

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Belmarsh, in the Queen
Elizabeth Hospital
in November 2008**

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

March 2010

This is the report of an investigation into the death of a man at HMP Belmarsh. He died on 2 November 2008 in hospital in the local area, having been transferred there from the prison a month earlier. He died of natural causes.

One of my family liaison officers contacted the man's brother to explain our role. I would like to reiterate what the family liaison officer said by way of condolences to his family. I much regret that a significant delay in receiving the clinical review has meant that this report is being issued some time after the man's death. I sincerely apologise for any added distress this might have caused.

The investigation was undertaken by one of my senior investigators. Both he and I would like to thank the Governor of Belmarsh and his staff for their participation in the investigation. The local Primary Care Trust (PCT) was asked to undertake a review of the man's clinical care. I appreciate both the clinical reviewer's assistance through the investigation process and her final report.

The clinical reviewer has found that the man's care was equivalent to that which he would have received in the community.

In response to the draft report, his brother commented that the investigation was thorough, and he understood and agreed with the Ombudsman's findings. He did feel that more could be done by the Prison Service to consider family engagement as a means of aiding a prisoner's recovery. He also felt that the continuing nature of the man's unco-operative behaviour could have implied some mental health issues, although he accepted that this was not the finding of the clinical review.

I make one recommendation to the Governor. I would also draw the Head of Healthcare's attention to the recommendations in the clinical review. I am pleased to see that the Prison Service has accepted my recommendation and is introducing a new policy accordingly.

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

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Prisons and Probation Ombudsman

March 2010

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SUMMARY

The man who is the subject of this report was serving an indeterminate sentence. He had originally been released from prison on licence, but was recalled in January 2006 after further offences came to light.

After his recall, the man often did not participate in prison life. He often refused to eat, declined contact with healthcare services, and would not interact with staff or fellow prisoners. Because of refusing to eat, he was frequently monitored under special procedures for prisoners thought to be at risk of harming themselves (known as ACCT). Although the nature of his offence meant he could have asked to be treated as a vulnerable prisoner, he insisted on remaining on normal location. He was transferred to HMP Belmarsh on 11 July 2008, following periods in Manchester, Elmley and Swaleside.

He was not happy at the transfer. He was noted at reception to be non-compliant, and once again refused to see healthcare staff. He continued to refuse food, and to avoid mixing with staff or other prisoners. The mental health team assessed him and found no evidence of mental illness.

On 2 October 2008, the man had been refusing food for some days. When his cell was unlocked in the morning, he declined breakfast and asked to be locked back in his single cell. At lunchtime he again turned down the option of a meal and asked to be locked in his cell.

When cells were unlocked for the evening meal, he rejected the meal. On this occasion he did not ask to be locked in his cell, but it seems he did not leave it before he was locked back in. The officer who locked the cell was not aware of any problems at that stage.

Some 20 minutes later, another officer looked through the observation panel in the man's cell door, and saw that he appeared to be injured. Staff could not get a response from him so entered the cell, and he was found to be unconscious. Medical staff attended and, although he was stable, they agreed that he should go to hospital. The duty doctor was consulted and, having assessed the man himself, he confirmed the nurses' decision.

The man was taken to hospital, where he remained for a month. Sadly, whilst there his condition deteriorated. He suffered a stroke, and developed pneumonia as a result. He died on 2 November 2008.

I make one recommendation to the Governor to ensure that staff involved in emergency response are offered appropriate support.

