Investigation into the death of a man whilst in the custody of HMP Belmarsh in June 2011

Report by the Prisons and Probation Ombudsman for England and Wales

August 2012

This is the report of an investigation into the death of a prisoner at HMP Belmarsh. He died in June 2011, having been discovered in his cell with a ligature around his neck. I offer my sincere sympathy and 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 the clinical reviewer and his colleague 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 during the course of the investigation.

The man was remanded to Belmarsh having been sentenced to 180 days imprisonment. This report covers his time in prison prior to his death, the events on the day that he died and the actions of relevant people involved. I would also like to thank the man's family for their engagement with this investigation under the most distressing of circumstances.

This investigation has found no indications that staff could reasonably have foreseen that the man might take his life. However, some lessons may be learned from this tragic case and a number of recommendations are made to achieve this. Unusually, one recommendation relates to the competence of a member of nursing staff, although I do not believe this issue effected the overall treatment the man received. Other recommendations refer to the need for improvements to health screening on reception, prison doctors attending medical emergencies and staff attendance at hot debrief meetings following a death in custody.

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 **August 2012**

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SUMMARY

1. The man was remanded to HMP Belmarsh, having been sentenced to 180 days imprisonment (with 120 days to run concurrently) for driving offences and one of theft. He had been in Belmarsh previously in 2007 and, by all accounts, seemed undaunted by the length of his sentence on this occasion. He wrote to his wife and told her that he was looking forward to seeing his grandchildren when released and was positive about the future, when he spoke to her on the telephone.

2. He arrived at Belmarsh just after 7.00pm and was assessed by a nurse who noted issues with asthma and previous amphetamine misuse. The man was also assessed by a detoxification nurse, who noted no withdrawal symptoms present and referred him to the prison drug misuse service. It is not clear whether the man then had an appointment with a doctor or whether the doctor prescribed the man's asthma medication on the basis of the information the nurse provided. If the latter was the case, the clinical reviewer notes the doctor should have made a follow-up appointment with the man. The clinical reviewer also makes a recommendation with regards to the reception healthscreen being revised to allow for information regarding the management and severity of long-term illnesses which I have endorsed.

3. Over the following few days, the man went through the usual induction process in the prison and received both group and one to one input. He also had a secondary healthscreen with a nurse. During both these conversations, and more casual ones with wing staff, the man did not give staff any cause for concern with regard to potential thoughts of self-harm or suicide. He denied any such feelings on numerous occasions and was described as "cheerful" during his secondary healthscreen. Coupled with his apparent lack of history of such thoughts, the investigation found the care given to the man entirely appropriate and, based on the information provided, we consider that staff could not have predicted that he would take his own life.

4. When the man was discovered hanging in his cell, staff acted promptly and professionally in attempting to resuscitate him. Despite these attempts, they were unable to save him and the air ambulance doctor pronounced him dead in his cell. However, concern was raised over one nurse's confidence in emergency procedures and a recommendation is made regarding this. Further recommendations include ensuring that doctors are included in the emergency procedure policy, staff attendance at hot debrief meetings following a death in custody and lastly, that the reception health screening tool be amended to include information on the severity and management of long-term illnesses such as, in the man's case, asthma.

THE INVESTIGATION PROCESS

5. The Ombudsman's office was notified of the man's death in June 2011. The investigation was allocated to one of the Ombudsman's senior investigators, who visited Belmarsh on 8 June to open the investigation. He met with the Governor, a member of the Prison Officer's Association (POA) and Independent Monitoring Board. (IMB). The prison appointed a liaison officer for my investigator.

6. My investigator issued notices inviting staff and prisoners to contact him with any information they thought might be relevant to the investigation. There was no response to the notices. My investigator was provided with copies of the man's prison and medical records covering his brief time at Belmarsh.

7. NHS Greenwich commissioned the clinical reviewer to review the clinical care the man received at Belmarsh. The clinical reviewer and my investigator carried out joint interviews with staff in July and August 2011. The transcripts of these interviews are attached as annexes to this report. The Governor of Belmarsh was given written feedback on the progress of the investigation in August 2011.

