

**Investigation into the death of a man
at HMP Belmarsh in May 2010**

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

December 2011

This is a report into the death of a man who was found hanging in his cell in the Segregation Unit at HMP Belmarsh.

I would like to offer my sincere condolences to his family for their loss. I hope my report addresses the concerns that they have raised.

The investigation was carried out by one of my investigator, with assistance at some interviews by another investigator. I must apologise for the length of time taken to produce this report and the additional anxiety caused to the man's family at an already sad and difficult time. The clinical review which was commissioned to consider the man's health care and mental health care was not received until the end of January, which added to the delay. However, I would like to thank them for their thorough and full review. I would also like to thank the Governor of Belmarsh and his staff for their assistance with the investigation.

The man was received into HMP Highdown on 6 May 2010. He had a history of harming himself and of depression and mental health issues. Two days later the man was discovered making a ligature from a television wire. He told staff this was not a serious attempt to harm himself, but a cry for help. On 10 May the man was transferred to HMP Belmarsh after appearing at the Central Criminal Court. He was initially taken to a normal wing, then transferred to healthcare and then to the Segregation Unit, due to his behaviour. I make criticism of his transfer to Segregation as he had been assessed as not suitable to be held there only a few hours previously. Due to his history of attempting to harm himself, the man was subject to suicide and self harm monitoring procedures. However, he was discovered in his cell, suspended from a ligature on 13 May, and all attempts to resuscitate him sadly proved unsuccessful.

I make nine recommendations to the Governor, the Head of Healthcare and to both jointly. These surround locating vulnerable prisoners in the Segregation Unit, self harming procedures, receiving important correspondence into the prison, first aid equipment, and clinical records and the standard of record keeping.

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

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Prisons and Probation Ombudsman

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SUMMARY

1. The man was found hanging in his cell in the Segregation Unit. He had been at Belmarsh for three days, having previously been at Highdown for four days. He was charged with a serious offence, and it was his first time in prison.
2. The man had a history of harming himself and of depression and was receiving treatment and medication in the community. He had spent time in a psychiatric hospital.
3. Whilst at Highdown, the man made a ligature from a television wire. He told staff this was not a serious attempt to take his life but a cry for help. This prompted staff to initiate suicide and self harm prevention measures for the man, known as Assessment, Care in Custody and Teamwork (ACCT).
4. After an appearance at court, the man was taken to Belmarsh prison. During his time there he displayed disruptive and difficult behaviour which resulted in him being located in the Segregation Unit. He was seen by a nurse who assessed him as unfit to be detained there, so he was moved to healthcare. However, he continued to behave disruptively in healthcare and it was decided to move him back to the Segregation Unit. This time he was assessed as fit enough to stay there. It was also during a review in the Segregation Unit that the man's observations were reduced from a constant supervision to hourly checks. This report expresses concern both about the decision to locate the man in the Segregation Unit and about the subsequent reduction in observations.
5. The man's medication and clinical care remained an issue throughout his time at Belmarsh. He was prescribed medication which he did not appear to receive and a mental health assessment was never carried out for him. Also, a faxed solicitor's letter detailing the family's concerns about the man's mental health did not reach the appropriate department before he died.
6. I make nine recommendations. These include the decision to locate the man in the Segregation Unit, suicide prevention procedures and observations, clinical records and mental health assessments, correspondence, and first aid equipment.

THE INVESTIGATION PROCESS

7. Following notification of the man's death, one of my investigators was appointed to conduct the investigation. She visited HMP Belmarsh on 18 May, to open the investigation, meet members of the Senior Management Team, visit the cell where he died and collect documentation. Notices were issued to both prisoners and staff inviting anyone who had information regarding his death to make themselves known to the investigator. No other witnesses came forward.
8. My investigator visited Belmarsh on 22 June, 13 July, 18 August and 17 September to carry out recorded interviews with staff.
9. One of my family liaison officers wrote to the man's mother on 22 June to explain the role of the Ombudsman and to offer the opportunity to participate in the investigation. The man's mother contacted my family liaison officer at the beginning of August and raised a number of concerns. These were:
 - Why was the man on 15 minute observations at Highdown prison as he had attempted to take his life there, but when he moved to Belmarsh these were reduced to hourly observations?
 - Who made the decision to reduce the observations, did they have the authority to do so and why did they decide to do it?
 - Why was the man alone in a cell with only hourly observations given that he was unwell?
 - Did the man receive his medication correctly?
 - Why didn't the man receive any of the mail or postal orders sent in to him? Not being able to buy tobacco would seriously impact on his ability to cope with imprisonment
 - The man had been an in-patient at the Chiltern Hospital in July 2009 for mental health problems, as he had attempted to gas himself in his car. His mother said she had made the police and prison staff aware of this so that they knew his history.
10. I hope this report goes some way to explaining what happened to the man whilst in prison and addresses the family's concerns.
11. On 8 September, my family liaison officer forwarded a photocopy of all the man's prison records to his mother. A month later she wrote again to explain the delay in issuing the report and that we were still awaiting a clinical review.
12. NHS Greenwich was commissioned to conduct the clinical review. The clinical team comprised the Clinical Lead and Investigations Manager, Independent General Practitioner and Medical Director at NHS Hillingdon and

an Independent Investigator. This report was received in this office on 24 January 2011.

13. On 18 March, the man's legal representative wrote to the Ombudsman. In their letter they said that they had sent a fax to Belmarsh on 11 May explaining their concerns and that of his family for his welfare, given the attempt to take his own life the previous weekend (whilst at Highdown). They did not receive a response from the prison and on 13 May were informed by the man's mother that he had died. The solicitors are concerned that the contents of their letter were ignored by the prison and that the man was located in a cell rather than in healthcare. They ask that their concerns are considered as part of the investigation.
14. A letter apologising for the delay in producing this report was sent to the Governor and the Coroner on 20 April 2011. No feedback was provided to the Governor in person as he was unavailable, although feedback was given to another member of the Governor's senior management team.
15. A response to the report was received from Highdown and Belmarsh prisons on 23 September. Highdown identified two factual errors. The first regarding prisoners being permitted to smoke in their cells in healthcare. Also, the Healthcare officer was mistakenly identified by a wrong name.
16. My investigator and another family liaison officer met with the man's family on 2 November to discuss the draft report. The family agreed with the recommendations made, but remained very concerned about the lack of communication between the prisons, and the lack of postal orders and letters he appeared to receive.