THE INVESTIGATION PROCESS

1. My investigator visited Belmarsh and spoke to staff who came into contact with the man who died during his time there. He interviewed three members of staff. These interviews were recorded and transcripts are annexed to this report. Copies of these transcripts were sent to the interviewees to confirm their accuracy. One signed copy was returned. The investigator also spoke to the doctor who was the duty doctor in the prison at the time. He has since left that position. A note of the conversation, which was agreed with the doctor, is also annexed to this report.
2. After the man had died, allegations were made by a Belmarsh prisoner about what happened on the evening of 2 October 2008. These were passed to the police by the Governor, and they carried out a full investigation. The investigator was in frequent contact with the police throughout his own enquiries, and visited the police station for discussions with the officers in charge of the case. After lengthy enquiries the police concluded that the allegations were unfounded. The investigator was supplied with a copy of the police report.
3. Notices were posted to staff and prisoners about my investigation, inviting contributions if necessary. None was received. The investigator studied all relevant prison records relating to the man who died. These include his main prison record, medical records, statements made by staff, and the papers from the prison's internal investigation.
4. The local Primary Care NHS Trust asked a clinical reviewer to carry out a review of the man's clinical care. I am grateful to her for undertaking this review. My investigator discussed aspects of the man's treatment both with healthcare staff at Belmarsh and with the reviewer.
5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.
6. One of my Family Liaison Officers (FLOs) contacted the man's brother as his listed next of kin. She told him of my investigation and invited him to ask any questions or raise any issues for consideration. His brother asked if my investigation could consider how the man may have come by bruising and abrasions to his face and head which appeared to be recent injuries. I address the question of whether he was assaulted in my report. Moreover, I hope that overall my investigation will provide his family with a better understanding of his time in custody and the events leading to his death.

HMP BELMARSH

7. Belmarsh is a local prison, primarily serving the Central Criminal Court and magistrates' courts in South East London and Crown and magistrates' courts in South West Essex. It also holds category A prisoners. It has a capacity of 910, with 40 per cent of its cells being single cells.

8. Should prisoners require urgent medical attention, there is a first response team made up of members of the nursing staff. The team carry radios and will respond to emergency calls. The first response team are able to arrange for prisoners to transfer to outside hospital. The prison's doctors are not part of the first response team, although they may be called upon for a medical opinion or medical assistance if necessary.

Suicide and self harm monitoring

9. Assessment, Care in Custody and Teamwork (ACCT) procedures are used to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk. Each prisoner is assessed within 24 hours of the ACCT being opened, and then reviewed at intervals decided on an individual basis.

Previous deaths in Belmarsh

10. The death of the man who is the subject of this report was the twelfth at HMP Belmarsh since I took over responsibility for investigations into deaths in prison custody in 2004. There have been a further three deaths. The circumstances of these other deaths are not comparable to those of this man.

Her Majesty's Chief Inspector of Prisons

11. The most recent inspection report published by Her Majesty's Chief Inspector of Prisons was that following a full announced inspection in October 2007. There were no issues raised in that report that are relevant here.

Independent Monitoring Board

12. Every prison in England and Wales has an Independent Monitoring Board (IMB) responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The most recent report published by the IMB at Belmarsh before the man's death does not contain any issues of relevance to this investigation.

KEY FINDINGS

13. Originally sentenced to life imprisonment in 1974, the man who died was released on licence in 1985. As noted above, he may have been diagnosed with a personality disorder in 1998 although it is not clear whether this was confirmed. He also suffered from a head injury at his place of work in 2005. His licence was revoked in January 2006 when he was reported missing and, during their inquiries, the police uncovered possible further offences.
14. The man was taken to HMP Manchester on 20 January 2006. Three days after his arrival he said that he would take his own life at the first opportunity. He was therefore placed on an open ACCT. His reception health screening noted that he had recently suffered from frostbite whilst he was a missing person, and that he claimed to have taken some 60 aspirin or paracetamol tablets before he was found. On 29 January, the man was noted to have a borderline personality disorder.
15. Having refused almost all food since 24 February, he began to eat properly again on 12 March. But he remained on an ACCT, and spent periods in the healthcare centre including some time in a gated cell so he could be under constant observation. Whilst in Manchester, he suffered an embolism (a blockage of an artery). In April he developed deep vein thrombosis in his right leg, complained of chest pains, and was coughing up blood. He was taken to hospital, where he underwent tests including blood tests, electrocardiogram (ECG – tests on the heart) and x-rays. Records dated 26 April indicate that he was suffering from upper lobar pneumonia (a form of pneumonia affecting only a specific area of the lung).
16. On 11 May, the man was found with an injury above his right eye. He said that he had been assaulted by someone, but could not remember who. No further action was taken.
17. The man was due to attend hospital for a scheduled appointment on 16 June, but refused to do so. A note in his record dated 19 June again indicates that he had been diagnosed as having a borderline personality disorder. His ACCT was closed on 4 July, and the following week he was reported to be attending work daily.
18. On being transferred to HMP Elmley on 8 September, the man refused to attend his induction process. He was reported to have made numerous threats of assault against staff following his transfer, as well as threats to probation staff who he blamed for his recall. Following further instances of food refusal, he was again placed on an ACCT on 13 September. He had been refusing food for six days, and agreed to go to the healthcare centre. On 24 September, he reportedly fell in the exercise yard, but no injuries were logged as he did not complain of any and refused to let staff examine him. The ACCT was closed on 20 November.
19. In April 2007, the man was told that his father had died.
20. On 12 June, he reportedly fell on some stairs, but declined any treatment from healthcare. On 28 June, police came to the prison to interview him in relation to a production order (to appear in court) and in the course of the interview he assaulted one of the officers. The following day another ACCT was opened, and the man had

