Investigation into the circumstances surrounding the death of a man at HMP Belmarsh in November 2007

Report by the Prisons and Probation Ombudsman for England and Wales

November 2008

This is the report of an investigation into the circumstances of the death of a man at HMP Belmarsh. The man was found hanging in his cell on 8 November 2007. He was 22 years of age. I apologise for the time it has taken to issue this report.

I also wish to offer my sincere condolences to the man's family and friends for their loss.

The investigation was carried by one of my colleagues. A clinical review was carried out by Greenwich Teaching Primary Care Trust. I would like to thank the new Governor of Belmarsh, and his staff for their help and assistance.

The man was young and he died just days after being convicted of murder and sentenced to life imprisonment with a minimum term 15 years. Those three factors – The man's youth, the nature of his offence and the length of sentence – are all indicators that he might have been at high risk. That said, the man seems to have been a self-contained individual. He appears to have given no sign that might have caused staff to think he was considering any act of self-harm.

I have made six recommendations. One is about support for life-sentenced prisoners, another is about the response to emergencies and third is about religious observances following a death in custody. The final three recommendations arise from the clinical review, all of which I endorse.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2008**

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SUMMARY

The man was a 22 year old black Londoner who was arrested in May 2007 and charged with murder. He was initially remanded into HMP Elmley but as his trial approached he was transferred to HMP Belmarsh on 13 September.

The nature of the man's charge meant that he faced a mandatory life sentence if found guilty. The man's induction interview following his arrival in Belmarsh included addressing this prospect. At interview, the officer who conducted the induction interview could not specifically recall the man, but she had recorded him saying that he could not understand why he was in prison as there was no evidence against him. The induction officer also recorded that the man refused to take an information pack about the life prisoner system.

Nothing of significance occurred in the first weeks after the man's arrival in Belmarsh. He did, however, attend Sunday mass and also attended a religious faith discussion meeting held every Wednesday. One of the Roman Catholic chaplains described the man as very polite and very quiet – a person who listened rather than talked at the Wednesday meetings. The chaplain always made a point of asking the man if he needed any help but he always replied that everything was fine.

The man's trial started at the end of October and on 5 November he was found guilty of murder and sentenced to life imprisonment with a minimum term of 15 years. On his return to Belmarsh, the man was interviewed by a nurse due to this significant change in circumstances. The man denied any thoughts of self-harm. As the man was being escorted from reception to his cell by the duty governor he asked if he could make a telephone call. He said that his family were not at court and he wanted to let them know what had happened. The duty governor arranged a telephone call and also asked if the man needed to speak to a Listener[1], which he declined.

The person the man telephoned was his partner. From their conversation it is clear that the man was shocked to have been convicted.

Houseblock 1 in Belmarsh is used to hold life and longer sentenced prisoners. The man was transferred to that houseblock two days later on the morning of 7 November. He was located into a shared cell with one cell-mate. That same day the man attended the Wednesday religious faith discussion meeting as usual. The chaplain thought that the man seemed his usual self. The man did not tell the chaplain that he had been convicted and sentenced.

The man telephoned his partner on the morning of 8 November and, as in their conversations over the past few days, they spoke about the length of the sentence and its likely effect on the continuation of their relationship. One comment from the man would suggest that he asked his partner to cut her arm and that he would do the same. However, she told him not to do such a thing.

[1] Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community.

Later that morning both the man and his cell-mate went to the chapel to watch a DVD about black history. At about 10.20am the man told staff that he was not feeling too well and asked if he could return to his cell. He was taken back and locked alone in his cell. Around an hour later the man's cell-mate was taken back to the cell. When the door was opened the man was found hanging from a ligature. All efforts at resuscitation proved unsuccessful and the man was pronounced dead at 12.12pm.

