Investigation into the circumstances surrounding the death of a man at HMP Belmarsh in July 2010

Report by the Prisons and Probation Ombudsman for England and Wales

April 2011

This is the report of an investigation into the death of a man in July 2010 at HMP Belmarsh. He was discovered hanging from his bed by a member of staff at 12.24am, and the alarm was raised. Prison staff entered the cell and nursing staff attempted to resuscitate him, with the help of paramedics. However, despite the efforts of medical staff, he was pronounced dead at 1.27am. He was 37 years old and had been in prison for less than 24 hours.

I offer my sincere condolences to the man's family and everyone touched by his death. I am sorry that my report has been delayed and I regret the additional distress which this may have caused.

My colleague conducted the investigation on my behalf. A review of the man's medical care was commissioned by Greenwich Primary Care Trust (PCT). The review was undertaken by two clinical reviewers. I am grateful to them for their report and contribution to this investigation. I would also like to thank the Governor of Belmarsh and his staff for their cooperation. I am particularly grateful to the member of staff at Belmarsh who provided a high level of prison liaison and ensured that the documentation was in good order.

The man was sentenced to four weeks in custody and arrived at HMP Belmarsh in July from a magistrates' court. On his arrival, he was assessed by nursing staff and considered to need drug detoxification. He said that if he was placed in a cell with another prisoner, he was likely to assault them. He was therefore considered to be of 'high risk' to share a cell, and given a cell on his own. Throughout the reception process, he is described as happy and relaxed and, apart from the issue of sharing a cell, raised no other concerns.

Just after midnight, at around12.24am, a member of staff making a routine check of prisoners discovered the man hanging from the top of the bunk bed in his cell. The officer raised the alarm and both prison staff and healthcare staff responded. Officers released the ligature and began cardio pulmonary resuscitation (CPR). They were assisted by nursing staff and efforts to revive him continued until the paramedics arrived. Paramedics continued CPR before he was pronounced dead by a prison doctor at 12.57am.

The investigation has found a number of failings in the reception process and clinical management in the man's short time at Belmarsh prison, particularly the initial medical assessments. Some of this is attributable to staff either being unaware of or not following established guidelines and procedures. I am disappointed to repeat recommendations made after a previous death in the prison and again I believe that the healthcare department has failed a prisoner by not providing care to the standard he would have expected in the community. I also recognise the actions of a particular officer in his conscientious approach to his duties and the management team for their considerable efforts to trace the man's next of kin.

I make nine recommendations. They address the way in which drug and alcohol assessments are conducted, accessing previous information and training for nursing staff were made. I am pleased to note that eight were accepted by the Prison Service. In response to five of the recommendations, they indicate that relevant policies are in place. It is not clear when the policies were introduced and they were

not presented to the investigator during the investigation. It is imperative that the Governor establishes that these policies are being followed and I trust that this will lead to substantive and meaningful change at the prison.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **April 2011**

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SUMMARY

The man arrived at HMP Belmarsh in July 2010, after being sentenced to four weeks' imprisonment at a magistrates' court for an offence of theft. He was 37 years old.

He had been released only three days earlier from HMP Chelmsford, after completing a previous sentence. On his release, he was on a methadone programme and had a long history of both drug and alcohol misuse. He had spent numerous periods in custody throughout his adult life as a result of his ongoing problems with his addictions. For two weeks in January 2010 the suicide support and monitoring procedures (ACCT) had been in place.

On arrival at Belmarsh, the man was calm and relaxed and joked with staff that he remembered an earlier time which he had spent at the prison. He gave no cause for concern other than being unwilling to share a cell. This was an issue at previous prisons and his reason was that, if placed in a shared cell, he would assault the other prisoner. This made him a 'high' risk and unsuitable to share. He was therefore allocated a single cell.

As part of the reception procedures, the man was assessed by a nurse who completed both an initial screen of basic health information as well as a drug and alcohol assessment. The investigation has found that neither of these assessments was completed adequately, with a number of key questions and observations being left unanswered or incomplete. He was considered to require treatment for drug detoxification, and provided with diazepam on the first night. However, during the health screens he did not request any further medication or complain about the treatment offered.

Once the reception and first night procedures were complete, the man was shown to a cell designed for three prisoners where, as a result of his refusal to share, he remained on his own. An officer who was carrying out night duties spoke with the man shortly after he arrived on the wing. At the time, he was watching television and, when asked, said he was alright and gave the officer no cause to be concerned.

There was no requirement for the man to be monitored regularly during the night despite being identified as detoxifying. However, the officer who had spoken with the man shortly after he arrived on the wing made a point of checking new prisoners more frequently to reassure them and satisfy himself as to their well-being. At 12.24am, the officer looked in on the man and discovered him suspended by a ligature around his neck from the end of the bunk bed.

The officer raised the alarm and staff responded. They released the ligature and along with nursing staff, paramedics and a doctor, cardio pulmonary resuscitation was attempted. Despite the efforts of all staff, the man did not respond to treatment and he was pronounced dead at 1.27am by the prison doctor.

My investigation and the review of the man's medical care have found that the attempts to resuscitate him were appropriate. However, the clinical review also concludes that the initial health assessment and drug misuse assessment were

unacceptable and that the management of his care did not follow the current guidelines recommended for such patients. The clinical review team conclude that the level of medical care in relation to this was below the level of care expected in the community.

I made eight recommendations regarding clinical matters, covering the way drug and alcohol assessments are conducted, implementation and auditing of policies and processes and training for nursing staff. I also made a recommendation about the use of the electronic prisoner case management system to access previous information about a prisoner. The report recognises the actions of the officer who first discovered the man hanging in his approach to his duties and the management team for their efforts to trace the man's next of kin.

THE INVESTIGATION PROCESS

1. The investigation was opened by the investigator at HMP Belmarsh on 27 July 2010, where he met the Litigation Manager and a member of the Independent Monitoring Board (IMB). Documents relating to the man were given to the investigator by the prison. Notices were issued informing both staff and prisoners of my investigation. They asked anyone who had information pertinent to my investigation to contact the investigator, but no responses were received.

