Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Walsh, a prisoner at HMP Belmarsh, on 19 July 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Richard Walsh hanged himself in his cell at HMP Belmarsh on 19 July 2015. He was 43 years old. I offer my condolences to Mr Walsh's family and friends.

Mr Walsh had a number of risk factors for suicide but prison staff did not identify or consider this risk when he first arrived in prison at HMP High Down at the end of June 2015 or when he transferred to Belmarsh a few days later. Although Mr Walsh was not being monitored as at risk of suicide at the time of his death, he should have been checked four times through the night as a security measure. However, the night officer did not check Mr Walsh the night before he died and falsified records to show he had.

I am concerned that during his time at Belmarsh, Mr Walsh was subject to a very restricted and inadequately regulated regime, inappropriately called the 'duty of care' regime. This regime did not comply with Prison Rules and meant he was unlocked from his cell for just half an hour each day. Mr Walsh never had the opportunity to spend any time in the open air, which is a legal entitlement, or mix with any other prisoners. Effectively he was held in solitary confinement without the safeguards that would have applied had he been serving a punishment of cellular confinement in the prison's segregation unit. Staff appear to have had no meaningful engagement with Mr Walsh, other than to respond punitively when, his behaviour started to deteriorate. The night before he hanged himself, they removed his cell television, which further restricted his very limited facilities. I have previously been critical of restricted regimes at Belmarsh and repeat many of the same concerns in this investigation report.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Summary

Events

1. On 26 June 2015, Mr Richard Walsh was charged with the attempted murder of two boys. The police noted he had a history of depression, self-harm and had been treated as an inpatient in a psychiatric hospital. The police considered he was at high risk of suicide and he was constantly supervised.

2. On 29 June, Mr Walsh was remanded to HMP High Down. Mr Walsh had a number of risk factors for suicide and self-harm, including a history of self-harm and depression, being charged with a high profile violent offence against two boys, homelessness and having no support from family or friends. However, no one assessed Mr Walsh as at risk and staff did not monitor him under Prison Service suicide and self-harm prevention procedures, known as ACCT. As a potential high security prisoner, Mr Walsh was held in the prison's segregation unit.

3. On 2 July, Mr Walsh was moved to HMP Belmarsh, a high security prison. He told staff he was worried about his safety and asked to go to the vulnerable prisoners unit. As Belmarsh allows only prisoners charged with or convicted of a sexual offence in its vulnerable prisoners unit, Mr Walsh was put on a 'duty of care regime' on a standard prison wing. This meant he was kept separate from other prisoners on the wing and was locked in his cell for over 23 hours a day with no meaningful contact with officers or other prisoners.

4. On 13 July, Mr Walsh was warned about his behaviour as he was reported to have been abusive to an officer he had asked about his medication. He was subsequently reported to be abusive to officers about his food and, in the evening of 18 July, the day before he died, a supervising officer placed Mr Walsh on the basic regime of the Incentives and Earned Privileges Scheme, which meant his television was removed. Mr Walsh was a potential category A prisoner and a night patrol officer should have checked him four times during the night of 18/19 July. This did not happen.

5. At 10.43am on Sunday 19 July, an officer found Mr Walsh hanged in his cell. Although it was clear that Mr Walsh had been dead for some time, nurses attempted to resuscitate him. Very shortly after they arrived, paramedics recorded that Mr Walsh had died.

Findings

6. We are concerned that reception staff at both High Down and Belmarsh did not identify that Mr Walsh might be at risk of suicide despite his risk factors. It does not appear that the staff were aware of factors known to increase prisoners' risk of suicide and they placed too much reliance on Mr Walsh's assurance that he did not intend to kill himself, rather than his evident risks.

