Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason O'Rourke, a prisoner at HMP Belmarsh, on 2 April 2019

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 Jason O'Rourke died on 2 April 2019 after he was found hanged in his cell at HMP Belmarsh. He was 34 years old. I offer my condolences to his family and friends.

Mr O'Rourke was at Belmarsh for approximately four weeks, during which time he isolated himself and declined support from prison and healthcare staff. I am concerned that there is no evidence that staff engaged adequately with Mr O'Rourke to find out and address his needs, particularly as he was isolated and subject to a very restricted regime. Despite this, we have seen no evidence that he gave staff any indication that he was at imminent risk of suicide or self-harm.

Mr O'Rourke had a history of depression and I am concerned that staff did not prioritise his mental health needs or have a plan in place for how best to interact with and monitor him. I am also concerned that a roll check was not properly completed the night before and on the morning, that Mr O'Rourke was found hanged.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2020**

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Summary

Events

1. On 19 November 2018, Mr Jason O'Rourke was remanded to HMP High Down. It was not his first time in prison. He had been diagnosed with a personality disorder and attention deficit hyperactivity disorder (ADHD), and had a history of attempted suicide, depression and anxiety. He was prescribed medication for anxiety and depression. Mr O'Rourke told staff that he had no thoughts of suicide or self-harm.

2. In December 2018, Mr O'Rourke stopped taking his antidepressants as he said that they did not help him. He said he did not want the prison GP to review him and asked for his medication to be stopped.

3. On 28 February 2019, Mr O'Rourke was transferred to HMP Belmarsh. During his reception interview, Mr O'Rourke told staff that he had conflict with anyone from Bermondsey but had no thoughts of suicide or self-harm.

4. From 1 March, Mr O'Rourke told staff that he had decided to isolate himself in his cell and did not attend his prison induction sessions and secondary health screen.

5. Belmarsh had no procedures in place to monitor prisoners who isolate themselves, and no one monitored Mr O'Rourke's movements on the wing. A mental health nurse visited Mr O'Rourke on three occasions to check on him. Each time, she spoke to him through his cell door observation panel and he declined support.

6. A roll check (including a welfare check) was not completed on the evening of 1 April or morning of 2 April.

7. An officer unlocked Mr O'Rourke's cell at 9.33am on 2 April, and found him hanged from a ligature made from a bed sheet. He radioed a medical emergency code blue and the control room called an ambulance immediately. Staff did not try to resuscitate him as rigor mortis was present. The healthcare team and prison GP arrived promptly and established that Mr O'Rourke had died.

Findings

Assessment of risk and self-isolation

8. Although staff appropriately assessed that Mr O'Rourke was not at immediate risk of suicide or self-harm when he arrived at Belmarsh and gave staff no indication that he was at imminent risk during the four and a half weeks he spent there, there was no evidence to indicate that staff had tried adequately to engage with him, particularly as he chose to isolate himself in his cell and was on a very restricted regime. Although an officer said that he had a "long conversation" with him a week before he died, he did not record it and took no subsequent action although Mr O'Rourke had presented as being "exceptionally worried" during that conversation.

9. Belmarsh did not have a self-isolation policy and there was no formal process for monitoring prisoners who isolated themselves. There was no evidence to say what interaction Mr O'Rourke had with staff.

Roll check

10. Staff failed to conduct the evening roll check on 1 April and the morning roll check on 2 April 2019 and did not check that there were no immediate concerns with Mr O'Rourke.

Clinical care

11. The clinical reviewer concluded that the care that Mr O'Rourke received at Belmarsh was not equivalent to that which he could have expected to receive in the community. However, when a nurse found him in distress on two occasions, she should have escalated her concerns about his mental health and ensured that he was seen promptly by the mental health team. This did not happen. Nursing staff should also speak to prisoners face-to-face when they have concerns about them rather than through cell door observation panels.

