PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Belmarsh in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

Ashley House, 2 Monck Street, London SW1P 2BQ Tel: 020 7035 2876 Fax: 020 7035 2860
E-mail: mail@ppo.gov.uk www.ppo.gov.uk

This is the report of an investigation into the death of a man, a prisoner at HMP Belmarsh. He died in May 2011, having been discovered in his cell with a ligature around his neck. He was 47 years old and had been in prison for nine months. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A review of the man's medical care in custody was carried out by a clinical reviewer and the Interim Prison Health Commissioner on behalf of Greenwich NHS. I am grateful to them for their assistance. I would also like to thank the Governor and staff of Belmarsh for their co-operation with the investigation. I would also like to thank the man's family for their engagement with this investigation under the most distressing of circumstances.

The man was a foreign national prisoner who was arrested and charged with the murder of his girlfriend. He was remanded into prison custody at HMP Wormwood Scrubs on 31 July 2010 before being transferred onto Belmarsh on 3 August. This report covers the man's time in prison prior to his death, the events on the day he died and the actions of relevant people involved.

The investigation found that staff could not reasonably have foreseen that the man might take his life when he did. He had previously been monitored under suicide prevention procedures and, following its closure, was considered not to be at risk. Overall, the general management of these procedures was appropriate. In addition, the clinical reviewers generally regard the health care received by the man as appropriate, and describe his mental health care as "exemplary".

However, some lessons may be learned from this sad case and a number of recommendations are made to achieve this. These include the need for prisoners charged with murder of a relative/partner always to be referred to the mental health team, the need for healthcare staff to obtain prisoner community GP records, improvements to procedures for repeat prescription of medication, the need for healthcare staff to take follow up action on abnormal test results, avoiding inappropriate use of prisoners as translators at ACCT reviews, the need to use the correct medical emergency alarm codes and ensuring expeditious access for ambulance staff. One recommendation is addressed to Governor and the Head of Healthcare at Wormwood Scrubs and seeks better recording of risk information received from other Criminal Justice agencies.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2012**

CONTENTS

SUMMARY

1. The man was a Russian national whose family came from Riga in Latvia. He spoke Russian and very little English. He had worked in London for around six years where he lived with his girlfriend. Following her death, he was arrested on 26 July 2010 and charged with her murder. He was remanded to HMP Wormwood Scrubs on 31 July 2010. This was his first time in prison custody. After three days and following a court hearing, he was transferred to HMP Belmarsh to await his trial due to take place in July 2011.

2. On admission to Belmarsh, the man said he had no thoughts of self-harm or suicide. His ability to speak English was deemed poor so a translation service was used. The use of a translation service continued whenever it was required throughout his time in custody. Although it was also noted that he did speak to staff at times who were able to understand him with the use of an interpreter. He was also located in a cell with other foreign national prisoners who spoke Russian.

3. On 22 March 2011, the man cut his wrist. He also developed suicidal thoughts. He was admitted to the prison healthcare inpatient unit. Suicide and self-harm monitoring procedures were opened and he was assessed by the mental healthcare team. He was subject to continuous supervision and treated with antidepressant medication. Following his act of self-harm, the man disclosed that he had a past history of mental health problems and had been treated by a psychologist in Latvia. He had also apparently tried to hang himself years earlier due to depression and alcohol misuse.

4. Unexpectedly, and during his time in healthcare, the man's solicitor forwarded two psychiatric reports regarding him to the prison. The first stated that he suffered from depression which was reactive and did not meet the requirements for antidepressants. The second report indicated a depressive illness which might worsen as his trial approached.

5. When the man was reassessed by the psychiatrist in the inpatient unit on 12 April it was noted that he had improved and no longer had any thoughts of harming himself. On 19 April, he was discharged back to a normal residential wing and located with two Russian speaking cell mates. No concerns were raised about him over the next few weeks.

6. The night before the man's death, he played cards with his cell mates until around midnight. The following morning, his cell mates again had no cause for concern that he might harm himself. Not required to attend work in the afternoon, he remained in his cell while his cell mates attended their workshops. They last saw him around 2.00pm. Around 2.30pm, he was escorted by a wing officer to collect his medication. When he was returned to his cell by the same officer, his demeanour raised no concerns.

7. Around 4.50pm that afternoon, the man was discovered hanging in his cell. He had used a belt as a ligature and attached it to the top bunk bed. Staff acted promptly and professionally in attempting to resuscitate him. Despite these

attempts, they were unable to save him and the paramedics pronounced him dead in his cell.

THE INVESTIGATION PROCESS

8. One of the Ombudsman's investigators opened the investigation into the man's death on 10 May 2011. He visited Belmarsh and met with the Deputy Governor, a member of the Prison Officer's Association (POA) and the prison's family liaison officer, one of the chaplains. The prison appointed an operational manager as their liaison officer for the investigator. A member of the Independent Monitoring Board (IMB) was not available, although the investigator's contact details were left should the IMB have any it wished to raise.

9. The investigator issued notices in advance of his visit inviting staff and prisoners to contact him with any information relevant to the investigation. One prisoner came forward and was interviewed. The investigator was provided with copies of the man's prison and medical records covering his time at Belmarsh.

10. NHS Greenwich commissioned a clinical reviewer and the Interim Prison Health Commissioner to review the clinical care the man received at Belmarsh. The clinical reviewer and the investigator carried out joint interviews with staff. The Governor was given written feedback on the progress of the investigation on 22 August 2011.

11. Her Majesty's Coroner for the Inner South London district was notified of the investigation. The Coroner will receive a copy of this report to assist with his enquiries into the man's death.

12. I apologise for the delay in issuing this report which was due to staff shortages and the internal checking process that this report has gone through.

13. One of the Ombudsman's family liaison officers contacted the man's brother in Latvia using a telephone interpretation service. She explained the purpose of the investigation and invited him to raise any questions or concerns. She also explained to the man's brother that any correspondence could be translated. A translated version of this report will be made available to the man's family. His brother raised some matters outside of the remit of the office, as well as the following concerns:

.

- The man's brother asked for more information about the psychiatric report regarding his brother.
- The man's brother wanted to know if the hospital in Riga had sent a mental health certificate about his brother's nervous breakdown to his solicitor in the UK.
- The man's brother asked if he was treated for depression.

14. As part of the consultation period the man's family received a copy of the draft report. Although the family had no further comments to make about the investigation, they said that they believed he could have been saved if the response to the emergency had not been delayed. The family found it very upsetting to read.