7. The investigation found that the 'duty of care' regime at Belmarsh was oppressive and restrictive. It did not offer Mr Walsh the statutory basic minimum time in the open air and isolated him without any safeguards to prevent his mental health deteriorating. Mr Walsh had little meaningful contact with staff or other prisoners and nothing constructive to occupy his time. No member of healthcare staff

checked him, as would have happened had he been formally segregated. We have previously identified similar concerns in the investigation into a death at Belmarsh in November 2014, when the prisoner was being held separately on another wing, waiting for a space to become available in the vulnerable prisoners unit.

8. While Mr Walsh had not been identified as at risk of suicide and self-harm, the failure of the night patrol officer to carry out security checks as required is a concern. We do not know what time Mr Walsh hanged himself, but this means a potential opportunity to intervene was missed. Although it would not have altered the outcome for Mr Walsh, staff did not use a medical emergency code when they found him hanged and there was a delay in calling an ambulance. As it was apparent that Mr Walsh had been dead for some time, it was unnecessary and inappropriate for healthcare staff to attempt resuscitation.

Recommendations

- The Governors of High Down and Belmarsh should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm. These should ensure that reception, first night and induction staff have a clear understanding of their responsibilities to share and refer to all available information and to take into account and record all known risk factors when determining a prisoner's risk of suicide or self-harm.

- The Governor of Belmarsh should ensure that all prisoners who need to be kept apart from other prisoners for their own protection have a full prison regime, equivalent to other prisoners.

- The Governor of Belmarsh should ensure that prisoners subject to a restricted regime, tantamount to segregation, are formally segregated under Prison Rule 45 and are managed under the provisions and safeguards of PSO 1700, wherever they are held in the prison.

- The Governor should ensure that prison staff use the appropriate emergency code whenever there are serious concerns about the health of a prisoner and that the communications room calls an ambulance immediately when there is a medical emergency.

- The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances when resuscitation is not appropriate.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. Another investigator visited Belmarsh on 22 July 2015 and obtained copies of relevant extracts from Mr Walsh's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Walsh's clinical care at the prison

12. The investigator interviewed four members of staff at High Down and eleven members of staff at Belmarsh between August and October 2015. The clinical reviewer and investigator interviewed some staff together.

13. We informed HM Coroner for HM Coroner Inner South London District of the investigation. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Walsh's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The investigator and family liaison officer met Mr Walsh's mother and her solicitor. His mother asked why her son had not been identified and monitored as at risk of suicide at the time of his death. She asked whether he should have been more closely checked because of the medication he was taking and whether it had been appropriate for staff to attempt to resuscitate him.

15. Mr Walsh's family received a copy of the interim report. The solicitor representing Mr Walsh's mother wrote to us raising a number of questions that do not impact upon the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HM Prison Belmarsh

16. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds over 900 men. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and an inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Belmarsh was in February 2015. Inspectors found that officers in the first night centre interacted well with prisoners during comprehensive first night interviews.

18. Inspectors also reported that prisoners on the 'duty of care' regime were kept in what amounted to solitary confinement and had an extremely impoverished regime. There was insufficient governance of the regime and inspectors recommended improvements to the regime and that prisoners subject to the regime should have regular, documented reviews.

19. Inspectors considered that healthcare services were satisfactory and health screening of newly arrived prisoners was thorough. GPs provided good care. A small, integrated team provided mental health services, but there was insufficient psychological support for those with primary mental health needs.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report, the IMB at Belmarsh reported that the number of self-harm incidents had decreased and fewer prisoners than previously were assessed as at risk of suicide and self-harm. The IMB was concerned about the lack of confidentiality for reception interviews.

Previous deaths at HMP Belmarsh

21. Mr Walsh's death was the fourth self-inflicted death at Belmarsh since 2012. There have also been five natural cause deaths in that time. In previous investigation reports, we were concerned that staff attempted resuscitation inappropriately and about delays in calling an ambulance in an emergency. We repeat these concerns in this report.

22. We have previously identified concerns about the restricted regimes for prisoners who were not formally segregated in investigation reports into deaths at Belmarsh in November 2013 and January 2014.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

26. Mr Richard Walsh had served several short prison sentences for theft, affray and drink driving since 1991. In March 2015, Mr Walsh's GP prescribed him mirtazapine for depression. Mr Walsh said he was homeless and that his family did not want anything to do with him.

