not all staff were comfortable talking to the chaplaincy.

13.18. Some of the staff indicated that they preferred to choose which member of the Care Team to approach rather than talk with whoever happened to be on duty.

Summary and observations

13.19. Some prison staff found that the Prison Service had been careless of the impact of distressing incidents. Staff told us that for the most part they relied on each other for support and that healthcare staff were just expected to be resilient.

13.20. It may well be that support for staff after distressing incidents is much improved since 2013 but **we draw to the attention of the Governor, HMPPS and the healthcare agencies**, the sometimes sad comments of the staff, and a manager's misconception that an incident of life-threatening self-harm required less rigorous follow-up than a death in custody. We also note the comments about reduced staffing levels.

PART SIX:

OTHER REVIEWS AND INVESTIGATIONS

Part Six is about the inquiries into the circumstances of TA's self-harm conducted shortly after the event by the agencies responsible for healthcare at HMP Chelmsford, and by the prison.

We examine the findings of the inquiries and the evidence on which they were based. Chapter 14 is about the healthcare reviews and Chapter 15 about the investigation by the prison. Chapter 16 considers HMPPS policies on investigation of incidents of serious self-harm.

CHAPTER FOURTEEN: HEALTHCARE RECORDS AND REVIEWS

The healthcare agencies

14.1 The arrangements for commissioning prison healthcare in England changed in April 2013. Before then, prison healthcare was commissioned by local primary care trusts but these were abolished from 31 March 2013 by the Health and Social Care Act 2012. The Act located the legal obligation to commission healthcare for people in prisons with the NHS Commissioning Board (known as NHS England). From April 2013 there was a National Partnership Agreement between NHS England, the National Offender Management Service (now called Her Majesty's Prisons and Probation Services), and Public Health England, for the co-commissioning and delivery of healthcare services in prisons. Healthcare in prisons was commissioned by NHS England through regional teams. Chelmsford prison was in the NHS East of England Region. I understand that there have been further changes to the commissioning arrangements for prison healthcare since then.

14.2 From March 2012 to April 2015 primary healthcare at Chelmsford prison was provided by Care UK, which is now called Practice Plus Group (PPG).

14.3 The current healthcare provider is Castle Rock Group (CRG) who have been contracted to provide healthcare at HMP Chelmsford from 12 April 2019 to 31 March 2024.

14.4 We have referred to information from the healthcare records and reviews in the chronological account in Part Three of the report and in Part Four, the clinical review. In the present chapter we examine the findings of the reviews conducted by the healthcare agencies.

Healthcare records

Reception health screen

14.5 Nurse 1, who was a Clinical Team Manager, undertook the initial healthcare interview with TA in reception when he was admitted to the prison on 20 June 2013. The reception interview follows a template covering a wide range of aspects of clinical history.

14.6 There are three prompts for asking about self-harm. The record of the interview in SystmOne says:

- no self-harm in past five years,
- when asked whether he had tried to harm himself outside prison, it says TA *'overdosed a few years ago – did not mean to kill himself.'*
- does not feel like self-harming or suicide currently.

Serious incident report by Nurse 1 – dated 3 September 2013

14.7 Nurse 1 was also the lead nurse attending to TA after his self-harm on 1 July 2013. Nurse 1 completed a Prison Service Serious Incident Report Form. This is dated 11:00hrs Tuesday 3 September 2013, but when we spoke to Nurse 1 in 2021 she told us she thought this was a mistake as incident reports were always completed on the day of the event. She recalled that she had *'invited herself'* to the prison's hot debrief and it was the prison who asked her to write it.

14.8 The report gives the time of the incident as 09:33. Nurse 1 says that on the way to the cell she saw officers running up the stairs. On arrival, she saw Senior Officer 8 and Officer 6 putting TA into the

recovery position on the cell floor between the bed and the toilet. The wing staff told Nurse 1 TA's name and age but not that he had been cut down from hanging. Nurse 2, the Head of Healthcare, and two healthcare assistants arrived.

14.9 In her report of TA's injuries, Nurse 1 says:

'*On arrival I suspected TA had suffered a seizure as he was unconscious and had been incontinent of urine.*

We then turned TA over to his back to assess further at which point I felt TA had taken an opiate overdose and instructed [Healthcare Assistant] to collect the drug box from centre treatment room

I was then informed that he had just been cut down. Emergency medical care continued until the paramedics arrived and assumed responsibility.