15. Since the PPO took responsibility for investigating deaths in custody in 2004, there have been eleven self-inflicted deaths at Belmarsh. Similarities to recommendations made in previous death in custody investigation reports are mentioned in this report and concern prison doctors' attendance at emergencies.

HMP BELMARSH

16. HMP Belmarsh is a local prison serving the courts in the surrounding London area. It can hold up to 933 adult male prisoners, predominantly those on remand from court. Harmoni, a private company, has run healthcare services in the prison since February 2011, commissioned by Greenwich Primary Care Trust (PCT).

Her Majesty's Chief Inspector of Prisons (HMCIP)

17. Belmarsh last underwent an unannounced full follow up inspection by HMCIP in April 2011. The inspection report acknowledged that Belmarsh is a large and complex prison, having to meet high security standards while supporting the majority of lower risk prisoners. It found that looking after the needs of both these populations had got better since the last inspection, two years earlier, but that there were still improvements to be made.

18. The inspection reported that despite the large range of prisoners received at Belmarsh the early days in custody were "generally well managed". However, the inspection was concerned that foreign national prisoners, who made up 20% of Belmarsh's prisoners at the time of the inspection did not get such a good induction:

> "A professional interpreting service was used during the first night process for new arrivals but not always within 24 hours. During the induction process we observed a Lithuanian prisoner who spoke no English and with whom staff were struggling to communicate. He had been in the prison for four days before interpreting had been available for his first night interview."

19. The inspection also found that vulnerable prisoners and those at risk of harming themselves were generally well cared for, although gaps in provision remained. There had been a high priority given to suicide prevention following recent deaths in custody.

Independent Monitoring Board (IMB)

20. Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community whose role is to ensure standards of decency and care are maintained. Board members have full access to every part of the prison and all prisoners held there. The Board must produce an annual report to the Justice Secretary. The latest available for Belmarsh covers the period 1 July 2010 – 20 June 2011.

21. The report noted that:

> "…a well managed prison, operating within the reasonably resourced High Security Estate of the Prison Service. The Prison's management has coped well with imposed budget constraints and the regime for

prisoners has remained broadly satisfactory. Generally speaking, prisoners are safe, treated humanely and fairly…"

Person Escort Record (PER)

22. 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 those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular, known risks of escape, assault, suicide or self harm or harassment should be communicated to those with responsibility for the prisoner; to protect prisoners, staff and the public. It is important that any new risks that arise during a movement are recorded and flagged up. The PER is the key method for ensuring that information about the risks is always available to those responsible for their custody.

Reception and induction

23. A Cell Sharing Risk Assessment (CSRA) is undertaken 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 aimed at establishing the level of risk of prisoners sharing cells, it also includes other occasions when space may be shared, for example when a prisoner asks to see a Listener.

24. All new prisoners are located on the induction wing. They are asked whether they have any immediate concerns, such as disability, 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, and access to the telephone and telephone pin numbers and visiting arrangements are explained.

Big Word

25. Big Word is a telephone interpreter service. It can be used when conducting reviews or interviews.

Listeners and Insiders

26. Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners at risk of self-harm.

27. Insiders are prisoners who volunteer to work in the First Night and Induction wing and Reception. They welcome new prisoners and explain the processes they will encounter in the early days of custody.

Roll check

28. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct. Staff carry out a physical head count to ensure that the prisoner is in his cell and the cell door is locked. If they cannot see the prisoner, staff must open the door to investigate further until they are satisfied that the person is in the cell.

29. Local procedures at Belmarsh state that roll checks should be conducted at the following times:

- 6.00am by the night staff before handing over to day staff
- 12.30pm (11.45am 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

Mental Health In-Reach Team

30. The In-Reach team offers a mental health service for all prisoners who have enduring mental illnesses. They also treat and support prisoners who have mental health problems, offering intervention in crisis situations. The team supports prisoners who are at risk of harming themselves and attend most of their review meetings.

Suicide and self harm monitoring procedures

31. 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 safe and caring environment, identify prisoners' individual needs, and provide individual care and support before, during and after a period of crisis. Once the ACCT procedures are closed, a post closure review should take place within seven days.

Constant supervision

32. Constant supervision is used in response to an immediate and life threatening risk of suicide or self harm. It is carried out on a one to one basis and is designed to allow the supervising member of staff to:

- Raise the alarm in the event of self harm or attempted suicide occurring
- Intervene in line with the Constant Supervision Intervention Plan
- Provide the individual with active and ongoing interaction and encouragement to reduce the level of risk
- Maintain accurate records for the period of supervision

Emergency response codes

33. Emergency codes are used to summon staff to deal with a particular situation. If there is a medical emergency the call “Hotel 99” (which refers to healthcare) is put over the radio. This refers to life threatening situations 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.

34. The general alarms are linked to the Control Room. When the button is pressed (the buttons are found on the wing landings), the Control Room broadcasts the location across the radio network throughout the establishment so that staff from other areas can respond.

35. Healthcare staff have emergency green bags located around the prison. They contain life support equipment including airways, ambu bags (breathing aids), oxygen, needles and syringes. There are 12 defibrillators[1] located around the prison.

Critical debrief

36. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, and review their reactions after the incident.

[1] A defibrillator is a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest.

KEY EVENTS

Prior to the man's arrival at Belmarsh

37. The man was born on 10 December 1963 and was 47 years old when he died. His family came from Riga in Latvia. He was divorced and had a 16 year old daughter, an older brother, a sister, and elderly mother, all of whom still live in Riga. He had worked in London for approximately six years where he lived with his girlfriend.

38. He was arrested on 26 July 2010 and charged with the murder of his girlfriend. He remained in police custody until 31 July. During this time, he was reported as being very quiet and was seen crying. It was noted on a risk assessment form that he admitted to having harmed himself in the past but declined to give any information on this. He was initially subject to observations every 30 minutes. He later appeared at a magistrates' court on 31 July. The Person Escort Record (PER) that travelled with him to court recorded "No Known Risk" but noted he was charged with the murder of his "wife". He was subsequently remanded to prison custody.

The man's arrival at HMP Wormwood Scrubs

39. The man was taken from court to Wormwood Scrubs on 31 July 2010. The Person Escort Records which travelled with him between the police station, court and Wormwood Scrubs noted he was charged with murder but posed no known risks.

40. Upon his arrival, as with all new prisoners, he went through a reception screening process and was interviewed by reception staff. A reception officer completed the cell sharing risk assessment (CSRA). He considered that the man presented as "Low" risk to others. It noted with regard to the man: "First time in prison, prefers to share a cell with a Russian speaking prisoner because of his "small" English". His Personal Summary Sheet was completed and also noted that he was Russian and his religion was Orthodox. He told staff that he unable to eat spicy food and his occupation was a "sweeper".