2. One of my Family Liaison Officers (FLOs), contacted the man's foster parents on 16 November, and offered them the opportunity to be involved in the investigation. The family raised no concerns and a copy of this report will be made available to them.

3. Greenwich Primary Care Trust (PCT) was asked to conduct a review of the medical care provided to the man at Belmarsh. The review was carried out by the Investigations Manager, NHS Greenwich and a doctor. They conducted joint interviews of healthcare staff with my investigator during the course of the investigation. Given the short period of time that the man was in custody, much of my investigation has focused on the clinical care which he received. The review completed by the clinical review team details this care and makes relevant recommendations on the areas of concern. Regrettably there was a significant delay in completing the clinical review, which was eventually received by my office on 24 January 2011. This, in turn, delayed the issue of my report.

4. As mentioned above, during the investigation the investigator conducted a number of interviews with staff and also jointly interviewed nursing staff with the clinical review team. Following the conclusion of the interviews, the investigator sought to discuss the emerging issues with the Governor in person, but this was not possible as he was away from the prison. The investigator wrote to him instead, providing details of the findings.

5. The investigator also wrote to HM Coroner to inform him of my investigation and also request a copy of the post mortem report. The report was kindly passed to the investigator on 14 January 2011, and the cause of death is given as 'hanging'. A copy of my report and the additional annexes will be made available to HM Coroner to assist with the inquest process.

HMP BELMARSH

6. HMP Belmarsh was opened on 2 April 1991 and is a local prison, serving primarily the Central Criminal Court and its feeder magistrates' courts in South East London. In addition, the establishment serves Crown and magistrates' 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 Prisons

7. The most recent inspection by Her Majesty's Chief Inspector of Prisons, was an unannounced full follow-up inspection of Belmarsh in April 2009. Published in December 2009, her comments included:

> "Suicide and self-harm prevention was taken seriously, and there was some good work, but with a tendency to over-medicalise the issue. Over half the prisoners at Belmarsh said that they had at some time felt unsafe there, and the prison's own bullying survey had revealed low levels of confidence in the anti-bullying system.
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> "Relationships between staff and prisoners had improved, but were still mixed. Most interactions we observed were good, particularly on the first night and drug treatment units, and more prisoners said that there was a staff member they could turn to.
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> "Healthcare services had deteriorated since the last inspection, and there was an urgent need for re-engagement between the prison and the primary care trust (PCT). Mental health provision had decreased considerably, and the excellent and much-needed Cass Unit was under-used and under threat. Primary healthcare in general was in some disarray, with the ending of the current GP contract, poor management of clinical records and some serious deficiencies in pharmacy services." [The CASS Unit is a purpose built therapy unit for both inpatients and outpatients.]

Independent Monitoring Board

8. The Prisons Act 1952 requires every prison to be monitored by an Independent Board. Members are appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The role of the Board is to:

- Satisfy itself as to the humane and just treatment of those held in custody within its prison and the range of the programmes preparing them for release.

- To inform promptly the Secretary of State, or any official to whom he has delegated authority as it judges appropriate, any concern it has.

- Report annually to the Secretary of State on how well the prison has met the standards and requirements placed on it and what impact these have on those in custody.

9. The most recent report published by the IMB comments that:

> "The principle concern of the Board during the reporting year, and subsequently, is the unsatisfactory state of healthcare at Belmarsh. This was highlighted during the year by the outcome of a number of long delayed inquests where the Coroner and Juries expressed serious reservations about failures in the medical care given to prisoners whose untimely deaths were being investigated. The quality of healthcare has been the subject of numerous complaints by prisoners and, in some instances staff. Our enquiries have revealed an unacceptable situation in many cases."

Cell Sharing Risk Assessment (CSRA)

10. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners, taking into account the context of any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a plan to minimise risk for those identified as high or medium risk which is reviewed at regular intervals.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

11. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes, and can offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary, by application.

Critical debrief

12. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, review their response and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment.

Cut-down tools

13. Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners must be provided with and carry their own personal issue tool when they are on duty.

Detoxification policies

14. The **'**Clinical Management of Drug Dependence in Prisons' states that:

- The risk of suicidal behaviour among opiate dependent prisoners is highest in the first 24 hours of custody in prison.

- Prescribed management of withdrawal by a doctor in reception in a local prison will lower risk of suicide.

- A valid short opiate withdrawal scale should be used to determine the presence and severity of withdrawal.

The recommended management includes:

- Provision of prescribed opiate for withdrawal by a doctor in reception of prison on the day or evening of admission.

- Opiate withdrawal to be managed by stabilisation on a licensed opiate substitute medication for minimum of five days before deciding on future planned care.

- Observation through open healthcare hatches is recommended for initial accommodation.

- It is recommended that patients reporting recent heavy stimulant use and who test positive on admission to either cocaine or amphetamines are admitted to the withdrawal management unit, where neurological observations and BP monitoring for signs of hypertension should be done for the first three days.

- Prisoners with substance misuse problems located outside of the withdrawal management unit should be observed for fluctuations in mood or behaviour. Among this group are `crack' users in whom withdrawal can cause marked fluctuation of mood leading to potential acts of violence towards self or others.

15. The Prison Service policy on the treatment of prisoners received into custody and identified as withdrawing from opiates states that "methadone and buprenorphine (Subutex) should be offered as first line of treatment in opioid withdrawal". Methadone is one of a number of synthetic opiates (also called opioids) that are manufactured for medical use and have similar effects to heroin. Methadone and Subutex (buprenorphine) are used as opiate substitutes for heroin in the treatment of heroin addiction.

16. Most prisons now have an Integrated Drug Treatment Service (IDTS) and are able to maintain prisoners on methadone while in custody. If a prisoner is only serving a relatively short sentence, a maintenance programme will usually be provided until they are released back into the community, with a view to the treatment continuing after release. If they are serving a longer-term sentence

then the programme will provide a gradual reduction with a long-term aim of eventually reaching a point when the prisoner no longer requires the support of methadone.

17. Belmarsh does not provide methadone on the first night, but it may be prescribed the next day once necessary checks have been completed.

