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

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

This is the report of an investigation into the death of a man at HMP Belmarsh in March 2007. The man was found hanging in a ward in the healthcare centre. He was 43 years of age. My colleagues and I offer sincere condolences to the man's family and friends for their sad loss.

This investigation has been undertaken by my colleague. I would like to thank the Governor of HMP Belmarsh and her staff for their participation in the investigation. Particular thanks go to the liaison officer.

A multi-disciplinary panel was convened to undertake the review of the man's clinical care on behalf of Greenwich Teaching Primary Care Trust (PCT). This consisted of clinical professionals. I greatly appreciate their assistance.

After his arrival at Belmarsh on 24 May 2006, no concerns were raised about the man until six months later when, on 24 November, he cut his wrist. He was then located in a gated cell in the healthcare centre on constant observation. The next day, the man banged his head twice in the cell and this resulted in him going to outside hospital. Little more than a month after he harmed himself, the man was referred for assessment for a place at a psychiatric hospital. Throughout his time in the healthcare centre, between 24 November and 3 March 2007, the man developed an immovable paranoid belief that he was going to be killed by the Security Service (MI5) and that his family were involved. At times he also refused to eat or drink. He was evidently in a very disturbed mental state, but was adamant that he did not have any suicidal or self-harm intentions. He did not self harm between 25 November and his death.

On 28 December 2006, the man moved from constant observation in a gated cell to a single cell where he was on intermittent watch. On 12 January 2007, the man was assessed by a specialist registrar from a medium secure unit who concluded that he was acutely psychotic and needed to be assessed urgently for transfer to a high security hospital (Broadmoor) under section 48 of the Mental Health Act. On 16 January, the man was transferred to a six bed ward at Belmarsh. He appeared to settle in well with the other prisoners on the ward. Throughout his time in the healthcare centre, the man was regularly reviewed by the psychiatric team. The man was waiting for an assessment for admission to Broadmoor when he died. The clinical review concludes that the man was referred and assessed for admission to a high security psychiatric hospital in a timely way, but his transfer was complicated by his category A status. (Category A is the highest security category for holding prisoners in custody.)

The clinical review has raised a number of concerns regarding the man's care. My report includes four recommendations based largely on that review. .

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 **January 2009**

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SUMMARY

The man was remanded in custody at HMP Wormwood Scrubs on 17 May 2006 charged with possession of firearms. During the initial health screen, the man said he had stomach troubles for which he was taking prescribed medication. He said he did not have any other physical ailments. The man denied that he had any problems with drugs or alcohol. Finally, the man was adamant that he had never had any psychiatric problems and had never tried to harm himself. The man was transferred to HMP Belmarsh on 24 May.

No concerns were raised about the man until 24 November 2006 when he cut his left wrist in three places. The man was placed on an ACCT (Assessment, Care in Custody and Teamwork) form, and located in a gated cell on constant observation in the healthcare centre. (ACCT is the system used by HM Prison Service to monitor and support a person at risk of suicide or self harm. Constant observation is where a prisoner is observed by a designated member of staff who remains constantly in his or her presence (in accordance with each establishment's local strategy). The man was convinced he was going to be killed but would not say by whom.

On 25 November, the man cut his head twice by banging it against hard surfaces in the cell. He was taken to hospital after the second incident. On 3 December, it was noted in the man's medical record that he had lost a significant amount of weight. His weight on 18 May was recorded as 79kg and this had dropped to 66kg by 3 December. The man believed he had been accused of being an informant and that the Secret Services (MI5) were looking for him. The man was referred for an assessment to transfer to a secure psychiatric hospital.

The man remained on constant watch until 28 December and he had regular reviews and input from the psychiatric team. He declined medication and became increasingly paranoid. On the next day, the man was moved to a single cell in the healthcare centre and he was placed on intermittent (30 minute) observation. The plan was for staff to watch his food and drink intake as he was refusing to eat or drink.

On 12 January 2007, the man was seen by a specialist registrar from a medium secure unit who concluded that the man was suffering from delusional persecutory beliefs. He felt that, if there was no significant improvement in the man's mental state, he should be assessed for urgent transfer and treatment in a high security unit under the provisions in section 48 of the Mental Health Act. On 15 January, the man started taking the antipsychotic medication, Olanzapine. Two days later, the man was moved to a six bed ward in the healthcare centre.

On 19 January, the man was eating better and had been taking his medication since 15 January. The man was not eating again by 31 January and said he wanted to starve himself. He complained that he had been suffering from stomach pains for two days. The man was due to see a doctor about the stomach pains but this did not happen.

On 15 February, a consultant psychiatrist at Belmarsh, wrote to a Crown Court to recommend they delay sentencing the man until he was assessed for transfer to a

high security unit. The psychiatrist pointed out that the process could take some time as the man was a category A prisoner. The regular reviews by the psychiatric team identified that the man had ‘persecutory paranoid delusional beliefs’. The man was not consistent in taking his medication and at times refused to eat or drink.

The man was waiting to be assessed for transfer to a high security unit when he was found hanging on 3 March 2007.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical record and statements made by prison staff.

2. Greenwich Teaching Primary Care Trust (PCT) was asked to carry out a review of The man's clinical care. I am grateful for this review being undertaken in a timely manner.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation, and to request a copy of the Post Mortem report. This records the cause of death as hanging. My report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. One of my family liaison officers and my investigator met the man's partner in the company of her solicitor. The man's partner raised various concerns which are addressed later in this report in paragraphs 84 to 88 under 'family concerns'. I hope this report will help the man's family better understand what happened in the time leading up to his death.

5. My investigator discussed aspects of the man's treatment with both staff at Belmarsh and the clinical reviewers. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. During the course of the investigation, 22 members of staff were interviewed including the head of the healthcare centre. My investigator spoke with two prisoners and with the police in relation to their investigation. All statements taken by them were also obtained.

6. My investigator has been unable to interview three members of staff who are on long term sick leave.

HMP BELMARSH

7. HMP Belmarsh opened in 1991. It is a local prison that can hold category A prisoners (the highest security category). 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.

8. Together with HMP Brixton, Belmarsh has piloted the model for treating prisoners with mental health problems in a 'community' setting. The healthcare centre (HCC) is a three storey building that 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.

9. There is also a day care centre for prisoners with mental health conditions (the Cass Unit). 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. There are two staff care psychiatrists and four community forensic psychiatric nurses, a social worker, two occupational therapists, an administrator, and an in-patient manager.