41. As with all CSRAs, it had to be signed off by a senior officer to confirm the assessments made. The unit manager noted that, although the man was suitable to share a cell, due to the serious nature of his alleged offence his CSRA should be "Medium risk"[2].

42. A nurse carried out the reception health screen. He noted the man had a stomach problem, his mood was stable and he had no thoughts of self harm. No mention was made of the risk assessment form that was completed in police custody that made reference to his history of harming himself. He was registered with a GP in Hounslow. He was referred to the prison doctor. The prison doctor identified the man's stomach problem as longstanding gastritis[3]

[2] Medium risk denotes no immediate risk, but situation will need to be reviewed regularly.
[3] Gastritis is an inflammation of the lining of the stomach.

and prescribed a month's supply of omeprazole (a drug used to reduce stomach acid) to treat this. The man said he had a history of depression but had never needed treatment for this and had no mental health problems. The doctor noted that the man was feeling down at the time but had no self-harm issues. The man's demeanour was described as flat and his eye contact was poor. The doctor advised him to inform wing staff if his depression got worse.

43. In spite of the man's mentioned lack of English, some staff who had contact with him, appeared to have been able to obtain information from him without using interpretation.

The man's arrival at HMP Belmarsh

44. The man appeared in court on the morning of 3 August. He was subsequently remanded back into prison custody to await his trial date, scheduled to take place in July 2011. He was transferred to HMP Belmarsh.

45. He went through the reception screening process and was interviewed by reception staff. The PER noted that the man's category was not "Cat A", despite him being transferred to a category A prison and charged with murder. Self-harm was highlighted as a risk on the PER, although no other details about this were given.

46. It was entered on P-Nomis (the prison's computer record system) that the man could not speak English well. Due to this, staff immediately arranged to interview him using a telephone interpreter service, the Big Word. During the interview with the interpreter, he was asked if he had any thoughts of self harm or suicide. The man said he did not and would inform staff if matters got too much for him.

47. An immediate needs assessment was also completed and noted no self harm issues. An officer completed the CSRA and noted that the man's risk as "Low" and that he wished to share a cell with "other Russian speaking prisoner".

48. The man received his first reception health screen from a nurse. The nurse recorded that the man said he had no history of self harm, mental illness or contact with mental health services. He said he had no thoughts of self harm or suicide but would ask to see the doctor if things got too much for him. There were no concerns about his behaviour or mental state and he was considered a low risk of self harm. It was also noted he was receiving medication for his longstanding stomach complaint.

49. An officer completed the man's "Induction Passport Immediate Needs" form. It recorded that it was his first time in prison and the man said he had no immediate needs or concerns. He also said he had no thoughts of self harm and felt "OK". He was offered a drink and something to eat but declined the offer to make a telephone call. It was recorded on the document that the man referred to himself as a Latvian national. He spent his first night in the prison induction wing with no concerns raised.

50. The following morning, the man received his secondary health[4] screening from a nurse. He was examined and the nurse further recorded in detail his medical history including his basic observations of blood pressure, height and weight. He presented to the nurse as “oriented, cheerful, communicative, co-operative”.

51. That afternoon, an officer carried out a one to one interview with the man. A fellow prisoner was used as an interpreter. The man completed the prison compact, signed it and provided his brother’s details (in Latvia) as his next of kin. He raised no issues of concern and said he had no thoughts of harming himself. An application was later put forward for him to attend the ESOL course[5].

52. On 30 August, an officer made an entry in P-Nomis. Having used a fellow prisoner as an interpreter, he noted that the man said he was struggling to cope at present. He said he was okay but, given that he might possibly receive a life sentence, wanted to share a cell with another eastern European whom he would be able to speak with in his own language. He said this would help him cope. He denied having any thoughts of self harm or suicide. This matter was referred to a senior officer. Later that afternoon, the man was relocated to share a cell with two other eastern European prisoners.

53. Further to this, between September 2010 and mid March 2011 and following staff interaction with the man, his records indicated that he had settled into the prison regime with no concerns raised. Personal officer entries noted on P-Nomis raised no concerns about his wellbeing. He continued to attend the education department for his ESOL classes and was described as a quiet person who kept himself to himself.

54. On 22 March, one of the man’s cell mates rang the cell bell at approximately 9.25pm. The cell mate alerted staff because the man had cut his left arm with a razor blade. The officer who responded to the cell bell saw the man sat on the bottom bunk bed with a small cut which was bleeding. The officer went to telephone for healthcare assistance and, while he was doing this, the cell bell was pressed again by the cell mate. The officer returned to the cell to find that the man had made the cut worse and was pumping his wrist to make it bleed more. The officer called a ‘level 2 alarm’ (general alarm for staff to attend location level 2) over the radio. Other staff responded and he was treated and taken to healthcare.

55. The telephone interpretation service was used by the prison locum doctor when he interviewed the man, when he treated his wounds. He had four stitches to the cut on his arm. Through the interpreter, the man said he had previous mental health issues (paranoia) a long time ago and used to visit a psychologist regularly whilst in Latvia. He had also been on psychiatric medication. He had not seen the mental health team at Belmarsh and said he wanted to see them. He told the doctor that he had cut himself because he did not want to live as there was "no point for him to stay in this live (sic)". The man disclosed that he

[4] Secondary health screening is carried out to obtain a more detailed account of a prisoner’s health history
[5] English lessons for foreign speaking prisoners.

had previously attempted suicide in the past by trying to hang himself. The doctor recommended he be located in the in-patient unit in the Healthcare Centre, and constantly supervised with a "psychc" (psychiatric) review. The following medication was also prescribed:

- buspirone 5mgs, to be taken until 4 April 2011 (to treat symptoms of anxiety)
- diazepam 5mg (to reduce anxiety and help sleep)
- mirtazapine 30mg (antidepressant)

56. Self harm monitoring procedures were begun and an ACCT assessment interview was completed by an officer, who also used another member of staff as a Russian interpreter to assist with the interview. The man said that, when he harmed himself, he had not thought about what he was doing, felt confused and had enough of life. He admitted to cutting himself previously and also an attempted hanging some years before because he felt depressed. He also said he was depressed and felt withdrawn at present. He had no family support as they were in Latvia. On a scale of one to 10 (with 10 being the highest) he told the officer that he considered himself an eight in terms of desire to take his own life.