THE INVESTIGATION PROCESS

1. The investigation was opened on 12 November 2007 when my colleague visited HMP Belmarsh. He met Belmarsh's Head of Residence and a trade union representative. My colleague informed them of the nature and scope of the investigation. My colleague also met a member of the Independent Monitoring Board (IMB). Notices were issued for staff and prisoners notifying them of the investigation. No prisoners came forward in response to the notices. My colleague subsequently interviewed 14 members of staff and one prisoner. He was told that the man's cell-mate for the last two days was badly affected by the man's death and did not want to be interviewed. My colleague did, however, obtain details of the cell-mate's evidence to the police investigators.

2. Greenwich Teaching Primary Care Trust agreed to carry out a review of the man's clinical care and treatment.

3. One of my Family Liaison Officers spoke by telephone to both the man's mother and his partner. The man's mother raised no specific issues, she just wanted to know what had happened.

4. The man's partner told my Family Liaison Officer that she believed the man's death could have been prevented. She asked why he had not been on any kind of 'watch' or monitoring given that he was a 22 year-old who had just received a minimum sentence of 15 years. She felt strongly that his circumstances made him particularly vulnerable and staff should have recognised this. The man's partner also felt there were other signs that staff should have noticed. She questioned why staff had not noticed that her partner had received no visitors apart from herself. She felt this would have been very depressing for him. She also said that her partner was noticeably quiet and withdrawn during visits and that this had stood out compared to the boisterous and loud behaviour of other prisoners.

5. The man's partner said she had kept in regular contact with him and they had spoken by phone on the day of his death. During the call he told her that he felt like cutting his wrists, however, as the call progressed he seemed to brighten up and appeared more positive by the time it ended.

HMP BELMARSH

6. HMP Belmarsh opened in 1991. It is a local prison which also holds category A prisoners. Most of its 915 prisoners are accommodated on four residential houseblocks. Houseblock 1 contains mainly life and longer sentence prisoners. Life sentence prisoners are held until appropriate spaces can be found elsewhere in the prison estate.

7. In her introduction to the report of a full, announced, inspection of Belmarsh in October 2007 Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, wrote:

> "Belmarsh is the best known of the three 'core local' prisons managed within the high security estate. It is also the most complex, holding a significant number of category A prisoners – including alleged and convicted terrorists – along with a majority of the lower-risk, short-sentenced prisoners who can be found in any local prison. It has had a succession of poor inspection reports, reflecting a prison culture that focussed only on security and did not adequately grapple with safety, decency or the need to reduce re-offending.
>
> "This inspection found that there was a considerable change under the direction of a management team that was determined to promote and embed a different approach and culture. Managers had rightly taken the view that this was an incremental process, rather than a series of quick wins …"

8. The man's death was one of four apparently self-inflicted deaths at Belmarsh during 2007. There were no clear similarities between the man's case and two of the other deaths. However, in the remaining case the man involved was also young, indeed several weeks younger than the man subject to this investigation. He too was in prison on a charge of murder although his death occurred while he was still awaiting trial.

KEY FINDINGS

9. The man subject to this investigation was a black Londoner, born on 22 December 1984. He had spent 18 months in custody as a young offender after his arrest and conviction for being in possession of a firearm.

10. In May 2007, the man was arrested near his home in Islington in North London following an incident that resulted in the death of a taxi driver. He was remanded into HMP Elmley in Kent. During a First Reception Health Screen interview at Elmley, the man reported having no history of mental health problems. He also denied having ever harmed himself in the past and said that he had no present thoughts of self-harm.

11. With his trial due to commence in October, the man was transferred on 13 September from Elmley to HMP Belmarsh. The man was seen by a member of Belmarsh's healthcare team who noted that the man was fit and well and was not suicidal. The man was located in the first night centre (houseblock 3).

12. On 14 September, the man was seen by an Induction Officer. All prisoners newly arriving into Belmarsh receive such an induction with each interview tailored to the needs and circumstances of the individual. For the man this included completing a life sentence planning form (an LSP0) which is used in the case of potential life sentence prisoners. One of the questions on the LSP0 concerns the prisoner's initial reaction to his remand in custody. The Induction Officer recorded that the man: "States there is 'no evidence, I shouldn't be here'. Asked me why I keep mentioning a life sentence." The Induction Officer also recorded that the man had declined to take a 'lifer-prisoner information pack' (a booklet containing detailed information about the lifer system).