10. The most recent report by HM Chief Inspector of Prisons, Dame Anne Owers, in October 2005 came after a full announced inspection and report in May 2003. Dame Owers's October 2005 report says:

> "Most of our 2003 recommendations about healthcare had not been addressed, although prisoner perceptions about the quality of healthcare and the service from doctors had improved. There was a very limited regime for in-patients, who had poor access to regular exercise and limited association opportunities. The Cass Unit for prisoners with mental health conditions was closed regularly."

11. The man's death was the fourth apparently self-inflicted death to occur in Belmarsh since I began investigating fatal incidents in prisons in April 2004. There are common issues between this inquiry into the death of The man and two of my previous investigations. I shall refer to these later in my report.

KEY EVENTS

12. The man was remanded in custody at HMP Wormwood Scrubs on 17 May 2006 charged with possession of firearms. The man saw a member of healthcare staff who completed the first reception health screen form for him. The purpose of this form is to gather medical information from the prisoner about his physical and mental health. The man said that he was being treated for stomach problems for which he was taking prescribed medication, Omeprazole. The man said he did not have any other physical ailments. He also said that he did not have any problems with drugs or alcohol. Finally, the man was adamant that he had never had any psychiatric problems and had never tried to self harm. A general health assessment was also completed (on 18 May) when no additional ongoing health issues were identified.

13. The man was transferred to HMP Belmarsh on 24 May due to his category A status. There is no evidence of the reception health screen being repeated. The induction checklist says that the initial screening form was completed but it is not in the paperwork. A cell sharing risk assessment was completed for the man and it was concluded that he would not be a risk to anyone else sharing with him.

14. The man appeared to settle at Belmarsh and no concerns were raised until 21 June 2006 when he complained that his heart was racing and he had palpitations. He was seen by a healthcare officer who referred him to a doctor. The man was examined by a prison doctor the next day. The doctor concluded that the man's problems had possibly been related to excessive caffeine intake and he taught him some relaxation techniques. No other issues or concerns were raised until 24 November.

15. At around 11.00pm on 24 November, the man cut his left wrist in three places. He was examined by the doctor who cleaned the cuts and closed them with steri-strips. At around 11.55pm, a principal officer (PO) opened an ACCT form. The man said that he was worried about his impending court appearance in January 2007. He also told the PO that cutting his wrist had been an impulsive act and he would not self harm again. The man was seen by a registered mental health nurse (RMN), who completed an ACCT assessment interview with him at around 00.25am on 25 November. The RMN noted that the man's mood seemed low and he had general anxiety about his court case. The RMN also noted that the man's act of self harm had been impulsive. The man was admitted to the healthcare centre for constant observation in a gated cell.

16. The man was seen by a healthcare worker, and a senior healthcare officer (SHCO), for his first ACCT case review on 25 November. The man had suddenly and without warning become paranoid that 'people' were going to kill him. He was also anxious about his court case. He asked the healthcare worker how long the human body could last without food or water. The man was placed on a food monitoring regime and his weight was to be checked weekly.

17. At around 2.15pm, the man cut his head after apparently hitting it against the bed. The wound was cleaned and dressed by a nurse, but the man refused to have sutures or further treatment from the duty doctor. The man signed a disclaimer confirming this. The man had a visit from his partner later that afternoon.

18. Between 6.30pm and 8.00pm, he again smashed his head open, possibly against a sharp edge in the cell. An entry in the ACCT form says that he stood on the table in the cell and deliberately jumped down head first. The table and chair were immediately removed from the cell. The man was transferred to an A&E at a local hospital They took x-rays and the wound was closed with sutures. There was no fracture to the head. The man returned from hospital at around 00.25am on 26 November and remained on constant observation in a gated cell in the healthcare centre. He was quiet but paranoid and suspicious.

19. On 26 November, the man refused to leave his cell and expressed paranoid thoughts. He said that he feared for his own safety and for the safety of his family. He remained on constant watch. The prison doctor contacted a psychiatrist at home to discuss the man's treatment. The psychiatrist a consultant psychiatrist at Belmarsh. He recommended that the man be prescribed anti-anxiety drugs. The man was subsequently prescribed a low dose of Lorazepam, although initially he refused this and any other medication. Later on he saw his co-defendant on the authority of a governor. The governor felt that this meeting might help the man who was paranoid and did not trust any of the staff. The man expressed concerns that his partner and children had been killed and he could not be reassured that this had not happened. The governor spoke to the man's partner as the man was so concerned about her. After the telephone call, the governor told the man that his family was fine and he seemed relieved that she had spoken to them. The governor said that the man's partner was concerned about the man and could not understand why he was feeling the way he was.

20. The man was assessed by a psychiatrist, on 27 November. The psychiatrist saw the man in his cell, and the man said he had felt depressed since being in prison and away from his family but felt alright in the healthcare centre. When the psychiatrist said he would see him the next day, the man said, 'Tomorrow never comes. I won't be here tomorrow.' He gave the psychiatrist permission to speak to his solicitors. The psychiatrist spoke to the man's solicitors and they confirmed that, in a meeting with them on 20 November, he had been tearful but had become calmer towards the end of the meeting. The man also told the psychiatrist that his partner was due to visit him, but he appeared convinced she was dead. The psychiatrist also noted that the man had not been eating.

21. The psychiatrist spoke to the man's partner on 27 November and made a note of the conversation in the man's medical record on 28 November. The man's partner had visited him on 21 November. She told the psychiatrist that before the visit she had not detected any problems with her partner. The man's partner said that when she saw him on 21 November he was not making

sense, his conversation was limited and he appeared like a stranger. She said that her partner had been looking around and questioned her about what was happening. He said to her, 'Now the penny has dropped.' The psychiatrist asked the man's partner some questions about him, such as their background, any previous contact with psychiatric services and the man's previous employment. He told her that the diagnosis was unclear and they were going to keep her partner in the healthcare centre to continue observing and reviewing him.

22. Later on 27 November, the man's partner visited him with one of their sons. This was a special visit and took place in the healthcare centre. The man told her that the prison was bugged and people were spying on him. The man's partner noticed that he had lost weight and he said to her, 'I won't be here for too long' and 'Don't believe them'. The man told her he was being accused of being an informant and someone was going to kill him. The man's partner felt it was very out of character for him to behave like that. The man told his partner that he could not remember what had happened when he cut himself, but that he would never commit suicide.

23. The man refused to come out of his cell later on 27 November and said 'Tomorrow is not over yet'. The man repeatedly said he would not be here tomorrow and that he would be killed. He told the psychiatrist that he could not be helped and that he would see him in the next world.

