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

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is a report into the circumstances surrounding the death of a man at HMP Belmarsh in January 2007. He was found hanging in his cell. The man said he was 32 years old, although both the name and the date of birth he gave to the police on his arrest in July 2005 may not have been his real ones.

I know very little about the man's life. He came to this country in June 2005 from France and committed the offence which led to him receiving an indeterminate sentence the following month. He was also the subject of extradition proceedings on a charge of murder in Germany. Unfortunately the police and Interpol have been unable to trace his family and I have not been able to include them in my investigation. The man gave some glimpses of his past to several psychologists during his time in Pentonville, Brixton and Belmarsh prisons. During his time in prison in this country he remained despairing of his future and deeply suicidal.

The investigation was led by one of my investigators with assistance by one of her colleagues. An independent clinical review into the care received by the man in prison was undertaken by three medical professionals from Greenwich Teaching Primary Care Trust. I am grateful to them for their assistance. I am also grateful to the Governor and staff of HMP Belmarsh, for their help during this investigation.

The management of someone who is determined to take their own life poses an enormous challenge for Prison Service staff. I believe that for the most part the man was well cared for during his time in prison. I am critical of a lack of communication of his risk factors between Belmarsh's Healthcare Centre and Houseblock 1. A breakdown in communication is a feature of all too many of my fatal incident reports.

That said, the sad, violent life and death of the man (or whatever his name really was) challenges the view that somehow suicide or self-harm is always someone's 'fault'. His story presents no easy answers.

I make three recommendations and highlight two examples of good practice.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2007**

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SUMMARY

The man died, apparently by his own hand, in January 2007 in HMP Belmarsh. Little is known about his life apart from the details he shared with the probation service and various psychiatrists who interviewed him in prison. He told his probation officer that he came to the United Kingdom in June 2005 on a false passport. In July 2005, he broke into a flat and raped the woman who lived there. Following his arrest, he was taken to HMP Pentonville. In March 2006, he received an indeterminate sentence for public protection, with a minimum time to serve of six and a half years.

The man was wanted by German police for the murder of a shop assistant in 2005 and was the subject of extradition proceedings. It is likely he would have been deported to Germany at the conclusion of his life sentence.

The man remained in Pentonville until July 2006 when he was transferred to HMP Brixton. At Pentonville he self harmed on five occasions and attempted to kill himself four times. He saw two psychiatrists and was described variously as “depressed”, “impulsive”, “reckless” and “anti-social”. He was managed under the Prison Service’s self harm and suicide monitoring procedures for almost the entire time he was in Pentonville, and repeatedly told staff that he had nothing to live for.

His low mood continued at Brixton and he remained subject to self harm and suicide monitoring for the duration of his time there. In July 2006, he was reviewed by a doctor from a Regional Secure Unit (a medium secure NHS facility). The doctor concluded that the man was depressed but not suffering from any formal mental illness which required a transfer to a NHS facility.

The man was reviewed again by the doctor in August 2006 after he had set fire to his cell and suspended himself from a noose tied to his cell light. In this second report, the doctor identified a number of situational triggers that increased the man’s vulnerability and the likelihood he would try to kill himself. These triggers included news about his extradition to Germany and “ruminations” on the negative aspects of his life. The doctor concluded that the man would remain at “a persistently high risk of deliberate self harm and completed suicide for the foreseeable future.” I have seen no evidence that these situational triggers were listed on the man’s F2052SH forms or his ACCT document at Brixton.

The man was recategorised to standard category A and transferred to Belmarsh on 25 September 2006. He was located in the Healthcare Centre (HCC) between 25 September 2006 and 5 January 2007. He had two periods of constant observation, between 25 September and 2 October, and then for 47 consecutive days between 9 October and 28 November. At all other times while he was in the HCC, the man was observed at 15 minute intervals. On 9 October, The man set fire to his cell in an attempt to kill himself. While on constant observation he attempted to self harm twice, and twice had ligatures removed from his cell. His mood improved when constant observation was stopped at the end of November and there were no further incidents of self harm while he was located in the HCC.

The man was transferred to Houseblock 1 on 5 January 2007. Although there is no formal record on his ACCT document of the number of observations and

conversations staff on Houseblock 1 were required to make, it appears that he was observed three times every morning, three times every afternoon and every hour during the night.

I have found no evidence to show that staff on Houseblock 1 were told about the situational triggers that increased the man's vulnerability. In addition to those identified by the doctor in August 2006, a senior nurse in Belmarsh had noticed that his vulnerability increased after changes in his location. I have seen no evidence that the man received a follow up visit from HCC staff during his time on Houseblock 1.

On 9 January, he attended an extradition hearing via videolink and was told that he must appear in person at the next hearing on 6 February. After this hearing the man barely ate a meal, refused to take his medication and refused association. In the early hours of 12 January, he was found suspended from his cell light by his bedsheet. Despite the efforts of staff to revive him, he was pronounced dead by paramedics.

I make three local recommendations about ACCT documents, record keeping and the Listeners, and one national recommendation about constant observation.

I commend the prison's immediate response to the death of the man, especially the prompt response of the night patrol officer. I also praise the actions of the officer in the HCC who pulled the man from his smoke filled cell on 9 October 2006.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 12 January 2007. The case was allocated to two of my investigators on 15 January. On of the investigators visited Belmarsh on 19 January. She met with the Governor, the Head of Residence, and with representatives from the Independent Monitoring Board and the local branch of the Prison Officers' Association. She visited the man's cell and collected copies of his prison record, Inmate Medical Record (IMR), and the staff incident reports written following his death. A copy of the post mortem report was requested and later received from the Coroner.

2. My investigators interviewed staff and prisoners at Belmarsh on 30 January and 1, 2 and 12 February. They spoke to two representatives from the prison's Listener scheme in the company of a Samaritan. One of my investigators spoke to the head of healthcare, by telephone. She spoke to a member of staff in the Directorate of High Security Prisons. She also contacted the man's probation officer. My other investigator met with two staff members from the Prison Service's High Security Directorate at Prison Service Headquarters. She also spoke to a detective constable from the Metropolitan Police Extradition Unit and a staff member of the Crown Prosecution Service Extradition Squad.

3. A clinical review was commissioned from Greenwich North Primary Care Trust (PCT). The PCT appointed three medical professionals to undertake a clinical review of the man's medical care while in prison.

4. The police were contacted but, despite enlisting the aid of Interpol, they were unable to contact the man's family.

HMP BELMARSH

5. Belmarsh opened in 1991. It is a local prison but also holds category A prisoners. Most of its 915 prisoners are accommodated on four residential houseblocks. Houseblock 1 contains mainly life sentence prisoners, although no specific sentence planning or courses for lifers take place at Belmarsh. Life sentence prisoners are held until appropriate spaces for them can be found elsewhere in the lifer estate. In common with other prisons, Belmarsh is overcrowded and many prisoners spend most of the day in their cells. The situation is not helped by the number of people waiting deportation who remain there past their release date.

6. A representative of the Independent Monitoring Board (IMB), told my investigator that, despite the difficult conditions, staff/prisoner relations at Belmarsh are good. She said the Listener scheme is considered a prized asset at Belmarsh, and the Listeners are keen to extend the service to prisoners on the Healthcare Centre. This has not happened because of the pressure on places. (Listeners are volunteer prisoners trained and supported by the Samaritans to provide peer support to prisoners who ask for it.)

7. In March 2007 Belmarsh introduced a new core day which was designed to increase time out of cell, purposeful activity and to improve decency for prisoners. Since it's introduction time out of cell has increased from 6.3 to 8.4 hours a day and the purposeful activity target of 16.5 hours is now being exceeded.