13. At interview the Induction Officer said that many remand prisoners, especially younger prisoners, tend not to understand that a murder conviction carries with it a mandatory life sentence. In addition, many younger prisoners seem to think that the murder charge will be dropped to a lesser offence such as manslaughter or grievous bodily harm. The Induction Officer said she would reiterate the information about sentencing but the information would not register with many prisoners.

14. The Induction Officer was not certain whether she could recall the man but she could certainly remember one prisoner from around that time who declined a lifer-prisoner information pack, insisting that there was no evidence against him. The Induction Officer also asked the man about self-harm, which again is a standard part of the induction interview. The man replied that he had never harmed himself and had no current suicidal thoughts. The Induction Officer said that she had 15 years experience as an officer and if she had had any concerns that a prisoner might be at risk of self-harm she would always open an at risk monitoring form (originally the F2052SH form, now an ACCT – Assessment, Care in Custody and Teamwork – form). She was certain therefore that there would have been no indications that the man was at risk when she interviewed him.

15. On 5 October, the man was transferred to houseblock 2. This houseblock mainly holds short sentence prisoners as well as some others including remand prisoners.

16. In Belmarsh, the appointment of personal officers is based upon cell occupancy. On 17 October, the man's then personal officer recorded warning the man about the need for him to improve his behaviour. At interview, the Personal Officer said that he gave the warning as a result of another officer noting that on three separate occasions the man was found using the telephone at unauthorised times. The man accepted the warning without argument. The Personal Officer said that he would see the man out on association when he seemed to interact fairly well with the other prisoners.

17. One of Belmarsh's Roman Catholic chaplains told my investigator that he met the man around a month after his arrival in the prison. From that time onwards the man was a regular attendee of Sunday service and he also came to the informal discussion meeting held every Wednesday. The Chaplain described the man as very polite, kind and humble. The man was also very quiet and at the Wednesday meetings he would tend to listen rather than talk. The Chaplain said that he always made a point of asking the man if he was alright and if there was anything that he needed. The man always replied that everything was fine and he never asked to speak about anything in private.

18. The man's trial started on 29 October 2007. On that day he was transferred to houseblock 3 for ease of transferring him to and from court while the trial continued. On 5 November, the man was convicted of murder and sentenced to life imprisonment with a minimum term of 15 years.

19. My investigator spoke to a prisoner Listener who had gone to court that day in connection with his own case. The Listener said that the man looked shocked when he came back into the prisoners' waiting room after sentencing. However, he was no more shocked than any other prisoner given a lengthy sentence and after a while he began to relax.

20. When the man returned from court to Belmarsh that evening he was seen by a reception nurse for a 'further reception health check' (FRHC). There are several different circumstances when such a health check is carried out, including return to prison upon conviction. The Reception Nurse noted on the FRHC form that the man's change in circumstances was that he had been sentenced to life imprisonment. She also noted on the form: "Feels okay. No thoughts of [self-harm]." At interview with my investigator, the Reception Nurse said that the man was eating some food at the time she spoke to him. He had maintained eye contact when telling her that he was okay. She asked him if he was sure and if he would like to see her in a private room. The man repeated that he was okay and did not need to see her in private. She asked him about self-harm and he replied that he had no such thoughts. The Reception Nurse told my investigator that the man seemed fine. She concluded her conversation by telling him that if he began to feel worse about his situation nurses were available 24 hours per day.

21. Because a lot of prisoners had arrived at the prison quite late in the day on 5 November the Duty Governor he went to reception to lend a hand, for instance by escorting prisoners to the houseblocks. The man was in one of the groups escorted by the Duty Governor. The man told him that he had just been given a life sentence but his family did not know and he asked if he could make a telephone call. The Duty Governor said that he would organise that. The Duty Governor asked the man how he was and whether he would like to speak to a Listener. The man said he was fine. He did not need a Listener, he just needed to let his family know what had happened in court. The man was quite quiet but managed to smile and did not seem overly withdrawn. The Duty Governor asked one of the officers to arrange for the man to use the telephone.