27. On 26 June, police charged Mr Walsh with the attempted murder, robbery and assault of two young boys. While he was in police custody, a doctor concluded that Mr Walsh was at high risk of suicide and recommended that the police should watch him constantly. He remained constantly supervised until he left police custody three days later.

HMP High Down

28. On 29 June, Mr Walsh was remanded to HMP High Down until a further court appearance on 20 July. The person escort record (PER), which went with Mr Walsh from the police station to court then to High Down, noted that he had attempted to hang himself in prison in 2010, was facing two attempted murder charges and was liable to "flare up" if angry. The escort record noted that Mr Walsh had depression, was addicted to drugs and alcohol, and that he had refused to cooperate with a mental health assessment in police custody.

29. An officer interviewed Mr Walsh in reception at High Down and recorded that it was his first time in prison, that he was not worried about the possible length of his sentence and said he had no thoughts of suicide or self-harm. He told the officer he had tried to hang himself in 2010. The officer told the investigator that he had had a long conversation with Mr Walsh, who appeared happy to be in prison. The officer did not assess Mr Walsh as at risk of suicide or self-harm, but told Mr Walsh to speak to a Listener if he had any concerns. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.) Mr Walsh did not give any next of kin details. The officer said he could not recall seeing Mr Walsh's records from police custody, but he noted that he had checked Mr Walsh's PER, warrants, previous convictions, and prison records and that he did not arrive with a suicide and self-harm warning form.

30. At an initial health screen, Mr Walsh told a healthcare assistant that he had previously received psychiatric treatment and recently seen his GP for depression. Mr Walsh told her he was taking medication, but could not remember what it was. She noted Mr Walsh's recent use of drugs and excessive alcohol use. She recorded that Mr Walsh had taken an overdose four years previously and had tried to hang himself in 2010. She noted that Mr Walsh appeared fit, denied any thoughts of suicide or self-harm and referred Mr Walsh to the prison GP to discuss his substance misuse. She told the investigator that she knew what Mr Walsh had been charged with, but she did not assess that he was at risk of suicide or self-harm because of how seemed during the health screen. She said she had been given Mr Walsh's records, but did not remember reading them.

31. A prison GP reviewed Mr Walsh in reception. The GP noted that he was a heavy drinker, but as he was not experiencing any alcohol withdrawal symptoms, he did not need any medication.

32. The reception supervising officer identified that, because of his charges, Mr Walsh was potentially security category A (the highest security categorisation). In line with standard Prison Service procedures, he was held in the segregation unit. A nurse completed an initial segregation health screen. Mr Walsh said he had no thoughts of suicide or self-harm. The nurse considered there was no clinical reason why Mr Walsh should not be segregated. Officers checked Mr Walsh hourly when he was in the segregation unit.

33. On 30 June, Mr Walsh's community GP records arrived. His GP had recorded that Mr Walsh was homeless, had a history of depression and had taken an overdose of paracetamol in early 2015. The GP confirmed Mr Walsh was prescribed mirtazapine. A prison GP continued Mr Walsh's prescription of mirtazapine for one month.

34. Mr Walsh remained in the segregation unit at High Down for the next two days. The prison's duty governor, chaplain, IMB members, doctors, and nurses visited him during this time, to check his welfare, as required for a segregated prisoner.

HMP Belmarsh

35. On 2 July, as Mr Walsh had been identified as a potential category A prisoner, he was moved to Belmarsh, a high security prison. Mr Walsh told an officer, who interviewed him when he arrived, that he had no family or friends and would have no support in prison. The officer explained to Mr Walsh how he could speak to Listeners and use a special telephone to the Samaritans. He gave him an information booklet about the prison and a smoker's pack (an advance supply of tobacco, the cost of which is deducted from future prison pay).