8. Together with HMP Brixton, Belmarsh piloted the model for treating prisoners with mental health problems in a 'community' setting. The Healthcare Centre (HCC) is a three storey building which includes a 33 bed in-patient unit. The in-patient beds are mainly used for prisoners requiring psychiatric care. The HCC has four 'gated' cells which can be used for prisoners needing constant observation. In April 2005, Greenwich Teaching PCT assumed responsibility for commissioning healthcare services in the prison. The Head of Healthcare leads a multi-disciplinary team of nurses, healthcare officers, discipline officers and nursing assistants, and there is input from a Mental Health In reach Team (MHIRT), visiting GPs and a consultant forensic psychiatrist.

9. The man's death was the second apparently self-inflicted death to occur in Belmarsh since I began investigating fatal incidents in April 2004. Since he died there have been two further apparently self-inflicted deaths. At the time of writing, the reports into these latter deaths were not available.

THE EVENTS LEADING UP TO THE MAN'S DEATH

From 14 July 2005 to 23 May 2006 in HMP Pentonville

10. On 14 July 2005, the man arrived at Pentonville from police custody. The police record said he had self harmed, and the Pentonville reception officer who completed the man's cell sharing risk assessment (CSRA) noted he had scars from self harm on his arms. The following day he tested positive for benzodiazepines. He underwent a programme of detoxification but did not engage with CARATs (Counselling Assessment Referral Advice and Throughcare) workers despite several attempts to involve him in courses.

11. On 12 August, the man was admitted to the Healthcare Centre (HCC) after self harming on A wing. A F2052SH form was opened and he was placed on 15 minute observations. (A F2052SH was the form used by the Prison Service to monitor prisoners thought to be at risk of self harm or suicide. This was superseded by the ACCT (Assessment Care in Custody and Teamwork) process.) On 16 August, the level of observations was increased to constant observation (constant observation is where the prisoner is observed by a designated member of staff who remains constantly in his or her presence). On 25 August, the constant observation was stopped but the man remained on an open F2052SH form in the HCC. He was reviewed by a doctor on 26 August. The doctor wrote in the man's Inmate Medical Record (IMR) that he did not think he was psychotic but was depressed. He said that the man appeared to have been very affected by a road traffic accident a few years before.

12. On 30 August, the man left the HCC and was put in a cell on a normal wing. The next day he attempted to hang himself and was returned to the HCC. His IMR shows he would only tell staff that he had a lot of problems and that he preferred being in the HCC. On 1 September, the man was seen by a psychiatrist (signature illegible) who diagnosed him with a personality disorder and possible post traumatic stress disorder due to a road traffic accident. The psychiatrist recommended that the man remain in the HCC for evaluation, and that he see a Dutch or Spanish speaking psychiatrist who might be able to rule out significant mental illness.

13. At a review on 9 September, the man told staff that he was hearing voices telling him to kill himself. On 14 September, he was seen by a Spanish speaking consultant psychiatrist. The psychiatrist diagnosed the man with depression and "features of emotional unstable personality with impulsivity and DSH [deliberate self harm]". The psychiatrist put the man on a course of the anti-psychotic drug, olanzapine. On 12 October, he reviewed the man again and found he felt the "same" but had not heard any voices and had only occasional thoughts of self-harm. On 24 October, the man was discharged from the HCC and transferred to B wing. On 26 October, he refused to see the psychiatrist and on 8 November his ACCT form (his F2052SH had been converted to an ACCT document during this time) was closed. The man refused to see members of the Mental Health Team (MHT) on 16 and 22 November.

14. On 5 December, the man made superficial cuts to his arms. An ACCT form was opened the next day but appears to have been closed by the time the man saw the psychiatrist again on 21 December. At this review, the psychiatrist expressed surprise that the ACCT opened on 6 December had been closed. The man told him he felt "worse" than before and had not taken his medication for a month as it was "no help". The man said he had occasional suicidal thoughts. The psychiatrist recommended that another ACCT should be opened and the man should be monitored by the MHT. The psychiatrist saw the man a week later and reported that he appeared "brighter" and was not actively suicidal.

15. On 19 February 2006, the man cut a deep laceration on his right forearm with a razor blade. The psychiatrist saw him the following day. He said the man was "not mentally ill but had maladaptive personality traits associated with a difficult upbringing". He described him as "impulsive, reckless and anti-social".

16. On 25 February, the man cut a seven centimetre wound on his left arm with a razor blade. On 8 March, he was seen by staff about to hang himself from the light fitting in his cell. He told them he had "nothing to live for" and was being sentenced "tomorrow". He was taken to the HCC and put on 15 minute observations. On 9 March, the man received his indeterminate sentence for public protection (IPP).

17. On 10 March, the man told members of the MHT that he was distressed and guilty and wanted to stab himself. On 12 March, he was found in his cell trying to cut his arm with a razor. He told staff he was worried about "all the other cases" he had to face. He was placed on constant observation. On 13 March, the level of observation was reduced to every 15 minutes.

18. On 18 March, a piece of torn sheet was removed from the man and he told staff he was going to kill himself with it. On 20 March, he set fire to his bedding and was put back on constant observation. He was still threatening to kill himself when he was seen by the doctor the next day. On 22 March, he was seen by the psychiatrist. He threatened to end his life "at some point". He told the psychiatrist that he had nothing to live for since he had been sentenced. The psychiatrist again diagnosed a personality disorder and said that he could go back to a wing and 15 minute observations. The psychiatrist saw the man a week later and said that he was still "intimating he will ultimately kill himself".

19. On 18 April, the man set fire to some rubbish in his cell on C wing. He was taken to the segregation unit and placed on 30 minute observations. While in the segregation unit, the man slammed his cell door on an officer's foot. On 19 April, the psychiatrist saw him and confirmed that the man did not need to be in the HCC. The same day the man was found guilty at adjudication of breaking Prison Rule 51 paragraph 1 'commits any assault'. He was punished with 14 days loss of canteen (goods from the prison shop) and 14 days loss of 80% of his earnings.

20. On 29 April, staff found evidence of another fire in the man's cell. He was taken to the HCC as he was described as "low in mood". On 3 May, the psychiatrist saw the man and said that he was low in mood with recurrent suicidal thoughts. The doctor did not think the man needed to be in the HCC and he was discharged back to the wing on 6 May.

21. On 16 May, Pentonville received a request to produce the man at a Magistrates' Court on 23 May for an extradition hearing. The man was wanted by German police in connection with the murder of a shop assistant in 2005. On 23 May, the man was taken from court to HMP Brixton.

From 23 May 2006 to 29 September 2006 in HMP Brixton

22. As soon as he arrived at Brixton, staff opened an F2052SH on the man. On 29 May, he was admitted to the HCC after staff became concerned about his low mood, apathy and "suicidal ideation". He had apparently been found with a noose. He was placed on constant observation and referred to the consultant psychiatrist. On 2 June, he was seen by a psychiatrist and found to be "very low". This psychiatrist recommended the man should a Spanish speaking psychiatrist, and remain on constant observation. The man saw the psychiatrist on 5 June and told him that he was facing a life in gaol and had nothing to live for. The psychiatrist reported that the man became actively suicidal when he thought about his past. He said the man remained at risk of completed suicide, "but this is probably a moderately high chronic risk which is likely to occur on a moment of impulse". He recommended continuing constant observation and said he would liaise with the man's previous psychiatrist.

23. On 6 June, the man told staff he would kill himself because of his problems. On 9 and 12 June he attended Magistrate's Court for extradition hearings. On 13 June, he was seen by a doctor who thought he was depressed rather than suffering from a personality disorder. On 17 June, the man again said he would find a way to kill himself. The doctor saw him the same day and found him to be very depressed and not eating much. He recommended that shoelaces and other objects with which the man could self-harm be removed from him. The doctor referred the man to a Regional Secure Unit (a NHS medium secure facility) on 20 June.

24. On 23 June, a makeshift weapon made from a razor blade moulded on to a plastic knife was found in the man's cell. He was on constant watch at this time. On 27 June, the doctor agreed to put the man on intermittent watch after nurses reported that he was much better and interacting well.