24. The man was seen by a doctor on 28 November. He refused to leave the cell and would not let the doctor enter it. The man sat with his back to the wall and repeatedly said that he would be killed that night. He said he had felt scared for around a week and over the past year he had felt paranoid at times. The man was unable to give the doctor any proof that he was in danger and he refused any medication. He denied he was suicidal. The doctor's opinion was that the man had delusional views.

25. On 29 November, the psychiatrist saw the man again. The man told him that he thought he was going to be killed by someone but would not say by whom and added it was a hunch. He told the psychiatrist that he did not trust anybody. The man maintained his view that his partner and children were dead, despite having had a visit from his partner on 27 November. He told the psychiatrist that his partner had not looked well. The psychiatrist noted that the man smiled and laughed during the interview. He appeared dishevelled and was not sure about taking any medication.

26. On 30 November, the man's possible referral to an open regional secure unit was discussed during a management ward round. (Management ward rounds are weekly meetings attended by most of the mental health team, two doctors, the psychiatrist, and the community psychiatric nurses (CPNs). Other members of healthcare also attend as appropriate and if available. All prisoners who are under psychiatric care are discussed during these meetings.) One of the doctors recommended that the man should be referred for transfer to a medium secure unit. The doctor explained to my investigator

that the aim was to gradually build up trust with the man so he would eventually agree to take his medication.

27. On 1 December, the man was reviewed by the psychiatrist. The man told the psychiatrist that he believed his (the man's) partner was going to be killed. He was suspicious of any examination of his mental state. The man was also adamant that he was going to be killed but would not say who was going to kill him. He said he would never kill himself. As part of the referral process the psychiatrist needed to find out further information about the man, including details of his conviction. He contacted the man's solicitors and they told him that his case was now being handled by another firm. The psychiatrist also contacted with a medium secure forensic psychiatrist unit regarding the man's referral. The unit agreed to fax a referral form to the psychiatrist. The psychiatrist recommended that the man remain on constant observation and his food and drink intake monitored.

28. The man had a visit from his partner and daughter on 2 December. The meeting went well and it was noted in his ACCT by an officer that the man interacted well. The man and his partner were both in tears at the end of the meeting.

29. On 3 December, an ACCT review was undertaken by a charge nurse and a senior officer (SO). The man said his self harm had been a mistake and was adamant that he was not going to hurt himself although he continued to believe he was going to be killed. He told his partner not to visit him any more. The man remained on constant watch. The charge nurse also completed a secondary health screen for the man. She weighed him and noted that his weight was 66kg, whereas it had been 79kg on 18 May 2006.

30. On 4 December, the man told the psychiatrist that he had changed his solicitor as his previous solicitor had 'stitched him up at the back.' The psychiatrist noted that the man was sleeping and eating normally and he felt that the man's persecutory beliefs were not as intense as they had been. The man told the psychiatrist that the visit with his partner on 2 December had been 'fine.'

31. On 5 December, the man had a visit from his brother. He saw the psychiatrist after the visit and told him it had gone well. However, the man said he was scared to go to the visit with his partner in the afternoon. The man spoke to his partner on the telephone and told the psychiatrist that she was fine. The man spoke to the psychiatrist about his brothers being shot and killed in Ireland.

32. On 7 December, a note made after the management ward round said that there had been a gradual improvement in the man's mental state and he was less preoccupied than before. Later that day he told the psychiatrist that his car had been bugged by the police and he believed the intelligence agencies were going to kill his partner. The psychiatrist's conclusion at that time was that the man had persecutory beliefs but they were not of 'delusional intensity'. The psychiatrist discussed with the man whether he would like to

move to a ward. The man said he was not ready to be with other prisoners but felt he would cope in a single cell. The psychiatrist decided to keep the man on constant observation and review him the following week.

33. The man had an ACCT review on 10 December, completed by an officer and a nurse. The man told them he was alright. However, he became angry towards the nurse when she asked him when he was going to court. The man said he did not have any thoughts of self harm and was looking forward to going to court in January. The man's level of risk of self harm was still considered to be high.

34. The psychiatrist saw the man again on 11 December. The man still believed that he was going to be killed, but again would not elaborate. The man told the psychiatrist that his weekend had been fine, he had been on the phone to his family and had no concerns. The man complained he had been suffering from cold legs and numbness in both knees for two days. The psychiatrist noted that he was wearing shorts. The psychiatrist concluded that the man appeared calm but was slightly anxious. The man told the psychiatrist that he did not have any suicidal thoughts. He had a legal visit that afternoon and remained on constant watch.

35. On 13 December, the man was seen again by the psychiatrist. The man was feeling low as Christmas was coming and he would not be with his family. He told the psychiatrist that he did not trust anyone and that the intelligence agencies at Scotland Yard were 'stitching him up'. He also said he could not trust his current solicitor and was asking for a new one. The psychiatrist's opinion was that the man had persecutory beliefs, which appeared to be of delusional intensity. The psychiatrist asked the man whether he had any suicidal thoughts and he said that he did not know and only God knew. The man remained on constant watch.

36. On 15 December, the man's partner visited him. The visit only lasted 15 minutes as they had an argument and the man's partner left. The man told a principal officer (PO)he would not be here by Christmas. The man was extremely paranoid and believed there was a government conspiracy against him and that he was going to be killed in prison. The PO submitted a Security Information Report (SIR) recording that information and he updated the ACCT accordingly. The man spoke to his partner on the phone later that day and agreed for her and the children to visit the following week.

37. On 17 December, a note in the man's Caremap (care and management plan) within the ACCT indicated that the food refusal issue had been resolved. The man had an ACCT review, which was undertaken by a HCO and a SO. The man said he felt alright but did get upset when he argued with his partner. He felt she was trying to make him look bad. The man also maintained somebody was going to harm him but said he felt safe in the healthcare centre. He was concerned that police were going to try to 'stitch him up.' His level of risk of self harm was lowered from high to raised.

38. On 19 December, the man was seen once more by a doctor. The man told the doctor that the police were trying to kill him. The doctor's opinion was that the man had persecutory beliefs. The man said he did not have any thoughts of suicide or self harm.

39. On 21 December, a note made after the management ward round said that the man's referral to a high security unit was discussed, and consideration was to be given to taking him off constant watch the following week. On 23 December, the man cancelled a visit from his partner.

40. On 24 December, the man had an ACCT review undertaken by a nurse and a SO. They noted that the man appeared unsettled and remained convinced that somebody was going to come into his cell and try to kill him. The man said he did not have any thoughts of self harm.

41. On 26 December, the man asked to have a table in his cell. A request was made by a SO for the man to have a cardboard table. This was agreed by the duty governor.