Learning Lessons

12. We have identified a number of concerns in this report and consider that staff should learn from our findings.

Recommendations

- The Governor should ensure that prison staff record all significant conversations with prisoners in the wing observation book and prison records (NOMIS) and take action where there are any concerns.
- The Governor and the Head of Healthcare should ensure that there is a robust policy in place so that staff know how to manage, monitor and support prisoners who isolate themselves, including sharing health information promptly
- The Governor should ensure that roll checks are properly carried out.
- The Head of Healthcare should ensure community GP records are requested for all prisoners who self isolate or do not engage with healthcare to assist in creating an informed risk assessment.
- The Head of Healthcare and Wellbeing Co-ordinator should ensure that there is a clear process in place so that staff understand what to do when a prisoner with potential mental health issues does not engage with the healthcare team.
- The Head of Healthcare should ensure that healthcare staff ask prison staff to open cell doors to speak to prisoners face-to-face when they have concerns.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with a nurse, an officer and an OSG and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

13. 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.

14. The investigator visited Belmarsh on 8 April 2019. He obtained copies of relevant extracts from Mr O'Rourke's prison and medical records.

15. NHS England commissioned an independent clinical reviewer to review Mr O'Rourke's clinical care at the prison. The clinical reviewer completed the clinical review on their behalf.

16. They interviewed 12 members of staff and one prisoner at Belmarsh during the investigation, some jointly.

17. We informed HM Coroner for Southwark of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr O'Rourke's next of kin to explain the investigation. Her solicitor raised the following issues on her behalf:

- Mr O'Rourke's next of kin believed that Mr O'Rourke was under threat from other prisoners at Belmarsh and wanted to know the extent to which the prison was aware and what steps they took to protect him.
- She wanted to know if there was evidence of third-party involvement in Mr O'Rourke's death.
- She said that Mr O'Rourke had previously been prescribed medication for depression and anxiety which was apparently stopped at HMP High Down and Belmarsh. She wanted to know why.
- She asked whether Belmarsh was aware of Mr O'Rourke's history of attempted suicide and self-harm and what steps they took to support him.

19. We have addressed these issues in this report.

20. Mr O'Rourke's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

21. The prison also received a copy of the report and identified no factual inaccuracies.

Background Information

HMP Belmarsh

22. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds approximately 900 men. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and a 32-bed inpatient unit.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Belmarsh was in February 2018. Inspectors reported a significant shortage of frontline staff which was being addressed but had resulted in a severely depleted daily regime and regular redeployment of specialist staff to ensure that prisoners could be given even a basic period of daily time unlocked. Inspectors noted that some good work was being done to identify vulnerable prisoners, including those at risk of self-harm.

Independent Monitoring Board

24. 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 latest annual report for the year to 30 June 2018, the IMB reported that it was very concerned about the safety of staff and prisoners where houseblocks had been managed with considerably reduced staffing levels. These shortages also had an impact on most areas of prison life such as access to property, attendance to activities, and time spent dealing with prisoners' applications.

Previous deaths at HMP Belmarsh

25. Mr O'Rourke was the first prisoner to take his life at Belmarsh since April 2017. Four other prisoners died from natural causes between April 2017 and April 2019 when Mr O'Rourke died. There were no similarities between our findings in our investigation of Mr O'Rourke's death and the other investigations.

26. Since Mr O'Rourke's death there have been three further deaths: two were self-inflicted and one was an apparent homicide. We have not completed our investigations into these deaths.

Key Events

27. Mr Jason O'Rourke had a history of attempted suicide, depression, anxiety and a personality disorder. He had previously been diagnosed with attention deficit hyperactivity disorder (ADHD) although he had stopped taking medication for this in February 2014. In October 2018, Mr O'Rourke took an overdose of prescribed medication.

28. On 16 November 2018, Mr O'Rourke was remanded to HMP High Down, charged with assisting murder. He attended court on 19 November and returned to High Down. This was not Mr O'Rourke's first time in prison and he was last released from custody in April 2016.

29. Mr O'Rourke's person escort record (PER) noted that Mr O'Rourke had a history of attempted suicide and self-harm, depression, anxiety and had been sectioned under the Mental Health Act in 2011.

30. During his reception health screen, Mr O'Rourke told staff that he had had depression and had deliberately tried to harm himself in the past. Mr O'Rourke said that he had no current thoughts of suicide or self-harm and was aware of the support available to him in prison. He said that he was currently taking the following medication: zopiclone (a sleeping aid), co-codamol (for pain relief), diazepam (for anxiety), propranolol (for anxiety) and mirtazapine (an antidepressant). The reception nurse referred Mr O'Rourke to the mental health team.

