

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Stephen Cope, a prisoner at HMP Belmarsh, on 18 November 2019

**A report by the Prisons and Probation Ombudsman**

## 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*



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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 Stephen Cope was found hanged in his cell on 18 November 2019 at HMP Belmarsh. He was 30 years old. I offer my condolences to Mr Cope's family and friends.

When he transferred from HMP Pentonville to HMP Belmarsh on 2 September, Mr Cope was subject to suicide and self-harm monitoring (known as ACCT). I am concerned that staff at Belmarsh closed his ACCT prematurely without having identified or addressed his key issues or updated his ACCT caremap.

I am also concerned that there is no evidence that wing staff had any meaningful engagement with Mr Cope during the 11 weeks he spent at Belmarsh. Mr Cope told officers that he felt under threat and he self-isolated during the days leading up to his death. I am concerned that staff did not recognise the impact of violence and self-isolation on his wellbeing or take action to support him.

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**

**October 2020**

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# Summary

## Events

1. On 5 August 2019, Mr Stephen Cope was remanded to HMP Pentonville for attempted murder. On 12 August, Mr Cope cut his arm and staff started suicide and self-harm prevention measures (known as ACCT).
2. On 2 September, Mr Cope was transferred to HMP Belmarsh and officers there closed his ACCT two days later. Mr Cope continued to have thoughts of suicide. He started a methadone reduction programme and received support from the substance misuse team.
3. On 16 November, Mr Cope told a supervising officer (SO) that he had been assaulted and showed him injuries on his stomach and finger. Mr Cope would not say who had assaulted him. The SO offered Mr Cope a move to another wing, but Mr Cope refused. Over the next two days, Mr Cope hardly left his cell.
4. On 18 November, at around 2.45pm, an officer unlocked Mr Cope's cell and his cellmates went to classes. Mr Cope did not want to leave the cell, so the officer locked him back in alone. At around 4.45pm, another officer found Mr Cope hanging from a ligature made of bedsheets.
5. The officer shouted for staff assistance and other officers started cardiopulmonary resuscitation (CPR). Two minutes later, nurses attended. At 5.09pm, paramedics arrived at Mr Cope's cell and took over CPR. Mr Cope was pronounced dead at 5.48pm.

## Findings

6. We are concerned that officers closed Mr Cope's ACCT prematurely when he first arrived at Belmarsh, before all his issues had been identified and addressed.
7. We are also concerned that officers did not support Mr Cope sufficiently throughout his time at Belmarsh, and particularly when he said he was under threat and would not leave his cell in the days leading up to his death. We are particularly concerned that staff did not recognise the impact of violence and self-isolation on Mr Cope's wellbeing.
8. After Mr Cope's death, it emerged that he was in debt and his family was paying money to another prisoner on his behalf. We are satisfied that the prison was not aware of Mr Cope's debt, but debt was another risk factor for Mr Cope that could have been better addressed or explored if there had been meaningful officer contact and support for Mr Cope on the wing.

## Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular, that:
  - they identify all risk factors and assess a prisoner's risk using all relevant information;
  - they complete and update caremaps at case reviews, setting out specific and meaningful actions, identifying who is responsible for actions and reviewing progress at each review;
  - they ensure that the ACCT is not closed until the prisoner's concerns have been fully addressed; and
  - post-closure reviews are carried out thoroughly.
- The Head of Healthcare should ensure that healthcare staff and substance misuse staff share all risk information with those involved in a prisoner's care.
- The Governor should ensure that:
  - wing staff know what is expected of them in terms of engagement with prisoners and record these interactions;
  - key workers have regular meaningful discussions with the prisoners on their caseload; and
  - key workers are clear whether they should see prisoners weekly or fortnightly under the prison's key officer policy.
- The Governor should ensure that there is a policy in place setting out how staff should manage, monitor and support prisoners who isolate themselves.
- The Governor should ensure that a copy of this report is shared with staff named in this report.