42. On 27 December, the man was reviewed by the psychiatrist. He told the psychiatrist that he still believed his life was in danger. The psychiatrist made a referral to the secure unit by faxing the completed referral form. He also sent a detailed covering letter to the secure unit with the referral. The man told the psychiatrist that he had spoken to his partner on Christmas Day and had no concerns about her. The man still believed that he was going to be killed. A PO noted that the man 'snapped' a CD during the night and threatened to use it. All CDs were removed from his cell, pending a revised cell sharing assessment. On 28 December, constant watch was stopped on the psychiatrist's advice and the man was placed in a single cell on intermittent watch. The psychiatrist noted in the medical record the man had eaten and agreed with the plan to relocate him to a single cell.

43. There is an entry in The man's ACCT by an officer dated 27 December which says:

> "On several occasions we had sensible conversations but when he thinks no one else is listening he says inane things like, 'what time are they coming for me' and 'have I got time for a sleep before we go'. He also wants to know what I am writing in the log or ACCT before coming to the cell door and saying something idiotic. I haven't seen any indication of intent to self harm but I have seen a lot of signs of attention seeking."

44. There is another entry by the officer, dated 28 December, which says:

> "He seems to thrive on people thinking he is paranoid. He even asked me if I thought he was paranoid and did not seem impressed when I told him I didn't. I have seen many prisoners attempt to fake madness and the man's is one of the most unconvincing I have come across."

45. On 29 December, the man saw the psychiatrist with a nurse. The man refused to leave his cell. He discussed a letter he had received from his partner in which he said she had written, 'You will know where you stand next year.' He said he doubted the letter was from his partner and interpreted this as a reference to him not being alive next year. The man said he was going to be beaten up and 'hung drawn and quartered' before the New Year. He denied any suicidal intention. The psychiatrist instructed that the man continue to be monitored on intermittent watch in a single cell and staff were to observe his food and drink intake. The psychiatrist discussed medication with the man again, but he said he did not need any.

46. On 2 January 2007, the man told the psychiatrist that he believed his family and friends along with the secret services were involved in a scheme to kill him. An ACCT review was held by a nurse and an officer. They noted that the man believed he was going to be taken to the segregation unit. He feared that he would be beaten and killed by Intelligence Services. He was convinced his family and friends were involved. He was not eating much, and only drinking milk. The man said he was not going to kill himself but was convinced somebody else was going to kill him. On 3 January, there is a note in his medical record that he had been picking the wound on his scalp which had become locally infected. He was prescribed an antibiotic.

47. On 4 January, at a management round meeting it was noted that there was no change in the man's mental state and that he had 'unshakeable persecutory beliefs.' He was reviewed by the psychiatrist, and the man now said he was going to be killed before his trial on 29 January. The man said he had been 'beaten up' by the security service, MI5. He believed that his partner and others were behind this.

48. On 5 January, the man had a visit from his partner. The man told the psychiatrist after the visit that his partner was trying to kill him, although she denied it. On 8 January, The man was reviewed by a doctor. The man said he was going to be killed and he told the doctor that the IRA might have something to do with it. The man denied any connection with the IRA but said, 'They want to blame me as an informer and link me to the peace process.' He told the doctor that he believed he had been 'set up' over the past two years and his partner had been involved in that. The man said he had been bugged and had been under surveillance for years. He believed the case had been reported in national newspapers in Ireland when he was arrested and the IRA had seen those.

49. The doctor wrote in the review of the man's mental state that the man remained preoccupied with persecutory paranoid delusional beliefs. The man believed there was a conspiracy against him and he thought he had been bugged. The doctor also noted that the man had poor awareness of his current illness. The man had taken Diazepam 10mg twice daily for the past two days but he had only been partially compliant with taking his medication previously. On 8 January, the man had an ACCT review by a healthcare worker, and an officer. The man still believed he was going to be killed in his cell although he said he did not have any suicidal or self harm ideation.

50. On 9 January, the doctor wrote to a Crown Court about the man:

> "In terms of forthcoming trial, it is overall my opinion that he is fit to plead and stand trial. Despite having a mental illness he understands the nature of the charges, could give evidence and follow proceedings … If possible I would suggest that some consideration should be given to delaying proceedings until he has been assessed further and most likely in hospital. My own view is that he is likely to show a good response to treatment."

51. On 12 January, the man was seen by a specialist registrar from the secure unit. The registrar's opinion was that the man was acutely psychotic and needed to be transferred urgently to a high security hospital under section 48 of the Mental Health Act. On the same day the man had an ACCT review which was undertaken by senior healthcare officer (SHCO) and a nurse. The man did not have any thoughts of suicide or self harm but still believed somebody was going to kill him. The level of risk of self harm was now reduced from raised to low.

52. On 15 January, the man was seen by the psychiatrist. The man asked about his transfer to hospital. The psychiatrist told him that if he got better he would not have to go to hospital. The man said he wanted to start mixing with other prisoners and wanted to go onto the ward. He did not want to go to hospital. The man denied any deliberate self harm/suicidal thoughts or intention. He repeatedly wanted reassurance from the psychiatrist that he would still be in prison the next day and would not be transferred to hospital. The man started taking his antipsychotic medication, Olanzapine.

53. On 16 January, the man was seen yet again by the psychiatrist. The man repeated that he wanted to move to the ward. He said his partner was due to visit him later that day but he had cancelled the visit. The man denied any deliberate self harm or suicidal intention and said he would do anything to get better. However, the psychiatrist noted that ultimately the man would not accept that he was ill. The man said he would attend exercise and association and the psychiatrist agreed to discuss him attending the Cass Unit with staff there. The plan was for the man to continue taking Olanzapine and his evening dosage of Diazepam was reduced from 10mg to 5mg. Following the psychiatrist's review, the man was transferred to the ward.

54. On the next day, the man was seen by a nurse, who noted that the man appeared to have settled on the ward, 'Remains calm, fairly pleasant on approach. Compliant with his prescribed medication. Eating and drinking well, no evidence of any suicide or self harm attempt.' The man's weight was 64kg, compared with 66kg on 3 December.

55. On 19 January, an ACCT review was undertaken by a nurse and a SHCO. They noted that the man had not made any attempts at self harm and was eating better. They recorded that he still had thoughts of self harm but denied any current plans. The man continued to think that he would be killed by

someone. The man was seen by the doctor. He told the doctor that he had been 'set up' and was in danger from the IRA and the peace process was ultimately in jeopardy as a result. The man accepted his medication but said he did not want to go to hospital. The doctor spoke to the registrar from the secure unit, who told him that a decision was being made on the man's suitability to go to a medium secure unit.