31. Over the next few days, a mental health nurse reviewed Mr O'Rourke's medical record and noted that he should continue to receive his prescribed medication and be referred to the prison GP. An appointment was made for Mr O'Rourke to see a prison GP in the depression clinic on 13 December but he failed to attend.

32. On 26 December, a member of the healthcare team recorded in Mr O'Rourke's medical record that he had refused to take his medication because he said they did not help him.

33. On 1 January 2019, Mr O'Rourke's partner left a telephone message for the safer custody team to say that she was concerned that she had not heard from Mr O'Rourke for around ten days. An officer checked on Mr O'Rourke's wellbeing. Mr O'Rourke said that he had had no phone credit to make phone calls but expected his partner to visit him the next day.

34. On 11 January, a nurse recorded in Mr O'Rourke's medical record that he continued to refuse his medication. A prison GP reviewed Mr O'Rourke's medical records and suggested that he should see a GP. Mr O'Rourke refused to do so and a prison GP stopped his prescribed medication.

35. On 28 January, Mr O'Rourke failed to attend a GP appointment to discuss his depression. It was noted in his medical record that Mr O'Rourke "did not want to" attend.

HMP Belmarsh

36. On 28 February, Mr O'Rourke attended court but his hearing did not proceed. He was therefore returned to custody on remand, and sent to HMP Belmarsh. His PER noted that he was not subject to suicide and self-harm procedures (known as ACCT), had depression and was not taking any medication.

37. An officer completed Mr O'Rourke's reception interview. Mr O'Rourke said that he had no thoughts of suicide or self-harm but would have conflict with any prisoners from Bermondsey. Staff submitted a security intelligence report to record this.

38. A nurse completed Mr O'Rourke's reception health screen. He recorded that Mr O'Rourke said he had no current thoughts of suicide or self-harm and was not being prescribed medication. Despite previously recorded information about Mr O'Rourke, the nurse noted that he had no previous mental health issues but had anxiety. He offered to refer him to the prison GP but Mr O'Rourke declined. Mr O'Rourke had given consent for Belmarsh to obtain and share information from his community GP but there is no evidence that the healthcare team requested this information.

39. On 1 March, Mr O'Rourke was due to have continued his prison induction in the First Night Centre but refused to leave his cell. He told an officer that he had ongoing conflict with other prisoners but refused to name them. He said that he had been threatened at court and that "people" were "waiting for him".

40. As Mr O'Rourke refused to leave his cell, he did not attend his secondary health screen. Healthcare staff recorded that Mr O'Rourke had chosen to isolate himself and had stopped being prescribed mirtazapine at High Down at his request. They decided to review this issue with Mr O'Rourke at the weekend to see if he had changed his mind.

41. That day, a Custodial Manager (CM) spoke to Mr O'Rourke and tried to find out why he was isolating himself in his cell. (Belmarsh does not have a self-isolation policy.) Mr O'Rourke said that he had "severe conflict" with unnamed prisoners. The CM offered to move him to the vulnerable prisoners' wing but he declined. Staff noted in the wing observation book that Mr O'Rourke had chosen to isolate himself and therefore should not be unlocked with the general population of prisoners.

42. Shortly afterwards, a member of the chaplaincy team visited Mr O'Rourke as part of his induction but he raised no concerns.

43. On 3 March, Mr O'Rourke refused to attend the First Night Centre to continue with his induction. A nurse therefore visited Mr O'Rourke in his cell and tried to complete a health and wellbeing assessment. The nurse described Mr O'Rourke as looking well and noted that although he was initially in bed, he stood up to talk to him but refused to participate in the assessment.

44. On 4 March, a nurse attended the First Night Centre to try to complete Mr O'Rourke's healthcare assessment. Wing staff said that he was still isolating himself and so the nurse instructed them to open his cell door so that she could

speak to him face-to-face. Once this happened, the nurse asked Mr O'Rourke if she could assess him but he again declined and said, 'No Miss, close the door.'

45. A nurse, the Health and Wellbeing Co-ordinator, reviewed Mr O'Rourke's medical record. She noted that Mr O'Rourke had refused on three occasions to attend the First Night Centre for his induction and health and wellbeing assessment and he did not want to interact with them. She referred Mr O'Rourke to the primary mental health team. She noted that he was isolating himself, had a history of depression and anxiety and had stopped taking his antidepressants at High Down. The referral included information about Mr O'Rourke's medical history, including his mental health history, risks and treatment.