HMP BELMARSH

17. HMP Belmarsh opened in 1991 and is a local prison, serving primarily the Central Criminal Court and magistrate's courts in South East London. In addition, the prison serves Crown and magistrate's courts in south west Essex. Belmarsh has a dual role, in that it also holds category A prisoners. There are four residential house blocks and a High Security Unit within the prison.

HM Chief Inspector of Prison's report (HMCIP)

18. The most recent inspection of Belmarsh by Her Majesty's Chief Inspector Prisons, was an unannounced full follow-up inspection in April 2009. In a report published in December 2009, her comments included:
19. "Suicide and self harm prevention was taken seriously, and there was some good work, but with a tendency to over medicalise the issue".

Independent Monitoring Board (IMB)

20. Each prison has an Independent Monitoring Board (IMB) whose role it is to monitor the prison and report any concerns about the way prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The IMB holds regular meetings in the prison, with the Governor attending for part of the meeting. The Board produces an annual report that is submitted to the Secretary of State for Justice.
21. With regard to Safer Custody, the IMB report for July 2008 until June 2009 says:

"There were 81 incidents of self-harm in the reporting year, 12 of which involved foreign nationals.

"The most common form of self-harm remains cutting and scratching which accounts for 56 of the acts. More than twice as many of the incidents happened in the daytime rather than during the evening or at night. There is some concern that occurrences are not being properly recorded, particularly in Healthcare, but further guidance was given in governor's orders and it is hoped there will be an improvement.

"IMB members regularly carry out random checks on open ACCT documents, and concerns were raised in the past that trigger points were not being properly noted....and Care Maps (positive plans of action) were inadequately outlined. There has been a notable improvement in quality checking during the reporting year, not least because of regular management checks. The Board intends to carry out a more intensive and rigorous monitoring exercise in the near future".

Critical Debrief

22. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, review their feelings and normalise the reactions that some people experience after a traumatic incident.

Cut down tools

23. Each officer and member of staff who is in contact with prisoners carries an anti-ligature knife. These are knives which are specially designed to cut through ligatures in a safe manner.

Reception and induction

24. A Cell Sharing Risk Assessment (CRSA) is opened by an officer in reception who completes the basic details. The form is then passed to the First Night Centre staff where a confidential interview is conducted. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells.

Suicide and self harm monitoring

25. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to support and monitor prisoners at risk of harming themselves. The Key aims of ACCT are to create a safer environment, identify prisoners individual needs and provide care and support before, during and after a period of crisis. Once an ACCT is closed a post closure review should take place within seven days.

Other deaths at Belmarsh since May 2010

26. Since the man's death there have been a further four self inflicted deaths at Belmarsh. Two are still being investigated, whilst the other two do not have recommendations which impact on the man's death.

KEY EVENTS

Highdown

27. On 6 May 2010, the man was remanded to HMP Highdown following a hearing at Croydon Magistrate's Court. He was due to attend the Central Criminal Court on 10 May.
28. The man entered reception at Highdown and a first reception health screening (a check made by a member of healthcare staff) was carried out. The screening identified that the man had seen a doctor within the last few months for depression and mental health issues. The man described the problem as "schizophrenia and depression" and he said he had been an inpatient in Chiltern and Sutton Hospital for two weeks in July 2009. The man also said that he had a community care worker and was taking the medications diazepam and fluoxetine (an anti-depressant).
29. The man also told the member of the healthcare staff that he had asthma and an allergy to plasters. They discussed his alcohol consumption and he described himself as a social drinker, consuming approximately two bottles of spirits a week. The man was referred to see a doctor for substance misuse and a mental health assessment, and was described as being very depressed and low in mood.
30. Further medical history was taken by a member of healthcare staff at Highdown. The man said that in the past he had tried to harm himself by cutting and that he had also tried to gas himself in a car. Whilst an inpatient at Chiltern and Sutton Hospital, a diagnosis had been made of paranoid schizophrenia and that at the time of the alleged offence, he had been living at a centre for people suffering from alcohol and drug abuse.
31. Later that day, the man saw prison Dr A. The doctor recorded that he had no recollection of committing the offence for which he was charged, but the man admitted to drinking heavily, sometimes two bottles of Jack Daniels a day. The doctor confirmed that there were no signs of alcohol withdrawal and prescribed a daily 20mg dose of fluoxetine and chlordiazepoxide (a sedative for the short term treatment of severe anxiety which is also used for acute alcohol withdrawal) when needed.
32. The man was admitted into healthcare from reception at 7.30pm because of the seriousness of the charge. ACCT process were put in place to monitor and support the man and, as part of these, it was agreed that he should be located in a gated cell to enable him to be monitored closely on 15 minute observations. (Prison Service Order (PSO) 2700 Suicide and Self Harm Prevention prohibits the use of a gated cell for any prisoner who is not on subject to constant supervision.) It was also recorded that chlordiazepoxide (a drug for used for alcohol withdrawal) would be given to the man if needed and that review would be held with him the next morning.

33. The next day the man was described as being low in mood and uncommunicative although he did accept his prescribed medication. Later that evening he was noted as being tearful and spoke to a member of staff. He requested a hug, which was refused, but he generally became more settled.
34. On 8 May, it was recorded in the man's medical notes that he was agitated and crying a lot. He was seen by a doctor but the notes made following this consultation are illegible.
35. The man had been in a highly emotional state and told staff that he could not cope and should not be in prison. He also requested diazepam (it is not clear from the documentation supplied whether he was given this). The staff starting their afternoon shift were alerted to the man using a television wire as a ligature. He was lying in the corner of the gated cell (although not on constant watch) with the ariel around his neck attached to the hand rail by the toilet. He was also crying uncontrollably. The man's breathing was not affected. An immediate action plan (part of the ACCT process) was started by Senior Officer (SO) A. The plan was to allocate the man to a safer cell in healthcare, implement 15 minute observations, ensure that staff had three meaningful conversations with him a day, that he was observed hourly at night and given access to the Samaritans telephone. It is also recorded that the man had a visit that day, from 2.00pm until 3.55pm approximately, with his family.
36. Later that evening the man repeatedly requested tobacco. It was decided that his behaviour meant that he should have a full mental health assessment and a referral was made.
37. The next day SO A carried out an Assessment, Care in Custody and Teamwork (ACCT) review, following the man's attempt to harm himself the day before. The man told the SO that he had felt distressed because of his withdrawal from smoking, that he had no more money to buy any tobacco and he had smoked his smoker's induction pack. The man added that this was not a serious attempt to harm himself, but more a cry for help related to his withdrawal from tobacco. The Healthcare officer also noted at the ACCT meeting that the man seemed frail and vulnerable and was seeking sympathy.
38. It was also noted that the man said he had attempted to harm himself previously, by gassing, cutting and poisoning himself. He attributed this to not having had the "most happy of lives" due to family deaths and other issues which he did not elaborate on. The man told staff that he was feeling better and wanted to think about leaving healthcare and re-joining the main prison. He was told about coping resources available to him within the prison and a mental health assessment was requested. The next ACCT review was scheduled for 16 May.