56. On 21 January, the man was seen by a nurse. The nurse noted that the man seemed stable in mood, was less paranoid and was eating and drinking. The man was also taking his medication. The following day, the man was seen by the doctor and the psychiatrist at the man's request. The man said he felt he was ready for his trial and was going to plead guilty. He said he felt better since being located in the ward and the thoughts of being killed in prison were not as frequent as before. The man said if he was still around on 29 January, the date of his trial, he would agree that he was wrong and would apologise to the doctor and the psychiatrist for wasting their time. The man said he did not want to go to Broadmoor, and if he did have to go he would stop eating and drinking. The psychiatrist and the doctor concluded that there appeared to be some improvement in his mental state.

57. On 23 January, the man was seen by the psychiatrist. The man told the psychiatrist that he was keen to continue taking Diazepam. The man had a visit from his partner that afternoon. The psychiatrist lowered the daily dosage of Diazepam from 10mg to 5mg, morning and evening. The man was to continue taking Olanzapine. He appeared anxious.

58. On 25 January, the man was discussed during the management ward round. The impression was that he appeared settled in the ward and the plan was to continue to review him.

59. On 26 January, the man had a meeting with his co-defendant to discuss their impending court appearances. There is a note in the man's medical record by a nurse that the man appeared fairly settled and was interacting appropriately with staff and other prisoners. He also noted that the man was eating and drinking well and there was no evidence of any deliberate self harm or suicidal intent.

60. On 28 January, there is a note in the man's medical record by a nurse, 'Appears brighter in ward, attended exercise and association. Eating and drinking well. No evidence of deliberate self harm or suicidal intent.'

61. On the next day, the man attended Crown Court. The man pleaded guilty. On return to prison, there was no change in his category A status. He returned to the healthcare centre in Belmarsh to await sentence. The man went back to Crown Court on 30 January. On return, he went back to the healthcare centre.

62. On 31 January, an officer saw the man. She noted in his history sheet that there were no problems to report and he was settled in the ward. The officer

also recorded that the man was attending exercise and association and was polite towards staff.

63. The man was reviewed by the psychiatrist. The man told the psychiatrist that he had pleaded guilty at court on 29 January and had been told that he would probably get a ten year sentence. He said he had pleaded guilty because he believed the police and intelligence agencies were against him and his partner had set him up. The man said he could not trust anybody and still maintained that he would be killed in prison. The man said he felt calmer since he had been taking his medication. He was still paranoid and said his partner had set him up and she was having an affair. He said he had a fair idea who with but would not tell the psychiatrist. The man added that he was going to stop eating and drinking to starve himself to death. The man also said he was going to stop taking his medication from the next day. He said he had been suffering from pains in his stomach for two days but was not constipated, was eating and drinking and did not feel nauseous. The man appeared fixed in his persecutory belief and his desire to starve himself. He discussed his concerns with healthcare staff and the plan was to continue to review him. The man had an ACCT review completed by a nurse and a SHCO. They noted that the man seemed settled, and had not attempted to self harm. The man told them that he had pleaded guilty at court, and was awaiting sentence. The man said he might start to refuse food and fluid but he was eating and drinking sufficiently. He did not express any current thoughts of self harm.

64. On 1 February, the secure unit registrar wrote to a doctor and the psychiatrist regarding the assessment he had undertaken on 12 January:

> "It appears that the man may be suffering from a first onset paranoid psychotic episode with a possible underlying depressive aetiology or co-morbid depressive illness. In my opinion he is not fit to plead and stand trial currently as he has delusional persecutory beliefs regarding his legal representation and his ability to understand and follow trial proceedings would most probably be significantly impaired due to his current poor concentration and attention. If he once more becomes unwilling to voluntarily take anti-psychotic medication (I understand he started to take anti-psychotic medication on 17 January) or there is no significant improvement in his mental state I feel that he would be appropriate for urgent transfer and treatment in hospital under the provisions in section 48 of the Mental Health Act … As we discussed, if there is no improvement in his mental state I would be more than happy to review the man and refer him to the appropriate high secure service."

65. Also on 1 February, the man was discussed during the management ward round. Staff were to monitor his food and fluid intake. The psychiatrist reviewed the man. The man told the psychiatrist he had eaten some cornflakes and had a cup of tea, but had not eaten any hot food or lunch. The man said he was going to stop taking his medication as it was causing pains in his stomach at night. The plan was to continue to review him and for a doctor to see him about the stomach pains. (There is no evidence that he did in fact see a doctor about the pains in his stomach.)

66. On 5 February, the psychiatrist and a healthcare worker saw the man. The man told them that he had stopped eating and drinking three days previously. He said, 'I can't wait for my people any more. I am going to do it myself.' The man was tearful during the review. He asked the psychiatrist if he would put him on a drip if he continued to starve himself. However, he told the psychiatrist later that he had eaten something on 3 February and had eaten a cake on 4 February. The psychiatrist noted that the man had refused Olanzapine for three days but had accepted it the previous night and had asked for sleeping tablets during that time. The man told the psychiatrist that he had been passing urine that was dark.

67. The psychiatrist tested a urine sample which was negative for ketones which are present when a person is starving. The man was convinced his partner was dead and he told the psychiatrist that his partner had told him their children were not his. The psychiatrist noticed that the man's tongue was dry but he was alert and appeared physically well. The plan was to continue with medication, to encourage him to eat and drink, continue on intermittent watch and to liaise with the registrar about the referral to the secure unit.

68. On 6 February, an officer saw the man again. She noted that the man appeared to be more settled and was still attending exercise and association. She also noted that he helped to keep the ward tidy, spent a lot of time on the phone to his partner and was polite towards staff and other prisoners. The psychiatrist also saw the man. The man told him that he had been to court that day and said it was part of the plot as he had not been asked to give evidence. The man spoke about his partner and said she had been killed and was making their children lie to him. The man said he had two cups of tea and a glass of water that day but was not going to eat or drink any more. He was still worried that he would be killed in prison or in Broadmoor. The man asked for more Diazepam and the psychiatrist said he would prescribe more Diazepam if the man continued to eat and drink. The man denied any suicide or self-harm intentions but was adamant that he was going to stop eating and drinking. However, the man agreed to eat and drink when he left the interview with the psychiatrist. The psychiatrist sent a letter to a Crown Court which said:

> "The man was seen by specialist registrar on 12 January 2007. He was of the opinion that the man is acutely psychotic and needed urgent transfer to hospital. The registrar was of the view that the man will need to transfer to Broadmoor Hospital and we are currently awaiting assessment from Broadmoor Hospital."