46. That morning, a SO spoke to Mr O'Rourke about his self-isolation. Mr O'Rourke said that nothing had changed and he still felt under threat from prisoners and feared for his safety. The SO explained to Mr O'Rourke that because he had chosen to self-isolate, he would have to be placed on a restricted prison regime. Mr O'Rourke said that he understood.

47. The SO told us that it was not possible for the prison to have a specific regime to accommodate prisoners who self-isolate on a busy houseblock. However, at the daily morning staff briefing meeting, staff were reminded that prisoners who isolated themselves should be offered a shower, allowed to collect meals and make a phone call when there were no other prisoners on the landing. The SO said that staff should try to offer these opportunities every day but he said that occasionally it was not possible when staff were responding to incidents in the prison or because of the business of the wing. He said that if a prisoner who was isolating himself refused to attend the servery to collect their lunch or evening meal, staff would take their meal to them in their cell.

48. A mental health nurse reviewed a nurse's note of concern about Mr O'Rourke. She noted that he was to be added to the mental health patient list, referred to see a doctor and discussed at the team's next mental health referrals' meeting.

49. A security intelligence report submitted on 6 March noted that Mr O'Rourke may be under threat because the victim of his alleged offence had previously served a sentence at Belmarsh and had "a lot of friends there who would kill him". However, the intelligence report did not identify any specific threats or individuals. It noted that Mr O'Rourke's friend had said in January 2019 that he did not want to be at Belmarsh as a lot of his victim's family were in custody there and he feared for his safety.

50. On 8 March, a nurse from the primary mental health team visited Mr O'Rourke in his cell. She was aware that he had a history of depression and had stopped taking his medication. She noted in his medical record that staff were unable to unlock Mr O'Rourke's cell due to operational issues. (All prisoners were locked in their cells while staff managed 'canteen', the prison shop, on the wing.) She saw and spoke to Mr O'Rourke through his cell door observation panel. She told the investigator that Mr O'Rourke appeared sad and was crying. He declined her support and did not want to talk to her. She said that Mr O'Rourke did not respond to her when she told him that she would visit him again.

51. The nurse told us that she did not submit a report to the mental healthcare referrals' meeting to say that she had not been able to undertake an effective assessment of Mr O'Rourke, partly because she planned to see him again. She also said she did not know how to escalate her concerns.

52. A SO noted that Mr O'Rourke told him on 14 March that his situation had not changed, he still feared for his wellbeing and would continue to self-isolate.

53. On 19 March, Mr O'Rourke telephoned his sister and his partner. In both calls, he talked about his children and his court hearing date and said that he would soon be out of prison. Mr O'Rourke's partner told him that she would "sort out his money" for him.

54. On the morning of 21 March, a SO visited Mr O'Rourke to review his continuing self-isolation. An officer was also present. Mr O'Rourke said that his situation had not changed and he was fully aware that his actions would affect the regime that could be offered to him.

55. Later that afternoon, a mental health visited Mr O'Rourke. She had been on leave since she last saw Mr O'Rourke on 8 March and no one in the mental health team had seen him in the meantime. She recorded that staff were unable to unlock Mr O'Rourke's cell due to operational reasons. She told us that the wing was short-staffed and she had therefore spoken to Mr O'Rourke through his observation panel. She said that his bottom lip was quivering and he appeared to be trying to compose himself. She asked him if he wanted to speak to her and offered him the mental health team's support. He did not speak but declined support by shaking his head. She did not discuss the case with her manager or colleagues but made an appointment for Mr O'Rourke to see a prison GP and mental health nurse in the depression clinic on 1 April.

56. On 26 March, Mr O'Rourke phoned his next of kin. They spoke about his wish to change his solicitor. When his next of kin told him that she would visit him in prison, he told her to tell him in advance or he would not "get up".

57. An officer told the investigator that around 26 March, he visited Mr O'Rourke in his cell during an association period (when prisoners mix with each other) to check on his wellbeing. No other prisoners were on the landing at the time. Mr O'Rourke said that he was "exceptionally worried" that he would be found guilty at his impending trial. The officer reassured him and told him not to worry. Mr O'Rourke said that he would not do "anything silly" and was okay. The officer said that by the end of their "long conversation", Mr O'Rourke said that he felt much better and thanked him for talking to him. The officer did not record this conversation in Mr O'Rourke's prison records.