36. Mr Walsh told the officer that he had harmed himself in the past, but he had no thoughts of suicide or self-harm at the time. The officer told the investigator that he knew that Mr Walsh's alleged offences were against children and had attracted a lot of publicity. He said he did not assess Mr Walsh as at risk of suicide or self-harm because he was open about his previous self-harm and seemed concerned about his future safety. He said that he did not take into consideration any other risk factors when considering Mr Walsh's level of risk.

37. The office said Mr Walsh thought he was at risk from other prisoners because of the nature of his alleged offences and the related media coverage, so he asked to go to the vulnerable prisoner unit. As he had no history of sexual offending, Mr Walsh did not meet Belmarsh's criteria for the vulnerable prisoner unit. The officer said he checked with the duty governor whether Mr Walsh could be located in the vulnerable prisoner unit, as an exception to the usual criteria, because of the publicity, but the duty governor refused. He said he explained to Mr Walsh that he could apply for the prison's 'duty of care' regime and told him that this would mean he could only expect half an hour out of his cell every day and he would not mix with other prisoners. Mr Walsh agreed to this and the duty governor approved.

38. At an initial health screen, a nurse noted that Mr Walsh had been homeless, had a mental health problem and had taken an overdose five years earlier. The nurse did not record that he had taken an overdose earlier in 2015 or had previously tried to hang himself. Mr Walsh said that he was in a good mood, appeared calm and said he had no thoughts of suicide or self-harm. The nurse referred Mr Walsh to the

prison's substance misuse team, the prison GP and the prison's mental health team. The mental health team agreed to discuss him at their next meeting. The nurse said he reviewed Mr Walsh's medical notes from High Down, but did not look at the community medical records, which had been uploaded to his medical record. He said that he did not know anything about Mr Walsh's alleged offences or that he was going to be on a restricted regime.

39. A prison GP reviewed Mr Walsh, who repeated that he had no thoughts of suicide or self-harm. The GP noted his history of depression and that he had overdosed four years before. He continued his prescription for mirtazapine. (Like the nurse, he did not see that Mr Walsh had overdosed earlier in 2015 or that he had previously tried to hang himself.) He did not know what Mr Walsh was charged with and said there was no indication that Mr Walsh was at risk of suicide or self-harm, so he did not open an ACCT. He told the investigator that officers and nurses would have picked up any concerns.

40. On the morning of 3 July an officer spoke to Mr Walsh for about 25 minutes to explain prison procedures and the duty of care regime. Mr Walsh said he had no thoughts of suicide or self-harm and had no family. He signed a number of prison compacts, asked about how to get further tobacco, and had a shower. The officer told the investigator that Mr Walsh was anxious about the restricted regime and they talked about his concerns that other prisoners might learn what he was charged with. The officer said he did not consider that Mr Walsh was at risk of suicide or self-harm so did not open an ACCT. He said that Mr Walsh was apprehensive about being in prison, but happy and calm.

41. An officer recorded that on the evening of 6 July, Mr Walsh had sworn at him been verbally abusive because he had not received his medication. The officer told Mr Walsh that he would check with the nurse, but his abusive language was unacceptable. (The officer said he believed he had spoken to the nurse who later gave Mr Walsh his medication but could not recall.)

42. On 7 July, the mental health team discussed Mr Walsh at their team meeting. (Belmarsh has one mental health team that integrates both primary and secondary care.) The team decided that Mr Walsh should be managed by the prison GP and there was no need for specialist mental health intervention.

43. Throughout his time at Belmarsh, Mr Walsh remained in a cell in the prison's induction and first night centre, on the restricted 'duty of care' regime. The investigator was unable to identify any officer who had any meaningful contact with Mr Walsh while he was at Belmarsh. An officer said that Mr Walsh was the only prisoner on the duty of care regime at the time, so he would not have mixed with any other prisoner. He said that such prisoners would be unlocked for half an hour each day, but there was no set time, as this would depend on when other prisoners were unlocked and officers had the time. The officer said he could not recall any prisoner on the duty of care regime ever going out to spend some time in the outside air in the exercise yard.