25. On 4 July, the man was assessed by a doctor from secure unit. The doctor wrote afterwards that the man should continue to be medicated, and monitored using a combination of constant and intermittent observations. He added, "overall this man poses a high risk of self-harm in the long term that cannot be entirely eliminated and is not directly related to mental disorder."

26. On 17 July, the man was escorted to the dentist. He told the escort that he would kill himself because it was his "personal choice". The man was seen the

next day by a doctor. When asked about his statement of 17 July, the man said that he was facing a long time in prison and intended to kill himself. He told the doctor that he had a plan but would not divulge it. On 20 July, staff found a noose in the man's cell.

27. On 24 July, the man set fire to his mattress and placed a noose around his neck suspended from the light fitting in his cell. He was placed on constant observation. He was seen by a psychiatrist later the same day. The man told him that he had hoped that the fire would obscure the officers' ability to see him hanging, and the flames were intended to prevent them entering the cell. The man said he regretted being cut down and had nothing to live for. He told the psychiatrist that he would kill himself even if he were watched closely. The psychiatrist recommended that constant observations continue and that the man be re-referred to the secure unit.

28. On 26 July, the man told staff he was disappointed he was alive and that he had nothing to live for except a lifetime of prison. On 5 August, he was found guilty of fighting with another prisoner and was punished with stoppage of 80% of his earnings, loss of canteen and loss of TV for 21 days.

29. On 7 August, the man was put on intermittent observations. The same day he attended court via videolink at the prison. On 8 August, he was seen by a doctor for a second assessment. The doctor concluded that the man was not suitable for transfer to an NHS secure mental health facility. He wrote:

> "The man will remain at a persistently high risk of deliberate self harm and completed suicide for the foreseeable future, particularly given that it is strongly related to his probable forthcoming trial on charges of homicide in Germany, and the very real prospect of his spending his life in prison in one country or another.
>
> "As over the last few months his risk of harming himself on any given day may be quite low, but then some situational trigger (such as news about his trial, contact from important figures in his life, or ruminations upon negative aspects of his life) may cause him to make a sudden, impulsive attempt to harm or kill himself.
>
> "In the long term, the persistent nature of this risk, and the lack of relationship to a specific mental illness (as opposed to any personality disorder) makes it intrinsically difficult to manage in any setting."

30. On 21 August, the man shaved his head in what was understood to be preparation for killing himself. The man was considered for a return to normal location on 30 August but staff decided against it. Efforts were made to try to find out the implications of the man's extradition hearings for his management. On 3 September, the man's F2052SH form was converted to an ACCT document. Staff recorded, "we are aware of his sense of hopelessness resulting from his sentence and deportation issues."

31. On 4 September, the man appeared at a Magistrates' Court via videolink. The court order shows that a warrant was issued on 30 May 2005 in Germany for the arrest of a man (an alias or the man's birth name) for murder, robbery followed by death and violation of the German law on firearms. At 1.30pm on the same day, the man made two deep lacerations on his arm and lost a significant amount of blood.

32. It is not clear from the ACCT form what level of observations the man was on following this incident of self harm or whether reviews took place regularly. The front of the file indicates the man was on 15 minute observations but this is undated. On 17 and 18 September, the man is recorded as making repeated threats to kill himself. On 19 September, a psychiatrist recorded on the man's IMR that he had a MALRAP (Multi-agency Lifer Risk Assessment Panel) meeting later in the month and he might become increasingly disturbed. The psychiatrist said the man's extradition to Germany was "his most stressful issue subjectively".

33. On 20 September, the security department at Brixton contacted a colleague at the Department of High Security Prisons at Prison Service Headquarters. They had received more information about the offence for which the man was wanted by German police. After discussion with that colleague it was decided that the man should be made a potential category A standard risk prisoner pending his extradition. A transfer to Belmarsh was arranged for 25 September. As he was a life sentence prisoner, a subsequent attempt was made to transfer him to Wakefield (a training prison which takes category A lifers and which also has a videolink facility for attendance at court). However, Wakefield was unable to accept the man because he was on constant observation and the prison's own healthcare facilities were full.

34. A MALRAP meeting took place on 20 September. The meeting recognised that the man was about to be transferred to Belmarsh and it was decided that the MHT there should be told about him. The man remained on intermittent watch.

From 25 September 2006 to 12 January 2007 at HMP Belmarsh

35. On 25 September, the man was seen in reception by a senior nurse and a mental health nurse (RMN). The nurse recorded on the man's IMR that he was feeling vulnerable due to his change in location. She said reports showed that he was at a high risk of self harm, and he had told her that he would self harm "as soon as he can". She decided that the man should be taken to the HCC and put on constant observation "for tonight". The ACCT form opened at Brixton remained open.

36. On 26 September, the man was seen by a psychiatrist. The psychiatrist recommended that the man remain on constant observation. He said he would liaise with the psychiatrist at Brixton.

37. On 27 September, the Night Orderly Officer (NOO) and the Duty Governor made separate entries on the man's ACCT noting that a review was overdue. A review took place later the same day attended by the nurse, the man and

Senior Health Care Officer (SHCO). The man was judged to be at high risk of self harm and suicide. He said he did not want to be in Belmarsh. He was kept on constant observation in a gated cell on the lower HCC landing. The caremap section of the ACCT was not updated.

38. On the same day, the nurse completed a care plan sheet in the man's IMR. The aim was to stabilise the man's mental state and minimise his risk of self harm. The plan asked nursing staff to monitor the man, to make sure he took his prescribed medication, to encourage him to talk about his anxieties and to ensure he had access to Listeners, the Samaritans and the chaplaincy. The man was to be assessed regularly by a psychiatrist and encouraged to use the Cass Unit (a therapeutic unit in the lower HCC where prisoners can do art therapy and other activities). This plan does not appear in the man's ACCT form.

39. On 2 October, the man appeared at a Magistrates' Court via videolink. Later that night he refused to take his medication, and at 1.00am on 3 October he made superficial scratches to his wrist with his thumbnail. He was seen the same day by a consultant psychiatrist. The psychiatrist said that the man wanted to come off constant observation. He told the psychiatrist he would not harm himself during Ramadan but could not guarantee not to harm himself after that. The psychiatrist discussed the man with the nurse, and it was decided that he should be moved to a single cell on intermittent observations.

40. On 4 October, the man attended an ACCT review with the nurse and a Health Care Officer. The man's risk was reduced from high to 'raised'. He told the review that he had occasional thoughts of self harm. Later that night he refused to take his medication.

41. On 9 October, the man set fire to his mattress. An officer entered the smoke filled cell and dragged the man out by his foot. The man's IMR shows he was moved to a gated cell and given oxygen. He was seen by the psychiatrist and "clearly indicated he would 'take myself'". At 1.05pm, the man told the officer on constant observation that he was determined to kill himself at Belmarsh. Later the same afternoon, the nurse completed a care plan review in the man's IMR. She said that the man had told staff that he had set fire to his cell because he had his TV taken away. (In fact, it appears the man was only warned that he might have his TV removed if he did not clean his cell.) The substance of the care plan remained the same as that of 27 September.

42. On 11 October, the man was found guilty at adjudication of breaking Prison Rule 51 paragraph 16, 'intentionally or recklessly sets fire to any part of the prison or to any other property whether or not his own'. When asked why he did it, the man replied, "I wanted to kill myself". He was given 21 days loss of 80% of his earnings as punishment.

43. The man attended another ACCT review on 13 October. He said he had no plans to self harm "at the moment". He was seen later the same day by the psychiatrist, and again denied he would self harm as it was "behind him". The psychiatrist advised staff to treat this statement with caution.

44. On 16 October, a mental health nurse (RMN) made an entry on the man's IMR that he was not taking his medication and that ligatures had been removed from his cell. The man told the psychiatrist and the doctor that he wanted to come off constant observation. The same day he was placed on report by an officer for spitting at her and calling her "a fucking bitch". The man did not attend an adjudication in respect of this report.