69. On the same day, the man told a SO that he had asked his legal team to compile a living will. This is recorded in the ACCT. The SO told my investigator that he could not recall much about it but did recall that the man had spoken to his solicitor at length about a living will.

70. On 7 February, the man went to the Cass Unit. Initially he was reluctant to stay there and asked to go back to the ward. He was persuaded to stay and

have a cup of coffee although he had said he was not eating or drinking. He played Scrabble for just over an hour. At the end of the session the man said he would soon go to either heaven or hell and maintained that he did not feel safe. The man said he did feel safe in the ward and in the Cass Unit but that was because he knew the people there.

71. On 8 February, the man was discussed during the management ward round. He was assessed as being stable although still a bit up and down. On 9 February, an ACCT review was undertaken by a nurse. The nurse noted that the man was eating and drinking small amounts. He denied any current thoughts of self harm, and believed somebody else would harm him. The nurse noted that the man was attending the Cass Unit and was going to exercise and association. The man's weight was stable at 64kg.

72. On 10 February, an unscheduled ACCT review was undertaken by a nurse and an officer. The man's review was not due until 19 February, but he was seen early due to the death of another prisoner. The man remained paranoid and believed somebody was going to kill him. He denied any suicidal intent and was eating and drinking small amounts.

73. On the next day, the man was seen by a nurse who noted that the man appeared settled throughout the day and was eating and drinking well. There was no evidence of suicidal or self-harm intention. On 14 February, the man went to the Cass Unit where he engaged in group work and interacted well with others. It was noted that he did express some feelings of paranoia.

74. On 15 February, the man was discussed again during the management ward round. It was noted that the man was still paranoid but overall he appeared settled. The doctor also saw the man. The man told the doctor that he had cancelled a visit with his partner. He said he was very scared of what was going to happen to him. He told the doctor that his partner had visited him 'the other day.' The doctor tried to get the man to think about other things. The man was taking his medication but he said he was not eating and could not see a way forward. The man told the doctor that by not eating he would die quicker than being tortured. The man was concerned about his partner's fidelity and still maintained that he was going to be killed. He feared that he would be killed by the time peace talks were concluded in Northern Ireland. The doctor wrote to the Crown Court:

> "The man was assessed by a specialist registrar from medium secure unit. The registrar informed me that he agrees with our diagnosis but in view of security concerns he could only be safely managed in a high secure hospital, he has therefore made a referral to Broadmoor. I would ask the court therefore to delay sentencing until this assessment can be facilitated. Regrettably beds in secure settings are in short supply and the process can take some time. I would ask for an initial adjournment of some four weeks. I would be happy to attend court for further explanation if this would be of help. My apologies once more for any delay to the proceedings. Our view overall is that the man should receive treatment and assessment in hospital."

75. On 16 February, a SHCO noted in the man's history record, 'Remains in ward, attends exercise and association, polite towards staff, no management problem.'

76. On 19 February, a SHCO and an officer conducted an ACCT review. They concluded that the man still appeared guarded with paranoid thoughts that people wanted to kill him. However, he continued to say he had no intention of killing himself. He was eating and drinking, and attending exercise, association and the Cass Unit.

77. On 21 February, the man was seen by a nurse who noted that he remained settled in mood, had good interaction with others and was eating and drinking well. The man was also seen by a doctor at the man's request. The man told the doctor that he had woken up with nightmares and his delusions persisted. The plan was for the man to be reviewed and his medication was to continue.

78. On 22 February, the man was discussed during the management ward round. It was noted that he was waiting to be assessed to transfer to a high security hospital (Broadmoor).

79. On 23 February, the man was seen by a nurse. The nurse noted that the man was still paranoid. She also recorded that he was anxious and complained of nightmares. However, he was compliant with treatment, was eating and drinking and denied any current thoughts or plans to self harm.

80. The man's partner phoned the prison on 23 February 2007.. The man's partner told an officer that she was upset as the man had told her that he had not been seen by a doctor and felt the doctor was avoiding him. The man had said he thought his life was in danger and he was convinced he was going to be killed if he was sent to the houseblock. The man's partner told the officer that the man had met with his co-defendant before the trial and as a result the man had become more paranoid. According to the man's partner, the co-defendant had told the man the police were looking into his case and that he could face further charges.

81. The man was due back in court on 16 March. He told his partner he could no longer face her visiting him. The officer reassured the man's partner that if he needed to see a doctor that would be arranged. The officer also indicated that the man had not seen his co-defendant since their last court appearance.

82. On 24 February, the man's partner phoned the prison to cancel her visit. On 27 February, a SHCO noted in the man's history record, 'Remains in ward conditions. Final case review. Closed ACCT after an improvement in his general condition. Interacting well with both staff and inmates. No management problems to date.'

83. On 27 February, a final case review was completed by the SHCO and a nurse and the ACCT was closed. The notes of the review say that the man was:

'nervous and anxious, asking for a single cell. Eating and drinking ok. In contact with his family, although declining visits with them as he feels scared. Last incident of self harm November 2006. Attends association, no thoughts of harming himself, still feels others are going to harm him. No recent attempts of self harm.'

84. Shortly after the man's review, the nurse completed an ACCT review for another prisoner. This prisoner told the nurse that she did not need to worry about him but she should be concerned about the man. The nurse told my investigator that she went to see the man after the other prisoner's review and asked him how he was. The nurse told the man that another prisoner had expressed concerns about him. The man told her again that he was fine. The nurse did not note this information anywhere in the man's record.

85. On 28 February, a doctor reviewed the man. The man was still paranoid and said he thought that MI5 would try to kill him. He said he did not feel suicidal. The doctor concluded that the man was paranoid but was not suffering from hallucinations. The man asked for his medication to be reviewed but he still believed he was going to be killed.

86. On 1 March, the man was discussed during the management ward round. It was noted that he was still paranoid and his medication was confirmed. The man was reviewed later by a doctor who recorded that the man was still paranoid. The man asked for an increase in his medication and to see another doctor. This doctor prescribed an increased dose of Olanzapine (from 10mg to 15mg).

87. On 2 March, the man was seen by the doctor. The doctor told the man he thought going to the houseblock would be bad for his health. The doctor's opinion was that the man misinterpreted this. The man was concerned for his own wellbeing. The man wanted the doctor to speak to his partner to reassure her that he was alright. The doctor spoke to the man's partner and tried to reassure her of his wellbeing.