Care continued between paramedics and nurses until he was dispatched to A&E at approx. 11:00.

TA had a superficial laceration to his forearm but this did not require immediate treatment.'

14.10 Nurse 1's entry in the SystmOne clinical record at 11:26 on 1 July does not include the information that she was not aware at first that TA had ligatured. Nurse 1 told us that this was on the advice of a non-clinical manager who said it would seem accusatory of the prison staff. The record does not mention a laceration to TA's arm. Nurse 1 told us that she did not recall this and it was probably because it seemed superficial. Nurse 1 said she was not involved in any of the healthcare reviews.

Healthcare Reviews

14.11 Reviews were conducted by the healthcare agencies as follows:

Serious Incident Initial Report – 2 July 2013

14.12 The initial report was completed by the Service Manager, Care UK on 2 July.

14.13 It quotes the entry from SystmOne made by Nurse 1 on 1 July and says that in the hospital ITU TA was initially managed in an induced coma then subsequently with light sedation. An update on his condition was awaited.

14.14 The initial view was that the healthcare team responded excellently to the incident and were able to preserve life in a difficult situation.

14.15 The report notes that the healthcare reception screen indicated that, on admission to the prison, TA said he had no history of mental illness, no current medication, and previously no medication except asthma inhalers, and no thoughts of deliberate self-harm. It was his first time in prison, he was assessed as low risk for holding any medication required in possession. He reported a previous overdose a number of years ago but claimed he did not do this to end his life. He had booked an appointment for mid-July to see the dentist.

NHS Mid Essex Serious Incident – 7 day report, 24 July 2013

14.16 This interim report was completed by the Care UK Service Manager for HMP Chelmsford, and dated 24 July 2013.

14.17 It noted that TA had been taken to hospital and subsequently managed in a medical high dependency unit. His condition remained stable. Initially 5% brain activity was detected but steady progress had been made. He had been released from prison custody on temporary licence and nursing staff had recommended he transfer from hospital to a rehabilitation facility.

14.18 An investigation was in progress, with the following actions completed so far:

- overview of TA's care up to his attempted suicide
- multi-disciplinary meeting undertaken to review the case
- the officers responding to the prisoner did not make it clear to the responding nurses that the prisoner had attempted to hang himself, and had placed him in the recovery position, therefore his neck had not been immobilised.
- healthcare assistants are being trained to familiarise themselves with the emergency bags when assisting.

14.19 The review said TA had limited contact with healthcare services, and did not previously present with any current mental health problems. Previous medical history could not be accessed because TA could not remember his GP's address.

14.20 Next steps were to be completion of Root Cause Analysis, with associated lessons learned and actions.

Root Cause Analysis Investigation Report – Care UK 23 August 2013

14.21 The report was prepared by the Care UK Service Manager and the Head of Healthcare at HMP Chelmsford.

14.22 The investigation was a Level 1 – Concise investigation. There were found to be no delivery problems for primary care. All responding healthcare staff were up to date with immediate life support training. There were said to be no contributory factors from a healthcare perspective. TA had presented as unremarkable during the reception screen. He had noted that he '*accidentally overdosed*' at least three years previously but raised no cause for concern.

14.23 The root cause was considered to be that TA had recently found that his ex-girlfriend was seeing another man. It was inferred that TA had a poor coping mechanism for bad news, which led to his attempted suicide.

14.24 Lessons learned were that all previous suicide attempts must be shared with all partners, via the healthcare record and C-Nomis.

14.25 Recommendations were that all previous suicide attempts should be shared.

14.26 Learning from the investigation would be shared at the healthcare team meeting, with the governance team, with commissioners and with partner providers.

NHS England East of England Health and Justice Team Serious Incident Closure Form

14.27 This was signed off by the Quality and Safety Manager for NHS Health and Justice Team (East of England). My copy is not dated.

14.28 The summary of the incident says TA was found hanging from a window with a ligature made from bed sheets. Some seizures were

noted and TA was transferred to hospital where he was managed for an extensive period of time. He was found to have suffered severe cognitive and physical damage. TA was paralysed from the neck down and would require ongoing 24/7 nursing care.

14.29 The investigation was said to be completed. An action plan with deadlines and a responsible person would be monitored through Prison Health Partnership Board meetings and performance/contract monitoring meetings.

14.30 The key finding/root cause was said to be that on arrival TA had disclosed a previous accidental overdose but this information had not been shared.