45. On 17 October, a noose was found in the man's sink during a locks, bolts and bars check of his gated cell. Later the same day, he asked the officer observing him when he would be moving cell. When the officer told him he did not know, the man began to destroy the unit in his cell and started trying to swallow the screws from it. Staff removed the screws from his hands and mouth and took the man under restraint to an unfurnished cell. The man charged at the officers as they left the cell and spat at them. An entry on the man's ACCT form at 5.48pm (signature illegible) says that the man "would not speak", that an ACCT review was not required and that the psychiatrist would see the man.

46. The psychiatrist saw the man on 18 October. The man again asked to be put on normal location. He talked about a court appearance due on 13 November but said that he no longer cared about going to Germany. On 19 October, an officer had a long conversation with the man and arranged for him to go to the Cass Unit the following day. The man did this and also attended Muslim service. He was reported to have enjoyed both and to have been in a good mood.

47. The man attended an ACCT review on 25 October. He was reported to be low in mood but denied he had thoughts of self harm. He again asked to come off constant observation. The man attended another ACCT review on 2 November. His risk level was increased to high. He told the review that he wanted to come off constant observation because it caused him stress. Staff reported that his behaviour was "unpredictable".

48. On 7 November, the man told a psychiatrist that he would kill himself whether he remained on constant observation or not. The next day some pieces of laminate were removed from the man's cell after he threatened to self harm with them. On 9 November, the man was placed on report for telling an officer to "fuck off". HCC staff did not pass him fit for adjudication and he was given an IEP (incentives and earned privileges scheme) warning instead.

49. On 9 November, the man attended an ACCT review but refused to participate in it or answer any questions. Staff reported that he had refused two of his meals and been abusive to staff. Later the same evening, the man smashed his cell table and attempted to self harm using broken pieces of laminate. The man refused breakfast and lunch on 10 November and told staff at 4.45pm that he was on food and fluid refusal. At 6.15pm, the man had a long conversation with the officer observing him (signature illegible) who arranged for him to go to the Cass Unit on the following Monday. The man also agreed to eat his evening meal and took his breakfast pack and some fruit.

50. At 7.00pm on 12 November, an officer came on duty and asked the man when he had last eaten. The man told him he had not eaten anything since 10 November. The officer reported this to HCC staff and the Orderly Officer, and was told that the man would see the doctor in the morning. The man later accepted two cups of tea that evening. A succession of entries on the man's ACCT form between 13 and 21 November describe him as being stable and in a relatively good mood. The man regularly went to the Cass Unit and did art therapy and drama group there. On 16 November, he attended an ACCT review and his level of risk was reduced to 'raised'. A Mental Health Management Board was held the same day and it was agreed to try to find out the details of the man's extradition hearings. It was decided he should remain on constant observation, especially if extradition was likely. On 17 November, the man was seen by a psychiatrist. The man said he had no intention of self harming and wanted to come off constant observation.

51. On 22 November, the man attempted to self harm. He used his socks as a tourniquet to bring up the veins in his arm and then tried to cut himself using the plastic from a carton of orange juice. He was taken upstairs to have his wounds dressed and then returned to his cell and strip searched. When staff left his cell, he ran head first into his window and had to be prevented from doing it a second time. Less than two hours later, he threw his bedding out of his cell and shouted abuse at staff.

52. The man attended an ACCT review on 23 November. He remained at 'raised' risk. He said that constant observation made him feel worse but that he liked going to the Cass Unit and interacting with the other prisoners. A Mental Health Management Board on the same day noted that the man had told staff that constant observation made him feel worse, and that he self harmed to relieve the pressure he felt. He said he was bored and wanted to be considered for regular trips to the Cass Unit and education. The man was seen by the Duty Governor (signature illegible) at 6.40pm. The Duty Governor told him that he could use the gym equipment in the cell next door, and could go to the Cass Unit more frequently "if possible". The Duty Governor wrote on the man's ACCT form, "He needs to do more to reduce the chances of self harm."

53. On 28 November, the man was seen by the clinical lead for in-patients. She described him as "cheerful and hopeful" and positive that his extradition would not go ahead. She decided that he should come off constant observation. The following day, the man was moved to a single cell on the HCC on intermittent observations.

54. At an ACCT review on 1 December, the man's risk was reduced to 'low'. Staff reported that he remained stable and had not self harmed. The next day he told an officer that he was "fed up" with being on the HCC. Another officer noted on his ACCT form that he was "much more settled" since being taken off constant observation. The man reused to attend his ACCT review on 8 December. In his absence, staff reported that he had been settled in mood and should be considered for a transfer to one of the houseblocks.

55. On 13 December, the man was seen by a psychiatrist. He said he had lots of problems “outside” but was trying not to think about them and keep himself busy. He said he felt there was not much to do on the HCC and wanted to go to a houseblock and “do things”. The psychiatrist said the man appeared to accept that there might be a long wait before he would be able to attend education or get a job on the houseblock. The psychiatrist said he would review the man again in a week and would think about discharging him to a houseblock.

56. On 15 December, the man attended an ACCT review. His mood was stable and his interaction was described as good. He agreed to take his prescribed medication which he had been refusing to do for the past two weeks. He attended another review on 22 December. His mood continued to be stable and he again expressed a desire to go to a houseblock.

57. On 29 December, an officer wrote on the man’s ACCT that he had been quiet for the last couple of days. A review took place an hour later and it was noted that the man had poor eye contact with staff. The following day, the officer wrote on the man’s ACCT form that he was upset about the late delivery of a letter from the hospital. (The man was waiting for a knee operation.) The officer wrote, “his mood and behaviour has definitely taken a turn for the worse”.

58. On 2 January 2007, a psychiatrist attended a Mental Health Team review. He said the plan was to move the man to Houseblock 3 “today”. However, a later entry on the man’s IMR shows that he refused to meet the psychiatrist for a review and told the officer sent to collect him that it was “the same old shit”. The IMR shows that staff had noticed the man had been in a low mood for a few days and it was decided that he should remain on the HCC.

59. On 5 January, the man attended an ACCT review with a nurse and a doctor. He said he was ready to go to a houseblock. Thirty minutes later a discharge review took place. The man said he was keen to go on normal location and wanted to “move on”. It was decided to take him off 15 minute observations as part of his moving forward strategy. (I should mention that it was my investigator’s judgement that, in practice, the staffing levels on the houseblocks mean that 15 minute observations are impossible there – which is why serious self-harmers remain in the HCC when the state of their health might not otherwise require them to do so.) The doctor wrote on the man’s IMR that he was “pleasant and cheerful”. The man denied having thoughts of self harm, and they had a long discussion about whether the man should opt to be treated as a vulnerable prisoner. The man said he did not want to go to the vulnerable prisoners unit. The nurse completed an ‘in-patient unit exit plan’. He said that, since the man had been taken off constant observation, he had not self harmed and was presently in a stable mood. He said that a community psychiatric nurse (CPN) would provide follow up care on the houseblock.

60. The man was moved to Houseblock 1 on 5 January. His ACCT form shows that he told staff he was glad to have left the HCC. The ACCT form is not clear about what level of observation the man was on, but it appears from his ACCT

on-going record that he was checked three times during the morning, three times during the afternoon and every hour by night staff from 8.00pm.

61. On 9 January, the man attended an extradition hearing at a Magistrates' Court via videolink. The court paperwork shows that the next hearing was scheduled for 6 February and the man was required to attend in person. That evening, the man declined his meal and did not go on association. The next day, he did not want his lunch but told staff he was "ok". Wing staff also noted that this was the third day on which the man had refused his medication. A nurse was informed and he told wing staff that a psychiatrist would be told.

62. At 5.01pm on 11 January, an officer wrote on the man's ACCT, "sat on floor, all lights off, opened door to talk to him, mumbled a response, when I asked again grunted, put his head down and became non-responsive." Later that evening, the man did not come out of his cell for association. At 10.37pm, he was observed sitting on the floor of his cell.