57. The man's first ACCT review meeting took place shortly after the ACCT assessment. Two members of staff, an interpreter and the man attended. There was no change in the man's mood since his ACCT assessment. He welcomed being prescribed medication to help him and was appreciative of the level of support he was offered. He was subject to constant supervision. From this review, staff instigated an immediate action plan designed to help keep him safe. This included being located in the healthcare centre in a single cell with access to the Samaritans help line and referral to the doctor. As part of the ACCT procedures, the senior officer on the wing and healthcare staff also completed a Caremap which highlighted action that would be taken to address the areas of risks that had been identified.

58. The next day, 23 March, a consultant forensic psychiatrist, with a staff interpreter, saw the man. The consultant forensic psychiatrist noted in the medical record that, by coincidence, the mental health team had received information from the man's solicitor the previous day. The information provided was two psychiatric reports. The reports had been prepared for the courts under the instruction of the man's solicitor. They raised concern around his risk of self harm and lowered mood in the time before his trial.

59. While speaking to the man, the consultant forensic psychiatrist noted that he managed to smile and laugh despite saying he felt depressed. He said that his trial was set for 25 July at the Old Bailey Court. Referring to cutting his arm the previous day, the man said there was nothing "special" about the events and that he had just had enough. He was still depressed and had felt this way for around a year, although he had not told anyone. The consultant forensic psychiatrist wrote that there were changes in terms of the man's sleep pattern. He also had a loss of appetite, reduced concentration levels, no sense of the future and low mood. The man said he could not reassure the doctor that that he would not harm himself again.

60. The consultant forensic psychiatrist summarised the two psychiatric reports received from the man's solicitor. The first report, for which he was examined in October 2010, deemed that his depression was reactive and did not meet the requirements for antidepressants. The other report was dated 27 January 2011, although the assessment of him was carried out on 31 December 2010. It indicated that he had a depressive illness which might worsen as his trial approached. The consultant forensic psychiatrist felt that the man had a low mood but it would be best to view this over a short period of assessment in the healthcare centre. He noted that the man had begun a course of antidepressants the previous day. His preliminary view was that the man had a "mild to moderate depressive episode of uncertain duration".

61. The man had an ACCT review on 24 March, when an interpreter was used again. Two other members of staff from healthcare attended, one of whom was the consultant forensic psychiatrist. The man said he felt slightly better although he felt stressed because his court date was approaching. He said he had some feelings of self harm but agreed to tell staff if these got on top of him.

62. The next day, a nurse led the man's ACCT review accompanied by another member of staff. No interpreter appears to have been used on this occasion as it was noted that he was able to "interact reasonably well, English is fair". The man said he harmed himself if his mood was low and sometimes felt that, if he was dead, it would all be over. However, his appetite had improved and he was sleeping better because of the medication he was prescribed. He was to remain in healthcare and his observation level was subsequently reduced to hourly.

63. On the morning of 26 March, the man was seen by a nurse in the healthcare centre for a physical observation. The nurse recorded his pulse rate, weight, temperature, respiratory rate and blood sugar level. His blood sugar level was recorded using a glucometer[6] as 6.3 which is considered within the normal range.

64. A week later, 1 April, the same nurse again conducted an ACCT review with the man. There is no mention of an interpreter being used. His mood and mental state were described as settled and his appetite was good. He said he had no current thoughts of self harm or suicide. Staff reminded him to tell them if his mood lowered.

65. On the morning of 2 April 2011, the man was seen again for physical health observations by nursing staff. He said he still felt depressed. Once again, amongst the observations taken, was his blood sugar level which was recorded as 5.9. Later that afternoon, his blood sugar level was taken again by another nurse and recorded as 15.6. The clinical reviewer notes that this level is probably indicative of an individual with diabetes. However no further tests were carried out, nor were any comments recorded on his medical record.

[6] A glucometer is a blood sugar monitoring device which measures your blood sugar is too low, too high or in a good range for you. Especially used by diebetics.

There is no record of a referral to the doctor or advice sought about this abnormal result.

66. Over the next week, there were no concerns from staff about the man. He complied with his medication prescription regime and appeared settled on the healthcare wing. He did not express any thoughts of self harm or suicide.

67. The Roman Catholic Chaplain at Belmarsh supported the man while in the inpatient unit by visiting him twice a week. The Chaplain was fluent in a number of languages including Russian and ensured he was available to talk to him whenever he needed to. Initially, the man regularly attended mass on Sundays and Tuesdays although, after he stopped attending mass, the Chaplain continued to visit him.

68. On 11 April, the consultant forensic psychiatrist reassessed the man with a staff interpreter present. There were no mental health concerns or thoughts of self harm. His mood was good which he rated at seven out of ten. He was sleeping well and had a good appetite. The consultant forensic psychiatrist recorded that the man had good insight and there was no evidence of psychotic symptoms. The plan was to discharge him to the main prison and review him again in three weeks. He agreed with the doctor's plan.

69. The following afternoon, the man attended houseblock two for an ACCT meeting entitled "Review Prior to Discharge from Healthcare". The review was led by a senior officer, assisted by another member of staff from healthcare. No mention was made of an interpreter being present. The senior officer noted that the man had no thoughts of self harm or suicide and was eating and sleeping well. He was located in a cell with Russian speaking prisoners and would be registered to participate on ESOL, which had ceased while he was in the healthcare centre. However, it was agreed at the review meeting to keep his ACCT document open for the time being. Staff were also to observe him at least twice during the day, speak with him and also observe him five times during the night period.

70. On 19 April, the same senior officer conducted a further ACCT review, accompanied by a member of staff from healthcare and the man's cell mate and used as an interpreter. The man attended the ESOLs course daily, said he was eating and sleeping well and was happy sharing a cell with two Russian speaking prisoners. He had stopped attending the weekly church services but said he had no thoughts of self harm or suicide. It was agreed that his ACCT document would be closed, with the post closure review scheduled for 26 April.

71. No changes were noted in the man's demeanour at the ACCT post closure review on 26 April. The senior officer, assisted by the Chaplain in his role as an interpreter, noted that the man had no thoughts of self harm, continued to eat and sleep well and was settled in his cell. He also continued to attend the ESOLs course. The man said he still felt some uneasiness about being in prison, although he raised no concerns when asked. The ACCT document remained closed.

72. No concerns were raised about the man during the night before he died. After the man's death, his cell mates told the Chaplain that they played cards with him until midnight and he had laughed and joked with them. He had also completed his ESOL Skills for Life course within education and received a certificate for Speaking and Listening.