58. On 27 March, a SO noted that he had visited Mr Rourke again to review his self-isolation. An officer was present. Mr O'Rourke said that his situation had not changed, that he would continue to self-isolate and was fully aware of the regime that could be offered to him.

59. Later that day, a mental health nurse tried to speak again to Mr O'Rourke. She told us that she would have asked a wing officer to unlock his cell door if he had

agreed to talk to her. However, Mr O'Rourke was lying in his bed and raised his head from his pillow and shook it to indicate that he did not want to talk.

60. That day, prison managers held a safety intervention meeting and discussed Mr O'Rourke's self-isolation. They noted that he was isolating himself because of "severe conflict" and that he was "on trial". (There is no further information noted about the outcome of the meeting.)

61. Around 30 March, an officer told the investigator that she visited Mr O'Rourke to complete a fabric check of his cell. (This is a check of the cell to make sure that everything works, the window bars, cupboards hinges are secure and intact and the cell bell is functioning.) When she went into Mr O'Rourke cell, he was initially in bed and appeared half asleep before he got up. The officer noted no concerns about him.

Events on 1 April

62. On 1 April, a mental health nurse recorded that Mr O'Rourke failed to attend his appointment with a GP and her in the depression clinic. She discussed this with the mental health team and noted that the psychiatric registrar would review Mr O'Rourke in his cell the next day.

63. An officer unlocked Mr O'Rourke's cell door at around 4.30pm to offer him his evening meal. The officer said that this was routine for prisoners who isolated themselves. Mr O'Rourke was lying on his bed, watching television, and declined the meal. The officer then relocked the door. He told us that Mr O'Rourke generally declined to leave his cell and his conversations with staff were limited.

64. A prisoner who served food to prisoners, had accompanied the officer to Mr O'Rourke's cell to offer him food. The prisoner confirmed in his police statement that Mr O'Rourke declined food and said that he had food in his cell. (When police searched Mr O'Rourke's cell after his death, they discovered food in his cell and empty food cartons in the bin.)

65. CCTV footage shows that an officer completed a roll check at 7.28pm and noted that Mr O'Rourke was lying on his bed, watching television. The officer told us that she said "goodnight" to him through his observation panel and he acknowledged her by waving.

66. An Operational Support Grade (OSG) arrived for his night duty shift shortly before 7.39pm. CCTV footage shows that the OSG walked along the wing landing at 7.39pm and checked that all cell doors were locked. He did not however complete a roll check as he was required to do.

67. At 7.45pm, the OSG signed the prison's night patrol report and recorded that he had taken over the night duty responsibilities from an officer. The handover did not include any concerns about Mr O'Rourke. At 8.00pm, the OSG noted in the prison's night patrol report that he had ensured that all cell doors on the houseblock were locked.

Events on Tuesday 2 April

68. CCTV footage shows that the OSG walked along the wing landing at 4.46am but did not check any cells.

69. The OSG signed the night patrol report to say that he had completed a roll check of the wing at 5.30am. However, CCTV footage showed that he did not do so. The OSG finished his duty shortly after 6.00am when an officer arrived. The officer told us that the gave him a verbal handover but raised no concerns.

70. CCTV footage shows that between 8.00am and 9.00am, staff unlocked some prisoners from their cells to participate in exercise and association. Mr O'Rourke's cell was not unlocked as he was noted as a "self-isolator".

71. Around 9.30am, two officers started the accommodation fabric checks of all the cells on the houseblock. At 9.33am, an officer arrived at Mr O'Rourke's cell while that the other officer was checking the cell next door. He looked through the cell door observation panel and saw Mr O'Rourke hanging from strips of bed sheet, attached to the window bars.

Emergency response

72. An officer immediately unlocked the cell door, pressed the general alarm button on the landing and shouted for staff assistance. He went into Mr O'Rourke's cell and supported his body, assisted by the officer, while he cut the ligature from the window and placed him on the floor. An officer had radioed a medical emergency code blue (to indicate that a prisoner is unconscious or has difficulty breathing) at 9.33am. Staff in the control room immediately called an ambulance. Ambulance records recorded that the emergency call was received at 9.34am. An officer noted that Mr O'Rourke's body was cold and rigor mortis was present.