14.31 The key lessons were that all previous suicide attempts must be shared with all partners, via healthcare records and C-Nomis. The learning would be disseminated through Prison Health Partnership Board meetings and performance/contract monitoring meetings.

Responsibility for reviewing serious incidents

14.32 NHS England has explained that Serious Incident Reviews are produced by the organisation providing care at the time. NHS England reviews them and if they appear reasonable, accepts them and approves the closure of the incident. In this case, closing the incident on the basis of the information given by the provider appeared reasonable at the time. There was no additional complementary enquiry or investigation because TA survived the incident; when a death in custody occurs, there is an independent clinical review and an investigation by the Prisons and Probation Ombudsman.

Observations

14.33 The seven-day report by the healthcare provider says that officers did not make clear to the responding nurses that TA had ligatured and consequently his neck was not initially immobilised.

14.34 There is no further reference to this in any of the other reports by the healthcare agencies or in the prison's serious incident review. There is no assessment as to whether it in any way compromised TA's care. Nor any consideration of whether the importance of briefing healthcare staff in an emergency should be drawn to the attention of prison staff.

14.35 We do not know on what evidence the Root Cause Analysis relied for its conclusion that the cause of TA's suicide attempt was inability to cope with news that his girlfriend was seeing another man. Whilst there is reason to believe that relationship problems may well have been a factor, this is too simple a conclusion, which neglects consideration of whether there were other risk factors that could have been anticipated, or triggers related to TA's time in prison.

14.36 The nurse's entry in SystmOne says that in reception TA said that when he took an overdose a few years ago he did not intend to kill himself. That is not the same as *'accidental'*, as reported by the Root Cause Analysis and the Serious Incident Closure report.

14.37 In spite of the conclusion that the overdose was accidental, the Root Cause Analysis and the closure report both recommended that previous suicide attempts should be shared with all partners through C-Nomis and SystmOne. We do not know how that recommendation

was taken forward and what the current method is for flagging past suicidal or self-harming behaviour in SystmOne.

14.38 The healthcare reviews and the Prison's internal investigation proceeded in parallel. There is no indication that the healthcare reviews obtained evidence from non-healthcare records or staff, or that the prison's investigation took account of any evidence from healthcare staff. We consider this further in Chapter 16.

CHAPTER FIFTEEN: THE PRISON'S INVESTIGATION

15.1 Prison Services polices require that the circumstances of any serious incident must be investigated to establish the facts, to learn from them, and to establish any accountability.

15.2 In earlier chapters we have noted some of the findings of the serious incident review by Chelmsford prison, in particular, where there are discrepancies between the account of the facts reported in the review report and the evidence obtained by my predecessor's investigation. This chapter highlights those discrepancies, notes the key findings and conclusions to the prison's serious incident review and examines the investigation process, in the light of HMPPS policies at the time. In Chapter 16 we examine current policy on investigating serious incidents of self-harm.

Prison Service Order PSO 1300 – Investigations

15.3 At the time of TA's self-harm, policy on investigations was set out in PSO 1300 Investigations. This is a generic instruction about investigating incidents of all kinds, not specifically incidents of self-harm. It provides that whenever an incident takes place the circumstances must be assessed by the appropriate manager who will determine whether and how the incident will be investigated (PSO 1300, paragraph 1.1 and 1.2.1).

15.4 The PSO says that the level of investigation into an incident must be decided by line management based on a judgment of its nature, seriousness and how much is known about its circumstances. However, it specifies that if the incident resulted in serious harm to any person a formal investigation is required.

15.5 Formal investigations were to be managed through HMPPS Professional Standards Unit's Investigation Support Section. Normally the investigation would be carried out by a local team but the investigation must be registered with the national Investigation Support Section who could advise on procedure and who would undertake analysis of findings, recommendations, and the quality of reports.

15.6 The PSO contains detailed guidance on the conduct of a formal investigation. This includes, for example, the requirement for terms of reference, set by the person commissioning the report, who is responsible for quality assurance and actions following the report, the arrangements for taking evidence, and for findings to be clearly based on evidence.

Prison Service Instruction PSI 64-2011 - Management of prisoners at risk of harm to self, to others and from others (Safer Custody)

15.7 Chapter 12 of PSI 64-2011 explains procedures to be followed in the event of a death in prison. If a prisoner dies, there is an independent investigation by the Prisons and Probation Ombudsman and a Coroner's inquest, and there may be an investigation by the police. Consequently, the investigation responsibilities of the prison are concerned primarily with the preservation of evidence, notifying the relevant authorities and facilitating the independent investigations.