to be forcibly removed from the segregation unit. Whilst under observation, he was seen to bang his head against the wall.

21. The man was transferred to HMP Swaleside on 3 July. He was again non-compliant when he arrived there. He refused to speak to healthcare staff, or to members of the mental health team. A security report noted a possible assault on him, with some marks visible on his forehead. The man said it had taken place at Elmley, but refused to say what had happened.

22. After once again refusing food for some days, the man was transferred to the healthcare centre on 31 July. He began to eat again on 11 August, and returned to the wing at the end of the month. His ACCT was closed on 15 September, and he was even said to be mixing with a few prisoners.

23. However, on 14 November, he refused treatment for a cut to his head. On 20 January 2008, he refused to accept a letter from his brother in connection with his father's will. By 9 April, he was once again declining meals, and refusing to interact with others. He refused to see healthcare staff on 13 April. On 16 April, a prison doctor asked if an ACCT was open on the man. On being told that one was not, and asked if it should be, the doctor replied that it was not necessary as the note in the wing observation book was a record of any concerns.

24. Records show that the following day the man was still not eating. It is not clear if he was abstaining from food completely or if he was declining some meals.

25. When found to have grazes to his head on 24 April, he said that he had fallen. He declined any treatment. He received another injury, this time to his hand, on 11 June when he was being removed from the healthcare centre. He refused to allow staff to examine or treat him.

26. During his trial for the offences that had led to his recall to prison, the man refused to attend court on some of the days. He was convicted in his absence and, on 18 June, given an indeterminate sentence of imprisonment for public protection. He was told that he would serve a minimum of two years.

27. Records show that the man was on an ACCT on 25 June, although it is not clear when this was opened. His cell sharing risk assessment was upgraded to 'high' because he had said that he would like to murder fellow prisoners, particularly gay prisoners or those serving time for sex offences.

28. Still refusing food and refusing to interact with staff, the man was transferred from Swaleside to HMP Belmarsh on 11 July 2008. He was not happy with this move, and his reception notes indicate non-compliant behaviour and that he was very withdrawn. His cell sharing risk assessment was marked 'high', with a note that he had previously attacked cellmates (it is not clear when this was). His continuous medical record showed that on reception he refused to undergo any kind of nursing assessment, and over the next few days he refused to have any interaction with healthcare staff. He continued to refuse food and was described as appearing emaciated. On 14 July, he was referred to mental health services for assessment.

The mental health team concluded that there was no evidence of mental illness at that time.

29. The man was still refusing food on 22 July when he refused to speak to a member of the nursing team. He was seen by a mental health nurse the following day. He was aware that refusing food would have an adverse effect on his health. He appeared to be rational, and said that he was refusing food to engineer a transfer out of Belmarsh. The nurse concluded that there was no evidence of mental illness.

30. On 25 July, it was recorded in the wing observation book that healthcare action was being considered, and a case conference was held that day. He refused to attend. The conference noted that the man had previously used food refusal as a tool to manipulate the circumstances he was in. The conference concluded that he would be asked daily to allow basic health monitoring observations to be carried out. He would be offered the opportunity to move to the healthcare centre, and staff would offer a blood test on a weekly basis. When told this outcome, the man said he would continue to refuse any healthcare input and refuse food. Asked if there was anything that could be offered to him, he replied that there was not.