44. On 13 July, a custodial manager gave Mr Walsh a first stage IEP basic warning for his behaviour towards an officer. The manager said he did not put Mr Walsh on the basic regime, as he would usually do, as he was already on such a restricted regime and he left him with his television. He said Mr Walsh did not raise any

issues or concerns, but he did not really engage with him. He said that Mr Walsh's cell was not particularly clean and his personal hygiene was not good. He confirmed that prisoners on the duty of care regime do not have any time in the open air, and are unlocked for half an hour each day for domestic tasks such as showering, cleaning their cells, and making phone calls. Later that day, an officer noted that Mr Walsh had sat on the wing for half an hour when his cell was unlocked and did not ask to have a shower until he was due to return to his cell. Mr Walsh does not appear to have been allowed a shower that day.

45. On 16 July, an officer noted that Mr Walsh had 'demanded' more bread with his meal, and described him as having a poor attitude. When Mr Walsh went back to his cell, he started banging on his door. Officers warned him that his behaviour was unacceptable.

46. At lunchtime on 18 July, Mr Walsh complained about the size of his meal and a custodial manager told him all the portions were the same size. Mr Walsh started shouting at staff. The manager and a Supervising Officer (SO) tried to speak to Mr Walsh, but he swore at them and said he did not care. The SO went to Mr Walsh's cell and told him that because of his negative behaviour his IEP level would be reduced to the basic regime. When the SO tried to explain what this would entail, including removing his television, Mr Walsh told him to fuck off. The SO said that he would have asked one of the officers to take Mr Walsh's television away that night.

47. Around 7.00pm, Mr Walsh shouted abuse at an officer from his cell, when she was talking to prisoners in the cell opposite. At around 7.20pm, an officer unlocked Mr Walsh and he went to collect his medication from a nurse at the treatment hatch. Neither the officer nor the nurse noticed anything wrong with Mr Walsh. At 7.31pm, an officer noted Mr Walsh's abuse towards another officer in his prison record and that this appeared to come out of nowhere. The officer recorded that Mr Walsh appeared to be becoming more and more abusive towards staff, male and female, and directed towards no one specific.

48. According to the night patrol report, an operational support grade (OSG) checked all prisoners were in their cells at 7.45pm. As Mr Walsh was a potential category A prisoner, the OSG was expected to check Mr Walsh four times during the night of the 18/19 July. He recorded in the night observations log that he had checked Mr Walsh at 10.38pm, 1.28am, 4.23am, and 5.37am. However, CCTV shows that he did not check Mr Walsh at these times or at any other time that night.

Sunday 19 July 2015

49. At 10.43am on Sunday 19 July, an officer went to unlock Mr Walsh's cell while the other prisoners were outside in the exercise yard or locked in their cells. The officer found that Mr Walsh had hanged himself from a sheet tied to the ceiling light fitting. He shouted to nearby officers and they went into the cell. Someone radioed that there was a medical emergency, although the investigation has been unable to establish who that was.

50. A SO supported Mr Walsh's weight and an officer cut the sheet from around Mr Walsh's neck. The officers described Mr Walsh as very stiff and cold to the touch. The SO said that it was apparent that rigor mortis had set in and he believed that

Mr Walsh was dead. He said that as they laid Mr Walsh on the floor, the healthcare staff were outside the cell so he moved aside to let them take over.

51. At 10.44am, a nurse confirmed over the radio that he would attend with emergency equipment, as he was already on the unit. The nurse said that Mr Walsh was cold, stiff and showed no signs of life but he started cardiopulmonary resuscitation, assisted by another nurse and other healthcare colleagues who arrived a short time later.

52. At 10.46am, the Head of Safer Custody asked the control room to call an ambulance. Nurses continued to try to revive Mr Walsh until paramedics arrived at 11.01am. The paramedics assessed Mr Walsh and at 11.05am, recorded that he had died.