15.8 Although incidents of serious self-harm may require independent investigation under Article 2 of the European Convention on Human Rights, the initial responsibility to investigate lies with the prison. PSI 64-2011 says that serious incidents of self-harm must be investigated, and prisons must have procedures in place to learn from incidents to

prevent future occurrences and improve local delivery of safer custody. In 2013, there were no specific instructions about how such an investigation should be conducted, over and above the general requirements in PSO 1300. There are now new instructions in place which are considered in the next chapter.

The Serious Incident Review at HMP Chelmsford

15.9 A Serious Self-Harm Incident Review was conducted by Officer 12 who was the prison's Suicide Prevention Coordinator at the time. Officer 12 no longer works at the prison. My predecessor met her, but Officer 12 has not confirmed the transcript of their meeting and I have not interviewed her.

15.10 I have not seen any record showing who commissioned the investigation, when it was commissioned, what the terms of reference were, to whom it was submitted, or what consideration was given to the conclusions and recommendations. I have seen serious incident reports completed on the day by some of the staff who attended TA when his self-harm was discovered, and a note of an interview with his cellmate conducted at about 09:45 on Monday 1 July by Officer 9, who worked in the Safer Custody Team, at the request of a governor. Otherwise, I have not seen the evidence on which the review is based.

15.11 The serious incident reports refer only to the immediate events when TA was discovered. They do not include significant events which apparently occurred earlier that morning. There was no report from the officer who was first at the scene.

15.12 The serious incident review is not dated. Curiously, the unconfirmed transcript of my predecessor's interview with Officer 12 suggests

without explanation that it was '1 January' when she was asked to prepare a 'near miss' report. It seems likely that this is an error but I have not been able to confirm it. Neither the prison nor Prison Service headquarters have any record that the investigation or indeed the incident itself were reported to the national Investigations Support Unit or to the national unit responsible for monitoring serious incidents.

15.13 I have not seen any incident report by the Custodial Manager who was duty manager on the day and apparently took charge of the incident., Interviewed by my predecessor in May 2017, the Custodial Manager had only a vague recollection of the occasion. He remembered going to the cell and seeing the nursing staff attending to TA but said his job then as *'Victor 1'* was to arrange for TA to be escorted to hospital, then to isolate the area and to do whatever needed to be done there. Victor 1 is the call sign for the duty governor in charge of the prison at the time. It is not clear whether the custodial manager, was Victor 1 or Victor 2. We have seen no reference to any involvement of the governor who, according to the incident log, appears to have been the duty governor at the time. The custodial manager no longer works in the Prison Service.

15.14 The report follows a template headed Annex A. It is not dated. It begins with consideration of recent custodial history. Key points are as follows:

- When asked about the self-harm warning on the Person Escort Record, TA said it was an issue in the past and he had moved on; the interviewing officer found him very responsive; and he stated to the interviewing officer and to the nurse he had no thoughts of suicide or self-harm.

- On F wing it was explained to TA he would not be issued with a PIN for the telephone, due to the harassment charge. The requisite form was sent to the wing for signature on Wednesday 26 June enabling a PIN to be issued, and the last known contact was a three-minute phone call by TA to his mother asking her to text his former partner, whom he was not allowed to contact, to say that he loved and missed her.

- On his first night on F wing, TA was issued with a smokers' pack. (TA's first night was Thursday 20 June 2013.)

- *'On arrival on C wing'* (Monday 24 June) TA told Officer 7 he had no tobacco and threaten to *'smash up'*, and Officer 7 organised for him to be provided with tobacco the following day as it could not be arranged that night. (From my predecessor's investigation it is more likely this occurred on Wednesday 26 June but Officer 7 had no recollection of it.)

- *'Staff had no further issues with TA.'*

15.15 There is no indication of the evidence on which this account of events relies.

15.16 The account of events on the morning of TA's self-harm differs from the account given by Officer 7 to my predecessor's investigation. The serious incident report says that, having been alerted by TA's cellmate that he had seen specks of blood on the soap and the floor, Officer 7 immediately went to TA's cell, at about 09:30, found the observation panel covered, and on entering the cell found TA suspended from the bars of his window by a twisted sheet.