31. Continuing to refuse food, the man also refused to allow healthcare to conduct health checks. He was seen to be sick on 1 August, but declined to see a nurse. A further case conference was held on 4 August. The man would not attend the conference, but said that – as he was now getting help with the move that he sought – he would eat. That same day, he accepted lunch and was noted to be eating over the following days.

32. By 17 August, although now eating properly, the man was still not interacting with others. On 10 September, he was warned for refusing to go to work in the Contract Workshop. He further refused to attend work on 12 September, and his records noted that he continued to be a “recluse” who was quite abrupt with staff.

33. A note in the wing observation book on 16 September showed that the man had not collected any meals for three days. On 20 September, he declined to see a nurse, and at this point he was put on an ACCT. He was moved to Houseblock Two, and on arrival told staff that he was refusing food. He remained on the ACCT for three days.

34. The man continued to decline meals. He appeared to be suffering from abdominal pain on 22 September but refused quite vehemently to see anyone from healthcare. Documentation suggests that he did not eat from 23 – 26 September. He then briefly accepted food, but recommenced refusing meals on 29 September.

35. On the morning of 2 October, Officer A was on duty on Houseblock Two. On unlocking the man’s cell, knowing that he had been refusing food, Officer A asked him if he wanted breakfast. He said that he did not. Officer A then asked if he wanted exercise or to spend some time out of his cell. The man said that he did not and, as was his habit, asked Officer A to relock his cell door. Officer A did so. The next contact Officer A had with the man was when he returned to unlock the cell at lunchtime. Once again, the man declined his meal and was locked back into his cell without having left it.

36. Officer B was on duty on Houseblock Four. In the evening, due to a shortage of staff, he was asked to undertake some duties on Houseblock Two. He made his way there at approximately 6.45pm. He told my investigator that he did not know the man and had had no previous dealings with him. On arrival on Houseblock Two, Officer B unlocked the cells on the man's landing to allow prisoners to collect their evening meals. In interview, Officer B said that when he unlocked a cell door he would shoot the bolt so that prisoners could not shut themselves back in unaided. If a prisoner wanted to be locked back into their cell they would need to ask. Officer B told my investigator that, if a prisoner asked him to lock them back into their cell he would do so, having ensured that this was what the prisoner really wanted. On this occasion, however, no prisoners asked to remain locked in their cell.

37. At approximately 7.55pm, Officer B began to relock the cells on the man's landing. In interview, Officer B said that when locking prisoners back into their cells, he always made a point of getting a response from them. Even if it was only a minor movement, he would not lock a cell door without an indication that a prisoner was okay. Although he did not know the man, and therefore did not specifically remember him, Officer B was adamant that – even if the man had appeared to be asleep – he would have got a response from him before he locked the cell door. He said that, had the man been unconscious, he would have noticed.

38. Officer C began her night shift on Houseblock Two at 8.00pm. She made a patrol of the cells, and reached the man's cell at approximately 8.17pm. She would usually speak to him through his cell door, and he would normally respond with a wave of his hand. On this occasion, however, he made no response. Officer C switched on the nightlight in the cell, and could see that the man had injuries to his face.

39. Officer C spoke to the man, but he was unconscious. He was lying on the bed with his head and shoulder on the headboard, his head leaning on his right shoulder. Officer C said that she saw a cut on the bridge of the man's nose, a lump on the side of his face, and blood on the side of his face. Officer C thought that the injuries did not appear consistent with those of someone who had fainted and fallen. She said there was no evidence of blood around the cell, which she would have expected if he had done so. She called her colleague, Officer D, and said that she thought they should go into the cell.

40. When the prison has been locked in the evening, it is in night state. Staffing levels are at a minimum, and staff must be fully aware of maintaining security. Officer D called to the man and kicked the cell door, but did not get a response. In contrast to Officer C, he could not see any injuries, and had no concern that he might have been assaulted. With the prison in night state, he was not content to open the cell door without further staff present, and so Officer C called over the radio for assistance.