53. Mr Walsh did not leave a note, but had left a homemade calendar in his cell. He had not crossed off Saturday 18 July and had written, "Life x 2" on the calendar with a drawing, which resembled the light fitting where he had tied the sheet.

Contact with Mr Walsh's family.

54. Mr Walsh had not given the prison details of his next of kin or anyone he wanted the prison to contact in an emergency, so the Head of Safer Custody contacted Hampshire police and asked their help. The police located Mr Walsh's mother and the Head of Safer Custody agreed with the police that the police should inform her of his death. This was because the distance from the prison and the likely media coverage, which made it important that she should be informed as soon as possible. The police told Mr Walsh's mother about her son's death at 2.45pm and the prison contacted her later that day to offer condolences and support. The prison offered to contribute to Mr Walsh's funeral expenses in line with national instructions.

Support for prisoners and staff

55. Managers debriefed the prison staff involved in the emergency response and offered support. The prison notified other prisoners of Mr Walsh's death and offered support. Officers reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Mr Walsh's death.

Post-mortem report

56. We had not received the post-mortem report at the time this initial report was issued. A toxicology report showed that Mr Walsh had no alcohol or drugs in his blood at the time he died.

Findings

Assessment of risk

57. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 07/2015 (Early Days In Custody), both list a number of risk factors and potential triggers for self-harm and suicide. These include early days in custody, previous self-harm, first time in custody, being charged with a violent offence, substance misuse, relationship instability, lack of social support, prison transfers, court appearances and a history of mental health problems.

58. Mr Walsh had been charged with the attempted murder, robbery and assault of two boys. His case was very high profile and had received significant media coverage. He was a potential category A prisoner, homeless, had no support from family or friends, and reported a history of depression. He had tried to hang himself in 2010, and his community GP report, received by High Down the day after he arrived, indicated that he had taken an overdose of paracetamol earlier in 2015.

59. It is evident that Mr Walsh had a number of risk factors when he arrived in prison which were significant indicators of a heightened risk of suicide, yet there is no evidence that reception, healthcare, or other staff at High Down or Belmarsh identified these risk factors or took them into account when assessing his risk. PSI 07/2015 has a mandatory action that all available, relevant information must be considered when assessing risk. It is concerning that some of the staff responsible for assessing risk of suicide did not have access to all the available information about Mr Walsh and, when they did, they did not consult it. PSI 07/2015 requires Governors to ensure that all staff employed on reception, first night, and induction duties carry out the mandatory actions of the PSI and are familiar with the relevant parts of the specifications and the instruction. Not all the staff were aware of the risk factors for suicide listed in the instruction.

60. PSI 07/2015 requires reception staff to examine the Person Escort Record (PER) form that must accompany each new prisoner, and other relevant and available documentation. This is to identify any immediate needs and risks already recorded' in order to identify the potential harm a prisoner may pose to themselves. An officer could not recall having access to the PER and both she and a colleague said they did not see the police custody records. There is no evidence that staff used this information when assessing Mr Walsh's risk of suicide and self-harm and we are concerned that this information was not used effectively to help assess his risk.

61. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we identified that, too often, assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. The members of staff we interviewed at High Down and Belmarsh, who spoke to Mr Walsh during the reception and induction process, said that they were not concerned about his presentation and accepted what he said when he told them that he had no thoughts of suicide or self-harm. No member or staff considered Mr Walsh's risk factors or thought it necessary to open an ACCT.

62. Staff judgement is fundamental in the operation of ACCT procedures. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. It is not an exact science, but we are concerned that the staff relied so heavily on Mr Walsh's presentation, rather than his known risk factors, not least because they did not know him. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered only as a single piece of evidence when making a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

63. We consider that staff should have begun ACCT suicide and self-harm monitoring procedures when Mr Walsh first arrived at High Down and that staff should have considered his risk factors more thoroughly when he arrived at Belmarsh.