63. An officer was the night patrol officer on duty on Houseblock 1 on the night of 11/12 January. At interview, he said he was aware that the man was on an ACCT. He said he was required to check him every hour but it was his practice to check prisoners on ACCT forms every half hour. The man's ACCT form shows that another officer checked him at 12.00am and 12.30am. At 1.00am, that officer found the man hanging from his cell light by his bedsheet.

THE PRISON'S IMMEDIATE RESPONSE

64. The following account of what happened when the officer discovered the man hanging in his cell has been gathered from interviews with each member of staff and the incident reports they completed. The officers' accounts are broadly consistent and tally with the timings on the control room logs.

65. The officer said he discovered the man at approximately 1.00am. He used his radio to call for assistance from the Night Orderly Officers. He then broke the seal on his pouch to obtain his emergency cell key, entered the man's cell and supported his body. Within a couple of minutes, a Senior Officer (SO), radio call sign Oscar 2, an officer, radio call sign Oscar 3, and another officer, radio call sign Oscar 4, arrived in the man's cell. One of the officers used his radio to call an emergency 'level one', and the control room put out a call to a Health Care Officer (HCO) to go immediately to the man's cell.

66. Two of the officers supported the man's body and another officer left the cell to collect the anti-ligature scissors which were kept in the wing office at the end of the landing. The SO and an officer removed the ligature from around the man's neck and placed him on the floor of the cell. Both officers checked for a pulse and could not find one. The SO and an officer began cardio-pulmonary resuscitation (CPR) and an ambulance was called for. Principal Officer (PO), radio call sign Oscar 1, one more officer and a HCO arrived at the man's cell when CPR was in progress. As standard practice, only Night Orderly Officers carry keys, and an officer had gone to the HCC to collect the HCO as soon as the officer's first call for assistance came over the radio. The officer brought with him a defibrillator from the wing office.

67. The HCO took over chest compressions from one of the officers and the defibrillator was attached to the man's chest. The machine indicated "no shock required continue CPR". The officers continued CPR until paramedics arrived and took over. The man was taken by ambulance to hospital at 1.47am. The prison was informed officially at 2.22am that he had died.

68. The control room log shows that the officer called for assistance at 1.04am, the second officer called an emergency 'level one' at 1.06am and the ambulance was called at 1.08am. The first response paramedic arrived at 1.12am and an ambulance arrived at 1.15am. The procedures necessary to escort a category A prisoner to hospital in an emergency were followed. The police, the prison doctor, the Duty Governor, the Governor, Prison Service National Operations Unit, the Independent Monitoring Board, the chaplain and the Care Team were all properly informed of the man's death.

69. All of the staff interviewed by my investigators felt that they had received appropriate support. However, not all staff were sure whether there had been a hot debrief and I have seen no record that one took place.

ISSUES CONSIDERED DURING THE INVESTIGATION

The identification of the man's risk factors

70. There are 11 incidents of self harm and nine incidents of attempted suicide in the man's prison records between 12 August 2005 and 22 November 2006. In addition, he made numerous verbal threats that he would kill himself. He was diagnosed with depression and a personality disorder at Pentonville. Subsequent reviews by consultant psychiatrists working within the prison system and in the NHS agreed with this diagnosis. The man's most frequent explanation for his self harm and attempted suicide was frustration and anxiety about his court cases (first his conviction for rape and then his extradition hearings), and a sense of hopelessness brought on by the very real prospect of a life in one prison or another. The man was seen regularly by consultant psychiatrists throughout his time in prison.

71. The clearest link between the man's self harm and attempted suicide and his extradition hearings was made by a doctor from the Regional Secure Unit. On 22 June 2006, the man was referred for assessment to unit because staff at Brixton were worried about the progressive deterioration of his mental state and his potential for completed suicide. He was seen by the doctor on 4 July. In his report, the doctor wrote that the man had experienced depressive symptoms including low mood, suicidal ideation and attempts to harm himself. He said, "these symptoms have been precipitated by bad news, especially relating to his court case." The doctor said the man had been well managed in Pentonville and Brixton and should continue to be offered anti-depressants, nursing support and counselling as necessary. He concluded, "he may again need close supervision if his risk of self harm or suicide increases again in response to bad news, such as news about extradition."

72. On 24 July 2006, the man made a very serious attempt to kill himself by setting fire to his cell and suspending himself from the light fitting using a bedsheet. On 8 August, he was re-referred to the secure unit and seen by the doctor the same day. In his report of 9 August, the doctor said that the man gave a "lengthy" explanation for his suicide attempt of 24 July, "which boiled down to feeling very frustrated about his situation, being unable to sleep, being repeatedly disturbed by an officer checking on him overnight and switching on the light and ruminating on 'never seeing his daughter'". (This is the first and only time the man made any reference to having a child.) The doctor concluded that "the man will remain at a persistently high risk of deliberate self harm and completed suicide for the foreseeable future …" (see para 34 above).

73. The doctor said that the man was being well cared for in Brixton and it was not appropriate to transfer him to a NHS secure facility. He said staff should continue to manage him with anti-depressants and use constant and intermittent supervision as necessary during periods of increased risk. He recommended that staff monitor the man's behaviour closely and act upon indications of increased rumination and anticipated bad news. He cautioned that staff should recognise that, "the risk of harm to himself is persistent and cannot be eliminated entirely, no matter how well he is cared for."

74. The man attended court (either in person or via videolink) about his extradition hearing on 12 occasions between 23 May 2006 and 9 January 2007. His records often show an increase in anxiety before these appearances, and a deterioration in mood afterwards. On two occasions he self harmed or attempted suicide on the same day. On 19 September 2006, a psychiatrist at Brixton wrote on his IMR that, "the prospect of deportation to Germany is his most stressful issues subjectively". There are numerous entries on the man's record reporting his stated anxiety about his court case. After his appearance by videolink at court on 27 November 2006, the man told a nurse that he was positive his extradition would not go ahead. This appears to have precipitated (or at least coincided with) his most settled period at Belmarsh when he came off constant observation and did not self harm. At his appearance at court via videolink on 9 January 2007, the man was told that he was required to attend in person at the next hearing on 6 February. The entries in his ACCT show that his mood became very low after this hearing. He missed meals and did not go on association.

75. The link between change of location and self harm is less obvious from the records. The clearest example is on 31 August 2005 when the man attempted to hang himself in his cell on C wing in Pentonville after being transferred there from the HCC the day before. The man was obviously very anxious about his transfer to Belmarsh, and a nurse was right to highlight this as a possible trigger point on his IMR and on his ACCT.

The management of the man's risk at Belmarsh

76. The inside front cover of an ACCT document has a section where 'trigger' points and warning signs that should prompt immediate review should be listed. This was entirely absent from the ACCT document provided to my investigators. It does not appear that staff at Brixton listed any trigger points when they converted the man's F2052SH form into an ACCT document on 3 September. I have not seen a copy of the previous F2052SH document (which was 'live' when the psychiatrist assessed the man in July and August 2006) and so I do not know whether they were ever listed. I have seen no evidence that they were listed at Belmarsh. Nevertheless, two significant trigger points had been identified by the time the man transferred to Belmarsh – the man's extradition hearing and changes in his location and environment.

77. At interview with the clinical review team, a doctor said he spoke to the psychiatrist at Brixton on the day of the man's transfer to Belmarsh. He said that the psychiatrist had also faxed copies of three psychiatric reports to Belmarsh. Belmarsh had copies of the man's IMR from Pentonville and Brixton which contained copies of several reports by the psychiatrist at Pentonville and the psychiatrists at Brixton. His IMR from Brixton contained several copies of the secure unit doctor's first report on the man following his review of 4 July. The man's IMR from Belmarsh contained a copy of the doctor's second report of 9 August which had been faxed to the prison on 27 December 2006. It is not clear from the records what prompted the request for this report at this time. There is evidence that HCC staff at Belmarsh were aware of these situational

trigger points – a meeting of the Mental Health Management Board on 16 November 2006 decided the man should remain on constant watch "especially if extradition was likely". At interview, a doctor and a psychiatrist said that there were many factors which affected the man's condition and many triggers – including extradition. They added that extradition was a long process and, as it was not imminent, it was not considered a major risk factor. All the evidence appears to contradict this view.