15.17 Officer 7 told my predecessor's investigation, and confirmed to us recently, that he went to TA's cell twice, that on the first occasion he saw evidence of blood and spoke to TA, he resolved to go back later, and that when he did so he saw through the observation panel that TA had ligatured. When we interviewed Officer 7 in 2021, he told us that he did not write a report and went back to work on the wing immediately after the initial 'hot' debrief.

15.18 A note of the interview with TA's cellmate was attached to the report of the serious incident review and I have seen serious incident reports prepared on the day of TA's self-harm by Officers 5 and 6, Senior Officers 8 and 10, who were all first responders when TA was found hanging. There is no reference to the serious incident report by Nurse 1.

15.19 The review includes an account of support to the staff involved and to other prisoners, and of contact with TA's family, and it says that the cell was padlocked to preserve evidence.

15.20 Records of actions taken after the event are not complete. I have seen no information about whether the police were called, about who secured the cell, about the contents of the cell, who authorised its release, which according to TA's records was on 4 July, and what became of the contents of the cell.

15.21 The conclusions of the serious incident review include key points as follows:

- It has been suggested that TA was wound up by other prisoners on the wing who knew this to be his first time in custody but this

has not been confirmed. (There is no indication in the report of the source or basis of this.)

- His cell mate inferred that TA was upset that his relationship with his former girlfriend was over.

- Intelligence received on 5 July (so after the incident) suggested TA might have been in tobacco debt but this was not confirmed. (A security report that referred to this was no longer available at the time of the present investigation.)

- Staff could not have predicted TA's actions and their expedient intervention saved his life.

15.22 The report explained the protocol for the system of notifying Safer Custody of new prisoners admitted with any self-harm warnings. It says that as a result of an investigation into the death of a prisoner, the Prisons and Probation Ombudsman recommended that an ACCT should be opened for every new prisoner with any self-harm warnings, past or present. The prison had felt this would dilute the effectiveness of the ACCT process, so instead a system was put in place for reception staff to email Safer Custody with details of prisoners with self-harm warnings. Safer Custody then forwarded this to the relevant wing SO the following day for the SO to speak with the individual then email Safer Custody with a summary of the conversation and update the wing observation books and P-Nomis.

15.23 The report recommended that an email should be sent to all SOs reminding them of the importance of compliance with the system and for this to be highlighted in refresher training.

15.24 The report also identified lack of entries on case notes and that there were no personal officer entries. It recommended that managers brief staff on the importance of documenting key issues affecting individual prisoners, stating that all such issues relating to behaviour and safety must be logged in observation books and on C-Nomis. In addition, staff would be reminded of the expectation for a personal officer entry to be made every 14 days.

15.25 A Custodial Manager recommended that staff should be commended for their actions in reacting sensitively to TA's request for tobacco, and swiftly in response to the information they were given by the cellmate.

Observations on the serious incident review

15.26 The serious incident review did not meet the requirements of a formal investigation. It was immediately clear that TA's injuries were grave. A senior manager should have commissioned a systematic inquiry to examine the care and management of TA up to and including his self-harm, and to advise on any lessons to be learned. Prison Service Order 1300 requires that this should have been a formal investigation registered with the Investigations Support Section at HMPPS Headquarters.

15.27 We have seen no record of how the investigating officer was instructed to conduct the investigation, or what terms of reference were set. My copy of the report is not dated. There is no evidence that the investigation was registered with the national investigations Unit.

15.28 A note of an interview with TA's cellmate was attached to the report and I have seen serious incident reports prepared on the day of TA's

self-harm by some of the first responders when TA was found hanging, but there was no record of any evidence from the officer who was first at the scene and who had spoken with TA earlier after being alerted by his cellmate. In the case of the death of a prisoner in custody, PSI 64-2011 (Chapter 12) requires that staff directly involved in the incident, particularly those who were first on scene, must complete incident report forms as soon as practicable. This should apply equally to incidents of serious self-harm.

15.29 The serious incident report by the lead nurse is dated 3 September 2013. This may be a mistake, but there is no reference to the nurse's report in the report of the Prison's review. We do not know whether it was available to the Prison's investigating officer when she conducted her review.

15.30 The serious incident reports from staff are exclusively about what happened when the alarm was raised and the care given to TA in the cell until he was taken to hospital. Rightly, the focus of the review was wider than this. It included consideration of TA's admission to the prison and the time he spent on F wing and C wing. But I have seen no record of the evidence on which the investigating officer relied for this part of her report.