Emergency response

18. Emergency codes are used to summon staff to deal with a particular situation. If there is a medical emergency a 'Hotel' call sign (healthcare) is called over the radio and a code referring to a life threatening situation such as hanging, severe blood loss or cardiac arrest. Such emergency situations require immediate attention from healthcare staff as the prisoner cannot normally be escorted to the healthcare centre for treatment.

19. The general alarms are linked to the control room. When the button on a wing landing is it will register in the control room and then will be broadcast over the radios throughout the establishment so that staff from other areas can respond to the alarm in that location.

20. Healthcare staff have emergency bags located around the prison. They contain life support equipment, which includes airways, ambu bags (breathing aid), oxygen, needles and syringes. There are 12 defibrillators located around Belmarsh. Defibrillators are portable devices that can be attached to a patient who is suspected of having a cardiac arrest, and will deliver a controlled electric shock to put the heart back into a normal rhythm. A defibrillator cannot restart a heart that has stopped.

Person Escort Record (PER)

21. The police, courts, escort and prison services have an agreed procedure for sharing information about prisoners as they are moved between their establishments. It is essential that when a prisoner is moved between a police station, court, prison, hospital or other destination, those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular, it is essential that known risks of escape, assault, suicide/self harm or harassment are communicated to others into whose custody the prisoner is passed; to protect prisoners, staff and the public. It is also essential that any new risks that develop during transfers are recorded and flagged up for others. The PER is the key means of ensuring that information about the risks posed by prisoners moving externally from prisons or transferred within the criminal justice system is always available to those responsible for their custody.

Reception and induction

22. A CSRA is opened by a reception officer who completes the basic details. The form is handed 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. While primarily referring to cell sharing, it also includes other occasions when space may be shared, for example to accommodate a Listener. (Listeners provide confidential support for prisoners who may be at risk of suicide and/or self-harm.)

23. Reception staff do not routinely have access to a prisoner's past records and so the prisoner is the main source of information. If a prisoner has transferred from another prison, his previous record would arrive with him. Prisoners also have a PER form which will have been completed by the escort staff.

24. The initial healthcare screen concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

25. All new prisoners are located on the induction wing. Prisoners are asked about any immediate concerns, such as any disabilities, their offence and general well- being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack that contains information on the prison regime, and services available to them, they are also provided with telephone (personal identification number) PIN numbers and visiting arrangements are explained. Prisoners are able to use public telephones in prison and access these by putting in an individual PIN number, this allows prisons to monitor the numbers that are being contacted, and ensures that someone else cannot access a prisoner's account.

Roll check

26. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks take place on a number of specified occasions during the day and night, and staff sign that the roll is correct. Staff must carry out a physical head count to ensure the prisoner is in his cell by seeing the prisoner's face or getting a response from him and prove the cell door is locked. If the prison cannot be seen, staff must open the door to investigate further until satisfied.

27. The Belmarsh local procedures state that roll checks should be conducted a the following times:

- 6.00am by the night staff before handing over to day staff.
- 12.30pm (11.45 on Fridays) at lunchtime lock-up.
- 5.15pm at the end of the core day, following activity/association.
- 8.30pm (Monday to Thursday) at the end of the association.
- 9.00pm at the end of the working day by the late patrol officer.

Suicide and self harm monitoring

28. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of

ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individualised 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.

Integrated Drug Treatment System (IDTS)

29. The integrated drug treatment system (IDTS) aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:
    - early custody;
    - improving the integration between clinical and CARAT Services; and
    - reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

Previous deaths at Belmarsh

30. In 2004 my office took over the responsibility for investigating all deaths occurring in prison. Since then there have been eight deaths at Belmarsh which are considered to have been self-inflicted. Recommendations made as a result of earlier investigations at Belmarsh have been about quality of healthcare provision, which is also a focus for this investigation.

KEY EVENTS

31. The man was 37 years old when he died. He had been released from HMP Chelmsford on Friday 16 July 2010, after completing a previous sentence. However, he committed an offence of theft the next day, Saturday 17 July, and spent the remainder of the weekend in police custody. While at Chelmsford, he was on a methadone programme which was expected to continue in the community.

32. While he was in police custody on 18 July, the man was assessed by a doctor. The doctor recorded that he was a daily drinker and that he was on a methadone programme. He also recorded that he was showing moderate symptoms of alcohol and opiate withdrawal. He expressed no thoughts of self-harm and had no history of mental health problems. The doctor prescribed 10mg of diazepam to be given three times daily and 60mg of dihydrocodiene to be given four times a day. Both of these medications are commonly used to treat alcohol and drug withdrawal. While in police custody, he was observed at 30-minute intervals.

33. The man appeared at a magistrates' court in July, where he was found guilty of theft and sentenced to four weeks in custody. Following his court appearance, he was taken by the prison escort services to Belmarsh. He arrived, with his property, at 5.25pm, and reception staff took him through the booking in procedures. On the PER handed over to and signed by the reception staff at Belmarsh, there were a number of warnings relating to him. The warnings had been written by the police and were obtained from information in his police record. They included, "conceals weapons, self-harm, cuts to forearms 2009-2010, cannabis user and violence against police". The form noted that he had cut his arms in 2009 and 2010. The medical form completed at the police station was also amongst the documentation handed over to the prison staff.

34. One of the officers on duty in reception when the man arrived signed that he collected his property from the escort staff. The officer told the investigator that he had known him previously from his other sentences. He said that when the man walked into reception he looked at him and said "hello stranger". He also asked the officer whether they had saved his cell, and was laughing and joking. The officer explained the reception process. He said that the man was called forward by the senior officer (SO) who explained what had happened at court, asked if he had any problems, to which he replied "no". The SO asked him to sign for any money that belonged to him that had been handed over by escort staff. He was then asked to wait in a room, before being called out to have his initial paperwork completed, which included the CSRA. The CSRA would otherwise have been fully completed once he was moved across to the first night unit on houseblock three.