## 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. The investigator obtained copies of relevant extracts from Mr Cope's prison and medical records.
11. The investigator interviewed eight members of staff at HMP Belmarsh on 24 and 27 February 2020. He provided initial feedback to the Governor on 27 February 2020.
12. NHS England commissioned an independent clinical reviewer to review Mr Cope's clinical care at the prison. The clinical reviewer conducted six interviews jointly with the investigator.
13. 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.
14. Mr Cope's family received a copy of the initial report. They did not raise any issues, or comment on any factual inaccuracies of the report.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

# Background Information

## HMP Belmarsh

16. 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

17. The most recent inspection of HMP Belmarsh was in February 2018. Inspectors reported that the number of incidents of violence had increased since the last inspection and some were serious incidents. Inspectors found, however, that the increase was not significant as in many other local prisons. Inspectors noted that technology was being used to support efforts to manage violence and drug use at the prison, for example through the body scanner being piloted in reception. Inspectors noted that the prison had taken a zero-tolerance approach to poor behaviour, but said this needed to be developed to ensure management better understood the causes of violence and to offer more proactive work to address the underlying issues.
18. Inspectors found some good work being done to identify vulnerable prisoners, including those at risk of self-harm. They also found that ACCT initial interviews were generally thorough, and that reviews took place regularly and were usually multidisciplinary. Inspectors found however that care plans were not always updated or followed up effectively. Entries in case notes did not always demonstrate that officers had had meaningful interactions with prisoners.
19. Inspectors found that staff-prisoner relationships were mixed and not enough was being done to ensure all staff understood the importance of their role in supporting prisoners' rehabilitation, alongside maintaining good order. On the house blocks inspectors observed too many functional, distant interactions, and some officers were dismissive and disrespectful towards prisoners. At the time of the inspection there was no personal officer or key worker scheme and only 23% of prisoners said a member of staff had spoken to them about how they were getting on in the previous week.

## 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 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 house blocks 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, purposeful activity, and time spent dealing with prisoners' applications.

## Previous deaths at HMP Belmarsh

21. Mr Cope was the second prisoner to take his life at Belmarsh since April 2017. Four other prisoners died from natural causes between April 2017 and April 2019. In our investigation into the previous self-inflicted death (which took place in April 2019), we were concerned that staff did not try adequately to engage with the prisoner, particularly as he chose to isolate himself in his cell and was on a very restricted regime.
22. Since Mr Cope's death there have been two further deaths: one was self-inflicted and one was an apparent homicide. Both are subject to ongoing investigation.

## 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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 multi-disciplinary review meetings involving the prisoner.
24. 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. 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.

## Incentives and Earned Privileges (IEP) Scheme

25. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

## Key worker scheme

26. The key worker scheme— which has been in place across the prison estate since March 2019 - is designed to help reduce violence and self-harm in prisons by encouraging meaningful contact and positive relationships between officers and prisoners. As key workers, all prison officers will hold a small caseload of around six prisoners. They will meet regularly and provide supportive challenge to prisoners, to motivate them to use their time in custody to best effect. Key work seeks to develop constructive, motivational relationships with individuals in prison, supporting them to make appropriate choices, giving them hope and responsibility for their own development.

## Key Events

### HMP Pentonville

27. On 5 August 2019, Mr Stephen Cope was remanded to HMP Pentonville for attempted murder. His trial was scheduled for January 2020. This was not his first time in prison as he had served previous short sentences for burglary in 2018 and 2019.
28. Mr Cope told staff at Pentonville that he had used heroin and cannabis in the community for many years and taken an overdose of drugs when he was 14 years old. Mr Cope started a 10ml per day methadone maintenance programme, which was increased to 15ml per day on 9 August.
29. On 12 August, Mr Cope cut his arm, so officers started ACCT procedures to monitor his risk of suicide or self-harm. During the ACCT assessment interview, Mr Cope told an officer that he was feeling very stressed about his trial in January. Mr Cope said that he had not self-harmed in the past, but had had suicidal thoughts. However, he said that he did not have any plans to kill himself.
30. The next day, Mr Cope had his first ACCT case review and repeated that he was feeling very stressed because he was going to receive a long sentence. Mr Cope said that he had never engaged with mental health teams in the past but wanted mental health support. Staff recorded three issues in the ACCT caremap: “stress”, “drug use” and “purposeful activity”. A nurse referred Mr Cope to the mental health team, psychology services and the substance misuse team.
31. On 21 August and 28 August, Mr Cope had two further ACCT case reviews at Pentonville. Mr Cope said that he still had thoughts of self-harm, but was coping well. At the case reviews, it was agreed that Mr Cope was at low risk of suicide and self-harm.