8. 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.

9. One of the Ombudsman's family liaison officers contacted the man's wife to explain the purpose of the investigation and invite her to raise any questions or concerns. The man's wife raised the following concerns below. It is hoped that the report answers her questions:

    - Why had the prison contacted the man's probation officer in the community and asked whether her husband had any history of self harm?
    - How had it been possible for the man to use a towel as a ligature?
    - When the man's property was returned, his silver wedding ring was missing. The man's wife said it was of great sentimental value and was concerned the prison had been unable to locate it.

10. As part of the consultation period the man's family received a copy of the draft report. The family had no further comments to make about the investigation.

11. The man is the twenty second prisoner to die at Belmarsh since the Ombudsman began investigating deaths in prison in 2004, eleven of which were apparently self-inflicted. In two investigation reports in 2010, previous recommendations were made regarding advanced life support training for nurses in administering emergency drugs and regarding clarifying the job descriptions for all primary care staff.

HMP BELMARSH

12. 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. It also accommodates some category A prisoners and so is part of the high security estate. There is a separate high secure unit, holding high and exceptional risk category A[1] prisoners. (The man was not a category A prisoner and he was not held in the high secure unit.) 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)

13. 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.

14. The Inspectorate reported that, despite the large range of prisoners received at Belmarsh, early days in custody were "generally well managed". However, their survey of prisoners indicated that they did not feel they were treated well on transfer to and from the prison or in reception. The Inspectorate's observations were that:

> " … staff were businesslike in a busy environment but that they did not interact with prisoners more than was necessary, which some prisoners perceived as indifference to their needs. New arrivals on main location received a comprehensive and informative induction with helpful presentations from a range of staff. Prisoner peer supporters were also available on the induction spur to reinforce information and support prisoners."

15. The Inspectorate noted that staff prisoner relations varied greatly between units and the personal officer scheme[2] was generally ineffective. Most prisoners were not aware of their personal officer and few found them helpful. They also noted that healthcare required improvement. The Inspectorate also found that vulnerable prisoners and those at risk of harming themselves or suicide were generally well cared for, although gaps in provision remained. There had been a high priority to suicide prevention following recent deaths in custody.

Independent Monitoring Board (IMB)

16. 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

[1] Category A prisoners are those who, if they escaped, would be highly dangerous to the public, the police or to the security of the state.
[2] The personal officer scheme allocates a named officer to each prisoner who they can approach for advice or to resolve complaints.

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, with the latest available for Belmarsh covering July 2009 to June 2010.

17. The report noted that:

> "Despite our fears, the management and staff at Belmarsh successfully met and dealt with the budgetary and organizational challenges of the year under review but face even greater pressures in the years ahead."

18. The IMB also recorded progress in the healthcare department since the previous year and some "positive steps towards better performance"

Reception screening

19. All prisoners go through reception procedures when they enter a prison. A cell sharing risk assessment (CSRA) is opened by the reception officer who completes the initial details. The form is first 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. 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.

KEY EVENTS

20. The man was born in February 1961. He had two children and, prior to entering custody, lived with his wife. He had been in custody in Belmarsh once before in 2007. He had no past history of mental health issues, including depression or self-harm.

Events from 27 – 31 May 2011

21. On 27 May 2011, the man was sentenced to 180 days imprisonment at Dartford Magistrates Court for theft, with 120 days to run concurrently for driving whilst disqualified. He was eligible for release, at the earliest, on 11 July 2011. He was taken to Belmarsh. The person escort record[3] (PER) indicated that there was no known medical, security, suicide or self-harm issues. The only marker ticked was that for drug or alcohol issues. The man arrived at Belmarsh at approximately 7.15pm and went through the prison reception screening process.

22. At 7.21pm, Nurse A entered the man's personal details onto his healthcare record as the man stood in front of him at the reception desk. The man denied having any concerns to the nurse.