73. CCTV footage shows that a CM, and an officer and other staff arrived at Mr O'Rourke's cell in approximately 50 seconds. The officer's body-worn camera footage shows that Mr O'Rourke was in a seated position at the back of the cell against the wall. Staff present did not try to resuscitate him. The CM cut off the ligature which was around Mr O'Rourke's neck. He realised that Mr O'Rourke's body was cold and stiff. He said it was evident that rigor mortis was present and so resuscitation attempts would not be appropriate. He told staff in the cell to make room for healthcare staff who arrived within approximately 30 seconds.

74. Two nurses arrived at 9.35am, followed by more nurses a minute later. They both checked Mr O'Rourke for signs of life but found none. The nurses noted that rigor mortis was present in Mr O'Rourke body and therefore any attempts at resuscitation would be futile.

75. At 9.44am, the prison GP arrived at Mr O'Rourke's cell. He confirmed Mr O'Rourke had died at 9.53am. When the paramedics arrived at 9.38am and 9.46am, they too recognised that resuscitation was not possible.

Contact with Mr O'Rourke's family

76. At 1.40pm on 2 June, a prison manager and a family liaison officer (FLO) visited Mr O'Rourke's next of kin to break the news of his death but no one was in. They tried unsuccessfully to telephone her that afternoon. At 4.15pm, they returned to Mr O'Rourke's next of kin's home and managed to speak to her and other family members to break the news of Mr O'Rourke's death. They stayed in regular touch with her until Mr O'Rourke's funeral, which the prison arranged. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

77. After Mr O'Rourke's death, the Head of Reducing Offending, debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

78. The prison posted notices informing other prisoners of Mr O'Rourke's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr O'Rourke's death.

Post-mortem report

79. A post-mortem examination established that Mr O'Rourke died from "hanging". Toxicology tests detected no illicit substances in his system when he died.

Other information

80. A security intelligence report submitted after Mr O'Rourke's death noted that his partner had said that she had spoken to Mr O'Rourke a few days before his death. She said that Mr O'Rourke had asked for £400 which she said had been sent to him (although she said she knew nothing further about who sent the money or what it was for). She said Mr O'Rourke had talked about wanting a duvet and a stereo and was planning to make his life in prison more comfortable.

Findings

Assessment of risk of suicide and self-harm

81. When he arrived at Belmarsh, staff appropriately identified and addressed Mr O'Rourke's health issues. He had a history of attempted suicide, depression, anxiety, ADHD and a personality disorder. Although he had been prescribed antidepressants, he had stopped taking them at least three months before his death. Despite Mr O'Rourke's risk factors, he gave staff no indication that he was at imminent risk of suicide.

82. Although there were deficiencies in monitoring Mr O'Rourke's mental health, there was no evidence to suggest that staff should have monitored Mr O'Rourke under ACCT procedures. Mr O'Rourke had never expressed thoughts of suicide or self-harm during the four weeks he spent at Belmarsh. He decided to isolate himself without providing detailed reasons.

Self-isolation

83. The needs and risks of prisoners who isolate themselves from others often go unnoticed. Our previous investigations have identified that social isolation in prison is a major risk factor for suicide and self-harm. Withdrawing from the regime and activities may lead to negative, self-critical thoughts, feelings of isolation and helplessness.

84. Although Mr O'Rourke isolated himself during his time at Belmarsh and had not engaged with staff, it appeared that he feared for his safety at the prison due to "severe conflict" with other prisoners. A security intelligence report submitted after his death indicated that he had been sent £400 but there is no further evidence to say what this was for or who it was from. There is no evidence to indicate that he might have been bullied as he isolated himself in his cell and no records were kept to monitor his movements.

85. Belmarsh did not have a self-isolation policy. There was no formal record of Mr O'Rourke's daily contact with staff or when he was offered time out of his cell for personal hygiene reasons or to use the phone. There is no evidence that prison staff had any meaningful conversations with him, and we are concerned about their lack of attempted engagement with him. The entries in Mr O'Rourke's prison records are infrequent and lack detail.

86. Although an officer told the investigator that he had a "long conversation" with Mr O'Rourke around 26 March 2019, there is no evidence that he recorded it. While we recognise that the officer spent time talking to Mr O'Rourke, he should have recorded the conversation and flagged his concerns to staff through an entry in the wing observation book and Mr O'Rourke's prison records, particularly as Mr O'Rourke presented during the conversation as being "exceptionally worried" about the outcome of his court hearing and was isolated with a very restricted regime and a lack of engagement with others.