41. Officer E was on his initial training, and saw Officer C look into the man's cell through the observation panel. She called for medical assistance and, unable to get a response from the man, asked other staff to look. Officer E saw the man on his bed, with his television set on the ground. Officer E remembers seeing a "big cut to

the back of his head on the hairline". At this point, other members of staff arrived, and Officer E stepped away from the cell.

42. Senior Officer (SO) F and SO G both heard the call over the radio and went immediately to the man's cell. Officer C told them that she could not get a response from the man, and the two Senior Officers went into the cell. In his statement, SO F said that the man was lying on his right hand side on the bed. They were unable to get a verbal response from him, so laid him onto his back and checked for signs of life. He was breathing, and moaned slightly when SO F shook him. SO F said that he noticed a cut across his nose and some dry blood on his pillow and around his mouth. He checked his head for injuries but could not find any. SO G said that the injuries he noticed were a graze on his right cheek and a small line of blood on his forehead. They then turned the man onto his right side to aid his breathing.

43. Nurse H was carrying one of the medical emergency response radios that day. She was just finishing her shift and was in the healthcare centre when she heard the emergency medical call over her radio. The call said that assistance was required on Houseblock Two. Nurse H went immediately to the Houseblock. When a medical emergency is called over the radio network, all available medical staff are required to attend. Nurse I and Nurse J were also in the healthcare centre when the emergency call came through, and they went with Nurse H to Houseblock Two.

44. When Nurse H arrived at the man's cell, the door was already open. He was lying on his bed, unconscious and unresponsive. She said that she noticed blood on the right side of his temple and in his beard, although it was not fresh and it had congealed in his beard. Nurse I recalled seeing some, though not much, blood on the man's face, but the nurses could find no wound or injury that was bleeding. Nothing in the cell had been disturbed, nor was there any blood elsewhere in the cell.

45. The nurses carried out vital observations on the man, which included checks on his blood pressure, pulse, breathing, oxygen saturation levels (the level of oxygen in the blood), oxygen intake, and blood sugar levels. The results were all in the normal range. Even so, the nurses made a joint decision that he ought to go to hospital, and an emergency ambulance was requested. The prison's incident log shows that the ambulance was called at 8.39pm. Nurse H asked that the duty doctor, Dr Peter K, should attend while the ambulance was on its way. This request was made at 8.23pm.

46. Dr K was working in the First Night Centre with newly arrived prisoners. As such he was not part of the medical team to respond to the emergency call, but remembers that an officer asked him to go to Houseblock Two to see a prisoner. The officer did not have any further information at the time, so Dr K went straight to the Houseblock. On arrival he saw a group of people gathered around the man's cell, and he went in. The nurses briefed him on what they had found. The man was lying on his bed and had been placed in the recovery position (a stable position to ensure that an unconscious person's airways will remain clear). Dr K checked the results of the man's vital observations and then personally assessed him. Although he was breathing normally and the pupils of his eyes reacted to light, he was unresponsive. Dr K noted a red mark on his forehead, and wondered if this might

have been an indication of the cause of his unconsciousness. Dr K did not notice any blood, or any wound or injury that was bleeding. Although the cell was busy with people, he did not notice any signs of a disturbance having taken place. He agreed with the nurses that the man should be taken to hospital. As his condition was stable, nursing staff were in attendance, and the ambulance was already on its way, Dr K returned to his duties.

47. Governor L was on duty that evening. When the emergency call was made he was in the First Night Centre. With him at the time was the Night Orderly Officer (NOO – in charge of the operational running prison when it is in night state), Principal Officer (PO) M. Governor L and PO M made their way to Houseblock Two. On arriving at the man's cell, Governor L noted that the cell was in good order, with no sign of a struggle. He was aware of the man's ongoing habit of refusing food, and knew that his physical condition had deteriorated as he did so. He noticed that he had a small cut above his eye and a small amount of dried blood around it.