23. Around an hour later, Nurse B completed the first reception health screen assessment. The nurse told the investigator that he had a "good conversation" with the man and "quite a laugh" during the assessment. He noted that the man needed to see the doctor for medication since he was prescribed salbutamol and beclomethasone inhalers for asthma. The man told the nurse he had never tried to harm himself or received psychiatric care in the community and currently had no thoughts of harming himself. He also disclosed that he had taken amphetamines for the last twenty years. The nurse had no concerns regarding the man's behaviour or mental state and assessed him to be at a low risk of harming himself and others.

24. Due to the man's admission of amphetamine misuse, he was referred to the substance misuse team. Detoxification Nurse A then completed a substance misuse assessment. The man told the nurse he had been taking £10 worth of amphetamines daily but currently had no withdrawal symptoms. The nurse recorded that he seemed in a "good mood" and she referred him to the prison drug misuse service known as CARATS (Counselling, Assessment, Referral and Throughcare Services).

25. During the reception process, a cell sharing risk assessment (CSRA) was also completed. (The CSRA assesses the risk of harm a prisoner presents to a cellmate if they are required to share a cell.) The healthcare part of the CSRA was completed by Nurse C, who indicated there was no increased risk from the man to others on the basis of healthcare information. Normally Nurse B would have also completed this but he had finished work at 8.30pm. Nurse C subsequently told him (Nurse B) the next day that she had completed the

[3] The PER is a form that accompanies each prisoner between police station, court and prison. It provides information about the prisoner's needs and the risk he poses to others and himself.

CSRA. Two officers completed the rest of the CSRA and assessed the man to be of standard risk, which meant that there was no immediate risk but the situation would be monitored. (The CSRA has two ratings, standard and high.)

26. At 9.07pm, Dr A entered on the medical record that the man had asthma and prescribed him inhalers for this. It is not clear from the record whether the doctor met with the man or not. Nurse B told the investigator that doctors at Belmarsh sometimes write such prescriptions having spoken to the nurse that saw the prisoner, without seeing the prisoner themselves.

27. A reception officer completed an immediate needs assessment and, due to a previous offence, the man was offered rule 45 status (meaning he could be located on a wing for vulnerable prisoners) but he declined. He was located onto the prison induction wing, given a hot meal, a drink, a telephone call and smoker's pack. Over the next few days, the man settled into prison regime.

28. On 30 May, Nurse A completed the man's secondary health screening and recorded he was "oriented, cheerful, communicative and co-operative". The nurse took the man's blood pressure, which was within the normal range and they discussed his asthma. Towards the end of the interview, the nurse told the investigator that the man became fidgety and anxious which he attributed to the man's admission that he had been constipated for three days. The nurse had no concerns with regard to any risk of suicide or self-harm and therefore no further referrals were made.

29. The same day, Officer A had a meeting with the man as part of the induction process. This was to obtain more detailed information about the man's background, whether he had any concerns such as outstanding fines or ongoing court cases. The officer said the only issue which the man raised was in relation to his past amphetamine misuse and he denied any thoughts of harming himself or suicide. (The officer told the investigator that the man would also have been part of a group induction the day before this when prisoners are told what is expected of them and what they can expect in return from Belmarsh.)

30. Officer A then summarised the interview on P-NOMIS (computer record system) writing that the man just wanted to "finish his sentence and return to his wife". The officer told the investigator that the man also completed the newly convicted visiting order form with his wife's details.

31. After his induction was completed, the man moved onto spur three of houseblock three, a normal residential wing. He was allocated a single cell, although the investigator found no evidence that this was for a particular reason.

32. Officer B was assigned as the man's personal officer. The officer became aware of this when he went to work that evening to complete his night shift (he had not been working over the weekend). He explained to the investigator that a prisoner is allocated a personal officer on arrival at the prison for the duration of their stay there on a wing. Each full-time officer is personal officer to around

seven prisoners and does a week of night shifts once every 26 weeks. Following the week of night shifts they have a rest week.