Events on the day of the man's death

73. On a morning in May both of the man's cell mates attended education classes. They returned just before lunch time. The man had no education class that morning and remained in his cell. The investigator spoke with one of the man's cell mates. His cell mate said he was from Poland but spoke some Russian and was able to communicate with the man. He described the man as someone who did not talk much and slept a lot. When he left their cell in the morning and returned at lunch time, he said he and the man had talked a little and he had no concerns about him.

74. An officer told the investigator she worked on houseblock 2. She had intermittent contact with the man and knew he had previously been subject to ACCT procedures. She described him as a "very quiet" man who would not partake in great conversations, and normally responded with monosyllabic words when asked how he was. Some of this, the officer believed, was due to his lack of English. The man however had never raised any concerns with her.

75. In the weeks leading up to the day of his death, that officer had been assigned to another wing and consequently had little contact with the man. However, she was working on the houseblock on the day of his death when she began her duty at lunchtime. Prisoners collect their lunch around 11.45am and are then returned to their cells which are locked. Staff then take their lunch break. Around 1.45pm, staff began unlocking the cells for prisoners to go to work places, workshops and visits. The man was not required to attend work that afternoon and remained in his cell. His cell mates left to go to work at 2.00pm. At this point, they said they had no concerns about him and subsequently told staff he appeared normal.

76. At 2.30pm, two officers unlocked the man so that he could collect his medication. They had no concerns about him as he was taken to the medication hatch[7]. One of the officers said that there was no queue at the hatch and the man went straight up and collected his medication. The same officer escorted him back to his cell and they talked about football as best they could given the language difficulties. The officer said the whole process of the man collecting his medication and returning to his cell lasted about five minutes and he observed nothing of concern in the man's demeanour.

77. Although one of the officers worked on houseblock 2, he had little contact with the man as he normally worked on a different spur[8]. He told the investigator that, on this day, he assisted wing staff in returning prisoners to their cells after

[7] The medical hatch is located on the houseblock and is where prisoners collect their medication from the nurses.

[8] The houseblock is broken up into three different spurs and each spur has three landings: ground floor, middle floor and top floor.

they returned from their various activities. This was around 4.50pm. The man's two cell mates were amongst these prisoners. When they arrived on the wing, they asked the officer to open their cell door for them. As he unlocked the cell, he noticed the man in the cell.

78. The officer said the man appeared as if he was "almost sitting on the floor", with his head slumped forward. As he looked into the cell to get a closer view, he realised that something was wrong. He immediately ushered the two prisoners away from the cell and shouted "staff to cell" down the wing to alert staff. (The call for assistance was recorded on the prison incident log as occurring at 4.53pm).

79. Although he had a radio, the officer said he shouted for staff assistance because his first reaction was to get help as quickly as possible. He explained that other staff would then be able to use their radios to broadcast the emergency.

80. The officer stepped back into the cell. He could see the man had used a belt as a ligature and tied it around his neck and around the slats of the top bunk bed. The belt was thin and made from brown leather. The officer cut the belt from the bed using his cut down tool[9] and placed the man in a sitting position on the floor.

81. Although the officer's first aid training certificate had expired, he was familiar with the skills needed. As he examined the man, an officer (a first aid trainer) and a further officer (also first aid trained), who had heard their colleague's shout for assistance, entered the cell. This was approximately 15 seconds after the shout for assistance.

82. When one of the officers entered the cell, she said she saw a strap from a belt hanging off the bed, which looked as if it had been cut. The man was sat on the floor with the upper half of his body slumped forwards and his legs out straight. The other part of the belt was attached around his neck and the officer who had first discovered the man was in the process of removing it. The two officers immediately helped their colleague place the man in a horizontal position on the floor, his head facing towards the door. When the belt was removed, it left an indentation on the man's neck.

83. All three officers checked the man's for signs of life. Although his body felt warm, they could find no signs of life and immediately began cardiopulmonary resuscitation[10] (CPR). One of the officers who had replied to their colleague's shout for assistance said he had a mouth guard in his pocket. Whilst he started chest compressions on the man, his colleague used the mouth guard and placed it over the man's mouth. After the officer had performed chest compressions, his colleague administered breaths. The two officers who had replied to their colleague's shout for assistance were both trained in the use of a defibrillator. As other staff arrived at the cell, they requested for it to be

[9] They are knives which are specially designed to cut through ligatures in a safe manner.
[10] Cardiopulmonary resuscitation (CPR) is a technique whereby oxygen is pumped around the body using a combination of chest compressions and rescue breaths.

brought to the cell. The defibrillator is located at the end of the landing on the wing. While they awaited this, CPR continued assisted by one of the officers.

84. A defibrillator bag arrived quickly. One of the officers said staff had brought the wrong bag and this one did not contain the defibrillator. The bag that was brought was the fire self-snatch hood equipment (equipment used in a fire emergency). Neither bag was clearly marked as to its contents. However, the correct bag was quickly obtained and one of the officers set up the defibrillator. When connected, it detected no signs of life and CPR continued. The senior officer arrived at the cell (followed very quickly by the duty governor) to see staff administering CPR. As healthcare staff were yet to arrive, the senior officer told the duty governor to call for healthcare medical response and an ambulance.

85. A nurse said he was in the pharmacy at the time when he heard on his radio that a general alarm had been activated on houseblock 2. As he was the identified nurse responsible for houseblock 2, he immediately responded and made his way to the wing. It was recorded on the incident log that he entered the cell at 4.57pm, the same time that the control room called for an ambulance.

86. The nurse told the investigator that there were two coloured alarm buttons on the wing; one green and used for a general alarm and the other red used for a medical emergency. When pushed, the control room would be alerted. As he had been alerted to a general alarm, as opposed to a medical emergency alarm, he went straight to the cell and did not collect the green emergency bag.

87. When he entered the cell, he could see that prison staff were carrying out CPR and had connected the defibrillator machine to the man. The defibrillator advised not to shock. The staff continued with CPR. The nurse assisted by performing chest compressions. Having requested the green emergency bag, a second nurse, who had arrived soon after (recorded as having arrived at 5.05pm), went and collected the bag and brought it back to the cell. The second nurse to arrive was the senior nurse on duty and was carrying radio Hotel 99. This meant that he would have to respond to any medical emergencies within the prison. Having initially heard the call for Hotel 2 (his colleague) to attend houseblock 2, he then heard a request broadcasted over the radio for Hotel 99 to attend too, and this is when he made his way to the houseblock.

88. As CPR continued, the first nurse to arrive on the scene examined the man periodically. He had no pulse, his eyes were open, his pupils dilated and he was not breathing. The second nurse to arrive had assembled the emergency equipment that was needed. This included setting up the oxygen tank and connecting it to the bag valve mask (breathing aid which covers the mouth). The second nurse had requested further assistance from healthcare staff, and a third nurse arrived quickly (recorded as arriving at 5.07pm) at the man's cell to assist. She relieved one of the officers undertaking chest compressions.