Belmarsh

10- 11 May

39. On 10 May the man attended the Central Criminal Court and as a result was transferred to Belmarsh prison from there. Whilst in reception, he underwent a Cell Sharing Risk Assessment. It was noted by the member of staff who completed the assessment that he was a smoker and that he would have to share a cell as he was on an open ACCT (although this is not necessarily required under the guidance in PSO 2700). A note was added to say that the man was on an ACCT (which had travelled to Belmarsh with him) but that he was not suicidal, and appeared to be well.
40. An Induction Passport (which holds details of the man's induction into the prison and outlines the rules and responsibilities of a prisoner at Belmarsh) about his immediate needs was also completed. It determined that this was his first time in custody, aside from the four days he spent at Highdown, and confirmed that he had been issued with an induction booklet, a comfort pack (which contains essential items such as a smokers pack supplying him with a quantity of tobacco, teabags, coffee and so on) a meal and a drink. He had also been allowed to make a telephone call, and had been seen by a member of the Detox Team.
41. During this induction meeting, the man was asked whether he considered himself to be vulnerable, and he said he did not. He had no concerns at that stage about sharing a cell on the First Night Centre and although he said that he had attempted to harm himself in the past, he did not feel suicidal at that time. The man said that he did not have any drug or alcohol issues and did not require any support in this area.
42. The man was seen by staff nurse A at 18.26pm on 10 May, who recorded details relating to his address, offence and other general matters. A short while later, he was seen by Nurse B. During her interview with the investigator, she said the purpose of the meeting was to 'register' the man and discuss any issues he might have. She recorded in the medical records after speaking to the man that he said that he did not feel suicidal, that there were no concerns about his mental health, but that he had received treatment in a psychiatric hospital in the community in the past. A previous note in the medical records indicated that he had tried to harm himself previously and had received medication for mental health problems. In particular it was noted that he had attempted to hang himself two days earlier whilst he was at Highdown prison. The man said he used cannabis but said he suffered from no health problems apart from occasional chest pains.
43. The man told Nurse B that he had received Fluoxetine 20mg (an anti-depressant) and Diazepam 5 mg (for anxiety) in the community and was also prescribed this medication at Highdown. It was acknowledged that he was on an open ACCT and was at risk of harming himself.

44. At 20.45pm, prison Dr B saw the man for a further assessment in the First Night Centre. The doctor recorded in the medical notes that the man had a history of schizophrenia and anxiety and that he told her he was taking Fluoxetine 20mg and Diazepam. She noted that he appeared well and not suicidal. The doctor referred him for an assessment by the mental health team and prescribed him 15 Fluoxetine 20mg tablets, one to be taken every morning, and two Diazepam 5mg tablets, one to be taken of an evening for two nights. This medication was to be administered to him by healthcare staff.
45. There is some discrepancy regarding the man's prescription and medication. The electronic medical records say that prison Dr B saw him on the evening of the 10 May and the medication was prescribed from them. However, there was also a paper prescription chart which suggests that the doctor saw the man on the 11 May, that he only took the Diazepam on the evening of the 11 May and did not take his medication on the 12 May. The paper prescription chart also shows that he was prescribed Fluoxetine on 10 May and took it on the mornings of 11 and 12 May. There is no record of either of these drugs being administered on the electronic records system. At interview, the Head of Healthcare agreed that the two records were recording different and conflicting information, but was unable to explain this further, although the confusion might have been due to the new electronic system that staff were getting used to using.
46. After the interviews with induction and medical staff, the man was sent to a shared cell in the First Night Centre, where it was recorded that he slept well overnight.
47. The next day, 11 May, the man was seen by Staff Nurse C. She noted that he had been diagnosed with schizophrenia and had been admitted to Jasper ward (a mental health ward) in the Sutton and Chiltern hospital several times in the past. There are also some entries which contradict the information collected the previous evening as on this occasion the man did not say he suffered from chest pain or say that he had asthma. (An entry made on the electronic medical records system on 14 May states that the nurse made a paper referral to the mental health team on 11 May at 12.30pm, which was handed to the team in time for their 1.00pm meeting that day). It is unclear whether this was an urgent or routine referral.
48. A Cell Sharing Risk Review was also carried out for the man on 11 May. It determined that he remained a low risk to other prisoners and could share a cell. A note made by the same officer (signature illegible) in the Wing Observation Book says that he had no thoughts of harming himself and that he was aware of the support that was on offer. It was recorded in the book that he was on an open ACCT but he said he felt "fine". He had been given all of the induction booklets and leaflets and had signed to acknowledge these, and had had all prison compacts (agreements between the prisoner and prison) regarding behavioural standards explained to him.

49. At 13.36pm a letter from the man's solicitors was faxed to the Governor's office. The letter explained the concerns that the man's family had about his welfare. These were that he had depression and anxiety and had been diagnosed with paranoid schizophrenia and that he had made many suicide attempts previously, most recently on 8 May whilst at Highdown. The man's mother was concerned that he had not been receiving his medication of Fluoxetine and Diazepam for a week prior to his arrest on 5 May. She believed that he should be located in healthcare and that he should be seen by a psychiatrist.
50. During a visit to Belmarsh, my investigator spoke to Nurse D about the letter. The nurse explained that the faxed letter was received in the Performance Management Unit (PMU) on 12 May. This is located in an office in the main administration block. PMU scanned the letter and sent it via e-mail to the nurse on the afternoon of 12 May. The nurse did not see the e-mail until the afternoon of 13 May but then took it to the Head of Healthcare. Unfortunately, the man was already dead by this time. It is not clear what happened to the fax between its arrival in the early afternoon of 11 May and its receipt into PMU on the morning of 12 May.
51. An ACCT review was held at 3.00pm the same day. Two senior officers attended the meeting with the man. It was noted that the review was brought forward as the man did not return to Highdown prison. The man seemed quite nervous and agitated during the meeting and said that his attempt to take his life three days earlier had been a serious one, although he was pleased that he had been found in time and did not die as it had made him realise how much his family meant to him. It was agreed that the ACCT should remain open and a review was to take place on 18 May. The frequency of observations remained as agreed at Highdown.