78. The man's IMR shows he was due to move to Houseblock 3 on 2 January 2007, but the doctor decided this should be postponed because staff had noticed he had been in a low mood for a few days. The man attended an ACCT review on 5 January with a doctor and a nurse. He said he was ready to go to a houseblock. Half an hour later, a 'review prior to discharge from healthcare' form was completed. Present at the review were a doctor, a SHCO, a nurse and the man. The ACCT form provides that, when a prisoner on an open ACCT transfers between the HCC and a wing, a pre-discharge case review should take place involving a representative of the receiving unit. There is no evidence that a member of Houseblock 1 staff attended this review. The review form shows that the man was keen to return to normal location and had been removed from 15 minute observations. The summary section invites the writer to include "significant, risk-pertinent events" during the in-patient stay. None of these is listed. The follow up healthcare section reads "handed over to mental outreach" and a case review was scheduled for 12 January.

79. The doctor wrote a comprehensive note of his review of the man on 5 January on his IMR. He said the man insisted he would be fine on the wing and did not want to go to the vulnerable prisoners unit. He denied thoughts of deliberate self harm and suicide. The doctor told the man there would be a delay in his being able to start education on Houseblock 1 because he was a category A prisoner. The doctor told him he would have support from a Community Psychiatric Nurse (CPN) and "F/U" (follow up). The doctor passed the man fit for ordinary location.

80. When asked at interview how wing staff would identify increased risk following the man's transfer to Houseblock 1, a doctor and a psychiatrist said that wing staff would refer to the exit plan and the ACCT document. A nurse said that the man's possible triggers were noted in the ACCT document which was given to the houseblock when the man transferred there. He said he would have expected wing staff to contact healthcare staff if there were any problems. There are references to the man's concerns about his extradition hearing in the on-going record section of the ACCT – for example in a conversation with a SO on 30 September 2006. A nurse made an entry in the man's IMR on 25 September that he was very vulnerable and at increased risk when his surroundings change.

81. An 'in-patient unit exit plan' was completed by the nurse on 5 January 2007. This document was placed in the man's F2050A wing history file, which was opened on 5 January. The nurse wrote on the form that the man had been on constant observation for several weeks until 29 November, but had not self harmed and had been stable in mood and behaviour since then. He said the

man was keen to go on normal location. The nurse wrote on the form that the man's clinical risk factors were "a history of impulsive self harm". He wrote that, "CPN will follow him up". Section two of the form was completed by a SO from Houseblock 1. The SO indicated on the form that wing staff should consult with the ACCT form. He wrote that the man would be kept in a single cell "due to cat A" and "on-going with CPN". In the section entitled 'support plan', the SO wrote "to comply with ACCT CAREMAP and support plan".

82. I have not seen any evidence that the man's trigger points were specifically highlighted or listed on his ACCT form or his exit plan. I do not think it is reasonable to expect wing staff to read the entire document in order to find entries such as the one made by a nurse. I consider that crucial information was absent from the man's ACCT and exit plan when he was transferred to Houseblock 1, and this seriously undermined the ability of staff there to recognise important warning signs of his impending suicide. In this case, a comprehensive written handover should have been provided by HCC staff to the Houseblock 1 manager detailing the man's trigger points and warning signs.

83. On 8 January 2007, an officer wrote on the man's ACCT form that he had refused his medication at tea time and she had informed the nurse. There is no record of this on the man's IMR. On 10 January, another officer (signature illegible) wrote on the man's ACCT form that he had refused to take his tea time medication and that the nurse had been informed. There is no record of this on the man's IMR either. Also on 10 January, another officer made an entry in the wing observation book that the man had refused his medication "for a couple of days". She said she had told the nurse who had told her he would inform the psychiatrist. There is no evidence that the psychiatrist was informed of this. There is no evidence on the man's wing file, ACCT document or IMR that the man was seen by a member of the healthcare team or a CPN between 5 and 11 January 2007. At interview, a nurse said that she would normally visit prisoners in the first couple of days after they transferred to normal location from the HCC. At the time of the man's transfer to Houseblock 1, the nurse was on annual leave. I consider that in her absence another member of staff should have taken responsibility for making a follow up visit to the man.

I recommend that, within three months of receipt of this report, the Governor of Belmarsh and the Suicide Prevention Co-ordinator ensure that an audit of all open ACCT documents takes place. Particular attention should be paid to ensuring that clear information about the number of observations and conversations, CAREMAPs and where appropriate, trigger points, is available to those responsible for managing the prisoner.

[The Prison Service has accepted this recommendation.]

Other observations on the man's ACCT

84. The man arrived at Belmarsh on 25 September 2006 on an open ACCT form. His ACCT form remained open during his entire time at Belmarsh. The man

was accommodated in the HCC at Belmarsh between 25 September 2006 and 5 January 2007. During this time he spent two periods on constant observation, the first for eight days, the second for 47 days. During the remainder of his time in the HCC, he was on intermittent observation every 15 minutes. This is a considerable period of time on ACCT at the two highest levels of observation. The man consistently presented a high risk of self harm and completed suicide and posed serious management problems for staff. I am conscious that he was not the only prisoner at Belmarsh with this profile. I am also conscious of the pressures faced by staff in the HCC at Belmarsh, and the number of ACCT documents they are responsible for, and also that in September 2006 ACCT was a new process for staff to master. During his time in the HCC, the man received considerable care and attention from staff. It is also clear from the ACCT document that regular management checks by the Duty Governors, Orderly Officers and the Suicide Prevention Co-ordinator take place. I am disinclined therefore to pick over every omission and illegible signature in his ACCT document. I hope the following observations provide helpful feedback to staff required to manage prisoners on ACCT in the HCC.

85. The front cover of the ACCT document has a section for recording the level of observations that a prisoner is on and from which date. The required number of conversations, and how many of these should be recorded, should also be written on the front cover. As these change, the cover should be updated. The man's ACCT cover was not updated at Belmarsh. This made it impossible to see at a glance what level of observations he was on and how the level had changed over time. It was only possible to find out the level of observations he was on from references in the on-going record section of the form - and sometimes only from other documents such as the man's wing file. It was not clear from any part of the form how many conversations staff were required to have with him, and how many of these should be recorded on the on-going record.

86. Following assessment and a first review, staff should complete a care and management plan (CAREMAP). The CAREMAP is designed to highlight the most pressing issues and set a small number of realistic and achievable goals to try to address them. There are two entries on the CAREMAP in the man's ACCT at Belmarsh, one dated 17 October in response to the man self harming, and one undated entry which refers to the man's desire to come off constant observation. There are several entries on the ACCT form made by a PO reminding staff that the CAREMAP should be updated. There are two 'care plan sheets' on the man's IMR. These include two quite comprehensive plans dated 27 September and 9 October. There is evidence that this was reviewed every week until 14 December, but there do not appear to be any notes of what these reviews consisted of. On 16 and 23 October, the PO made entries to remind staff to update the CAREMAP, and a review of the care plan sheet in the IMR took place on both days. I am not sure whether staff were confused about the difference between the CAREMAP in the ACCT and the care plan sheets in the IMR. It is clear that staff did have a plan for the man's management but this is not obvious from the ACCT. While the man remained in the HCC, staff would have had access to the care plan sheets. However,

once he moved to Houseblock 1, it is not obvious that wing staff would have known what plan was being followed.