22. When the Duty Governor arrived on houseblock 3 with the man he told one of the officers that the man should be allowed to make a telephone call as he had just received a lengthy sentence and was feeling a bit upset. The officer took the man to the telephone. She asked him if he was feeling a bit shocked and he said he was.

23. My investigator obtained a tape recording of the man's telephone calls. The call made at 9.00pm that evening was to his partner. The man said that he was surprised at the length of his sentence but that he would be able to appeal.

24. After the telephone call the officer asked the man if he was okay. He said that he was. There was nothing about his demeanour to give the officer any concern about his wellbeing.

25. Belmarsh's Head of Residence told my investigator that as well as having Listeners, houseblock 3 (the first night centre) also has prisoner Insiders[2] who look out for newly arrived prisoners who seem in need of help. The man would have been informed of the Listener and Insider schemes when he first came into prison custody.

26. The Listener who had spoken with the man on 5 November spoke with him again during association the next day. The man was more talkative than he had been at court and spoke about an appeal. The man was playing pool and the Listener thought there was nothing about his demeanour to cause concern. The Listener saw the man very briefly on 7 November just before he moved to houseblock 1. The man seemed the same as he had been the day before. The Listener added that the man got on well with other prisoners, but did not seem to have any close friends.

27. Houseblock 1 is used to hold Belmarsh's long sentence prisoners, including life sentence prisoners. The man was allocated to a double cell, cell 23 on the spur 1 second landing. My investigator spoke to the Head of Residence about Belmarsh's practice on accommodating life sentence prisoners. The Head of Residence explained that Belmarsh will generally try to locate life sentence prisoners into single cells to allow them some privacy. The exception would be a

[2] Insiders are prisoners who have received training in providing essential information for first time prisoners about life in prison. Insiders are also trained to recognise prisoners who may be at risk of suicide or self-harm.

prisoner potentially at risk of self-harm who would be put in a shared cell provided he posed no risk to others. The allocation of a life sentence prisoner to a single cell would, however, be dependent on cell availability. The man had never been identified as being potentially at risk so his allocation to a double cell was entirely coincidental.

28. The Chaplain told my investigator that on 7 November the man attended the Wednesday discussion group as usual. He was no different that day to how he always was. The Chaplain was not aware until after the man's death that he had been convicted and sentenced two days earlier.

29. The man telephoned his partner in the early evening of 7 November and, as in previous conversations, they spoke about the length of the sentence and its impact on their relationship.

30. Prison Service Order (PSO) 4700 deals with the management of life sentenced prisoners. The guidance contained in PSO 4700 includes that:

> "… newly sentenced lifers may present a high risk of suicide or self-harm. Governors of local prisons must take this into account when establishing systems for the monitoring and support needed by lifers … in the case of young lifers, Governors should consider establishing more direct contact between the prison and the family. This might include providing information and contact numbers for key staff working with their [relative]."

31. PSO 4700 goes on to say that Governors may also wish to consider:

> "the establishment of Lifer-Groups … which can provide an effective means of mutual support between prisoners …"

32. Belmarsh's Deputy Lifer Manager heads a team that carries out life-sentence planning for newly sentenced prisoners. Among other things, the initial interview explores the prisoner's immediate needs such as family or housing issues. The interview will also explore whether the prisoner might be at risk of self-harm. The completed paperwork must be sent to the Prison Service's lifer unit within seven days of the prisoner's reception into prison after sentencing. The Deputy Lifer Manager told my investigator that to assist in achieving that target, Belmarsh has set a local target of interviewing prisoners within 72 hours of sentencing. His team, however, has a flexible approach to the target so if a prisoner does not feel ready for the interview at that stage it will be re-scheduled a few days later. The 72 hour target in the man's case meant that he should have been interviewed during 8 November. However, Deputy Lifer Manager's team had been redeployed to cover staff shortages elsewhere in the prison that day so they would not have been able to meet the man.