35. The Prison Service has a new computerised case management system, Prisons National Offender Management Information System (P-NOMIS), which enables all the public prisons in England and Wales to identify prisoners from a unique number which is assigned to them. If a prisoner returns to custody after being released, this number can be put into the system and his previous history

can be obtained by prison staff. While the system does not allow for the prisoner's medical history to be shown as it is recorded on a separate system, information on certain interventions like detoxification is recorded. In addition, any past self-harm history is also readily accessible on the system.

36. As the man had been released only three days earlier, and his P-NOMIS number was the same, the investigator asked the officer whether there was a record of any past history of self harm or that he had been on a methadone programme. He had been monitored under the ACCT suicide and prevention of self-harm procedures at Chelmsford in January 2010 for two weeks. At the time, he had told staff that the death of his girlfriend (who had taken her own life in 2009) was playing on his mind, and also his detoxification treatment was being reduced. After the ACCT monitoring ended, there were no other recorded problems with him relating to self-harm.

37. The officer told the investigator that he did not refer to the computer in reception, which was a fairly new system, but he knew that a prisoner's unique number could make their history available. There is no evidence that reception staff, or those who dealt with him during the first night procedures, looked at any of the information on the computer system.

38. A nurse began the healthcare process for the man, in reception, by inputting his details into the healthcare computer system (SystmOne). The information was very brief and only gave his personal details. The system allows the nurse to input answers to a set of generic questions. The answers were obtained from the documentation passed on by reception staff. However, one question asks whether information has been received from an outside source. The answer was negative, which would indicate that the nurse did not see the record from the police. She did not see the man in person and her role was administrative. Therefore, she was not interviewed by the investigator or the clinical review team.

39. Once the reception procedures were finished, the man moved across to houseblock 3, which is the first night unit. New prisoners are initially allocated to the first night unit, and an initial induction is completed. The paperwork, which included the PER form and the police record, was passed to an officer who was working as the diary officer on the first night unit. He explained that his job was to go through each prisoner's record and identify any specific points from either the PER or other documents. He said that anything he noted down would be passed to the officer conducting the interview. He confirmed that he did not actually speak to the man or recall seeing him.

40. An officer interviewed the man on the first night unit and asked a series of questions relating to thoughts of self-harm, whether he understood why he was in custody, next of kin details, as well as completing the CSRA. The officer told the investigator that he could not fully recall the answers that he gave, apart from the CSRA. He said that when asked about sharing a cell, the man became very aggressive and said that he would assault anybody who was placed in a cell with him. Previous records show that he had given the same response at Chelmsford and had been allocated to a single cell.

41. The officer said that, given the man's response, he had to assess him as 'high risk' until further investigation into his reasons for not wishing to share could be made. The officer was asked whether during his conversation with the man he had noticed anything that might have been troubling him. He said that the man was "very chatty" and had only become aggressive when asked about cell sharing. He added that the man seemed to remember him from a previous sentence and was happy to chat. He told the officer that he only had a short sentence. He could not recall the man either mentioning a previous drug history or saying that he was taking methadone or that he had recently been released from Chelmsford.

42. The CSRA is also completed by the nurse who conducts the initial health screen. Any comments from the nurse take precedence over the score allocated by an officer. As such, if the nurse considers the prisoner to be a higher risk than the officer, then the nurse's assessment is followed.

43. A further nurse was the next member of staff to talk to the man. She conducted both the initial health screen and a subsequent drug and alcohol detoxification assessment. When interviewed by the investigator and the clinical review team, she explained that it is normally the first night centre nurse who carries out the initial health screen. However, she has experience of both and is a substance misuse nurse, so she sometimes conducts both parts. She also confirmed that all of the relevant documents relating to the man, including the PER form from the police, had been passed to her.

44. One of the clinical reviewers asked whether all the questions on the initial health screen are expected to be asked and the answers put on the system. Although the nurse confirmed that they were expected to be completed, some of the questions on the man's initial screen and subsequent detoxification assessment had no answers. Examples of the questions which were omitted are:

    - His alcohol intake a week before coming into custody.
    - Any drugs used in the past month.
    - Health related observations about his physical appearance.
    - His fitness to occupy any type of cell.
    - Any drugs which had been taken intravenously.
    - Information about heroin misuse.
    - Any recent physical injuries.
    - Cocaine dependence.
    - Whether he was homeless in the past year.

45. The nurse who conducted the initial health screen was unable to explain why these questions were incomplete, but said that she would have asked them as they were set out on the template. As well as completing the health screen and drug detoxification screens, she was required to complete the healthcare section of the CSRA. Despite an officer having entered the details on the form, which said that the man had threatened to assault a cell mate if he shared a cell, the nurse recorded him as being 'low' risk. She also answered 'no' to the

question on the health screen that asked, “Is there clear indication of high level of risk that the prisoner might assault cell mate?”.

46. The questions left unanswered were important to gaining a full understanding of the man’s physical and mental well-being and the medical notes from SystmOne were difficult to follow. The nurse recorded that there was “no immediate action required”, despite also recording that he required “detox” [detoxification]. When asked how this could be the case, she was unable to provide an explanation.

47. It was recorded that the man had been taking methadone, but no further information was given. The nurse who conducted the initial health screen said that she would have followed this up the next day, as she would not have had time on the first night. She also recorded on the initial health screen that he said that he had taken heroin and crack cocaine on Saturday. When completing the detoxification assessment, she did not go into any further details on this. She told the investigator and clinical review team “I am not asking them anymore if I have done the first screening”.

48. The nurse who conducted the initial health screen gave the man a urine test. She told the investigator that she could not prescribe medication without first establishing what the prisoner had been taking. The urine test for him produced a positive result for cannabis, opiates, cocaine and methadone. The nurse was asked whether a referral to the substance misuse team was made and said that, as a substance misuse nurse, she would have seen him herself the following day and no referral was made.

49. One of the clinical reviewers asked the nurse about the signs or symptoms which she would be looking for in order to assess the man’s level of withdrawal. She replied that she would look for flu-like symptoms, such as a runny nose, watery eyes, sneezing, lethargy and agitation. The signs recorded by the nurse were aches, sneezing, pains and yawning. She was asked whether she would record the prisoner’s pulse rate or blood pressure. The nurse said that it should be done, and when asked why, she explained that diazepam may be prescribed if the pulse is very low. The nurse was unable to explain why the man’s pulse and blood pressure was not measured.