87. Without a formal monitoring system in place to record how Mr O'Rourke's needs were being met, staff could easily and inadvertently have overlooked him and failed to provide the appropriate support. A self-isolation policy could have

outlined how staff should monitor and support those who isolate themselves and what support and interventions should be implemented and at what stage to encourage such prisoners to mix with others - for example, interventions such as contact with family and friends. Although prison staff offered to move Mr O'Rourke to the vulnerable prisoners' wing, there is no evidence that a move to another prison was considered. We make the following recommendations:

The Governor should ensure that prison staff record all significant conversations with prisoners in the wing observation book and prison records (NOMIS) and take action where there are any concerns.

The Governor and the Head of Healthcare should ensure that there is a robust policy in place so that staff know how to manage, monitor and support prisoners who isolate themselves, including sharing health information promptly.

Roll checks

88. Completing roll checks ensure the security and integrity of the prison and also enables staff to identify where there are immediate concerns with prisoners. An OSG signed a formal document to confirm that he had completed the roll check on the evening of 1 June and the morning of 2 June. However, CCTV footage showed that he had not done so. Falsifying documents is a serious disciplinary matter and we note that the OSG has been suspended from duty and is subject to disciplinary proceedings. While we cannot know whether or not the outcome for Mr O'Rourke would have been different if the OSG had conducted the required roll checks, it might be critical in other emergencies. We therefore make the following recommendation:

The Governor should ensure that roll checks are properly carried out.

Clinical care

89. The clinical reviewer noted that overall, the healthcare that Mr O'Rourke received was not equivalent to that which he could have expected to receive in the community.

90. At the time of his death, mental healthcare staff had identified that Mr O'Rourke had a history of depression and had not been taking his antidepressants medication for at least three months. He had chosen to isolate himself and refused to see a GP. The clinical reviewer noted that there was nothing in Mr O'Rourke's medical records to suggest that he was so unwell that it was necessary for healthcare staff to consider transferring him to a mental health hospital, where he could have been compelled to take medication. But given that Mr O'Rourke had given his consent to obtain medical records from his community GP, had this information been retrieved, it may have provided additional information to complete a more thorough and informed risk assessment. We recommend that:

The Head of Healthcare should ensure community GP records are requested for all prisoners who self isolate or do not engage with healthcare to assist in creating an informed risk assessment.

91. Given Mr O'Rourke's history and presentation (including being found crying in his cell), the mental health team should have assessed him. This was a missed opportunity to support him.

92. The clinical reviewer noted that if Mr O'Rourke had isolated himself in the community and refused to engage with healthcare services, there would be an expectation that his needs would be discussed with more experienced colleagues in team meetings or through professional supervision. This did not happen in this case. Mr O'Rourke was tearful on two occasions when he spoke to a mental health nurse. Having seen him in distress, the nurse was going to check on him again and referred him for a non-urgent GP appointment with the depression clinic a week later. This was inadequate and she should have discussed his behaviour within the mental health team and perhaps also with prison staff, even though he had declined assessment. While we recognise that the nurse was inexperienced, having started her role only a few months earlier, this was more reason for her to seek advice on what action to take to address Mr O'Rourke's needs. The lack of early escalation or intervention meant that the mental health team did not have clear oversight of Mr O'Rourke's needs and failed to meet them.

93. The mental health nurse saw Mr O'Rourke three times. On each occasion, she spoke to him through the cell door observation panel and he declined support. She should have instructed prison staff to open the door so that she could speak to him face-to-face. These were missed opportunities to encourage Mr O'Rourke's engagement and try to meet his needs. We recommend that:

The Head of Healthcare and Wellbeing Co-ordinator should ensure that there is a clear process in place so that staff understand what to do when a prisoner with potential mental health issues does not engage with the healthcare team.

The Head of Healthcare should ensure that healthcare staff ask prison staff to open cell doors to speak to prisoners face-to-face when they have concerns.

Learning Lessons

94. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend the following

The Governor and Head of Healthcare should ensure that a copy of this report is shared with a nurse, an officer and an OSG and that a senior manager discusses the Ombudsman's findings with them.

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