33. In a subsequent discussion, my investigator spoke to the Deputy Lifer Manager about the support available in houseblock 1 for life-sentence prisoners. He said that at one time members of his team would attend houseblock 1 to be available to answer questions from lifers. There tended to be a good response to that service but problems with staffing levels in the team led to it being withdrawn.

The Deputy Lifer Manager was hopeful that the service would be reinstated. My investigator asked about the training of the officers in the houseblock. The Deputy Lifer Manager said that although officers in the houseblock had completed the 'lifer in the 21st century' training course, much of the content of the course was no longer current. The Deputy Lifer Manager confirmed that peer support was available from life sentenced prisoners working as the houseblock cleaners. The Deputy Lifer Manager added that he was thinking of introducing regular consultation meetings for life sentence prisoners.

The day of the man's death

34. The man had three telephone conversations with his partner on the morning of 8 November. In total they spoke for just over 20 minutes. The man's partner told my Family Liaison Officer that he spoke about cutting his wrist. My investigator listened carefully to the recordings and at one point in the second conversation the man made a comment that he wanted his partner to do something to her arm, and that he would do the same. In response, the man's partner said that he should not do anything like that. In the third conversation the man sounded more dejected than in the previous two indicating that he was beginning to realise that their relationship might be over. The conversation ended with the man's partner asking him to telephone tomorrow and the man replying that he would.

35. During the morning both the man and his cell-mate went to the prison chapel to watch a DVD on black history (a themed activity at Belmarsh that week). A principal officer was patrolling in the chapel when he overhead the man telling another officer that he was feeling unwell and asked to return to his houseblock to rest in his cell. The Principal Officer offered to escort him back. This was at about 10.20am. At interview, the Principal Officer said that it took a couple of minutes to walk from the chapel to houseblock 1. He assumed that he would have exchanged some general conversation with the man as they walked but he could not recall any particular comments and he did not identify anything untoward about his demeanour.

36. Just after the man's return to houseblock 1, a stand-fast roll check was called. These additional checks are made when the conciliatory roll count of all prisoners – those at work, at education, in healthcare and elsewhere – does not tally with the full prisoner population count. Prisoners on the wing are usually asked to return to their cells for the count to be made.

37. One of the landing officers counted the prisoners on the second landing and that would have included the man meaning that she was probably the last person to see him alive. At interview, the Landing Officer said that she could not actually recall the man. All she could confirm was that she would have checked all the cells on the landing and counted all the prisoners present (during stand-fast roll checks officers would not interact with prisoners, they would merely count them).

38. At about 11.30am, one of the other officers took the man's cell-mate back to cell 23. When the officer unlocked the door he saw the man hanging from the light fitting. The officer pressed the alarm bell and without further delay went into the

cell and cut the ligature. Other staff arrived and helped place the man on the floor. Staff checked him for signs of life but they found none. A second officer then began mouth-to-mouth breathing. At first he tried to use the basic resuscitation aid[3] that he always carried in his pocket. However, the man's jaw was clamped tightly and the second officer found it difficult to force in air. Another member of staff then passed the second officer a different type of resuscitation aid. This one had a small tube that the second officer was able to push into the man's mouth allowing free flow of air. While this was going on another officer was giving chest compressions. He completed the first set of 30 chest compressions before the Emergency Response Nurse arrived and took over.

39. The Emergency Response Nurse told my investigator that she was Hotel 1 that day (meaning that she would normally respond to all medical emergencies). The alarm that went off at 11.30am was not a Hotel 1 call suggesting that it was not an emergency and that it was Hotel 2 rather than Hotel 1 who was needed. However, as the Emergency Response Nurse had finished the work she was doing she decided to respond to the call to assist Hotel 1. As she was making her way to the houseblock, the alarm was reissued informing that it was now a Level 1 call indicating that the person concerned was unconscious.

40. The man was checked with a defibrillator[4]. It instructed staff to continue with manual resuscitation which they did until relieved by ambulance paramedics around ten minutes later. The paramedics continued trying to resuscitate the man for the next 25 to 30 minutes. Unfortunately, all efforts proved unsuccessful and The man was pronounced dead at 12.12pm. The man did not leave a suicide note.