50. When she had completed her assessment, the nurse recommended that the man should be prescribed 10mg of diazepam for the first night. She said that the first night doctor was asked to sign the prescription, as she is not allowed to prescribe. She told the investigator that the doctor did not see the man before prescribing the medication and that it “was not necessary”. She also confirmed that her assessment was not seen by the doctor before he signed the prescription.

51. The clinical review team asked whether it was normal for detoxifying prisoners to only be prescribed diazepam or whether other treatment, such as methadone, would be considered. The nurse said that Belmarsh does not provide methadone on the first night, but it may be prescribed the next day once necessary checks have been completed. When asked whether prisoners

detoxifying from opiates are subject to regular observations while on the wing, the nurse said she would not normally ask for this, but those detoxifying from alcohol would be checked more frequently.

52. One of the clinical reviewers asked whether there was a risk to those arriving into custody and who were experiencing opiate withdrawal. The nurse said,

> "Yes, obviously they can self-harm. They cannot die from opiate withdrawal symptoms, alcohol you can, but obviously there is always the risk that they will do something to harm themselves."

53. The nurse said that she was aware of the Prison Service policy on detoxification, but "we don't do it at our prison". When asked why, she said that there is no detoxification doctor in the first night unit and that the doctors working there are not happy about prescribing methadone or Subutex on the first night health screen.

54. The investigator asked the nurse about her recording of the man's self-harm history as 'none', given she had all the documentation including the PER where it was written that he had cut his arms in 2009 and 2010. She said that the officers bring the paperwork and point out anything that is relevant, as she does not look at it herself. The investigator asked whether the nurse had looked at the police paperwork, and she said that she presumed she would have done. He pointed out that on the police documents the man had been considered by a doctor to be displaying signs of alcohol withdrawal, and the nurse had already said that if a prisoner is withdrawing from alcohol then her actions would be different. She said that, on the basis of her assessment, she did not identify this as a problem for him.

55. When asked how she had evidenced her assessment by using recognised withdrawal scales and other tools that may be used to determine a person's level of withdrawal, the nurse said that she does not use other tools such as withdrawal scales in the screening which is based on her clinical observations.

56. Once the man had been assessed by the nurse, he was seen by the duty governor who, despite the nurse's assessment, signed the CSRA to confirm that he was 'high' risk. He was taken to spur two of houseblock three and shown to a three person cell which he had to himself because of the concerns he had raised about sharing. When asked why he had been given a three person cell, the first night staff said it was likely that this was the only one which was vacant at the time. The cell consisted of bunk beds and one single bed, with a toilet and basin and table and chairs as well as a television. Despite being identified as detoxifying from opiates, as previously mentioned, he was not subject to any regular observations.

57. An officer was on night duty on houseblock three the night before the prisoner died. The investigator asked whether he is required to observe newly received prisoners more frequently during his shift. He replied that the only time he would observe them more often would be if a prisoner was either 'category A' (the highest security level), 'E list' (a high risk of attempted escape) or was

subject to ACCT monitoring. The officer said that prisoners who are not in one of these categories are routinely checked at the start and end of a shift.

58. While carrying out night duties staff carry a radio to enable them to summon assistance in an emergency. They are also provided with a sealed pouch containing a single cell key, which can be used in an emergency when entry to a cell is required, no other keys are carried by patrol officers. The prison policy for entering a cell at night, tells staff that they should summon help and wait for assistance before entering a cell. There are potential risks to any officer entering a cell at night alone and the guidance is there for their security and that of the prison.

59. That evening, after the last prisoner had been allocated to their cell from the first night unit, the officer on night duty said that he went round all the spurs and checked every prisoner. He said that he spoke to the man, who was sitting on the single bed in his cell watching television. The officer asked him if he was alright to which he replied “yes” and continued watching television.

60. The officer checked the man again at around midnight. He was asked why he made the extra check as the man was not subject to any special observations. He explained that as a night officer he feels that new people coming into the prison may be a little vulnerable, scared, or may not understand something. In view of this, he checks on all new prisoners more often than he is required to do because he wants them to be comfortable and also so that they know he is available if they need him. He said that he has always worked that way and will continue to do so. He said that he would usually make his first check at 9.30pm, with a further check again at 10.30pm, and then every hour and a half or two hours throughout the night. He said that it gives him, as well as the prisoners, peace of mind.

61. The officer said that at around 12.24am he was walking around spur two and had just checked on another two new prisoners. As he approached cell 17, which was occupied by the man, he could see that the light was on, and thought that he might still be watching television. As he looked through the observation panel, he saw that the man had tied a ligature around his neck and was hanging motionless from the end of the bed frame. Initially, he tried to communicate with him and gain a response.

62. The officer then ran to the end of the spur to press the general alarm bell, before returning to the cell. He continued to try and communicate with the man and also used his radio to ask healthcare staff to bring the defibrillator with them to the spur. (A defibrillator is a portable machine that can put a heart back into normal rhythm by delivering a controlled electric shock, but it cannot restart a heart that has stopped completely.) He explained that, for security reasons, he was not allowed to go into the cell alone until other staff were present. He continued talking to the man through the door, but got no response. He said that around 45 to 50 seconds later he was joined by two governors who were the orderly officers and responsible for the prison that night.

63. One of the orderly officers said that he and his fellow orderly officer were on houseblock 2 when he was notified over his radio that there was an alarm bell on houseblock 3. He said that at night only certain staff carry keys. He and his colleague were the first to arrive at houseblock three. On their arrival, they were alerted by the officer on night duty who was on spur two. One of the orderly officers said that he looked into the cell and could see the man suspended from the top bunk, with a ligature made from a shoelace around his neck. He explained that although he had keys, those carried at night do not contain a cell key which are kept in sealed pouches carried by the officers patrolling each houseblock. The officer on night duty handed over his sealed pouch to one of the orderly officers who broke the seal and opened the cell door. While the door was being unlocked, the other orderly officer contacted the control room and asked for an emergency ambulance to be called.