EVENTS ON 3 MARCH

88. The man was located in ward 3 with five other prisoners as per attached diagram (Annex 1). On 2 March, two officers a nurse and another staff member were on night duty. An officer, the nurse and a staff member were in charge of checking prisoners in the healthcare centre throughout the night. The second officer was carrying out constant observation on a prisoner. Two of the prisoners in ward 3 were on ACCT documents and would have required regular checks. (Staff on duty during night patrol take it in turns to check the prisoners within the healthcare centre throughout the night, although my investigator found that there is no standard procedure for doing this.)

89. On of the officers explained to my investigator that he normally completes checks at the beginning, middle and end of the night shift. Checks on ward 3 are made by looking through the main window of the ward, which gives a view of four beds (beds one to four in the diagram). The other two beds are observed through the windows of the doctor's office next to the ward (beds 5 and 6 in the diagram). The man was located in bed 5, close to the external windows of the ward. The officer aid that the last visible check he made on ward 3 was at 3.10am on 3 March. The officer noticed nothing untoward when he checked at that time. The next check he was due to complete was at 5.45am.

90. At around 5.30am, the nurse was in the doctor's office making up medical records. The nurse heard shouting and somebody banging on the main window of ward 3. The nurse left the doctor's office and saw a prisoner banging on the window and shouting. He looked into the ward and saw two prisoners trying to support the man. The man had made a ligature from a piece of bed sheet which was attached to the window behind his bed. The nurse immediately called for help from the officer and staff member then called for further assistance on his radio.

91. The officer broke his sealed pouch containing keys for ward 3 and entered the ward with the nurse and member of staff. (On night patrol officers carry cell keys in a sealed pouch; they are only to be used in an emergency.) The officer and member of staff supported the man whilst the nurse went to the staff office opposite ward 3 to get the ligature scissors to cut the ligature. Meanwhile, the officer pulled the ligature apart as it was too tight to cut off and the member of staff checked for vital signs. There were none.

92. By the time the nurse returned, the man had been laid on the floor and the member of staff and the officer had commenced cardiopulmonary resuscitation (CPR). The staff member commenced chest compressions while the officer ensured that the man's head was tilted backwards and his airway was clear. The nurse collected oxygen and the emergency resuscitation bag from the clinical room. The member of staff attached the oxygen mask which the officer held in place. A PO (the night orderly officer) arrived and saw the nurse, the officer and the staff member giving CPR. Another officer also arrived at the ward and relieved the officer from the constant watch he was doing. This officer and the nurse then collected the

defibrillator from the defibrillator cupboard in the corridor. A third officer arrived and helped the nurse move the other prisoners from the ward to the association room. An ambulance was called at 5.40am and arrived at 5.47am. A second ambulance arrived at 5.54am. The first paramedics continued with CPR and the man was taken to hospital. The ambulance left the prison at 6.20am. The man was later pronounced dead at 6.34am.

93. Prisoners in the healthcare centre were immediately offered the support of Listeners (prisoners trained to offer peer support) and Samaritans. ACCT case reviews were undertaken for all prisoners in the healthcare centre who were being monitored.

94. Staff involved were supported immediately by staff care and welfare and were offered Samaritans' support.

ISSUES

Family concerns

95. The man's partner and her solicitor raised various concerns. The man's partner asked why staff had not removed the chair that the man kept trying to stand on in his cell. As I have noted, The man's table and chair were immediately removed from his cell on 25 November. The table was replaced by a cardboard table on 26 December.

96. The man's partner was also concerned that the man's change in behaviour had come 'out of the blue' on 25 November. Prior to this episode of serious self-harm there had been few entries about the man and those recorded were positive comments, including his willingness to help with cleaning. The solicitor said he had seen the man in September 2006 and had been concerned about his mental health at this time. There is no documentation suggesting this concern was raised with prison staff.

97. In his police statement, a prisoner says that he was aware that the man had tied shoelaces and a piece of bed sheet in various knots a few days before he died. The prisoner said that the man had put these in a locker. The prisoner said he took the shoelaces from the man and placed the piece of bed sheet in a bin. The prisoner did not tell any member of staff about the incident.

98. The man's partner felt the man was showing clear signs of stress and agitation. She said that, prior to his death, she had been concerned that the man had appeared uncharacteristically calm and informed the doctor. The man's partner felt in hindsight this seemed an obvious sign of his intention to take his own life. She questioned why this was not picked up by healthcare staff. She was also concerned about the comment the doctor made to the man that returning to the houseblock would be bad for his health. The doctor felt that her partner had, unfortunately, misinterpreted this. The man's partner questioned the suitability of such a comment, given her partner's state of mind at this time.

99. The solicitor stated his strong concern about the difference in the psychiatric reports produced by the doctor and the specialist registrar about whether the man had been fit to plead. The doctor had agreed he was fit to plead, however, the registrar deemed the man unfit to plead. The solicitor thought it should have been standard practice to refer this decision further if agreement could not be reached. In its clinical review, the PCT say:

> "In relation to fitness to plead. Firstly there was a time delay of one month between the assessments which may have accounted for a difference. (the doctor's report was dated 9 January 2007 and the registrar's report was dated 6 February.) However, fitness to plead is a matter of clinical opinion and differences in opinion may well arise. Our understanding is that where differences of opinion arise then this is a matter for the court to decide which opinion they wish to take."

100. The solicitor questioned the independence of the clinical review as the local PCT have responsibility for healthcare services at Belmarsh. The solicitor believed that psychiatric opinion was crucial in determining the care the man received whilst in custody, and felt strongly that an independent psychiatric opinion was needed to assess the quality and appropriateness of the man's treatment. The PCT advise:

> "The review team consisted of two doctors and one lay person. None of the team were employees of the PCT but were paid by the PCT for their time in completing the report. The report was discussed by a multi-agency panel including representatives of Belmarsh and the PCT and some minor changes were made to the final report as a result. The report, however, is an independent statement of the review of the man's care by the review team."

I agree that the clinical review constitutes an independent assessment of the man's clinical care while in Belmarsh.

Clinical care

103. Guidelines for dealing with prisoners with mental health problems in prisons are set out in the document, Mental Health Observation, including Constant Observation: Good Practice Guidelines for healthcare staff working in prisons, Gateway Reference: 7003 (HM Prison Service and Department of Health) and Prison Service Order (PSO) 2700. One of the critical issues to consider is the prisoner's location. Initially, the man was located in a gated cell on constant observation. He was then located in a single cell on intermittent watch, and finally he was located in ward 3, a six bed ward. PSO 2700 states:

> "Constant observation can only be authorised by a doctor or nurse (in consultation with the duty governor) or the duty governor (in consultation with a doctor or nurse) … Prisoners placed under constant observation should be urgently referred for mental health assessment. Their case must be reviewed as soon as is practicable, and certainly within 4 hours (or immediately prior to unlock the following morning in cases where the prisoner is placed under constant observation during the night) and every 4 hours thereafter for the remainder of that establishment's core working day. 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."