33. In the man's case, Officer B's duties meant that he would not have been able to properly introduce himself as the man's personal officer or have a one to one session with him until at least two weeks after the man had arrived at Belmarsh because he was on the night shift, followed by a rest week. The officer said, however, that the man did not raise any issues with him when he completed his brief night checks on all prisoners on the nights of 30 and 31 May.

34. Officer C said he spoke to the man around 8.30am on 30 or 31 May and asked if he wanted to go to exercise. The man declined but stood in the doorway of his cell talking casually to the officer about where he was from and that he only had a short sentence to serve. On 31 May, the man also collected his inhalers.

Events on 1 June

35. The following day, Officer C and Officer D were working on the man's spur. Officer D explained that all the prisoners were given breakfast around 8.00am. As the man had not been at the prison long, activities such as workshops or education would not yet have been arranged for him so he stayed mainly locked in his cell during the morning.

36. At around 11.30am, the man's cell was unlocked so that he could collect his lunch. He asked to talk to Officer D when the officer locked the prisoners back in their cells approximately 45 minutes later. The man told the officer that a rash had appeared on his upper body which was "uncomfy". Officer D told the man he would come back to collect him later, once a nurse was available, at around 2.00pm. The man agreed to this and the officer told him that if the rash got worse before then he should press his cell bell. (Each cell has a bell to be used by prisoners in the event of emergency or if they require staff attention.) Officer D said he had no indication that the man was thinking of harming himself. He described the man as "always polite, very easy going" and "very sensible".

37. Officer D then went on his lunch break for an hour. At 1.30pm he attended the daily wing staff briefing. Fifteen minutes later he returned to the spur and started unlocking prisoners to attend their activities.

38. Just after 2.00pm, Officer C went to collect the man from his cell so that he could be taken to see a nurse about his rash. When he unlocked the cell, he saw the man hanging from a cupboard, having used a towel as a ligature. Officer C shouted to Officer D, who was nearby, to indicate there was a medical emergency. Officer C immediately went into the cell and supported the man under his arms in an attempt to alleviate the pressure on his neck until more staff arrived.

39. Meanwhile, Officer D announced there was a medical emergency in houseblock three over his prison radio and sounded the alarm bell. (Recorded on the prison log as occurring at 2.04pm) This emergency response immediately

alerts staff and healthcare to an incident requiring medical intervention. The officer then ran to get Nurse A from the nearby medical room. Officer D said the nurse immediately picked up the emergency bag (which contains emergency equipment including airways and oxygen) and ran to the man's cell. Nurse A had already heard the call on his radio and was locking his treatment room when Officer D came to collect him. The nurse had the radio assigned Hotel Three, which meant he was assigned as the first healthcare nurse to respond to any medical emergencies arising in houseblock three.

40. At interview with the investigator, Officer E, Senior Officer (SO) A and Officer F said they were nearby and all heard the medical emergency call. They quickly arrived at the man's cell and assisted Officer C. SO A and Officer F cut the man down, lowering him to the floor. Officer E said she noticed the man's feet were purple, whilst others said their initial reaction was that the man was dead. Officer E told the investigator that the towel was a standard prison issue towel which was quite thick and remained in one piece when the man used it as a ligature.

41. SO A told the investigator that, after the officers had cut the man down, Nurse A arrived at the cell and said, "Oh my God, does anyone know CPR?[4]" and then immediately left the cell. Officer G, Officer E and Officer F all agreed that this happened before they started CPR. The only officer not to corroborate this account was Officer C, who said he was only aware of concentrating on the man rather than what was going on around him.

42. In response to this, Nurse A told the investigator a different version of events. He said that when he got to the man's cell, an officer had already started doing chest compressions. He denied asking if anyone knew how to do CPR. The nurse said he went into the cell but there was no room for him so he came back outside to open the emergency bag and take the oxygen out. He said this was when Nurse B arrived. The nurse said he regularly receives life support training and his last training was in February 2011.