64. We have raised similar concerns at Belmarsh before about staff placing too much reliance on a prisoner's presentation rather that on their range of risk factors. This investigation reinforces the need for both High Down and Belmarsh to improve its risk assessment procedures for new arrivals. We make the following recommendation:

    The Governors of High Down and Belmarsh should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm. These should ensure that reception, first night and induction staff have a clear understanding of their responsibilities to share and refer to all available information and to take into account and record all known risk factors when determining a prisoner's risk of suicide or self-harm.

'Duty of Care' Regime

65. Mr Walsh was concerned for his safety when he arrived at Belmarsh and wanted to be protected from threats and attacks from other prisoners. Because of the charges he was facing and the publicity surrounding them, we consider that this was a reasonable concern and the prison had a duty to protect him. However, managers at Belmarsh had decided that only prisoners charged or convicted of sexual offences could be admitted to the prison's vulnerable prisoner unit. This was apparently in response to concerns flagged by this office about the deaths of other prisoners in vulnerable prisoner units in other high security prisons, who had been killed by prisoners not convicted of sexual offences.

66. While we fully recognise that there is a need to manage this risk very carefully we do not consider that this blanket approach of excluding all other prisoners is a reasonable response to this serious problem. There is no evidence that Mr Walsh was likely to have been any risk to other prisoners in the vulnerable prisoner unit, but he was automatically excluded. The officer, who assessed Mr Walsh when he arrived at Belmarsh, appears to have recognised this, yet the duty governor turned down his request for Mr Walsh to be regarded as an exception to the normal criteria. Instead, Mr Walsh was placed on Belmarsh's highly restrictive, inadequately regulated and inappropriately named 'duty of care' regime. Mr Walsh remained on this regime for over two weeks at the prison until he died.

67. The ‘duty of care’ regime meant that Mr Walsh was locked in his cell for more than 23 hours a day. He had an extremely limited regime, and was able to spend only a maximum of 30 minutes out of his cell each day for domestic tasks, plus time to collect his meals and medication. He had no work or education and was not able to go to the gym. He did not have the opportunity to spend any time in the open air, which is a legal requirement under prison rules.

68. The investigator spoke to staff who worked on Mr Walsh’s wing but, apart from unlocking Mr Walsh to collect his meals and medication, no one was able to recall any significant or meaningful contact with him. There was very little written about him in his prison record, apart from five negative comments about his behaviour, IEP warnings, and his downgrade to the basic regime level. He did not have an allocated personal officer.

69. PSI 75/2011, about residential services, requires that prisoners subject to a restricted regime must have a minimum of 60 minutes activity of which 30 minutes must be in the open air. The PSI emphasises the importance of staff building good relationships with prisoners, interacting with them regularly and encouraging them to engage with available regimes. It notes that officers have a key role to play in spotting any signs of distress, anxiety, or anger that might lead to the prisoners harming themselves.

70. At the inspection of Belmarsh in February 2015, HM Inspectorate of Prisons noted that the ‘duty of care’ regime amounted to solitary confinement. We are concerned that Mr Walsh was held isolated in a cell for over 23 hours a day, with little contact or interaction with other prisoners or with members of staff. Mr Walsh’s conditions were worse than segregation and without the safeguards that prisoners in segregation units have, such as regular healthcare assessments of his fitness, time in the open air, and frequent checks by officers, members of the Independent Monitoring Board and managers.

71. The detrimental effect of isolation in prison is well documented. Prison Service Order 1700, which governs segregation procedures, refers to research into the mental health of prisoners held in solitary confinement, which indicates that for most prisoners there is a negative effect on their mental well being. It reports that solitary confinement can be almost unbearable for the poorly adjusted personality types often found in a prison. Studies have found that many segregated prisoners suffered from perceptual distortions such as paranoia and many prisoners in solitary confinement were prone to losing their temper easily and committing random acts of violence against themselves and others. The evening before Mr Walsh died, an officer noted that he was becoming increasingly and randomly abusive towards staff but no one seemed to consider that this might suggest that Mr Walsh’s mental health was deteriorating. The response was to place him on the basic regime and remove his television, further isolating Mr Walsh.