104. I consider the man's location within the healthcare centre at various stages to have been appropriate. On each occasion the decision to relocate was made by the psychiatrist and was clearly documented in the medical record. I am concerned, however, that this was not documented clearly in the ACCT.

The Healthcare Manager should ensure that, when a prisoner is monitored on ACCT, staff clearly document important information such as decisions to relocate in the ACCT form as well as in the medical record.

105. The process for referring the man for an assessment for transfer to a psychiatric hospital was initiated on 27 December 2006 by the psychiatrist. The man was assessed by a specialist registrar from a medium secure unit on 12 January 2007. That assessment concluded that the man should be assessed for transfer to a high security unit. The clinical review concludes that:

> "The Forensic Service were involved and undertook timely assessment and supported the recommendation that hospital care was appropriate. His category A status meant that there were substantial delays in achieving this. He was awaiting assessment by Broadmoor. These delays are inherent in the referral system itself and did not relate to any actions taken within Belmarsh.
>
> "For his mental health The man was reviewed regularly and appropriately to a greater extent than that expected in the community. In the community he may have been sectioned as he was non compliant with his medication at times and very paranoid."

106. The man complained of stomach trouble and it was noted that he lost a significant amount of weight. There seems little evidence that beyond the health screen at Wormwood Scrubs, and attendance at A&E for his head injury, there were any other checks or investigations of his physical heath. His significant weight loss was noted on more than one occasion and the man's food and drink refusal was monitored. His weight loss, however, was not investigated for physical causes. Possible physical causes for his paranoia were not investigated. The clinical review concludes:

> "We would expect that outside a prison in a primary care setting he would have been offered a physical health check and investigations of his weight loss would have taken place. Physical health reviews are an established part of the National Service Framework (NSF) standards."

The Healthcare Manager should ensure that any action regarding a patient's care is taken forward appropriately and in a timely fashion to provide a more holistic approach to care to ensure all the patient's needs are met.

Despite this, I was impressed overall by the continuity of care given to the man within the healthcare centre.

ACCT management

107. The man was managed on an ACCT from 24 November until 27 February. Apart from the incidents of self harm on 24 and 25 November he did not indicate that he intended to self harm. The man was paranoid that others would kill him but did not express any suicidal intentions. I am satisfied therefore that it was appropriate to close the ACCT on 27 February. However, I am concerned that the ACCT was closed without input from psychiatrist services (that is the psychiatrist and the doctor) considering the close supervision he already had from them. The clinical review says:

> "In the ACCT guide it states that key people should be involved in case reviews. This should be particularly an issue at the point of closure. Where the Psychiatric team has continued significant involvement in the patient's management, it is appropriate to discuss the potential closure with the team prior to prison staff undertaking the case review and closure procedure."

This issue has been mentioned in another of my investigations at Belmarsh, the final report for which was issued in January 2007.

The Healthcare Manager should ensure, as a matter of urgency, that all staff are aware of the guidance for completing ACCT case reviews. Key people who have continued and significant involvement in the prisoner's care should be involved in case reviews.

108. A prisoner told a nurse that he was worried about the man. The nurse said she spoke to the man about the prisoner's anxieties and the man said he was fine. I am concerned that the nurse did not make a note of this anywhere in the man's medical record or ACCT. A similar issue has been raised in another of my investigations at Belmarsh, the final report for which was issued in November 2007.

The Healthcare Manager should ensure that staff make a note of important information in relevant documentation such as the ACCT form and the medical record to ensure continuity of care.

109. The entries in the man's ACCT form by an officer dated 27 and 28 December 2007, are unfortunate and inappropriate and based on inexpert opinion. Entries in the ACCT must be meaningful and include relevant information on the person's mood, behaviour and situation. However, I do not make a recommendation, other than to draw this to the attention of the Governor, as other entries are appropriate and include significant information as required.

110. Observation of patients in ward 3 was difficult. Due to its position, there was no complete view of the bed that the man occupied. The bed was in the corner of the ward in a recess and the healthcare centre is dark, particularly during the night. The only place to view the bed is through the window of the doctor's room next to the ward. A bright light was put on to check on prisoners which was disruptive when prisoners were trying to sleep. I agree

with the conclusion of the clinical review that all prisoners on the healthcare unit should be in a bed that is clearly visible to healthcare workers.

111. I am pleased that changes have been made to ward 3 since The man’s death. Lighting in the ward is now controlled by a dimmer switch which can be regulated to light the ward in sections. This makes it easier to check on prisoners during the night. The prison is also looking at implementing other measures, such as a buzzer system to indicate when prisoners go into the recess, as well as looking at camera positioning. In addition, the furniture in the recess has been re-designed as an anti-ligature measure. Glass windows in the ward are to be replaced, as they are scratched and discoloured, making it difficult to see through when observing. Finally, a cupboard in the doctor’s room next to the ward that does not allow staff to get close enough to the window to have full observation is going to be moved.

RECOMMENDATIONS

The Healthcare Manager should ensure that, when a prisoner is monitored on ACCT, staff clearly document important information such as decisions to relocate in the ACCT form as well as in the medical record.

The Healthcare Manager should ensure that any action regarding a patient's care is taken forward appropriately and in a timely fashion to provide a more holistic approach to care to ensure all the patient's needs are met.

The Healthcare Manager should ensure, as a matter of urgency, that all staff are aware of the guidance for completing ACCT case reviews. Key people who have continued and significant involvement in the prisoner's care should be involved in case reviews.

The Healthcare Manager should ensure that staff make a note of important information in relevant documentation such as the ACCT form and the clinical record to ensure continuity of care.

Comments following the draft report:

Factual inaccuracies:
Paragraph 31 has been amended to reflect the correct title of Charge Nurse rather than Nurse.
Paragraph 31 has also been amended to reflect that Charge Nurse completed a secondary health screen for the man and not a well man check.
The Prison Service has accepted the recommendations apart from the second one which has been partially accepted. The Action planned is attached.

At the close of the consultation period, the solicitors acting on behalf of the man's partner informed my office that they were not in a position to provide any comment on the draft report. The solicitors declined additional time to respond and explained that it was their intention to instruct their own expert to advise on the medical issues, once they were in a position to do so, in order that their client's concerns could be appropriately addressed at the Coroner's inquest.