12 May

52. The next day the man was unlocked for breakfast and after eating attended exercise. He asked a member of staff about the money he had available in his prison account and was told somebody would look into this for him. It seems that a postal order would take ten days to clear into a prisoner's account, so effectively a prisoner could be without money for two weeks. He had no other issues. That afternoon he attended day two of the induction programme and appeared quiet and polite. He collected his lunch and said he was "fine" and looking forward to attending the gym induction later that day.
53. Some time later, the duty governor for the day, received a message to say that a prisoner (the man) had "smashed up" his cell on the First Night Induction Centre. The man had been in the cell on his own when he did this. The duty governor agreed that the man should be escorted to the Segregation Unit and asked that he be informed when the man arrived there. At this stage he was not aware that the man was on an ACCT. He said during his interview that it was normal practise to place a prisoner in the Segregation Unit because of his behaviour, pending adjudication.

54. After the man was located in the Segregation Unit a segregation safety algorithm was carried out by a member of the mental health team. (This is an assessment tool used to establish whether it is appropriate for a prisoner to be held in the Segregation Unit). The member of the mental health team concluded that the man was not to be located in the Segregation Unit as although he was not showing signs of acute mental illness, he appeared “impulsively suicidal”. This note is made in the on-going record of the ACCT form, but not in the man’s medical records.
55. The duty governor for the day was told of the member of the mental health team’s assessment and it had been decided to take the man to healthcare. The man was admitted to Ward One and arrangements were made for him to be seen by a psychiatrist the next day. Ward One is a dormitory style unit, with six beds in it. The man was located there as there were no single cells available in healthcare.
56. At 4.10pm an ACCT case review was held in healthcare. It was noted that the review was as a result of recent events and the man’s admittance to healthcare. The man said at the meeting that he felt frustrated that his money had not been transferred from Highdown and that he did not have any tobacco. He said he did not have any thoughts or plans to harm himself and did not feel he needed to be in healthcare, but was happy to remain there until he was reviewed. There is no entry in the ACCT to explain what plans were made to alleviate these problems, but a review date was set for 18 May.
57. Less than an hour later it was reported that the man began to create a disturbance in Ward One. He was banging his fist on the wall and shouting. Nurse E, who was working in healthcare, went to see what was happening. The man said that Nurse E should get him out of Ward One before he “smashed up the place”. He was becoming very aggressive and said he would “kill someone” if he remained there. The nurse called for assistance and two officers came out from the day room to help. They opened the ward door, asked the man to stand in the corridor and tried to calm him down. The nurse began talking to him, but the man remained angry and demanding. He said that he did not want to be in healthcare, that it was not the place for him, that he was not mentally unwell and he just wanted a cigarette (smoking is not permitted in healthcare). He said that if he returned to Ward One he would “kill someone”. The nurse could not identify anyone to move from a single cell to accommodate the man, so called for the duty governor of the day for his advice and assistance.
58. Nurse E said that at this point, the man’s actions were strictly ‘behavioural’, meaning that they had had nothing to do with a mental illness, and therefore presented a control problem. When asked about this at interview, the nurse told the investigator that in his opinion the man was fully aware of the threats he was making and what he was doing and that, in his view, it would not be safe for him to return to the ward.

59. The duty governor of the day arrived in healthcare and saw the man who was standing in the corridor with a number of staff members. The governor tried to speak to him to ascertain what his issues were. (He had been told a short time earlier that the man had watched a television programme about Wormwood Scrubs and had seen a prisoner there say that if you “kick off” you can get anything you want.) The governor asked the man what was troubling him and he replied that he had no tobacco and wanted to smoke. The governor established that the man had already had two smoker’s packs given to him which contained a pouch of tobacco, Rizla papers and means of lighting the cigarette. The pack is supposed to last a prisoner a week, or until they have their own money to purchase goods from the prison canteen. At that stage the governor was not aware of how important smoking was to the man and had not seen the man’s ACCT (which said that not being able to smoke was a trigger for self harm for him).
60. The duty governor of the day tried to explain to the man that his behaviour earlier that day had meant he should be located in the Segregation Unit, but as it was deemed unsuitable to stay there, he had been moved to healthcare where he could only smoke during outside exercise. The man became very angry and said that the governor was “winding him up”. The man then jumped up and moved towards the duty governor and was restrained by staff. He put up a struggle, but was eventually placed in handcuffs. The governor said he believed the man was about to assault him.
61. The duty governor of the day said at this stage he was aware that there were no single cells available in healthcare and the man could not return to the ward environment. As he realised that the man would not be able to smoke in healthcare, but that he would be able to in the Segregation Unit, he thought that as part of a de-escalation attempt, the man should return there. The governor said he was aware that the nurse had assessed the man as unsuitable for the segregation unit.
62. The duty governor of the day completed a form ‘Exceptional circumstances for the continued segregation of a prisoner on an open ACCT’. This form is used to explain why it is necessary for a prisoner to be located in the Segregation Unit, despite being subject to the ACCT process. He wrote:
- “The man was removed from HB3 earlier today due to smashing his cell. He stated the reason for this was due to the fact that he had no tobacco. The man has been given two smokers packs since he arrived at Belmarsh but has used them up in a short period and now has no money to buy anymore. He was taken to the Segregation Unit due to his refractory behaviour but then moved to a ward on the HCC due to failing the initial segregation health screen. At approximately 17.10 hours a call was received in the Orderly Office stating that the man was smashing himself against the ward cell door. He was immediately removed from the ward to protect the other inpatients, however there was no unoccupied single cell in the HCC to accommodate him. The duty governor attended the HCC to speak with the man, however during his conversation with him the man attempted to assault the duty

governor and was restrained. Due to continued refractory behaviour it became necessary to locate the man in a cell in the Seg Unit. The man is currently on an open ACCT document (opened 9//5/10). His only trigger which is listed is “no tobacco”. It was decided that to keep the man safe, he would be placed in a gated cell in the Seg Unit and under constant supervision. A small smoker’s pack has been obtained and the man allowed to smoke but only at the discretion of the Seg PO – he is not to remain in possession of the tobacco as he will likely smoke it in a few days. It has to be a consideration that, whilst not desirable to hold him in the Segregation Unit on an open ACCT, he is able to smoke in the Seg Unit and not the HCC.”