72. The extremely restricted regime meant it was very difficult for staff to assess any changes in Mr Walsh. In a PPO Learning Lessons Bulletin about deaths in segregation units, issued in June 2015, we identified that segregation is an extreme and isolating form of custody, which reduces protective factors against suicide, such as activity and interaction with others. Such regimes need to be used sparingly and only in exceptional circumstances for those at risk of suicide. As

noted above, Mr Walsh already had a number of risk factors for suicide, which no one appears to have taken into account, and these can only have been compounded by Mr Walsh's impoverished regime.

73. We are concerned that we reported similar concerns in our investigation report into the death of a young man at Belmarsh in November 2013. This young man had also not been assessed as at risk of suicide or self-harm but he was recognised as vulnerable to threats and assault from other prisoners. Like Mr Walsh, he spent excessive amounts of time locked in his cell, with no real activity or access to the open air and very little staff contact. In another recently issued investigation report into a death at Belmarsh we were also critical that the man had been held separately from other prisoners in a very restricted regime without the safeguards of segregation.

74. We are not satisfied that the 'duty of care' regime at Belmarsh is appropriate or offers sufficient safeguards for vulnerable prisoners. We understand that Belmarsh is currently developing its policy in response to a recommendation from HM Inspector of Prison. We make the following recommendations:

The Governor of Belmarsh should ensure that all prisoners who need to be kept apart from other prisoners for their own protection have a full prison regime, equivalent to other prisoners.

The Governor of Belmarsh should ensure that prisoners subject to a restricted regime tantamount to segregation are formally segregated under Prison Rule 45 and are managed under the provisions and safeguards of PSO 1700, wherever they are held in the prison.

Night Patrol Checks

75. Although Mr Walsh was not being checked during the night, as part of suicide and self-harm monitoring procedures, he was supposed to be checked four times during the night, as a potential category A prisoner. These checks were not welfare checks, but a security requirement. CCTV footage shows that the night patrol officer did not complete these checks, as he was required to do. Had the night patrol officer carried out the checks, he might have intervened earlier and saved Mr Walsh's life. The Governor of Belmarsh dismissed the night patrol officer, after a disciplinary hearing into the matter.

Emergency code

76. PSI 03/2013 Medical Emergency Response Codes requires a code blue (or equivalent) emergency code to be used in a medical emergency, in circumstances such as when a prisoner is unconscious or not breathing. It directs that when a medical emergency code is called the control room must call an ambulance immediately and should not wait for a decision from healthcare staff or a duty manager.

77. When the officer found Mr Walsh at 10.43am, he did not call an emergency code blue. Shortly afterwards, someone radioed that there was a medical emergency, but the control room did not call an ambulance immediately in response, but waited until another officer requested one three minutes later. PSI 3/2013 makes it clear

that control staff should call an ambulance immediately in a medical emergency and should not wait for a member or healthcare staff or a manager to attend the scene and request an ambulance. In this case the delay would not have altered the outcome for Mr Walsh who was clearly dead, but in other emergencies, any delay could be crucial. We make the following recommendation:

The Governor should ensure that prison staff use the appropriate emergency code whenever there are serious concerns about the health of a prisoner and that the communications room calls an ambulance immediately when there is a medical emergency.

Resuscitation

78. It is clear that Mr Walsh had been dead for some time when he was found hanged. Despite this, nurses tried to resuscitate Mr Walsh until paramedics arrived and recorded that he had died. The clinical reviewer considered that the nurses' actions were unnecessary and inappropriate. He noted that it appeared to be the practice at Belmarsh that nurses should continue to attempt resuscitation until a GP or paramedic pronounced death.

79. European Resuscitation Council Guidelines 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances when resuscitation is not appropriate.

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