### HMP Belmarsh

32. On 2 September, Mr Cope attended court and was transferred to HMP Belmarsh. In his Person Escort Record (PER, a document that goes with prisoners when they move between police stations, courts and prisons and outlines prisoners’ risks) officers recorded that Mr Cope was subject to ACCT monitoring and had substance misuse issues.
33. During an initial health assessment at Belmarsh, a nurse recorded that Mr Cope was taking 15ml of methadone. Mr Cope agreed to a methadone reduction programme and the nurse referred him to the substance misuse team. Mr Cope said that he did not have any thoughts of suicide or self-harm but said that he was stressed about his court case.
34. The same day, a Custodial Manager (CM) chaired an ACCT case review. The CM recorded that Mr Cope did not have any thoughts of suicide or self-harm and appeared to be settled. The CM recorded that he reviewed the caremap but did not update it. He assessed that Mr Cope was at low risk of suicide and self-harm.
35. On 3 September, a nurse reviewed Mr Cope who repeated that he was stressed because of his court case. The nurse referred Mr Cope to the mental health

- team. The same day, a nurse carried out a mental health assessment on Mr Cope. She recorded that Mr Cope felt low in mood, suicidal and stressed about the prospect of not seeing his eight-year-old daughter. The nurse recorded that Mr Cope had been homeless for years and rarely had any contact with his family. She recorded that Mr Cope could receive a prison sentence of 16 to 22 years for attempted murder.
36. Mr Cope told the nurse that he had suicide and self-harm thoughts but did not have any immediate plan to kill himself because of his daughter. The nurse recorded his comments in his medical record, but not in his ACCT record. The nurse planned to continue monitoring Mr Cope and referred him to counselling and to the GP.
  37. In the afternoon, during a substance misuse assessment, Mr Cope told a drug recovery worker that he had been spending £50 daily on drugs in the community and had been taking drugs since he was 15. Mr Cope told the drug recovery worker that he had a son (12) and a daughter (8), who he had not seen for over a year. Mr Cope repeated that he had no diagnosed mental health issues. The drug recovery worker drew up a substance misuse recovery plan.
  38. On 4 September, Mr Cope had another ACCT case review. Mr Cope told the Supervising Officer (SO) and the nurse that he was stressed because he had spoken to his solicitor who told him that it was likely that he was going to receive a long sentence. Mr Cope said that he had felt fine at Belmarsh but was worried that there were prisoners who wanted to fight him. Mr Cope said that he was in contact with his mother. Mr Cope repeated that he had a daughter that he wanted to see and mentioned that a prison-based charity was helping him to arrange a visit.
  39. The SO told the investigator that he was going to follow up Mr Cope's family contact issues, but he did not update the caremap and could not remember whether he did anything. He also told the investigator that he did not think Mr Cope was at risk of suicide or self-harm, so agreed with the nurse to close Mr Cope's ACCT document.
  40. During a substance misuse review on 9 September, Mr Cope repeated to a recovery worker that he was feeling stressed about his court hearing on 27 January 2020 and said that he was expecting a 16-year prison sentence. Mr Cope said that he wanted to continue to try to establish contact with his daughter.
  41. The same day, a prison GP reviewed Mr Cope and prescribed sertraline (an antidepressant). A month later, a GP increased the dose to 100mg per day.
  42. On 11 September, a SO carried out Mr Cope's ACCT post-closure interview. Mr Cope told him that the issues that led to his self-harm were not resolved, but he was fine. The SO told the investigator that he would have asked Mr Cope to explain more about why he thought the issues had not been resolved but could not remember whether he did. He did not record anything to this effect in the post-closure document. The SO assessed that Mr Cope was no longer at risk of suicide or self-harm, so the ACCT document remained closed.