43. Once they had laid the man on the floor, SO A told the investigator that he asked if anyone was qualified in delivering CPR. Officer G began chest compressions and Officer C gave the man two breaths through a face shield, which he said he always carries as he is a trained first aider. Since the cell was quite crowded, SO A then asked those who were not needed to leave. Officer F and Officer E left. Officer E said that when she left the cell she heard Nurse A on the wing asking where the defibrillator[5] was in a panicked manner.

44. Nurse B had been in the first night centre when he heard a general alarm followed by a verbal message of "medical emergency houseblock three" over the radio. He immediately went to see if he could assist. By the time he arrived he told the investigator that the officers were attempting to resuscitate the man and Nurse A was standing in the houseblock with the emergency bag. Nurse D

[4] Cardiopulmonary resuscitation (CPR) is a technique whereby oxygen is pumped around the body using a combination of chest compressions and rescue breaths
[5] A defibrillator is a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest.

was carrying the prison radio labelled Hotel 99, which meant that he had to respond to any medical emergencies, also arrived around this time.

45. Nurse B entered the cell to assist with CPR. The officers continued CPR until Nurse B inserted an airway and blew two breaths into it. SO B was carrying the Oscar two radio that day. This meant that he had responsibility for responding to emergencies. Upon arrival at the man's cell, he asked SO A what assistance was required and was told an ambulance was needed. SO B did this immediately via the control room. A nurse asked for a defibrillator, SO B said he asked an officer to bring one to the man's cell. During this, Nurse A had began to pass pieces of the emergency equipment to Nurse B to assist with trying to resuscitate the man.

46. Nurse B had attached an Ambubag[6] to the man's airway and Nurse D and Nurse A helped him in getting the oxygen attached to the airway. Nurse B then attached the defibrillator when it arrived at 2.07pm and followed its instructions for use. At this point, Nurse D took over chest compressions from Officer G. Nurse E also arrived at the cell around this time and started making a log of the emergency response.

47. Some staff told the investigator they saw blood on the bed sheet when they went into the cell and one officer thought this may have come from the man's wrist, whilst others believed it had come from his nose or mouth.

48. SO B had been aware of issues in previous deaths at the prison when paramedics had been delayed in attending the incident despite arriving at the prison gate quickly. He therefore ensured a member of staff went to the gate to escort the paramedics straight to the cell, with the effect that they arrived at 2.15pm.

49. The paramedics took over the resuscitation efforts from prison staff. An air ambulance also arrived shortly after them and the doctor administered adrenalin to the man on three separate occasions whilst continuing to work on his airway. They also used the more advanced air ambulance defibrillator. Despite these attempts, the doctor pronounced the man had died at 2.34pm and the chaplain, who was now present, read the last rites to the man.

After the man's death

50. Governor A initiated the death in custody contingency procedures to inform the relevant agencies of the man's death. He held a hot debrief meeting at 2.50pm which was attended by 23 members of staff. They discussed what had happened during the emergency response and support was offered for the staff. Arrangement was also made to offer support to prisoners on the man's wing and review all those on suicide and self harm monitoring procedures. A

[6] Ambu-bag is a hand held medical device used to provide assisted ventilation to people who are either not breathing or are having trouble breathing.

notice referring to the man's death was also displayed. A critical incident debrief[7] was held on 13 July.

51. SO C was appointed as the prison's family liaison officer. He, together with a colleague, went to the man's wife's address after the hot debrief to break the news of her husband's death. The man's wife was shocked by her husband's death. She said he had been in prison before and was undaunted by it. The man's wife told the investigator she had spoken to her husband a couple of days previously and he had asked her to pick up a visiting order.

52. The man's wife received a letter from her husband on the morning of his death and did so again a couple of days later. In his letters to her, he had spoken positively about the future, that he did not have long to serve and was looking forward to seeing his grandchildren on release. There was nothing in his letters to suggest he was feeling down or considering taking his own life.

53. SO C remained in contact with the man's wife and the prison paid the full cost of the funeral. The man's wife told the SO that the man had told his son on the day of his sentencing that if he ended up going to prison he would kill himself. This was because an allegation of a sexual nature against himself had been mentioned in court and he thought he could lose his children. The man's wife told the SO that her husband had made similar remarks before and the family had never believed him to be serious.