64. When they went into the cell, one of the orderly officers supported the weight of the man and the other orderly officer cut the ligature using his cut-down tool. He was lowered to the floor, and laid on his back. One of the orderly officers checked his airway and also checked for a pulse. The orderly officer who had cut the ligature asked the officer on night duty to collect the defibrillator and, shortly afterwards, a nurse arrived.

65. Two nurses responded to the alarm raised by the officer on night duty. One nurse said that she was in the security office at the time signing PER forms for the following day and an officer collected her as she had no keys. At the cell, the nurse said she could see the man was not breathing and she checked his airway, breathing and circulation and started cardio pulmonary resuscitation (CPR). She explained that having come straight from the security office, she had no medical equipment with her. She continued CPR whilst waiting for her colleague to arrive. She added that the defibrillator had been brought up to the cell by officers, but until her colleague arrived she continued CPR with the help of one of the orderly officers.

66. The nurse said that when her colleague arrived a few minutes afterwards, the man was given oxygen via the ‘ambu-bag’. As this nurse was newly qualified, the nurse who first arrived at the cell asked one of the orderly officers to continue using the ‘ambu-bag’ while her colleague gave chest compressions. (An ‘ambu-bag’ is a hand-held device which is used to provide ventilation to a patient who is not breathing.) While she was doing chest compressions, the nurse who first arrived at the cell attached the defibrillator to the man. CPR continued and was alternated between the staff present, at a rate of 30 chest compressions to two breaths.

67. The nurse who arrived first at the cell said that the defibrillator indicated that there was no shockable rhythm to the man’s heart and so CPR continued until the paramedics arrived at around 12.42am. They took over the resuscitation attempt and administered medication to assist resuscitation, which the nurses were not qualified to do. Shortly afterwards at 12.47am, a prison doctor, who was also called by the control room, arrived and assisted the paramedics.

68. The prison doctor and the paramedics continued to try and resuscitate the man, but at 1.27am all their attempts at resuscitation were stopped and the prison doctor pronounced that the man had died.

Events following the man's death

69. After the arrival of paramedics, the two orderly officers spoke with all the prison staff who had been involved in finding and resuscitating the man. In particular, they spoke to the officer on night duty who had been affected by the discovery of the man and required support. (The officer had unfortunately discovered two other recent deaths at Belmarsh.) As the nursing staff were still assisting the paramedics, they were not spoken to until later when the two night orderly officers went across to the healthcare wing and spoke to both of them. The nurses were reminded of the support available and thanked for the efforts they had made to try to resuscitate the man. One of the orderly officers said that every effort was made to engage with all the staff involved, and provide them with the opportunity to discuss any issues or concerns.

70. The man had not provided any next of kin details when he arrived at Belmarsh. Therefore prison staff checked the P-NOMIS system and contacted HMP Chelmsford to try and gain more information. Chelmsford staff were able to clarify that he had made six telephone calls while he was there, the last being on 13 July to his grandmother and five to his father.

71. The Deputy Governor, a Governor, and a senior officer who was the prison family liaison officer had all come to the prison after being notified of the man's death. They tried to obtain addresses for the telephone numbers. The last known address for the man was searched on the internet and indicated that it was a homeless project in Southend-on-Sea. The telephone numbers supplied by Chelmsford were also e-mailed to police, and they were asked if addresses associated with the numbers could be identified.

72. Efforts to trace his next of kin continued throughout the day of the man's death, with previous prisons attended by him, social services, the police, as well as registry offices, all being contacted. Prisoners who had known him and were in custody at Chelmsford were spoken to by staff and provided useful information which assisted Belmarsh staff trying to trace his family.

73. On 22 July, the prison's family liaison officer was told that the man's adoptive mother had been traced. Due to the distance that his mother lived from London, staff contacted a prison closer to her home, HMP Bristol, and the FLO there was asked to visit the family and inform them of the man's death. The FLO at Bristol agreed to visit the family.

74. The FLO at Bristol contacted the FLO at Belmarsh by e-mail later that day and told him that she had contacted the man's mother who had taken the news well. His mother told her that she had not been in contact with her adoptive son since he was 14 years old. The FLO at Bristol explained that the family would get as much help and support as they required from Belmarsh. The man's mother said that she was concerned about the funeral arrangements and was

told that the chaplain at Belmarsh would be happy to help with any arrangements. Contact numbers for the prison were also provided.

75. When he arrived for duty on 27 July, the FLO at Belmarsh was told that the man's mother had contacted the prison and was to call back later that day, but she did not call again. He said that he was unable to contact her, as he did not have a contact number and, after hearing nothing, he wrote to her on 1 August to tell her that the prison would go ahead with making arrangements for the funeral.

76. The man's mother contacted the FLO at Belmarsh on 4 August and they had a long conversation. She repeated that the family had not seen the man since he was 14 when he had been placed back into the care of the local authority. The prison FLO explained that the funeral had been arranged and provided all the details. The man's mother was unsure as to whether she should attend but then agreed to do so and said that she would come with a family friend. She asked the prison FLO whether her son had ever been married or if he had left any children and he told her that they had not identified any other next of kin.

77. The prison FLO at Belmarsh spoke with the man's mother again on 5 August, after HMP Chelmsford had asked whether ex-prisoners who had known the man would be welcome at the funeral. The man's mother said that she would be happy for this to happen and was impressed that they would make the effort. His mother also requested a recent photograph of her son if one was available and this was arranged by the prison FLO.

ISSUES

Accessing PNOMIS information

78. When the man arrived at Belmarsh his P-NOMIS prison number was entered into the new computer system and as such all his previous history and records would have been available to reception staff. These would include any 'warning markers' such as whether he was an escape risk, violent or a self-harmer. It would also have been possible for reception staff to identify that he had been subject to ACCT suicide and self-harm prevention monitoring at Chelmsford and also on a methadone programme. There is no indication that staff sought this information on the system. Whether the information, had it been identified and recorded, would have led to better management of the man is unknown. It is unlikely, as his previous drug use was in fact later recorded by nursing staff who then had the opportunity to provide better clinical management. However, the PNOMIS system is a tool that prison staff can use to gain a great deal of information, rather than waiting for paper records, as used to be the case.