48. The ambulance arrived at 8.49pm. The paramedics were escorted through the prison to Houseblock Two and taken to the man's cell. After the paramedics had conducted their own assessments, the ambulance left the prison to take him to hospital at 9.43pm. He was accompanied by two prison officers, and handcuffed to one of the officers via an escort chain.

49. The following day, Officer N was supervising prisoners in the exercise yard. As he was counting the prisoners, he heard two of them talking. They had their backs to him and he was not able to identify them. He heard one of them say: "I see that nonce on spur two got it last night." A security report was raised in light of this, but the prisoners were unidentified and there was no further action that could be taken at that stage.

50. When a prisoner is transferred to outside hospital, the level of security required is reviewed daily, and after being admitted to hospital the man remained on an escort chain. It is also standard practice for healthcare staff at Belmarsh to remain in daily contact with the hospital, this being the responsibility of Nurse O. Nurse H said in interview that she regularly asked Nurse O about the man's condition while he was in hospital, but for the most part was told that he was unresponsive.

51. The man was in the Queen Elizabeth Hospital in Woolwich. Initially on a ward, he had to be moved to a High Dependency Unit on 6 October. At this stage his security requirements were amended so that no restraints were applied while he was unconscious. His condition was not good, and he was largely in an unresponsive state. Even so, on occasions when he became conscious, the man would pull at his ventilation and food tubes, and he chewed at his oxygen tube. It was suspected that he might have had a stroke, but medical staff were unable to confirm this was the case at the time.

52. The man had not been in regular contact with any of his family whilst in prison. But on 9 October hospital staff recommended that his next of kin should be informed of his condition. His brother was contacted, and he subsequently visited him in hospital.

53. Following the daily security review, a closeting chain was put on the man who died on 12 October. (A closeting chain is a set of handcuffs between the prisoner and a prison officer, but with a longer chain to allow a little more freedom of movement.) The next day, security was reviewed again and the chain removed. The man was not subjected to any restraint after this.

54. The man's condition deteriorated, and on 29 October 2008 treatment was discontinued. The following day he was put on the Liverpool Care Pathway (a programme for the care of a dying patient) and attached to a morphine pump to help control his pain. He died on 2 November. His brother was at the hospital at the time.

55. The prison arranged and made a financial contribution towards his funeral. His brother later wrote to the Governor thanking him for the kindness and support of the prison staff.

Internal Prison Service investigation

56. Governor P commissioned an internal investigation into the circumstances of the man being found unconscious. The investigation was carried out by Principal Officer Q.

57. The investigation concluded that it was unlikely that the man had been the victim of an assault on 2 October. The most probable explanation was that he had suffered some problem with his health stemming from his continual refusal to eat. No member of staff had noted any problems with him beyond his refusal to eat or to engage. None of the staff on his wing had noticed any incident nor anything untoward happening that evening.

Post Mortem

58. The post mortem gave the cause of death as

- 1a. Bilateral pneumonia
- 1b. Acute on chronic cerebral ischaemia

59. In essence, the man contracted pneumonia in both lungs as a result of suffering a stroke.

ISSUES

Clinical care

60. The man who died refused to have contact with the healthcare team in Belmarsh. Despite this, medical care was available and was offered to him on a frequent basis. The clinical reviewer notes that the man was reviewed on a number of occasions by the mental health team, and at no stage was there any evidence of mental illness. She shares my view that ACCT was used appropriately.

61. The clinical review team note that his medical record contained many instances of illegible handwriting and signatures. Being able to understand medical records is no trivial matter, and the Head of Healthcare at Belmarsh will wish to consider this, particularly in view of the clinical reviewer's positive comments about the printed records from Swaleside. The clinical reviewer does point out that the case conference of 25 July was well documented, and demonstrates good communication and multidisciplinary working. The clinical review recommends that a computerised record-keeping system is introduced into Belmarsh, and I draw this to the attention of the Head of Healthcare. The clinical reviewer also recommends that prisoners who require frequent contact from healthcare should be assigned a specific member of nursing staff to improve continuity of care.

67. The clinical reviewer has found that the man's care was equivalent to that which he would have received in the community.

68. I am pleased to see that the prison reviewed the security requirements on a daily basis while the man was in hospital.