63. At 6.00pm Nurse F carried out a second algorithm to ascertain the man’s suitability to be located in the Segregation Unit. The nurse acknowledged that the man had a history of harming himself and required frequent observation. However, this time the man was thought to be suitable to remain in the Segregation Unit. The duty governor for the day counter signed the form and confirmed that the man should be located in the Segregation Unit for operational reasons and that a case review was needed immediately. The man was placed in a gated cell which allowed constant supervision by staff, meaning a member of staff would sit outside the cell and watch him continually. They would also make a note in the Observation Book every 15 minutes.
64. During his interview with the investigator, the head of healthcare said that aside from the single cells, there was also a gated cell in healthcare which although occupied at the time may have been an option. Also, there were two gated cells in a contingency suite. He said he would have considered all of these options before moving the man to the Segregation Unit.
65. The Senior Officer (SO) in charge of the Segregation Unit when the man arrived there the first time that day. He recalled that there was no force involved when the man was escorted there and that he failed the algorithm completed by the member of the mental health team. The SO told the investigator that it is rare for a prisoner on an open ACCT to be located in the Segregation Unit, but it does happen.
66. Following his return to the Segregation Unit, the SO in charge of the Segregation Unit that day carried out the constant supervision of the man for the first two and a half hours. The man did not talk about anything significant, and the tobacco arrangement was that he could request it from staff when he needed to. The SO was relieved by Officer B at 8.35pm. He was fully briefed by the SO and introduced himself to the man. The man told Officer B that he was “ok” and showed no signs of self harm. Throughout the night, nothing of note was recorded and the man appeared to sleep on and off until the next morning.

The day the man died

67. The man ate breakfast at 8.30am and spent the rest of the morning laying on his bed, reading and smoking. When SO in charge of the Segregation Unit arrived back on duty he was told that the man had been fine overnight.
68. However, at 10.35am the man put toothpaste all over his head and face, which he then mixed with soap. As a result he was given a full body search and taken to the shower to clean up. He then returned to the gated cell and constant supervision was resumed.
69. At 11.50am an ACCT case review was attended by the man, the SO in charge of the Segregation, the member of the mental health team and two other officers. The man said that it was access to tobacco which affects his behaviour and it is the only way he can reduce the stress of being in prison. He told the review that he had no thoughts of harming himself or of suicide. It was noted that the man showed good insight into his current situation and was able to explain what plans he had for the future. These centred on a return to work as a scaffolder and “becoming a reformed character” and indicated that the man was thinking about his future. The man also apologised to the SO for his behaviour the previous day. The member of the mental health team said he was happy to provide mental health support and monitoring on a weekly basis, but said at interview that he was not aware at this stage that the man had still not been assessed by a psychiatrist, as this would normally happen before a prisoner is discharged from healthcare. The member of the mental health team said that if he had known that an assessment had not taken place he would have re-referred him.
70. All those present at the review believed that it was safe and appropriate to move the man from the gated cell to a normal cell in the Segregation Unit and it was agreed that observations could be reduced to an hourly watch. The man remained in the Segregation Unit because the issue of smashing his cell and the attempted assault on the duty governor were still outstanding and also because he was permitted to smoke there, which remained extremely important to him.
71. SO in charge of the Segregation Unit told my investigator that the man was moved to a normal cell in the Segregation Unit at approximately 12.15pm. The SO spoke to him about 15 minutes later and gave him a cigarette. The man appeared calm and relaxed. Staff on the Segregation Unit continued serving lunch to all the prisoners and then completed their paperwork for the morning.
72. An Officer C was covering lunch duty that day. When he arrived for duty that morning he had seen that the man had been located in the gated cell, but did not know any further information about him. Up until lunch time, Officer C had been completing paperwork in the wing office. The officer recalled that the SO in charge of the Segregation Unit had put the ACCT document for the man on the desk in the office and told the officer that he had rolled him some

cigarettes, had a chat with him and that he seemed okay, and “should be alright through lunch”.

73. At around 12.45pm the SO recalled that the officer offered to make some drinks and said he would carry out cell observations on the way. The officer explained that the observations were not particularly his responsibility, but as he was making drinks, he had offered, and he knew that the man was due to be checked.
74. When Officer C looked into the man’s cell through the observation panel, he noticed he was looking out of the window. They did not speak at all. The officer did not record this observation in the ACCT and said during his interview that this had been a mistake on his part.
75. From about 1.30pm the SO in charge of the Segregation Unit and four other staff were dealing with a prisoner in the Segregation Unit who required a senior officer and four officers unlock (the minimum number of staff needed to unlock this prisoner). They dealt with this prisoner’s applications, exercise and shower and a cell clean. The cell clean required staff to dress in protective clothing. Whilst attending to this prisoner the staff were also dealing with other prisoners applications and requests.
76. At 1.45pm the SO returned to the wing office to attend to some paperwork for the Segregation Unit prisoners weekly review. A member of the Independent Monitoring Board (IMB) (who was attending the reviews) and Nurse G were also in the office.
77. At this time another officer, Officer D, escorted a prisoner to use the telephone just outside of the man’s cell. Officer D said at interview that he had a feeling he needed to check on the man, and looked through the observation panel. The officer said that he saw the man at the window in a seated position, with a ligature (a jumper) around his neck and tied to the bars of the window.
78. Officer D immediately called to a colleague, Officer E, to ask for assistance and he then entered the cell. He was closely followed by Officer E and the SO in charge of the Segregation unit, who had heard her call for assistance. The SO shouted to Officer C to raise the alarm bell. Officer D recalled that the man appeared almost blue in colour and his mouth was open.
79. Officer D tried to untie the ligature but it was not possible to do so because of the way it had been tied. The SO and Officer E then lifted the man slightly to take the pressure off of him, and Officer D used an anti-ligature knife (a knife with a specially designed blade to cut through ligatures) to cut through the jumper. As it was so thick, Officer D could only cut a bit at a time which he estimated took two or three minutes. During this time, Officer E was trying to get a response from the man. Once the ligature had been released the three members of staff laid the man onto the floor of the cell. Officer D checked for a pulse in the man’s neck, but found none. (Officer D was a first aider with a current qualification.) He therefore began administering chest compressions immediately.