After the man's death

41. The man's next-of-kin was his mother, who lives in Islington. At around 2.00pm one of Belmarsh's Family Liaison Officers went with another member of staff to visit the man's mother to break the news. The man's mother asked a number of questions about her son's death and then telephoned several family members as well as her son's partner. Following these calls a number of people began to arrive at her home. Before leaving, the Family Liaison Officer offered the man's mother the opportunity to visit Belmarsh to see her son's cell. She was also told that the prison would contribute to her son's funeral expenses.

42. A debriefing meeting for staff was held that afternoon and those involved with the man were seen by the care team. A clinical debrief was held the following afternoon. A number of issues of concern were raised in the debriefing meeting. The second officer raised the issue of the ineffectiveness of the first resuscitation aid that he tried to use. Staff also reported that the manual sphygmomanometer (an instrument for measuring blood pressure) was awkward to use and it was suggested that an electronic version should be purchased. Another issue that

[3] A membrane with a one-way valve that provides protection from cross infection.

[4] A defibrillator measures electrical activity in the heart and gives audible instructions for the patient's management.

was raised was the system for summoning appropriate staff in the case of an emergency. The Head of Healthcare, explained at the meeting that procedures were in the process of being revised.

43. During his interview with my investigator, the Chaplain said that he was in the prison on the day of the man's death, but was not told that he had died. This meant that the man was denied the opportunity of being anointed with holy oils. This is a matter of great importance in the Roman Catholic faith and must happen within two hours of death.

44. The Samaritans co-ordinator spoke with the Listener and offered him her support. Both staff and IMB members spoke with the man's cell-mate.

MAIN FINDINGS FROM CLINICAL REVIEW

The main questions and associated findings from the clinical review were:

Is the documentation and record keeping adequate and appropriate?

No staff names are printed. Signatures are illegible. A previous recommendation for notes to be annotated with the staff number do not seem to have been implemented in this case. In particular the documentation of the interview as part of the further reception health checks following sentencing was inadequate.

Are there any lessons to be learnt?

Yes, prisoners remain vulnerable for a significant period of time post sentencing and therefore additional screening needs to be considered during that time. The potential for this exists through the lifer team.

ISSUES

Caring for prisoners who might be at high risk

45. The man arrived at Belmarsh on 13 September as a remand prisoner charged with murder. During his induction interview the next day the man declined to take a 'lifer-prisoner information pack' indicating that he was certain in his own mind that he would be acquitted. In fact, he declared that there was no evidence against him. Despite his optimism, the man was found guilty of murder on 5 November and sentenced to life with a minimum term of 15 years imprisonment.

46. The man was seen by a reception nurse on his return to prison after conviction and sentencing. The man said that he was okay and had no thoughts of self-harm. The Reception Nurse told him that nurses were available 24 hours per day should he need to see one. The Duty Governor and the officer on houseblock 3 both asked the man if he was alright and he replied that he was.

47. The man telephoned his partner that evening and telephoned her several more times in the following days. It is clear that the man was genuinely shocked to have been convicted of murder and shocked too at the length of his sentence. This is evident from listening to the man's conversations with his partner. Even so, the man and his partner spoke positively about the prospects of a successful appeal. Much of their conversation recurred, however, to the impact of the sentence on their relationship. The man repeatedly suggested to his partner that he could not expect her to wait for him for 15 years. In response, the man's partner repeatedly said that she loved him and could not imagine being with anyone else, but she also acknowledged that 15 years would be a very long time for her to wait. (I understand that the man's partner was 20 years of age at that time.) In one of their three conversations on the morning of 8 November 2007, the man said something indicating that he wanted his partner to cut her arm and that he would do the same. She responded by telling him not to do that.