79. The system was still relatively new when the man arrived at Belmarsh, but staff required to use it would have been trained in the use specific to their area of work. As the training was a national programme, I am in no doubt that reception staff would have received the training they required and it may be simply a problem of getting used to new technology and confidence in its use. I make the following recommendation on this issue:

    The Governor should ensure that all reception staff are adequately trained and confident in the use of the PNOMIS system.

80. The value of a national prison computer system was evident after the man died when staff were able to search the records from his previous sentences whilst trying to trace his next of kin.

Quality of the initial health screen and drug/alcohol assessment

81. The clinical review team and my investigation found that there was inadequate recording of basic information on the man's initial health screen. The assessment by the nurse who conducted the initial health screen was incomplete with important questions left unanswered. She was unable to provide any explanation for why these were incomplete. The clinical review team consider that without this information an accurate assessment could not be made.

82. No questions were explored about his past or present drug use and the man's methadone use was not probed. Despite the nurse saying that she had access to both the PER and police forms, no questions were asked about his alcohol use. During the assessment, she did not use a standard scoring system to help assess the extent of the man's withdrawal, and his vital signs such as pulse and blood pressure were not measured. She also appeared not to understand

the potential risk that someone detoxifying may pose to themselves during the first 24 hours of coming into prison.

83. Although the nurse who conducted the initial health screen accepted that the Clinical Management of Drug Dependence in Prisons guidelines were known to the substance misuse team at Belmarsh and were available, she said that they were not implemented. I do not criticise the nurse, who was following the prison's healthcare policy which was in place at the time. She was not herself responsible for drawing up the policy and it is important to stress that it is not her fault that the policy did not comply with recognised standards.

84. The standard management of detoxifying prisoners at Belmarsh is to provide 10mg of diazepam and nothing else on the first night in custody. This is not in line with National Institute for Clinical Excellence (NICE) guidelines, which state, "methadone or buprenorphine should be offered as first-line treatment in opioid detoxification." The reason given for this by the nurse was that the doctors working on the first night unit are not happy to prescribe these drugs.

85. In practice it seems that responsibility for prescribing medication on the first night lies with nursing staff, although the doctor has to sign for any medication which is prescribed. The doctors working on the first night unit confirmed this arrangement when they were interviewed by the clinical review team, and did not seem to realise that they had a responsibility to assess the patient before the medication is given.

86. Also during the health screen, the nurse completed the CSRA medical section. This required the following question "Is there clear indication of high level of risk that prisoner may assault cell mate?" Despite having the document in front of her and being able to see the comments recorded by the officer, she wrote 'no' in answer to this question.

87. On the whole, the clinical reviewers say that the man's assessment was unacceptable, that it did not follow the current guidelines and was below what would be expected in the wider community. The clinical reviewers make the following recommendations, which I endorse and have slightly recast.

The Head of Healthcare should ensure that all GPs working on the first night unit assess all prisoners before any detoxification medication is prescribed, in line with General Medical Council (GMC) Guidelines.

The Head of Healthcare should ensure that the responsibilities for both nurses and doctors working within the first night unit are clear and understood by all staff and consistent with their responsibilities to the GMC and Nursing and Midwifery Council.

The Head of Substance Misuse should review the current guidelines for the management of substance misuse at HMP Belmarsh.

The Head of Healthcare and Head of Substance Misuse should produce a written policy on prescribing for prisoners with opiate withdrawal on their first night in custody, following their assessment in reception.

The Head of Healthcare, with the input of other nursing professionals, should ensure that there is a procedure for shared prescribing decisions in first night reception and audit its implementation. They should also put in place a process to ensure that the PER form and other relevant documentation is always made available to nursing staff completing the initial health screen.

The Head of the Substance Misuse Team should require staff to use an approved withdrawal scale when assessing opiate withdrawal in new prisoners.

The Head of Healthcare should audit the recording of information taken during the initial health screen to ensure that there is comprehensive data collection.

Checking the man during his first night in prison

88. The night officer carried out more observations on new prisoners than was required. He did this every night as he wanted to reassure new prisoners in the light of their vulnerability. The way in which the night officer worked made the difference between the man being discovered just after midnight rather than at 6.00am the following morning. Although his check came too late for the man to survive, it was excellent practice which should be commended. The officer showed that he was committed to both his duties and to the care of those for whom he was responsible. I would urge the Governor to recognise the officer's excellent standard of care for new prisoners at night. This level of checking might be the difference between life and death.

Response and resuscitation

89. Like the clinical review team, I consider that the response by all the staff when the man was found hanging to have been appropriate. Nursing and discipline staff responded quickly and professionally in dealing with the situation. Nursing staff said during interview with the clinical review team that they thought that training to enable them to administer potentially life saving medication in such situations would be advantageous. On this issue, the clinical review team make the following recommendation:

The Head of Healthcare should ensure that all nurses called to attend a resuscitation emergency have had Advanced Life Support training to enable them to give cardio pulmonary resuscitation drugs like adrenalin and amiodarone.

Follow up to the man's death

90. It is the responsibility of all prisons to notify a prisoner's next of kin in the event of their death in custody. The Prison Service sets guidelines for what is expected, which includes visiting the next of kin in person, providing ongoing support, appointing a trained family liaison officer (FLO) and the offer of financial assistance with funeral costs. When a prisoner's next of kin lives

some distance from the prison, it is reasonable for staff to ask a prison closer to their home address to initially break the news, or in certain circumstances the local police. However, this should be followed up with contact by the main prison as soon as possible.

91. The man's family background was very vague and he provided few details on his reception at Belmarsh. Despite this, I have found that prison staff went to great lengths to try to identify his next of kin at the earliest opportunity. They did this by engaging the services of other agencies such as the police, social services and previous prisons. Their efforts resulted in the man's adoptive mother being traced and subsequently notified of her son's death in the correct way. The prison FLO at Belmarsh followed this up by contacting her and helping with her questions and concerns. It was clear that she had not had contact with her son for many years and he was able to provide the information that was known about her son's circumstances. The prison also supported the man's mother by making the funeral arrangements and maintaining regular contact. I consider that the efforts of the team at Belmarsh to trace the man's family should be recognised by the Governor.