87. Reviews are flexible under the ACCT process and timescales can be agreed by staff attending each review. Reviews should take place after attempted suicide, incidents of self harm and as soon as possible after any known stressors such as court appearances. The man did not have case reviews after the incidents of attempted suicide and self harm on 9, 17 October, 9 and 22 November. There was no record at all on his ACCT on-going record of the incident on 9 October, although entries were made on his wing file and in the HCC observation book. In addition, a nurse reviewed the man's care plan sheet in his IMR and he was seen by a psychiatrist. The ACCT document does not reflect the good response of staff to this incident. On 9 November, the man self harmed and also went on to refuse food for most of the next two or three days. There is very little reference to the occasions when the man refused to take his medication. At his case review of 15 December, it was mentioned that the man had been refusing his medication for the past two weeks but this is not clear from the on-going record or his IMR.

88. There are several examples of good interactions and conversations with the man in the on-going record section of his ACCT. The vast majority of these appear to have taken place while the man was on constant observation. I note particularly the entries on 30 September, 1, 19, 20 October and 12 November. The man's reviews took place as planned (although, as noted above, not always in response to incidents of self harm) and were always attended by at least two members of staff. He was seen frequently by the consultant psychiatrists, often on the same day as an ACCT review and always following an incident of self harm or attempted suicide. Belmarsh's local suicide and self harm policy was reviewed in the light of the man's death and is comprehensive and up to date.

The use of constant observation

89. Guidance on the use of constant observation is contained in Prison Service Order (PSO) 2700 Suicide and Self Harm Prevention. PSO 2700 says that constant observation is a temporary measure and should be used in cases where a prisoner is at acute risk. Paragraph 4.2.2 says:

> "… In those exceptional cases where this level of crisis lasts beyond 24 hours, further case reviews must be held at least three times during that establishment's core working day. Acute suicidal crisis is usually temporary and the aim of the case reviews should be to reduce the level of supervision progressively as the prisoner's condition improves. The temporary nature of this level of supervision must be reflected in the support plan."

90. In August 2006, Prison Health (now Offender Health) and the Safer Custody Group (then part of the National Offender Management Service) issued guidance on constant observation for healthcare staff working in prisons. Paragraph 3.4.8 says that an individual member of staff should not undertake a

continuous period of observation for longer than two hours. Paragraph 3.7.1 says, “staff responsible for carrying out constant observation should receive on-going training in observation so that they are equipped with the skills and confidence to engage effectively.”

91. Clearly the man was on constant observation for far longer than Prison Service guidelines anticipate. A prisoner like him who consistently claims he will kill himself poses enormous management problems for the Prison Service. I understand how some prisoners remain on constant observation for long periods and, in truth, I do not know what the alternative is. I do know that the long periods of constant observation for some prisoners in Belmarsh HCC is recognised as a problem. The Head of Healthcare told my investigator that, once a prisoner is on constant observation for a long period of time, staff are naturally concerned about reducing the level of observations. I understand this concern and the fear that prisoners may try to manipulate staff into believing that their period of self-harming has passed. However, there is a marked contrast in the man’s mental state on constant observation and his mental state when he was on intermittent observations. As the number of consecutive days that he was on constant observation grew, his behaviour became increasingly desperate. On 22 November, his fortieth day on constant observation, he tied socks around his arm and tried to puncture a vein with the plastic top of an orange juice carton.

92. The man repeatedly complained that constant observation was affecting him greatly. He told staff that his self harm attempts were an expression of the frustration and stress that constant observation made him feel. The man was taken off constant observation on 29 November. Significantly, he did not make any further attempt to self harm during the rest of his time in the HCC.

93. I note also that the man spent most, if not all, of his second period on constant observation in a gated cell on the lower level of the HCC. My investigators visited this cell in the middle of a bright January day and it was still necessary to put the cell light on. Staff in the HCC agreed that the gated cells in this area are particularly miserable. I understand that efforts are made not to use them where possible, but the high incidence of prisoners on constant observation at Belmarsh makes this impossible.

94. Constant observation in the HCC is undertaken by discipline staff and not healthcare staff. Officers do 12 hour shifts. There is no specific training provided and no specific selection criteria for officers who volunteer for constant observation. All officers are trained in how to complete ACCT forms and are given a protocol which tells them what the prisoner they are observing is allowed. The guidance provided by Prison Health and Safer Custody Group is intended for healthcare staff, but I consider it is sensible advice for all staff. I note that while on constant observation the man was found to have made nooses (16 and 17 October) and to have secreted pieces of laminate (8 November) with which he tried to self harm. There is no direct evidence to link this to the length of the officers’ shift. I simply note that 12 hours is a very long time to sit vigilantly observing anyone.

I recommend that, in the light of the guidance provided to healthcare staff, the Prison Service reviews the selection, training and shift length of discipline staff required to undertake the constant observation of prisoners at risk of self harm and suicide.

[The Prison Service advised me at draft report stage that the soon to be published revised PSO 2700 Suicide and Self Harm Management contains extensive constant supervision guidance and includes suggestions of the criteria supervising teams should meet prior to undertaking this process.]

Record keeping at Belmarsh

95. The clinical review makes several comments about the man's records. I draw the attention of the Head of Healthcare to their specific concerns about the legibility, dating and signing of entries. My investigators found the sheer number of different records and log books very confusing. It was difficult to track the planning of the man's care and follow the chronology of what happened. I have already drawn attention to the confusion caused by the CAREMAP in the ACCT document and the 'care plan sheets' in the IMR. In addition to the ACCT and the IMR, there was information on the F2050A wing history sheet, the HCC observation book and the 'ward round book'. Attempts had been made by several staff to update one or more of these documents at all times, but there was not always a consistent approach to which type of information was held in which record.

96. I consider that it would be of greater benefit to staff if the ACCT document were used as the main record for the care and management of prisoners in the HCC who are at risk of self harm and suicide. The ACCT form is the document that travels with a prisoner throughout the prison and is critical to providing continuity of care. All the information about care plans and trigger points should be in this one place. New F2050A wing booklets are often opened when a prisoner moves wings and the prisoner's IMR remains in the HCC.

I recommend that, within three months of receipt of this report, the Head of Healthcare at Belmarsh ensures that a review of record keeping within the HCC takes place with a view to adopting a less confusing and more consistent approach for those prisoners on open ACCT documents.

[The Prison Service has accepted this recommendation]

The man's clinical care

97. The clinical review concludes that the man received appropriate medical care for his physical health problems and was referred to secondary care services in a timely manner. The man received more regular psychiatric care than he would in the community. The review is critical of record keeping at Belmarsh and recommends the use of typed summaries. This echoes recommendations made in clinical reviews in other death in custody investigations, and I consider

the use of summaries might be particularly helpful in cases where a prisoner has a large volume of records.

98. The review says it was documented that the following indicators were felt to be linked to the man's self harm: his extradition proceedings, changes in environment/location and unpredictable mood swings. The review says that these factors were appropriately managed when the man was in the HCC, but when he transferred to Houseblock 1 there was no record of how it was planned to reduce those risks. There was a lack of documentation, and it was difficult to see who took the decision to move the man and how he was to be monitored. The review concludes that it appeared that staff on Houseblock 1 were not fully aware of the man's risk factors. Both his risk factors were present following his transfer to Houseblock 1 – he attended an extradition hearing and his environment had changed.

99. The review makes a number of recommendations under the headings communication, protocols and procedures. I endorse those recommendations

The man's punishment at adjudication

100. On 9 October, the man set fire to his cell. He was placed on a disciplinary report and appeared at an adjudication on 11 October. He was found guilty of breaking Prison Rule 51 paragraph 16, 'intentionally or recklessly sets fire to any part of the prison or to any other property whether or not his own'. When asked why he did it, the man replied, "I wanted to kill myself". At the hearing he admitted that he had not considered whether his actions might endanger anyone else's life or cause damage to property. He was given 21 days loss of 80% of his earnings as punishment. Paragraph 2.19 of PSO 2000 (the adjudications manual) says:

> "Disciplinary charges should not normally be brought either in respect of deliberate self harm or of preparation for this. This applies equally to repetitive acts of self harm … Exceptionally a disciplinary charge may be brought in respect of endangering the health and safety of others arising from attempting self harm (for example, by setting a fire). The person managing the incident should decide whether it is likely that the prisoner intended to cause injury to others or was reckless as to this. If s/he is satisfied about intention or recklessness, a charge may be brought … Otherwise the events should be interpreted as an indication of severe distress which do not warrant a punitive response."