80. Despite being a first-aider, Officer D had not been issued with any equipment, so Officer C ran to get a mask to use whilst administering mouth to mouth resuscitation. Officers D and C worked at the ration of two breaths to 30 compressions, however they were struggling to get air into the man.
81. At some point an ambulance was called, although the exact time is unclear, as is who made the call. The SO believed it was the Orderly Officer (Oscar One) and Nurse G could not remember who called the ambulance.
82. Nurse G arrived back at the cell after having left to ring healthcare to request an emergency response from the wing office. She was not carrying a radio that day and so had to use the telephone in the Segregation Unit office. At some point Officers D and C swapped roles and Nurse G continued to monitor the man's pulse.
83. The SO realised the cell was beginning to become cramped and decided to leave there to manage the rest of the Segregation Unit. He briefed staff from healthcare and security as they arrived. A member of healthcare, Nurse H arrived with an emergency bag, but not a defibrillator. (A defibrillator is a machine which detects whether there is a detectable heart rhythm which can be shocked into starting again.) As there was not a defibrillator in the Segregation Unit at that time, a member of staff ran to healthcare, which is located very close by. However, Officer D said that they had difficulty finding a defibrillator and it took around 15 minutes to locate one.
84. Whilst waiting for the defibrillator and the ambulance, Officers D and C continued with resuscitation, assisted by nurses G and H. Once the defibrillator arrived Officer D applied the pads to the man and pressed the start button. The machine indicated that no shock was advised, which meant it was not detecting any heart rhythm. Officer D said the defibrillator works in three minute cycles and recalled that he used the machine at least three times before the paramedics arrived. Each time no shock was advised.
85. The reverend and Governor A were in the prison at the time. They were together when they were told that there was an incident in the Segregation Unit and made their way over there.
86. The reverend recalled at interview that he saw the man and from his experience, thought he could not be revived. However, he understood that staff had to continue with their resuscitation attempts until paramedics arrived. The reverend realised he could not be of any assistance, so began to talk to the staff who had moved away from the man's cell and may have been in need of some support. He then collected the man's next of kin information and records. The reverend identified the man's mother and her address.
87. Staff continued with resuscitation attempts until the paramedics arrived. Their entry into the prison was quick and unhindered and they arrived in the Segregation Unit at approximately 2.10pm.

88. The paramedics asked that the man be lifted out onto the landing to give them more room to attend to him. Officer D and one paramedic did so. However, their resuscitation efforts were unsuccessful and the man was pronounced dead at 2.30pm. He was moved back into the cell and placed on the bed. Once the police had attended the prison, the man was taken to the mortuary.
89. Only one other prisoner in the Segregation Unit was on an ACCT and this was reviewed immediately, and all other prisoners in the unit were checked and offered the services of a Listener (a prisoner who has been trained by the Samaritans to offer confidential support in times of crisis) or the Samaritans.
90. A debrief was arranged by Governor A, for all staff involved with the man's death at approximately 3.15pm. Staff from the Care Team and managers checked on the well being of staff, and my investigator found that staff generally felt well supported. Staff were offered the opportunity to go home, but they all elected to remain and finished their shift. The Segregation staff then carried out their own informal debrief at the end of the shift to talk over what had happened and offer support to each other. (A critical incident debrief was also held some time after the man had died, but no record was kept and staff could not remember the date this was held.)
91. At approximately 5.00pm the reverend and Governor A left the prison to visit the man's mother. They had spent some time checking records and ensuring they had the correct name and address. They arrived at the address around an hour later. They knocked on the door but received no reply. They returned to the car and drove a little way away from the house, so they were not sitting directly outside, and decided to wait. The man's mother had been in when the reverend and the governor had knocked, but was reluctant to answer the door. She rang a neighbour who went to see them and asked what they wanted. The reverend said that he was unable to go into detail, but explained that they were from the prison. The neighbour proceeded to escort them to the house.
92. The man's mother had opened the front door, and was already very distressed. The reverend said that the man's mother had guessed what the news was as soon as she knew they were from the prison, and they hardly had the opportunity to relay any information before she left the room.
93. The man's uncle arrived (it is not clear whether he was telephoned) and the reverend spent some time explaining what had happened. The governor remained with the man's mother until she re-entered the room. The reverend explained that the prison would contribute to funeral expenses and offered to conduct the service, and said that they could visit the man's cell if they wished to do so. They stayed some time, and ensured the family had all of their contact details before they left.
94. A few days later the reverend took the man's belongings to his mother. It appeared that some items were missing that the prison were unable to trace. Two days later the reverend met the family at the mortuary to see the man. He then accompanied them to the prison, where they visited the Segregation

Unit and said some prayers. The reverend gave them some letters and postal orders that had arrived at the prison for the man. The next weekend the reverend visited the family to discuss the man's funeral arrangements, which he conducted the following week on 27 May. The reverend then interred the man's ashes at his father's grave on 7 June.

95. The reverend told my investigator of the family's concerns. The man's mother said she felt that her son had been let down by the whole system, including the mental health system. She was also concerned that both Highdown and Belmarsh were aware of the risks that the man might harm himself and questioned whether this information was passed from one prison to the other. She was unable to understand how the man had been able to take his life whilst being on an ACCT and did not understand why he had not been located in healthcare. She was also concerned about whether the man had received his medication and whether he was taking it whilst at Belmarsh.

ISSUES

Information passed from Highdown to Belmarsh

96. Highdown alerted Belmarsh to the man being a prisoner at risk of harming himself again, and was on an open ACCT. Belmarsh received all the relevant documentation when receiving the man, and immediately explored his health issues in reception. The man also had an ACCT review at Belmarsh the next day.