89. Despite regular checks by staff and the defibrillator, the man continued to show no signs of life. An operational manager and an officer arrived at the man's cell

at 5.10pm to assist. The officer, as well as being first aid trained, was an ambulance technician for the St John Ambulance. He entered the cell and relieved his colleague, who then left the cell. The officer gave the man two rescue breaths via the bag valve mask. CPR continued at the rate of 30 chest compressions to two rescue breaths. Each time the defibrillator was checked it advised staff not to shock the man.

90. The records indicate that the ambulance arrived at the prison at 5.05pm. However, the paramedics did not arrive at the man's cell until 5.22pm. CPR continued during this time. When the paramedics entered the cell, they were briefed on the man's condition and took over his care from the prison staff. Despite their efforts, which included the administering of adrenalin, at 5.33pm the paramedics pronounced that the man was dead.

After the man's death

91. The duty governor activated the prison's death in custody contingency plans. All the necessary agencies including the police were informed that there had been a death in custody.

92. The duty governor held a hot debrief meeting around 8.15pm. Staff were made aware of the support services available and prisoners were reminded of the Listener service. Staff reviewed those who were on open ACCT documents and ensured that the man's cell mates were supported.

93. The prison held a critical debrief meeting a few weeks after the man died and the staff who attended said they benefited from the discussion.

Communication with family

94. The man's next of kin was identified as his brother who lived in Latvia. He also had a sister and an elderly mother. The appointed family liaison officer and Co-ordinating Chaplain was briefed on the circumstances surrounding the man's death. Aware of the need for a Russian speaking person to speak to the man's next of kin, he contacted the Catholic Chaplain at his home. He informed him of the man's death and asked him to inform his family in Latvia.

95. Around 8.30pm, the Catholic Chaplain telephoned the contact number for the man's next of kin in Riga, Latvia to tell them of his death. He spoke to his brother and sister and broke the news to them in what he described as an emotional 20 minute conversation. He spoke to them again the following day and explained the procedures for the post mortem and police investigation. He tried to pass on to them as much information as he could. During their conversation, the Catholic Chaplain was also informed that the man had a daughter who lived in Riga, who the family said they would inform. The family said they wanted their relative's funeral to take place in Riga.

96. Over the next few days, the Governor sent a letter of condolence to the family which was translated into Russian. The Catholic Chaplain made several phone calls to the family, explaining the UK prison system and answering their

questions. He also made arrangements to ensure the man's body was repatriated to undertakers in Riga along with his personal possessions. Following Prison Service procedures, financial assistance was offered and the prison paid for this, as well as the funeral. The family had the Chaplain's telephone number and rang him several times to clarify issues and concerns. On the Sunday before the funeral in Riga, the Chaplain conducted a 32 minute memorial service for the man on the telephone for his mother and family. The family said they appreciated this. The co-ordinating Chaplain provided support to the Catholic Chaplain and co-ordinated the return of the man's personal possessions to Latvia.

ISSUES

97. The clinical review was conducted by a clinical reviewer and the Interim Prison Health Commissioner. It includes 20 recommendations, surrounding the delivery of healthcare service matters in Belmarsh. The clinical review will be shared with the Governor at Belmarsh and disclosed to the Greenwich Business Support Unit (previously Greenwich PCT) and the Director of Harmoni (the healthcare provider at Belmarsh). The most pertinent recommendations relating to the man's death are discussed below.

Clinical care

First night and secondary healthcare screening

98. The man was only at Wormwood Scrubs for a few days. Nonetheless, staff seem to have missed the fact that, while he was in police custody, a risk assessment document had been completed and noted that he had previously self harmed. This information does not appear to be recorded on his documentation following his reception screening at Wormwood Scrubs. For staff to be able to assess his current risk of self harm and to pass on to others who may then be responsible for his care, important information such as this must be recorded.

    The Governor and Head of Healthcare at Wormwood Scrubs should ensure that all risk information received from other relevant sources is recorded during the reception screening process.

99. It was identified at Wormwood Scrubs that the man suffered from a long term stomach problem. He had been prescribed omeprazole capsules by his doctor (GP) and had last taken the medication two months ago. He said his doctor's surgery was in Hounslow. When he arrived at Belmarsh on 3 August, his first and second health screening also noted he was taking medication for his stomach problem. However staff did not appear to ask him any questions about his symptoms, refer him for tests, or make a referral for him to see the prison doctor. In addition, Belmarsh's records stated that he was not registered with a GP which is not consistent with the information previously gathered at Wormwood Scrubs.

100. This suggests there is some doubt over whether staff fully read the man's documentation on arrival at Wormwood Scrubs and Belmarsh. The reference to his previous self harm was omitted and there was no follow up action or attempt made to obtain his GP records which may have contained relevant information.

    The Governor of Belmarsh and Director of Harmoni should ensure that healthcare staff request GP records within 72 hours of a prisoner's arrival where it is recorded that they are registered with a GP in the community.

The man's mental healthcare

Mental health assessments

101. The Prison Service Order 2700 (Suicide Prevention and Self-Harm Management) provides guidelines for prisoners charged with homicide against a partner or family member and which describes them as at an exceptionally high risk of suicide. The PSO states:

> "Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken."

102. The man's alleged crime was identified on paperwork when he arrived at Belmarsh. He had been accused of the murder of his partner which raises the risk of suicide. Although it is for the staff of the receiving prison to assess the risk of each prisoner, it is important to take into account factors such as this. A recent report into another death in custody raised the point that a referral for a mental health assessment, even when prisoners are not displaying overt mental health problems, for prisoners charged with this type of offence can act as an important safeguard. The impact of guilt, bereavement and the potential complications of contact with the rest of the family may well have an effect on a prisoner's mental health.

103. Before the introduction of the electronic medical record, a paper-based healthscreen process was used. Under this system, a mental health referral was mandatory in the case of a domestic murder. In the recent report mentioned above, the following national recommendation was made regarding making mental health referrals mandatory when prisoners are charged with domestic murders:

> **The National Offender Management Service should ensure that prisoners charged with domestic homicide are referred for a mental health assessment.**

104. A response has not yet been received from the National Offender Management Service but Belmarsh may wish to revisit their practices in the light of this national recommendation from the Ombudsman.