48. No prisoners came forward in response to the notices about my investigation into the man's death although my investigator did speak to one prisoner, the Listener who also happened to be at court on 5 November. The Listener said that the man looked shocked when he returned to the court waiting room immediately after sentencing, although no more so than most prisoners given a lengthy sentence. By the following day, however, the man had become more talkative, speaking about an appeal and playing pool. On the next day (7 November), the man went to the Wednesday religious faith discussion group as usual. The Chaplain said that the man was his usual self and did not ask to speak in private. (It was not until after the man's death that the Chaplain discovered that he had been convicted on the Monday of that week.)

49. The man's cell-mate during his brief time on houseblock 1 was badly affected by his death and did not want to speak to my investigator. He was, however, interviewed by the police investigators. The cell-mate's evidence to the police was that he could not speak English; his only language was Punjabi. He said

that the man spent the night of 7/8 November writing letters[5] and he was still awake at 4.00am. The man had been quiet throughout the time they were together.

50. PSO 2700 gives guidance on suicide and self-harm prevention. Although it has long been recognised that prisoners charged with murder and/or sentenced to life are at a higher risk of suicide, earlier versions of PSO 2700 did not specifically refer to any such association. The latest version of PSO 2700 was issued on 26 October 2007 setting a formal implementation completion date of 30 April 2008. Advice within this version of PSO 2700 includes that:

> "Prisoners charged with homicide are a particularly high-risk group … Reception/first night staff must be made aware of the suicide and self-harm risks associated with prisoners who are charged with offences related to … homicide … Care of such prisoners will require close monitoring of trigger points, for example during any trial …"

51. The man was just such a prisoner. In addition, he was a young man, just 22 years of age. The man's partner questioned why those factors did not result in him being made the subject of some kind of watch or monitoring. I can understand why the man's partner feels this way. However all the evidence, including that of the Listener and especially that of the Chaplain, indicates that the man did nothing to suggest he might have been at risk or that he wanted any support. It is difficult to imagine what more Belmarsh could have done to identify the man's needs, to identify that he might have been at risk and to identify what type or nature of support might have made a difference in his particular case. Even so, I make the following recommendation:

I recommend that the Governor considers implementing further support for life-sentenced prisoners, for instance:

- **Re-introducing regular visits to houseblock 1 by the lifer team.**
- **Establishing lifer groups.**
- **Arranging for a lifer Insider to speak to all newly convicted or sentenced life-prisoners upon their arrival in houseblock 1.**

How the man came to be alone in his cell

52. The man was occupying a shared cell and on the morning of 7 November both he and his cell-mate were in the chapel watching a DVD. At about 10.20am the man complained that he was not feeling very well and asked to return to his cell. While we cannot know, one might surmise that the man feigned a slight illness as he knew the cell would be his alone. (The Head of Residence explained, however, that it was only chance that had resulted in the man being in a shared cell as Belmarsh prefers to allow life-prisoners the privilege and privacy of a single cell. The Head of Residence also explained that had the man been

[5] The police discovered no relevant correspondence in The man's cell.

identified at risk of self-harm he would not have been left alone in the cell. Instead, officers would have placed him somewhere safe until the return of his cell-mate.)

The life sentence planning interview

53. Once convicted and sentenced to life the man was due to be seen for a formal life-sentence planning interview. Belmarsh's local target for these interviews is 72 hours from the prisoner's return to the prison after sentencing. This means that the man should have been seen on the afternoon of 8 November. My investigator was told that the man would not in fact have been seen that afternoon as staff from the lifer team had been redeployed to carry out other duties. The Deputy Lifer Manager expressed frustration to my investigator that his team was liable to be diverted in this way from its primary function. I understand from my investigator that the Deputy Lifer Manager was enthusiastic about his role and I am pleased he takes seriously the importance of the life sentence planning interview. However, Belmarsh's 72 hour target is a local target, the national target being seven days for the competed paperwork to be sent to the lifer unit. This means that the target had not been missed that day.

54. A separate matter of debate is the right time to carry out the life sentence planning interview. Some prisoners would probably welcome an early intervention. However other prisoners might want a little time to think matters over before meeting staff. I was therefore pleased to learn that the Deputy Lifer Manager's team will rearrange an interview if this is what the prisoner prefers.