The man's location in the Segregation Unit at HMP Belmarsh

97. The man was initially located in a ward in healthcare, awaiting a mental health assessment after smashing up his cell in the First Night Centre. He shared the ward with a number of other prisoners, some of which were elderly (one prisoner was 95 years old) and very unwell. The man became agitated and aggressive and said he did not need to be in healthcare and would "kill someone" if he remained there. He was also very upset because smoking is not permitted anywhere in healthcare. He did not calm down when the duty governor came to speak to him and the duty governor believed that the man attempted to assault him. Despite not being deemed suitable for location in the Segregation Unit earlier that day (after failing the algorithm), he decided that the man should be moved to the Segregation Unit and another algorithm carried out for him.
98. There are single cells in healthcare but these were all occupied at the time. However, the Head of Healthcare said that there is also a gated cell in healthcare and two further gated cells in a contingency suite. He said he would have considered all of these options, and moving other prisoners around, before moving the man to the Segregation Unit. I think that more thought should have been given at that stage to assessing the risks and possibility of moving some prisoners, to find an alternative location for the man. This is especially important given the algorithm assessment made earlier which found the man unsuitable to be located in the Segregation Unit. However, it is important to note that he still would not have been allowed to smoke in the other locations that may have been more suitable for him and it is clear that to be able to do so was vital to him. It is also important to acknowledge that the man was still displaying threatening behaviour and the safety of staff and other prisoners was also a deciding factor in where to place him.
99. The duty governor made a judgement about moving the man to the Segregation Unit and spent some time completing a form to explain why a prisoner on an ACCT was being located in the Segregation Unit. He also arranged for the man to be allowed tobacco. It was also agreed that the man should be given 24 hour observation in a gated cell. The decision to place the man in Segregation is questionable, and I consider that the other options should have been exhausted before this step was taken.

Prison Service Order 2700 says that prisoners on an open ACCT should only remain in the Segregation Unit in exceptional circumstances, whereby they are such a risk to others or no other location is appropriate. I accept that the man's behaviour was exacerbated by his lack of tobacco and not being able to smoke in healthcare, but I still believe that the possibility of moving other prisoners around to accommodate him in a single or gated cell in healthcare would have been a sensible option. I am not convinced that enough thought was given to this option. However, I also accept that whilst he was in the Segregation Unit he was treated with care and staff were alert and attentive to his needs.

The Governor and Head of Healthcare should ensure that all options are thoroughly explored by staff before a prisoner is moved from healthcare to the Segregation Unit, especially if they have failed the algorithm a few hours earlier.

Reduced observations

100. At the ACCT review on the morning of 13 May, all the staff present agreed that the man should be moved from the gated cell and observations should be reduced from a constant supervision to hourly checks. This is despite his odd behaviour earlier that morning when he covered his head and face in a mixture of toothpaste and soap. Staff said he presented himself well at the review meeting and said he had said that he had no thoughts of harming himself. Prison Service Order 2700 describes constant supervision as a temporary arrangement designed for prisoners in "acute suicidal crisis". However, I am surprised that the risk to the man appeared to diminish so quickly that his observations were reduced from constant to hourly with no stages in between.
101. Prison Service Order 2700 also says that prisoners charged with murder are a particularly high risk group and given that this was the man's first time in prison and he was clearly suffering with mental health issues, more care and consideration should have been given to reducing the observations so drastically.

Failure to carry out a mental health assessment

102. Despite the member of the mental health team attending the ACCT review meeting, there does not appear to have been a full and thorough assessment of the man's mental state at any stage. In fact, the member of the mental health team was not even aware that the man had not yet had a mental health assessment. I would have expected to see a record of a more searching and robust meeting, considering the man's behaviour. There is no explanation in the paperwork to explain why the assessment did not take place and why the member of the mental health team was unaware of this before he attended the review.

The Head of Healthcare should ensure that there are failsafe processes in place for referrals and follow through in a timely fashion.

103. I also question the voracity with which the man was asked about his intentions. I remain convinced that hourly observations were not adequate for a person who had just been removed from constant supervision and I bring this to the attention of the Governor for his consideration.
104. The clinical review recommends that a review of the ACCT panel membership, further training and random audits are carried out. It goes on to say that clarification is needed for the role of (particularly) healthcare staff and the importance of their specialist knowledge and experience. The reviewer also comments that all ACCT review members should be aware of the individual's full history and their previous ACCT documents. I endorse this recommendation.

The Governor and Head of Healthcare should ensure that staff carrying out an ACCT review are adequately trained, and should be fully aware of the prisoner's history. In particular, healthcare professionals should be aware of the importance of their specialist knowledge and responsibilities in this area (for example, mental health referrals).

Medication

105. The man's family were concerned that he was not receiving the correct medication. He was prescribed Fluoxetine and Diazepam in the community and at Highdown and this was also prescribed at Belmarsh on the evening on 10 May. There appeared to be an electronic record of the prescription on 10 May and also a paper record. It was the paper record which recorded that the man was given Diazepam on the evening of the 11 May and Fluoxetine on the morning of 11 and 12 May. This was not recorded electronically on the healthcare system and it is unclear whether prison Dr B had access to the electronic record and the clinical review makes a recommendation in this regard. There was no record anywhere to indicate that the man received any medication on the 10 May.

The Head of Healthcare should ensure that clinical records are available to clinicians or that the clinician has access to the electronic system before reviewing a prisoner.

106. Also, the paper prescription record indicates that the man was prescribed Diazepam for two days, but Fluoxetine for 28 days. However, there is a line drawn after the Fluoxetine dose administered on 12 May (which the head of healthcare said usually indicated that the medication was to be discontinued), and the man did not receive any the next morning. The head of healthcare was unable to explain this (and prison Dr B was unavailable for interview as she no longer works at the prison).
107. Further, there is no record to show whether the man took the second Diazepam tablet, as only the one given to him on 11 May is noted.

108. The prescription records are misleading and confusing. None of the decisions or actions are explained and nobody is able to clarify when the man received his medication. This is clearly unacceptable. The clinical reviewer also comments on the need for effective record keeping in line with General Medical Council guidance.

The Governor and the Head of Healthcare should undertake a review of medical record keeping within the prison and ensure that processes are introduced to maintain records in line with General Medical Council guidelines

Recording observations

109. While I am aware that Officer C did carry out a check on the man at approximately 12.45pm that day, he did not record it in the ACCT. I understand that Officer C was very busy, but the importance of recording ACCT checks can not be understated and staff should be reminded of this.