Events of the evening of 2 October

69. I have uncovered no additional evidence to show what happened to the man who died on 2 October to leave him in the state in which Officer C found him. Officer C herself initially formed the opinion that he might have been assaulted, although this was primarily because there were no signs of disturbance in the cell to suggest he had fallen. But equally, there were no signs of a struggle. SO F said that he thought it likely that the man had fallen because of his weak state as a result of not eating. Governor L said that there was no suspicion at the time that the man had been assaulted or that there was any cause other than a health issue stemming from his refusal to eat.

70. Staff who attended the cell on 2 October give varying descriptions of the injuries to the man's face and head. A common theme, however, is that the amount of blood was small and the injuries were minor. This may account for witnesses not remembering them exactly when asked to provide accounts some time later. The only member of staff who thought that the man might have been assaulted formed that opinion when she looked through the cell observation panel, not from a close-up examination.

71. As I have reported, on 3 October Officer N overheard prisoners in the exercise yard saying: "I see that nonce on spur two got it last night." He was unable to

identify them so they could not be questioned further. In any event, the prisoners' words do not necessarily imply that the man had been assaulted: they could simply mean that he had fallen ill or met with an accident. The police considered this statement in their enquiries, and found no evidence to back up any suggestion that he had been attacked.

72. The clinical reviewer notes the concerns that the man had received an injury to his head prior to collapsing in his cell. She points out that the pathologist found no evidence of this in conducting the post mortem.

73. Apart from Officer C, no prison staff who attended the cell on 2 October thought that the man had been assaulted. The prison's internal investigation concluded that it was unlikely that he had been the victim of an attack. The police also conducted a full investigation into what had happened and found no evidence to suggest that an assault had taken place. In these circumstances, it seems unlikely that his injuries were inflicted upon him by other prisoners.

74. Because he was in hospital for some weeks, no debriefing session was held after he died. He did not mix with other prisoners so there were no particular friends who needed to have the news of his death broken to them individually. But a consequence of this was that staff were unable to air any issues they might have wanted to, nor were they offered any support. All those staff my investigator spoke to said that they knew where to find support if they felt they needed it, and I do understand why a debrief may have been overlooked. All the same, I bring this to the attention of the Governor and recommend that he considers systems to ensure that – even if there is a time lapse – staff who are involved in an emergency response should be given the opportunity to discuss any issues arising and to be offered support.

The Governor should consider systems to ensure that staff involved in an emergency response have the opportunity to discuss any issues and to be offered support.

CONCLUSION

75. The man who died was an elderly man who had spent over two and a half years in prison since being recalled. He would not participate in prison life and, although he chose to remain on normal location, refused to interact with either prisoners or staff.

76. On several occasions, including the period up to when he was found unconscious in his cell, the man refused to take food. He said that he was not on hunger strike, but was not complying with the system. He appeared to use food-refusal instrumentally: as a way of retaining some control over his life, and to influence the decisions of prison staff.

77. Although the man refused contact with the healthcare team at Belmarsh, they nonetheless continued to try to engage with him and to offer him medical care. His mental health was also regularly considered and assessed.

78. On 2 October 2008, the man had not eaten and had not left his cell all day. When night staff came on duty, they found him unconscious in his cell. Medical staff quickly attended and, although he was stable, they quite rightly arranged for him to be transferred to hospital.

79. I conclude that it is unlikely that the man was assaulted prior to his being found unconscious. This view is supported by the prison's internal investigation, the police investigation, and the post mortem examination.

80. It is evident that the man was a difficult prisoner to manage. I judge that, in the circumstances, Belmarsh (and, in particular, its healthcare department) did the best that they could. His continual food refusal would undoubtedly have had an effect on his health, although it is uncertain what part this may have played in his eventual death.

RECOMMENDATIONS

The Governor should consider systems to ensure that staff involved in an emergency response have the opportunity to discuss any issues and to be offered support.

The Prison Service has accepted this recommendation with the comment "A new post-incident care policy has been developed and will be introduced and published in February 2010. This makes it clear when debriefs and support must be considered".