[7] A critical debrief ordinarily takes place within two weeks after a serious incident and gives the staff the opportunity to understand the incident in greater detail, review and identify any learning points..

ISSUES

54. The clinical review was conducted by the clinical reviewer and his colleague and is annexed to this report. It includes fourteen recommendations, the majority of which relate to specific healthcare matters. The clinical review will be shared with the Governor at Belmarsh, as well as being 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

The man's general well being on arrival at Belmarsh

55. The only known problems the man had related to asthma and taking amphetamines for twenty years. He had no past history of any mental health problems or attempts at self harm. His behaviour on admission to Belmarsh appeared normal and there were no concerns about his mental state. He denied any depression or thoughts of harming himself.

Treatment of asthma

56. The man's reception screening process and risk assessments were effective in establishing his past and current physical and mental history. However, the screening process did not establish the severity of his asthma. The clinical reviewer notes that the nurse asked if he had any problems with asthma. The box was ticked since he had asthma and was prescribed two different types of inhaler for this. However, the current screening does not request information about the severity of this illness or its previous management. The clinical reviewer comments that:

> "It would be relevant to know if he had severe acute attacks recently requiring nebulizer treatment, hospital referral or treatment with steroids. Such a history should have indicated a referral to the doctor for assessment."

57. Furthermore, the records from the man's doctor in the community were not requested, which may have provided further information in this regard. The entry from Dr A on the first night screening records: "consultation known to suffer asthma and on blue and brown inhalers request repeat." Again there is no detail regarding the severity of the asthma and this prescription may have been written at the request of a nurse, without the doctor seeing the man. If this was the case, the clinical reviewer comments that the doctor should have arranged to see the man shortly afterwards for assessment.

58. The clinical reviewer concludes that, without this information, it would have been difficult to assess how well the man's asthma was being controlled or what the risk of an acute attack was in the prison environment, where stress levels may have increased. The clinical reviewer adds that the man was using steroid inhalers to prevent attacks as well as an inhaler to dilate the airways.

This suggests the man had frequent enough asthma attacks to need long term prevention. A peak flow test would have indicated how well his asthma was controlled but there was no referral to the doctor for assessment. The clinical reviewer outlines that National Service Frameworks recommend taking a history and doing a peak flow test to assess severity and effectiveness of treatment when seeing a new patient with asthma. Despite this lack of a full assessment, the man was prescribed his inhalers without delay, these drugs were self-administered and met his immediate asthma needs. However, it is appropriate to make the following recommendation:

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The Governor and Director of Harmoni should ensure that follow-up appointments are scheduled when doctors prescribe medication without seeing the prisoner.

The Governor and Director of Harmoni should ensure that a suitably amended healthcare screening questionnaire is completed in all appropriate cases to identify details of the severity and management of any long term illnesses, together with the need for GP records.

Management of resuscitation efforts

59. Staff arrived at the man's cell extremely quickly once he was discovered. The clinical reviewer notes that Nurse B's management of the emergency was "exemplary". Staff told the investigator how calmly and competently he managed the situation. Nurse E made an excellent log of the response and said that he thought all the staff responding to this incident worked extremely professionally and as a team.

The actions of Nurse A

60. Four of the five officers who first responded to the emergency told the investigator that Nurse A was the first member of healthcare to arrive at the cell and immediately said "oh my God does anyone known CPR?" before leaving the cell. The only officer not to corroborate this account said he was at the other end of the cell and was so focussed on attempting to save the man he did not notice what was happening around him. Whilst this did not appear to detract from the care the man received, both the investigator and the clinical reviewer have serious doubts regarding the confidence of Nurse A in carrying out CPR.

61. SO A told the investigator he raised the issue regarding Nurse A with the duty governor and then the governing governor. The officers said they were appalled and shocked by the nurse's actions who they would have expected to initiate and manage the resuscitation attempt.