15.31 In her interview with my predecessor, the investigating officer mentioned speaking with Officer 7, who was first at the scene and a key witness. But I have seen no record of that conversation, nor the basis of the statements in the report about what TA said in reception. The evidence on which a serious incident review relies should be attached to the report. Notes of oral evidence given by staff should be dated and signed by the staff member concerned.

15.32 I would also expect to see a fuller account of what measures were taken after TA was taken to hospital, to secure the cell and preserve evidence, which might be required by the police or, if TA had died, by a Coroner. I have been unable to discover any inventory of the contents of the cell, of what happened to the contents, or when the cell was released. The observation book was not available to my predecessor's investigation and was apparently not preserved.

15.33 The serious incident review contained some useful insights, but the commissioning of the report and the absence of evidence supporting many of the statements in the report show a lack of the rigour that is necessary for a formal investigation of a serious incident.

15.34 This may also apply to the follow up to the review's conclusions. We note elsewhere (see paragraph 11.2) that, according to a report on a death at HMP Chelmsford some months after TA's self-harm, the system for following up self-harm warnings about new prisoners was still not working properly. At the time of our investigation, minutes of the Safer Custody Meetings from 2013 were no longer available so we do not know whether the review was considered there.

15.35 There are now more detailed national and local policies for investigating incidents of serious self-harm. We examine these in Chapter 16.

15.36 The healthcare reviews and the Prison's internal investigation proceeded in parallel. There is no indication that the healthcare reviews obtained evidence from non-healthcare records or staff, or that the prison's investigation took account of any evidence from healthcare staff. We say more about this in Chapter 16.

CHAPTER SIXTEEN: CURRENT POLICIES ON INVESTIGATING SERIOUS INCIDENTS OF SELF-HARM

National policy: Investigations and learning following incidents of serious self-harm or serious assaults - Prison Service Instruction PSI 15-2014

16.1 There are now special requirements for investigating incidents of serious self-harm. These were introduced in 2014 so were not in force at the time of TA's self-harm.

16.2 The current Instruction, PSI 15-2014, says the aim of the policy is to ensure that all reportable incidents of serious self-harm and serious assaults are followed up so that learning is identified and disseminated, and to ensure that, when required, an independent investigation is commissioned that meets the requirements of the State's investigative obligations under Article 2 of the European Convention on Human Rights.

16.3 The Governor must ensure that an appropriate level of investigation is commissioned and that any lessons are learned. In circumstances where the harm to self or others may cause long-term serious injuries to the prisoner concerned, advice on the appropriate level of investigation should be sought from the Equalities, Rights and Decency Group.

16.4 The Instruction lists mandatory actions for Governors, including:

- To ensure that all the relevant staff are aware of the requirement to investigate the circumstances of incidents of serious self-harm

- To ensure that all incidents of serious self-harm are reported to the National Operations Unit, that they are investigated at an appropriate level, and that any lessons are learned.

- That when requested by the national Equality, Rights and Decency Group (ERDG), a *'serious self-harm incident questionnaire'* (Annex A to PSI 15-2014) is completed and returned within three days of the incident being reported. Where ERDG indicates that an independent investigation may be required all documentation relating to the prisoner involved in the incident must be retained.

- In all cases in which a questionnaire was returned to ERDG, Governors must ensure that a copy of the investigation report is submitted to ERDG not later than one week after the investigation is completed.

- Governors are required to put in place local procedures to facilitate and disseminate learning from incidents of self-harm to prevent future occurrences and improve delivery of safer custody. Analysis of self-harm incidents may show patterns in time, place, method and triggers. Regular consultation with staff on safer custody matters is also recommended as a complement to data analysis.

Local policy: HMP Chelmsford's Prevention of Suicide Policy 2019-20

16.5 The current local policy commits to investigating serious, but unsuccessful, attempts at suicide in order to learn and make any necessary changes that could help to prevent similar incidents. It says that all such 'near misses' are to be investigated by a member of the

Safer Custody management team '*to the national template and three working day timescale prescribed by PSI 2014-15'*. Learning outcomes will be shared with relevant stakeholders and agencies involved. They will be discussed at the Safer Custody Meeting and become part of the Safer Custody action plan.