The Governor should remind all staff of the importance of following ACCT guidelines and of recording all prisoner observations in the ACCT documentation.

The faxed letter from the man's Solicitor

110. I find it unacceptable that the letter sent by the solicitors, regarding the man and his family's concern about his mental health, medication and general well being, was not acted upon with more urgency. It is surprising that the person who scanned the letter onto the e-mail system and forwarded it to Nurse D, did not read or note the serious nature of the contents. The failure to alert anyone to the letter, and purely to rely on it being routinely opened at some stage meant that nobody in healthcare saw it until after the man had died. I would suggest that the system of forwarding important correspondence and faxed documents is reviewed as a matter of urgency, so that staff are alerted to potential problems immediately. This recommendation is also made by the clinical reviewer.

The Governor should review the system for passing correspondence around the prison, to ensure that important documents are seen as a matter of urgency.

Defibrillator

111. There is no defibrillator in the Segregation Unit and staff had difficulty locating one in healthcare. This took around 15 minutes, which is unacceptable. It is not possible to say whether prompt access to the defibrillator would have made a difference to the man's condition at that stage. However, it is obviously of great concern that a key piece of emergency equipment could not be quickly and easily located. Staff must be told where all the defibrillators in the prison are situated and be able to gain access to them without delay.

The Governor and Head of Healthcare should ensure that all staff are told where defibrillators are situated around the prison, and are able to gain access to them in an emergency.

First aid equipment

112. Despite being a qualified first-aider, Officer D had not been issued with any appropriate equipment, and asked another officer to find a mask for him to enable him to administer mouth to mouth.

The Governor and Head of Healthcare should ensure that all qualified first aiders are issued with appropriate equipment.

Receiving postal orders and money for canteen

113. As the man had been at Belmarsh for such a short time it would have taken a while for him to receive any money. This is a service-wide issue and not particular to Belmarsh, it takes a few days to transfer the information from one prison to another. However, he was issued with smoker's packs and other essential items until funds became available. He was also given tobacco whilst he was in the Segregation Unit. This is usual practice in prisons.

CONCLUSION

114. This had been the man's first time in prison, and he was charged with a very serious offence. He also entered custody with serious mental health issues, for which he had been receiving treatment and medication. He had attempted to harm himself on a number of occasions while in the community.
115. His behaviour at Highdown gave cause for great concern and as well as receiving appropriate medication he was reviewed in healthcare on a 15 minute observations (prior to being placed on an ACCT) and then monitored under ACCT procedures immediately after he attempted to harm himself. His behaviour at court on 10 May was also worrying. This information was passed from Highdown to Belmarsh within the documentation that travelled with the man.
116. The man went through the appropriate induction procedures when he arrived at Belmarsh, and these were carried out well. However, his medical assessment, the clinical notes and the medication which he was prescribed are confusing and unclear. It does not seem that he was given more than one Diazepam tablet during his time there and for some unknown reason it appears that his prescription for Fluoxetine was discontinued. It is also worrying that a faxed solicitor's letter outlining their concerns about the man's mental health and need for medication did not reach the correct person until after he had died.
117. There is no doubt that the man was a very challenging prisoner for staff to deal with. He was somewhat obsessive about his need for tobacco and being allowed to smoke and this appeared to be an important trigger for his difficult behaviour.
118. He was quite rightly transferred to healthcare for assessment after smashing the contents of his cell on the First Night Centre, but given his unpredictable nature, perhaps more thought should have been given to where he was located in healthcare. I do not believe that staff had no other options available to them and could not move some prisoners around to accommodate the man in a more appropriate environment than the Segregation Unit. I question the decision to return him there so soon after he had failed the algorithm. However, I do understand that the issue with tobacco, and not being permitted to smoke in healthcare would have remained and would have needed to be managed carefully.
119. It is also of concern that the man seemed to slip through the net, and that his mental health assessment was not carried out, despite a referral. It is also worrying that mental health staff were unaware that the review did not take place. This is especially important given his behaviour during his time at Belmarsh, and in healthcare and the Segregation Unit in particular.
120. The decision to reduce the man's observations so drastically and suddenly also seems flawed. Given his bizarre behaviour in the Segregation Unit only a short time before the review, it should have alerted staff to the fact that

things were not as positive as they seemed. Also, despite the presence of a mental health professional at the ACCT review, they were not even aware that The man had not undergone his mental health assessment.

121. I have made a number of recommendations, in conjunction with the clinical reviewer, which I hope will alert staff to the issues which appear to have contributed to the man's death, and I hope the acceptance and implementation of the recommendations will make a difference for prisoners in the future.

RECOMMENDATIONS

To the Governor and Head of Healthcare:

1. The Governor and Head of Healthcare should ensure that all options are thoroughly explored by staff before a prisoner is moved from healthcare to the Segregation Unit, especially if they have failed the algorithm a few hours earlier.

Recommendation accepted by prison

2. The Governor and Head of Healthcare should ensure that staff carrying out an ACCT review are adequately trained, and should be fully aware of the prisoner's history. In particular, healthcare professionals should be aware of the importance of their specialist knowledge and responsibilities in that area (for example, mental health assessments).

Recommendation accepted by prison

3. The Governor and Head of Healthcare should ensure that all staff are told where defibrillators are situated around the prison, and are able to gain access to them in an emergency.

Recommendation accepted by prison

4. The Governor and Head of Healthcare should ensure that all qualified first aiders are issued with appropriate equipment.

Recommendation accepted by prison

5. The Governor and the Head of Healthcare should ensure that medical records are maintained in line with General Medical Council guidelines.

Recommendation accepted by prison

To the Governor:

6. The Governor should remind staff of the importance of following ACCT guidelines and of recording all prisoner observations in the ACCT.

Recommendation accepted by prison

7. The Governor should review the system for passing correspondence around the prison, to ensure that important documents are seen as a matter of urgency.

Recommendation accepted by prison

To the Head of Healthcare:

8. The Head of Healthcare should ensure that there are failsafe processes in place for referrals and follow through in a timely fashion.

Recommendation accepted by prison

9. The Head of Healthcare should ensure that clinical records are available to clinicians or that the clinician has access to the electronic system before reviewing a prisoner.

Recommendation accepted by prison.