Paragraph 4.1.2.3 of PSO 2700 Suicide and Self Harm Prevention says:

> "… Adjudicators should consider the implications of the punishment they may impose on a prisoner who is found guilty at an adjudication and who is subject to F2052SH [now ACCT] procedures, such as removal from association, loss of canteen and cellular confinement."

101. I do not take issue with the decision to charge the man under Rule 51 paragraph 16. His actions were clearly reckless to the health and safety of staff

and prisoners on the HCC. However, he was a deeply suicidal and distressed person on constant watch in the HCC. He was unemployed and was earning £2.50 per week. He was a smoker and had no family or friends to send money to him. A decision to withdraw 80% of his earnings for three weeks would have had a drastic effect on his ability to buy tobacco and other goods. I note an entry on the man's ACCT form to the effect that he was observed desperately re-rolling cigarette butts in his cell. It is not appropriate to make a recommendation about this but I consider that insufficient thought was given to the impact of this particular punishment on the man.

Good practice: I draw the attention of the Governor of Belmarsh to the role played by an officer who acted with commendable promptness and bravery to remove the man from his smoke filled cell.

Issues arising from the man's category A status

102. There was a general feeling among staff spoken to by my investigators that the ACCT process was superior to the F2052SH process which it replaced. However, staff expressed concern that category A prisoners were precluded from sharing cells because of security concerns. Putting a prisoner who was at risk of suicide and self harm in a shared cell, possibly with a Listener, was seen as an effective way of reducing this risk. The requirement that category A prisoners must not share cells, combined with the staffing levels on the houseblocks made it difficult to monitor category A prisoners at risk of suicide and self harm.

103. My investigator spoke to the Directorate of High Security Prisons. She was told that it was not usual for standard risk category A prisoners to share cells but there were circumstances where this was allowed. One of these circumstances was if the prisoner was deemed to be at risk of self harm or suicide. This is made clear in the Prison Service National Security Framework (NSF).

I recommend that the Governor of Belmarsh issue a notice to staff clarifying the local policy on the circumstances in which category A prisoners may share cells.

The prison's response to the man's death

104. I consider that the response of staff to finding the man hanging and the implementation of the death in custody contingency plans to be almost 'textbook'. I am particularly impressed that an officer entered the man's cell immediately. The man was a category A prisoner and, although it may have been clear that he was suspended off the floor, I have seen many instances of staff not entering a cell to try and preserve life in these circumstances.

Good practice: I draw the attention of the Governor of Belmarsh to the officer's prompt response to finding the man on 12 January.

105. I notice that staff were not carrying anti-ligature knives. This was not in line with Prison Service Instruction (PSI) 32/2006 which was implemented on 30 November 2006. In this case, staff managed to remove the ligature from the man's neck without a cut down tool. I understand that the tools have now been issued to staff.

106. I was surprised to learn that a single night patrol officer is responsible for making checks on 213 prisoners, including the extra checks on prisoners who are on open ACCT documents. My investigator was told that typically there are three or four prisoners on open ACCT documents at any one time on Houseblock 1. This seems to me to be a substantial responsibility for one officer, although I have seen no evidence in this case that the night patrol officer was unable to make the required number of checks.

The Listeners

107. My investigators interviewed two Listeners in the company of a Samaritan supervisor. The Listeners were concerned that they had not been made aware that the man had moved to the wing. They said that they had tried on a number of occasions to get agreement from staff that they should be informed when prisoners on open ACCT documents transferred to the wing. The Listeners were upset that they had not spoken to the man before he died. Chapter 4 of PSO 2700 on Suicide and Self Harm Prevention makes clear that Listener schemes are an integral part of the Prison Service's suicide and self harm prevention strategy. I do not know whether the man would have wanted to speak to a Listener, or whether events would have turned out differently had he done so. However, I believe it sensible for Listeners to be aware of which prisoners are considered to be at risk, especially given the amount of time prisoners spend in their cells at Belmarsh and the relative lack of interaction on association. At interview a PO, the suicide prevention co-ordinator, said that he had since issued a Governor's Instruction to Staff reminding them that they must let Listeners know when a prisoner on an open ACCT transfers to a wing.

CONCLUSION

108. The man was a very damaged. I believe that, in the most trying and challenging circumstances, a number of staff at Pentonville, Brixton and Belmarsh HCC looked after him very well. He received regular and prompt intervention from psychiatrists and there is evidence of a number of good interactions with staff. At Belmarsh he was given the opportunity to attend the Cass Unit and to use gym equipment which seems to have helped his mental state. Before his death his last recorded incident of self harm was on 22 November. This represented a significant period given the man's history of self harm, and HCC staff should take credit for this.

109. I do not believe that the decision to return the man to normal location in Belmarsh was wrong. Clearly, he could not be kept on a high level of observation in the HCC for the duration of his indeterminate sentence. However, wing staff were not told crucial information that would have helped them manage The man's risk. The man did not receive a follow up visit from HCC staff and was not seen by a CPN as stipulated by his exit plan. Crucially, a nurse was on leave at the time of the man's transfer but another member of staff should have covered her role in this respect. Wing staff alerted nurses to the fact that the man had refused his medication for three days before he died, but there is no evidence that this information was passed to senior HCC staff or to the psychiatrists as promised.

110. Once on Houseblock 1, the man faced a very different regime. Overcrowding and staff shortages meant that he spent the majority of time alone in his cell. Belmarsh houses a number of sentenced category A prisoners, but it is not a training prison and therefore does not offer any offence related courses. The waiting list for places in education is long. Wing staff did not believe they were allowed to put the man in a shared cell and the Listeners were not aware of his presence on the wing. The man was no longer on the highest levels of observation and the chances for interaction with staff were much less than he was used to in the HCC.

111. In August 2006, a doctor had noticed that the man's vulnerability to impulsive self harm increased when he had the opportunity to "ruminate" on the negative aspects of his life. On 23 November, a governor wrote on the man's ACCT that he needed to do more to decrease his chances of self harm. Between 5 and 12 January, it appears that the man had little to do but think about the life he had led, the offences he had committed, and a probable future of many years' imprisonment in one country or another.

112. The story of the man presents no easy answers. This account of his life and death is emblematic of the enormous difficulties facing Prison Service staff in caring for those prisoners who are deeply suicidal.

RECOMMENDATIONS AND GOOD PRACTICE

Local recommendations:

I recommend that, within three months of receipt of this report, the Governor of Belmarsh and the Suicide Prevention Co-ordinator ensure that an audit of all open ACCT documents takes place. Particular attention should be paid to ensuring that clear information about the number of observations and conversations, CAREMAPs and where appropriate, trigger points, is available to those responsible for managing the prisoner.

I recommend that, within three months of receipt of this report, the Head of Healthcare at Belmarsh ensures that a review of record keeping within the HCC takes place with a view to adopting a less confusing and more consistent approach for those prisoners on open ACCT documents.

I recommend that the Governor of Belmarsh issue a notice to staff clarifying the local policy on the circumstances in which category A prisoners may share cells.

I also endorse the recommendations made by the clinical review team.

[The Prison Service has accepted these recommendations.]

National recommendations:

I recommend that, in the light of the guidance provided to healthcare staff, the Prison Service reviews the selection, training and shift length of discipline staff required to undertake the constant observation of prisoners at risk of self harm and suicide

Good practice:

I draw the attention of the Governor of Belmarsh to the role played by an officer who acted with promptness and bravery to remove the man from his smoke filled cell.

I draw the attention of the Governor of Belmarsh to the officer's prompt response to finding the man on 12 January.