The Safer Custody and Violence Reduction Meeting

16.6 We have examined minutes of the monthly Safer Custody and Violence Reduction Meetings for 2018 and 2019. They show good attendance, including by senior managers, but there was not always healthcare representation. Representatives of the prisoner peer support groups, Listeners and Insiders, attend for part of the meeting and contribute to the discussion. Learning points are reported from PPO reports, inquests and sometimes other incidents and these are the subject of an action plan. There is statistical analysis of trends.

16.7 The prevalence of prisoners with a history of self-harm is notable. For example, the Safer Custody minutes record that 98 prisoners admitted in August 2019 and 102 prisoners admitted in November 2019 disclosed a history of self-harm. A perennial topic is how to strike the balance between excessive caution, so that ACCT plans are opened almost as routine and cease to become an effective safeguard, and failing to identify those prisoners significantly at risk.

Summary, conclusions and recommendations

16.8 Since 2013, more detailed guidance has been issued on the procedures to be followed after an event of serious self-harm. This includes more oversight by the national Equality, Rights and Decency Group. It may be expected that the current policy helps to promote more consistency

and quality assurance but it is our understanding that the new instructions in PSI 15-2014 supplement, but do not replace, the general requirements for investigations in PSO 1300 that we referred to in Chapter 15.

16.9 The Chelmsford local policy locates with the Safer Custody Management Team a responsibility to investigate incidents of serious self-harm so that lessons can be learned and shared appropriately. Minutes of the Safer Custody meeting show a commitment to learning lessons and applying them to practice. This is entirely right and commendable but the delegation of responsibility to investigate to the Safer Custody Team should not be at the expense of the overriding responsibility of the Governor to ensure that an appropriate level of investigation is conducted in line with PSO 1300. An incident of self-harm that is life-threatening or life-changing will usually require a formal investigation compliant with PSO 1300.

16.10 We note that the local policy refers to the questionnaire that has to be sent to the national Equality Rights and Decency Group within three days of a serious incident of self-harm. It does not refer to the more in-depth fact-finding investigation that must usually follow. The implication of the wording in the local policy is that the questionnaire completed within three days is sufficient. **We draw this to the attention of the Governor.**

16.11 **We recommend that** HMPPS and the Governor of HMP Chelmsford review current policy and practice to ensure that it is clear that compliance with national and local policies following an incident of serious self-harm does not replace the general duty under PSO 1300 to commission a formal investigation of a serious incident.

16.12 The healthcare reviews and the Prison's internal investigation proceeded in parallel. There is no indication that the healthcare reviews obtained evidence from non-healthcare records or staff, or that the prison's investigation took account of evidence from healthcare staff. The care and management provided to prisoners by prison staff and healthcare staff is a joint endeavour. Investigation in silos gives an incomplete picture.

16.13 **We recommend that:**

- An inquiry into an incident of life-threatening self-harm by a prisoner should include consideration of healthcare as well as the actions of the discipline staff

- Findings and conclusions should take account of both aspects considered jointly.

16.14 In response to the draft of this report, CRG Medical, the current provider of healthcare at Chelmsford prison, said they were supportive in principle of the concept of joint investigations at a local level but that this would need protocols agreed with HMPPS which would need to take account of patient confidentiality, and the potential of litigation and subsequent liabilities. CRG say that at present they are not allowed to take evidence from prison authorities or records for the healthcare investigation.

16.15 In response to a similar recommendation in another Article 2 investigation (the case of WA published on the website of the Independent Advisory Panel on Deaths in Custody), HMPPS said in January 2018:

'HMPPS has reviewed the annexes to PSI 15/2014 'Investigations and learning following incidents of serious self-harm or serious assaults.' Prisons are now asked to consult with their healthcare departments when conducting a fact-finding review of the incident so that relevant information can be shared and considered as part of the prison's fact-finding review. Additionally, and in the longer-term, HMPPS will consider this recommendation when revising PSI 15/2014 so that the benefits of sharing relevant information between the prison and healthcare provider during the local investigation process are explained.'

16.16 Our examination of the investigations conducted separately by the Prison and the healthcare provider shows that neither presented a complete or entirely reliable account of events. We understand that the healthcare agencies have their own structures and systems for reviewing adverse incidents quickly, but we hope that healthcare providers can be encouraged to enable staff to contribute to the investigation by prisons of incidents of serious self-harm, that HMPPS will enable their own staff to contribute to the healthcare reviews and that there should be arrangements at establishment level for joint consideration by HMPPS and healthcare staff of the findings, lessons and recommendations of reports on serious incidents of self-harm.