Mental health treatment

105. The man initially failed to disclose that he had a past history of mental health problems. He had been treated by a psychologist in his home country and had taken psychiatric medication. He also failed to disclose a past suicide attempt by hanging due to depression and alcohol misuse. He only disclosed this information when he saw the psychiatrist after he harmed himself in Belmarsh on 22 March 2011.

106. The clinical reviewer notes that the care provided by the mental health team at Belmarsh was exemplary. Prompt risk assessments were made at appropriate intervals using interpreters when needed. He also describes the management of the man's self harm as excellent and notes that his ACCT observations were appropriate. Medication and care provided by this team was consistent with best practice as outlined in National Service Frameworks

Repeat prescribing procedure

107. When the man first arrived in custody at Wormwood Scrubs, the prison doctor prescribed a month's supply of omeprazole for his stomach complaint. Three days later he was transferred to Belmarsh. The next prescription was written by the Belmarsh prison doctor on 11 January 2011, repeating the prescribed medication. The doctor made no assessment of the man to ascertain whether his needs had changed. This was especially pertinent given that there had been a five month gap between prescriptions. There were no further prescriptions issued for this drug after this time and the record does not indicate why it was stopped. The clinical reviewer notes his concern about the procedures followed to ensure safe long term prescribing of medication.

The Governor of Belmarsh and Director of Harmoni should ensure that patients are recalled for tests and review when their prescriptions are repeated.

Abnormal blood sugar level result

108. In April 2011, healthcare staff took tests and recorded the man's blood sugar level. The clinical reviewer notes that one of the test results obtained was of a "very high" level and further tests should have been done to confirm the possibility of a "diagnosis of diabetes". However there is no record of any further action being taken, no further tests were carried out nor a referral made to the doctor. It is important that when tests are carried out and produce abnormal results, action is taken to find out the why this has occurred so appropriate care can be instigated.

The Governor and Director of Harmoni should ensure that, where healthcare staff document abnormal medical test results, the prisoner is referred to a doctor.

Management of the man's risk of self harm

109. Before 22 March 2011, there were no clear indications to suggest the man was at risk of self harm. Although as noted, the charges themselves are an indicator of heightened risk and had been highlighted on his PER. When the man harmed himself on this day, he was promptly assessed by the mental health team, ACCT procedures were opened and he was admitted to the healthcare centre for appropriate treatment.

110. The investigation found that in general the management of ACCT procedures by staff was carried out to an appropriate standard. Staff tried to ensure that the man's risk was kept to a minimum and monitored by putting in place an

ACCT action plan and caremap, both of which assisted to manage the man while he was at risk of harming himself. The ACCT reviews were held at suitable intervals with attendance from staff from different departments, such as healthcare staff. His outlook appeared to improve and, when assessed by the forensic psychiatrist (via interpreter) on 11 April, he said he no longer had thoughts of self harm. Having been monitored and observed for a period of about three weeks in the in-patient unit, he was discharged back to houseblock 2 and ACCT procedures were ended on 19 April.

111. When the man was discovered hanging in his cell, the ACCT procedures had been closed for 16 days. There had been no concerns about him leading up to, and beyond, it's closure. His cell mates, who were able to communicate with him in Russian, told the Catholic Chaplain that the night before the man took his own life, they had all played cards, and he had laughed and joked with them until midnight. On the day the man killed himself he had given them no cause for concern and had appeared normal. An officer also escorted him to collect his medication approximately two hours before be was discovered hanging in his cell. His demeanour gave the officer no cause for concern.

112. When the man presented at risk of harming himself appropriate safeguards were put in place. The ACCT procedures were followed and closed appropriately. The ACCT system exists to support prisoners through a period of crisis and it is not envisaged that they continue indefinitely. There were no signs that he was likely to harm himself again at the time he did.

Communicating with the man

113. The man was identified as a foreign national prisoner who had difficulty speaking and understanding English. The investigation found that the overall standard of record keeping was appropriate to ensure effective communication between staff and himself. Some staff assessed his ability to understand as reasonable or good, while others thought it was poor. This explains why an interpreter was used during some interactions, but not all. Nonetheless, an interpreter was always available and the important assessments made by the psychiatrist and most ACCT reviews were done with the aid of an interpreter.

114. However, on one occasion (19 April), the man's cellmate was used as an interpreter for the ACCT review which took place in the healthcare centre. The ACCT was also closed following this meeting. ACCT case reviews should be confidential and private meetings. A prisoner who is subject to ACCT procedures may not wish to disclose personal or sensitive details about themselves at a review meeting in front of another prisoner. Such reviews might also include discussions about health-related matters. During her interview for this investigation, the ACCT Case Manager did not explain why a prisoner was used as a translator, although she said the prisoner had no input into the decision making process. Nonetheless, it is concerning that a fellow prisoner was used as an interpreter at an ACCT review as this could have hindered the man's willingness to be open and honest with staff.

The Governor should ensure that prisoners are not used as interpreters in meetings where confidential information is discussed, such as ACCT reviews and healthcare appointments.

Emergency response

115. The prison general alarm was used to alert staff to the emergency at the man's cell. However, this does not inform staff that they are attending a medical emergency and some staff attended without this knowledge. This was true of the first responding healthcare nurse who arrived at the man's cell quickly but without the emergency medical bag. Although the bag was collected very quickly by another nurse and brought to the cell, it is important to ensure that all first responding staff to an emergency receive the correct notification of what type of emergency they are attending. In this case, the emergency code that should have been used straightaway was Hotel 99 and informs of a life threatening situation. This would enable them to prepare themselves by, in this instance, immediately bringing with them the correct emergency medical equipment.

The Governor and Director of Harmoni should ensure that staff use the appropriate local emergency codes upon discovery of an emergency.

116. Nonetheless, staff arrived at the man's cell extremely quickly once he was discovered. They started CPR without delay and attached and used the defibrillator appropriately. It is unfortunate that the initial bag thought to contain the defibrillator was incorrectly brought to the cell. The correct bag did however arrive very quickly and we are informed the bags have since been made easier to identify. Overall, the clinical reviewer judged that the CPR management was good and it is unlikely that different management at any stage would have led to a different outcome for the man.

117. The lack of attendance of the prison doctor who was on duty is concerning. In this case, he did not appear to have been alerted to the emergency and the investigator was told he arrived at the man's cell approximately 36 minutes after the alarm was raised, which was after the paramedics arrived at the cell.

118. At the time of the man's death, prison doctors at Belmarsh did not carry pagers or radios and this made communication in a medical emergency difficult. This issue was raised in a recommendation in a previous report following the death of a prisoner at Belmarsh. This recommendation was accepted by the Prison Service in January 2012 and a pager service was introduced for doctors within the prison.