CONCLUSION

92. The man had spent the majority of his adult life in and out of prison, on short term sentences, for offences he committed as a result of his drug and alcohol use. He had been released from his last sentence at Chelmsford only three days before coming to Belmarsh, where he was to serve another four week sentence. In the short period that he was in the community, he had taken illicit drugs despite having been on a methadone programme at Chelmsford. While in police custody, he was considered to be suffering from both drug and alcohol detoxification and was provided with treatment.

93. When he arrived at Belmarsh, the man was described as happy and relaxed. He joked with staff that he remembered them from his previous sentences at the prison and gave no cause for concern. He denied any thoughts of self-harm when asked by both officers and nursing staff. During the health screen and substance misuse assessment he engaged with the questions he was asked, he did not request medication or complain of any particular ill-health. There were many omissions in the reception healthscreen, and no clinical observations were taken, which may have had a detrimental impact on his wellbeing.

94. What may also have made a difference to the man's wellbeing during his short time at Belmarsh was that the treatment for detoxification did not meet the accepted clinical and nursing standards. Instead of continuing the methadone treatment, he was given one dose of diazepam. In line with what appears to have been the practice at the time, the prescription was signed by a doctor who did not actually see him, as expected by the General Medical Council. My recommendations should improve the treatment of detoxifying prisoners and ensure that it meets national standards.

95. The man's only concern was that he did not wish to share a cell, which caused him to become quite irate, but this was dealt with appropriately by discipline staff. Records show that he had been considered as 'high' risk and given a single cell at other prisons, after he stated the same concerns as he did at Belmarsh. He was spoken to by the officer on night duty shortly after arriving on the unit and again gave him no cause for concern and had been provided with medication.

96. Although research has shown that the risk of suicide by opiate dependent prisoners is highest in the first 24 hours of custody, the investigation has not been able to find a possible reason for the man's actions and he left no letter. However, it is clear that during the short time that he was in custody at Belmarsh, I do not think that he received the clinical care to which he was entitled or which was equitable to that which he could have expected to receive in the community. It is therefore conceivable that had his clinical care been managed appropriately, he might not have taken the actions, which led to his death.

97. Because the night officer made more than the required checks, the man was found hanging several hours earlier than would normally happen. Although this

made no difference to the outcome and he could not be resuscitated, the officer concerned should be commended for his devotion to duty and to the prisoners in his care.

RECOMMENDATIONS

1. The Governor should ensure that all reception staff are adequately trained and also confident in the use of the PNOMIS system.

   The Prison Service accepted my recommendation and said:

   "All staff are trained including reception staff."

2. The Head of Healthcare should ensure that all GPs working on the first night unit assess all prisoners before any detoxification medication is prescribed, in line with General Medical Council (GMC) Guidelines.

   The Prison Service accepted my recommendation and said:

   "There is a written policy in place with regards to reception and first night unit. The policy covers nurses and doctor's responsibilities, clinical assessment and referral, first night prescribing for all drug and alcohol users and record keeping. Staff are regularly briefed on this."

3. The Head of Healthcare should ensure that the responsibilities for both nurses and doctors working within the first night unit are clear and understood by all staff and consistent with their responsibilities to the GMC and Nursing and Midwifery Council.

   The Prison Service accepted my recommendation and said:

   "There is a written policy in place with regards to reception and first night unit. The policy covers nurses and doctor's responsibilities, clinical assessment and referral, first night prescribing for all drug and alcohol users and record keeping.

   Staff are regularly briefed on this."

4. The Head of Substance Misuse should review the current guidelines for the management of substance misuse at HMP Belmarsh.

   The Prison Service accepted my recommendation and said:

   "There is a written policy in place with regards to reception and first night unit. The policy covers nurses and doctors responsibilities, clinical assessment and referral, first night prescribing for all drug and alcohol users and record keeping.

   Staff are regularly briefed on this."

5. The Head of Healthcare and Head of Substance Misuse should produce a written policy on prescribing for prisoners with opiate withdrawal on their first night in custody, following their assessment in reception.

   The Prison Service accepted my recommendation and said:

"There is a written policy in place with regards to reception and first night unit. The policy covers nurses and doctors responsibilities, clinical assessment and referral, first night prescribing for all drug and alcohol users and record keeping.

Staff are regularly briefed on this."

6. The Head of Healthcare, with the input of other nursing professionals, should ensure that there is a procedure for shared prescribing decisions in first night reception and audit its implementation. They should also put in place a process to ensure that the PER form and other relevant documentation is always made available to nursing staff completing the initial health screen.

   The Prison Service accepted my recommendation and said:

   "There is a written policy in place with regards to reception and first night unit. The policy covers nurses and doctor's responsibilities, clinical assessment and referral, first night prescribing for all drug and alcohol users and record keeping.

   Staff are regularly briefed on this.

   Reception staff pass the prisoner record and PER to nursing staff via induction staff."

7. The Head of the Substance Misuse Team should require staff to use an approved withdrawal scale when assessing opiate withdrawal in new prisoners.

   The Prison Service accepted my recommendation and said:

   "Staff currently use the COWS (Clinical Opiate Withdrawal Scale)."

8. The Head of Healthcare should audit the recording of information taken during the initial health screen to ensure that there is comprehensive data collection.

   The Prison Service accepted my recommendation and said:

   "All clinical records are now on system 1 and audits are carried out on a regular basis."

9. The Head of Healthcare should ensure that all nurses called to attend a resuscitation emergency have had Advanced Life Support training to enable them to give cardio pulmonary resuscitation drugs like adrenalin and amiodarone.

   The Prison Service did not accept my recommendation and said:

   "All staff are trained in Immediate Life Support on an annual basis as well as first aid in the workplace and anaphylaxis training. It is not felt necessary for staff to have Advanced Life Support training as this is a specialist training for emergency support staff such as paramedics."