62. Nurse A denied making the comment about CPR. He said that when he got to the cell an officer had already started doing chest compressions. The nurse said he went into the cell but there was no room for him, so he came back outside to open the emergency bag and take the oxygen out. He claimed to have recently had life support training and said he was confident in this regard.

Nurse A's experience of nursing in Britain was first as a nursing home manager. He was then employed by Brixton prison in 2008 and had been employed at Belmarsh since March 2011.

63. Given the evidence available to the investigation and the clinical reviewer's concerns, the following recommendation is included from the clinical reviewer's clinical review:

    The Director of Harmoni should assess the CPR competence of Nurse A and develop a personal development plan to address any deficiencies.

Prison doctor's involvement in the emergency response

64. The emergency services arrived at the man's cell very quickly and were followed by the air ambulance service. The prison doctor on duty, however, does not appear to have been alerted to the emergency and the investigator was told he was seen making his way to the man's cell after his death had been confirmed.

65. SO A told the investigator that, in the twelve years he has been working at Belmarsh, he has never known a doctor to attend a medical emergency. He said that they do not tend to carry radios or pagers and so, unless they were near a member of staff who was, they would not be aware of the emergency. Others said that sometimes doctors attended emergencies but their lack of keys or radios made this difficult.

66. Nurse B said that doctors would be useful at emergencies in order to administer drugs but that they do not carry pagers and are not always in the prison. The lack of emergency drugs within the prison was also an issue of concern and is highlighted in the clinical review: such drugs are not in the medical emergency bag at Belmarsh. Furthermore, the emergency out of hours doctor on call does not have the drugs needed to treat emergencies readily available. This greatly increases the risks to patients who develop a medical emergency in Belmarsh and is unacceptable.

67. The clinical reviewer concluded that this situation, "…causes unacceptable delays in GPs attending medical emergencies". He also highlights that a draft Belmarsh emergency response procedure, dated April 2011, excludes any role for the prison doctor. The document also does not indicate who is responsible for calling an ambulance, calling a doctor if they are available, or writing up medical records after a fatal incident. Furthermore, not all staff had seen this document. Additionally, the investigators found that prison doctors at Belmarsh do not have a job description, which the clinical reviewer says makes it difficult to identify their clear roles and responsibilities. It was also noted in the clinical review that, despite assurances given at the meeting with the clinical reviewer and Harmoni on 26 November 2010, that all doctors now carried pagers, it would appear that these have never been provided.

68. The following recommendation amends one in the clinical review:

The Governor and Director of Harmoni should ensure that all doctors working at the prison are issued with a pager and the emergency team procedures are finalised to include the role of the prison doctor and circulated to all staff.

Monitoring the man's risk of suicide and self-harm

69. The man had no history of mental health issues or thoughts of suicide or self-harm. He denied any thoughts of suicide or self-harm during the first and secondary health screens. Staff who came into contact with him all said they had no concerns in this regard. Moreover on 30 May, he was recorded as having been "cheerful". He was serving a relatively short sentence and had been in both prison custody and Belmarsh before.

70. The man spoke to his wife on the telephone a couple of days before his death. She said he was undaunted by his prison sentence and had asked her to pick up a visiting order. He also wrote positively in his letters to her and said he was looking forward to seeing his grandchildren when he was released.

71. When Officer C locked the man up over the lunch period on 1 June, he had asked to see a member of the healthcare department about a rash which had developed. The officer agreed to this and told the man to ring his cell bell if the rash worsened in the interim. The officer explained to the investigator that he had no cause for concern about the man's mental state.

72. Officers and healthcare staff did all that they could reasonably be expected to with regards to assessing the man's risk of self-harm and suicide. There was nothing in his background which suggested any issues in this regard and he voiced no such concerns to staff. The investigator also found no recorded evidence related to the man's probation officer, who the man's wife said had been contacted by the prison before his death, querying whether the man had harmed himself or attempted to take his own life in the past. This is a normal part of the information gathering process, when new prisoners arrive, so any potential risks can be identified at an early stage

73. It is therefore concluded that it was appropriate that formal suicide and self-harm monitoring procedures were not opened for the man.