Ambulance delay

119. Prison staff called an ambulance quickly after discovering the man. However, despite its swift arrival at the prison (arriving at 5.05pm), it took the paramedics a further 17 minutes (5.22pm) to arrive at his cell. This is a significant delay. The investigator was unable to ascertain from staff exactly why this delay occurred. One member of staff did say that, at the time of the ambulance

arriving, a prisoner escort vehicle was in the process of being searched in the vehicle holding area, where only one vehicle is allowed through at any time.

120. The clinical reviewer has remarked that the management of CPR was good and it is unlikely that anything further could have been done to resuscitate the man. The investigator and the clinical reviewer were told that there had been a recent simulation exercise to review the management of a medical emergency situation in the prison which went well. It is also noteworthy that, in the investigation of a prisoner that died after this man at Belmarsh, there were no issues in respect of the ambulance paramedics getting to the cell quickly. Nonetheless, time is paramount in such situations as he was discovered and given the specialised treatment paramedics are medically allowed to practice, their access to the patient should be unhindered. The following recommendation is made in light of this:

    The Governor should ensure that, when an ambulance has been called, paramedics are given clear, swift and easy access to the relevant location.

Contact with the man's next of kin

121. The man's family were informed of his death reasonably promptly. The Catholic Chaplain, who spoke fluent Russian, telephoned the family in Riga within four hours of the death. The Governor also sent a letter of condolence in Russian. The Chaplain made several telephone calls to explain the UK prison system and answer their questions. He also conducted a memorial service over the telephone for his family. Along with the coordinating Chaplain, they also arranged with the undertakers to ensure the body was repatriated to undertakers in Riga. Overall, communication with the man's family was managed well, was timely and carried out dignity and respect.

CONCLUSION

122. In spite of the scope for improvement identified in recommendations made in this report, it is unlikely that staff could have done more to have prevented the man taking his life at the time that he did. During his stay in prison he appeared to open up to some staff more than others and eventually told them of his previous mental health problems. There has been no particular evidence found to ascertain why, on the day the man died, he decided to take his life.

123. However, despite the man's unexpected actions on the day of his death, there are lessons to be learned. Insufficient attention was paid to the man's previous history, and the inherent risk caused by his alleged offence was not fully appraised. The issue of mandatory mental health assessments for those charged with domestic murder is currently the subject of a national recommendation, but Belmarsh will want to consider their practices in the light of it. Furthermore, the length of time taken for the paramedics to reach the man was unacceptable once they had arrived at the prison.

RECOMMENDATIONS

1. The Governor and Head of Healthcare at Wormwood Scrubs should ensure that all risk information received from other relevant sources is recorded during the reception screening process.

   The National Offender Management Service accepted this recommendation, writing:

   "All new receptions are seen with both the core record and PER, which has recently been revised. Additionally a checklist has been introduced which evidences what information is available as new prisoners arrive. This does not negate the need for healthcare staff to check the record but does confirm what accompanied the prisoner form court. All available paperwork is provided to healthcare staff at the point of reception to better inform treatment options, planning and risk assessment."

2. The Governor of Belmarsh and Director of Harmoni should ensure that healthcare staff request GP records within 72 hours of a prisoner's arrival where it is recorded that they are registered with a GP in the community.

   The National Offender Management Service accepted this recommendation, writing:

   "All prisoners entering HMP Belmarsh are requested to consent to a faxed communication to their registered GP requesting a summary of current treatment and medication. The request is sent by the admin team on the next working day. Responses are monitored and chased on a daily basis. Clinical records are scanned onto SystmOne."

3. The National Offender Management Service should ensure that prisoners charged with domestic homicide are referred for a mental health assessment.

   The National Offender Management Service did not accept this recommendation, writing:

   "Chapter 3 of PSI 64/2011 highlights to staff that prisoners charged with domestic violence related offences are of an increased risk of suicide. However, referral for mental health assessments must be based on the needs of the individual. Each prisoner undertakes a health screen at reception into prison where they are assessed for the risk they may pose to themselves. Mental health referrals are made where deemed necessary by healthcare staff. Where a prisoners mental health has been identified as deteriorating at any point during their time in custody, there are clear procedures in place in which to refer for a mental health assessment."

   This is a matter the Prison and Probation Ombudsman has previously raised with the National Offender Management service and we are currently in discussion about his issue with their Chief Executive.

4. The Governor of Belmarsh and Director of Harmoni should ensure that patients are recalled for tests and review when their prescriptions are repeated.

The National Offender Management Service accepted this recommendation, writing:

"The care and management of each prisoner is reviewed by the prescriber before any medication is prescribed. Revised procedures are now in place to receive pathology reports electronically direct to the patients SystmOne health record. The results are available immediately and are brought to the attention of the prescriber and duty Doctor. Paper reports are scanned onto SystmOne on the day of receipt and are brought to the attention of the duty doctor by TASK."

5. The Governor and Director of Harmoni should ensure that, where healthcare staff document abnormal medical test results, the prisoner is referred to a doctor.

The National Offender Management Service accepted this recommendation, writing:

"Revised procedures are now in place to receive pathology reports electronically direct to the patients SystmOne health record. The results are available immediately and are brought to the attention of the prescriber and duty Doctor. Paper reports are scanned onto SystmOne on the day of receipt and are brought to the attention of the duty doctor by TASK."

6. The Governor should ensure that prisoners are not used as interpreters in meetings where confidential information is discussed, such as ACCT reviews and healthcare appointments.

The National Offender Management Service accepted this recommendation, writing:

"Access to Confidential Interpreting services is available for all staff within HMP Belmarsh, to support prisoners"

7. The Governor and Director of Harmoni should ensure that staff use the appropriate local emergency codes upon discovery of an emergency.

The National Offender Management Service accepted this recommendation, writing:

"Irrespective of whether a general alarm or clinical alarm is called, the response is consistent. A local registered nurse will attend the scene of the incident with the clinical emergency equipment bag and will assess the casualty and advise on immediate action."

8. The Governor should ensure that, when an ambulance has been called, paramedics are given clear, swift and easy access to the relevant location.

The National Offender Management Service accepted this recommendation, writing:

"There is a detailed local procedure in place to ensure that the ambulance and crew are identified in advance, entry if facilitated and the vehicle and crew are escorted to the scene by a Zulu Unit. Arrangements to support a possible escort are anticipated and relevant forms and equipment are provided in a "grab and go" bag to reduce delay. Arrangements are made to staff the escort immediately. Every effort is made to ensure that the risk assessment is completed before the casualty leaves the prison however, completion is not allowed to delay exit."