The immediate response when the man was found

55. When the man was found hanging in his cell staff appear to have responded very promptly, both in terms of cutting the ligature and in commencing resuscitation. The second officer said, however, that his efforts to try to give emergency breaths were initially hampered because the man's jaws were clamped tightly. He was able to administer breaths when a colleague passed him a different type of face mask. This was fitted with a short tube that the second officer was able to force into the man's mouth. This matter was raised during the clinical debrief held on the day after the man's death. Other issues raised by staff included that the manual instrument for measuring blood pressure was awkward to use and should be replaced with an electronic version. Another was the system for summoning appropriate staff in the case of an emergency. In the first instance, it was a general alarm that was issued and it was only by chance that the Emergency Response Nurse, acting as Hotel 1, responded to the alarm.

I recommend that the Governor, in consultation with the Head of Healthcare, reviews whether all matters raised during the clinical debrief have been addressed with appropriate changes made to emergency call procedures and the replacement of emergency equipment.

Religious observance

56. Although the Chaplain was in Belmarsh when the man died he was not informed of his death and so was not able to attend to perform the anointing of the body. The Chaplain pointed out to my investigator that this is a matter of great importance in the Roman Catholic faith.

I recommend that the Governor ensure prompt contact with the chaplaincy in the event of a death in custody to allow appropriate religious observances to be conducted for those prisoners with a known faith.

RECOMMENDATIONS

The following recommendations were made in the draft version of this report. The Prison Service's responses appear in italics following each recommendation:

1. The Governor consider implementing further support for life sentenced prisoners, for instance:

    - Re-introducing regular visits to houseblock 1 by the lifer team.
    - Establishing lifer-groups.
    - Arranging for a lifer Insider to speak to all newly convicted or sentenced life-prisoners upon their arrival in houseblock 1.

    Prison Service response: recommendation accepted.

    - *Weekly visits by the Lifer Team will be introduced.*
    - *Lifer groups will be introduced and held monthly.*
    - *Lifer Insiders will be set up on HB1 to speak to all new lifers on HB1.*

    Target date for completion: 1 November 2008.

2. The Governor, in consultation with the Head of Healthcare, reviews whether all matters raised during the clinical debrief have been addressed with appropriate changes made to emergency call procedures and the replacement of emergency equipment.

    Prison Service response: recommendation accepted and completed. All matters raised in the clinical de-brief have been addressed.

3. The Governor should ensure prompt contact with the chaplaincy in the event of a death in custody to allow appropriate religious observances to be conducted for those prisoners with a known faith.

    Prison Service response: recommendation accepted. The Contingency plans on Death in Custody have been changed to reflect this. Target date for completion: 1 November 2008.

I also endorse the following three recommendations made by the clinical reviewers:

4. Training of all staff on houseblocks in detection of indicators that suggest a higher risk of self-harm should be instated. In particular this should increase awareness of the need for vigilance for a significant period after prisoners are sentenced for lengthy sentences.

    Prison Service response: recommendation accepted. Assessment, Care in Custody and Teamwork (ACCT) is the means by which the Service manages prisoners found to be at risk of suicide or self-harm. It focuses on individual need,

assessment and care-planning and involves the prisoner at all stages. It is a multi-disciplinary process managed by a Case Manager and involving staff who input directly to the care of the at-risk individual. Case Review decisions are registered in a CareMap which is then used to address the individual's problems. All prison staff receive ACCT Foundation training. Work on this is ongoing.

5. The prisoner potentially remains at risk over a period of time post sentencing. Consideration should be given to instigating a further medical screening interview after following on from that undertaken prior to 72 hours, in the following few days by a suitably trained individual.

Prison Service response: recommendation accepted. The establishment is introducing electronic record keeping in Healthcare. Cabling has been installed and funding has been obtained from the PCT for the computers and software. These are been installed. Training is now taking place on their use it is envisaged that the system will become operational in October 2008. Target date for completion: 1 November 2008.

6. The standards of medical record keeping should be improved significantly.