Staff support

74. Following a death in custody, staff support is always important. Good feedback was received from staff who attended the critical debrief. However, one officer who was involved in the resuscitation attempt said he was not aware of the debrief meeting, although this appears to have been an oversight. However, such meetings can be very helpful to staff involved in traumatic events and the Governor should ensure that all relevant staff are informed.

The Governor should ensure that all relevant staff are identified and invited to the hot debrief in any future death in custody.

The man’s alleged reference to harming himself

75. Following the man’s death, his wife told a member of prison staff that her husband had said that, if he were sent to prison, he would kill himself. Although he allegedly made these remarks to his family, there is no evidence he or his family raised any such concerns with prison staff.

The man’s personal property

76. When the man's property was returned to his wife, she told the investigator that his silver wedding ring was missing. As part of his investigation, my investigator reviewed the man's court property record (completed by the escort company on the man's transfer to and from court) and also his prison property card (completed on arrival at Belmarsh). All items of property, including any items of value, are listed on these property cards. Unfortunately, no ring is listed on either property records. This suggests the man did not have the ring on him when he went into court or indeed prison. It is very unfortunate that more could not be done to help locate the man's ring, which was evidently of great sentimental value to his family.

CONCLUSION

77. The man arrived at Belmarsh and appeared to settle into the prison regime well. Staff raised no concerns about him and his behaviour did not change significantly during his short stay. There were no indications that the man might take his life and staff acted appropriately in this regard. Concerns have been raised regarding the management of the attempted resuscitation of the man, but not to the extent that his life could have been saved.

RECOMMENDATIONS

1. The Governor and Director of Harmoni should ensure that follow-up appointments are scheduled when doctors prescribe medication without seeing the prisoner.

   The National Offender Management Service accepted this recommendation, writing:

   "It is the policy of Harmoni for Health that al patients will be clinically assessed prior to the prescription of any treatment. In exceptional circumstances, where expediency dictates that this is not possible, the patent will be clinically assessed at the earliest opportunity."

2. The Governor and Director of Harmoni should ensure that a suitably amended healthcare screening questionnaire is completed in all appropriate cases to identify details of the severity and management of any long term illnesses, together with the need for GP records.

   The National Offender Management Service partially accepted this recommendation, writing:

   "The Primary and Secondary Health screening tools are national procedures. The primary and secondary screens record details of all existing long term conditions and these records contribute towards holistic care planning. In addition contact with the GP is made within 24 hours of reception of every prisoner entering HMP Belmarsh, to ascertain current medication and medical history."

3. The Director of Harmoni should assess the CPR competence of Nurse A and develop a personal development plan to address any deficiencies.

   The National Offender Management Service partially accepted this recommendation, writing:

   "Agency Nurse A underwent Immediate Life Support Training under the auspices of the Resuscitation Council(UK) Agency Nurse A was assessed as being competent to deliver Immediate Life Support. However, he has now been dismissed from service by Harmoni due to other matters."

4. The Governor and Director of Harmoni should ensure that all doctors working at the prison are issued with a pager and the emergency team procedures are finalised to include the role of the prison doctor and circulated to all staff.

   The National Offender Management Service accepted this recommendation, writing:

   "The duty GP has been issued with a group pager. The Clinical Emergency Response Procedure is a nurse led service, because the GP is not on site for

the majority of the 24 hour period. However, when the GP is on site, the group pager will alert the GP of all clinical emergencies and he or she will respond as part of the clinical emergency response service."

5. The Governor should ensure that all relevant staff are identified and invited to the hot debrief in any future death in custody.

   The National Offender Management Service accepted this recommendation, writing:

   "Following any serious incident staff involved are invited to a hot debrief. It is not compulsory that they attend, but all are offered opportunity to speak to a senior manager on their own. Both the Unions and Staff Care and Welfare are involved in this process."