43. On 20 September, Mr Cope moved to another residential location where he shared a cell with two other prisoners. Five days later, Mr Cope had a fight with one of his cellmates, who he found searching through his property. Intelligence suggested that Mr Cope's cellmate was in debt and stealing from others to pay for it.
44. A SO downgraded Mr Cope's IEP level to basic because of the fight and started a CSIP investigation (CSIP - Challenge, Support and Intervention Plan - a national case management programme for managing prisoners who are violent, ensuring that punitive measures are not applied in isolation and providing support to individuals with challenging behaviours). The SO spoke to Mr Cope and his cellmate and, as a result, moved Mr Cope to another cell on the same wing. The CSIP investigation did not lead to any intervention plan or support measures for Mr Cope or his cellmate.
45. On 23 September, a nurse reviewed Mr Cope's mental health. She told the investigator that Mr Cope appeared to be well and felt more comfortable on the wing. The nurse said that she had no concerns about Mr Cope because he was receiving good support from the substance misuse team and was going to attend psychological therapy. She decided to discharge him from the primary care mental health team.
46. On 1 October, Mr Cope was moved to another cell which he shared with two other prisoners until he died. One of the prisoners told the investigator that they had a good relationship and there were never any issues between them. He said that Mr Cope struggled throughout the time that he knew him and was not in the "right frame of mind".
47. On 2 October, a substance misuse recovery worker reviewed Mr Cope, who told her that he had not had any thoughts of self-harm recently.
48. Over the next month, officers did not raise any concerns about Mr Cope and there were no meaningful entries about him in his prison or medical records. He continued to receive support for his substance misuse. By 4 November, Mr Cope was taking 7ml of methadone a day and was reducing it by 2ml a week.
49. On 7 November, a prison GP reviewed Mr Cope. He noted that Mr Cope was reducing his methadone without any issues and appeared to be well. The same day, a therapist saw Mr Cope for a counselling assessment. In his referral form, Mr Cope had written that he hoped therapy would help him come to terms with not seeing his daughter. Mr Cope told the therapist that he had "mild" thoughts of suicide, but no plans to act on them.
50. The therapist told the investigator that she explored Mr Cope's thoughts of suicide with him. She said that she was not concerned because Mr Cope said that they were "just thoughts" and did not have a plan to kill himself. She did not think that Mr Cope needed ACCT monitoring because he continued to be supported by the substance misuse team. There is no evidence that she told officers about their conversation.
51. On 13 November, a substance misuse recovery worker reviewed Mr Cope. She noted that he had already reduced his methadone dose to 5ml per day. She

recorded Mr Cope would continue taking 5ml for five more days, until 18 November, when he was expected to stop taking methadone altogether. Mr Cope said that he was not sleeping well but did not have any thoughts of suicide or self-harm. The substance misuse recovery worker recorded that Mr Cope had been referred to psychotherapy. This was the last time that the substance misuse team reviewed Mr Cope before he died.

52. On 14 November, an officer introduced himself to Mr Cope as his key worker. Mr Cope said that his trial was going to take place on 27 January 2020 and he was looking forward to “getting it out of the way”. The officer recorded that Mr Cope was keeping active and attending a maths class. Mr Cope told the officer that he has not had many family visits, but was expecting his mother to visit him soon. Mr Cope repeated to the officer that he wanted to see his daughter. He said he was communicating through letters sent via his sister. The officer told Mr Cope that he was going to see him every two weeks for further key worker sessions.
53. On 16 November, Mr Cope told an officer that he had been assaulted by prisoners. The officer asked Mr Cope to speak to the wing manager, a SO. Mr Cope told the SO that he had been “beaten up a few days ago”, but would not say who had assaulted him. Mr Cope showed the SO a “scratch on his stomach”, which had started to scab and a swollen finger. The SO said that the scratch did not look recent but the swollen finger was swollen, so he was worried it was infected. The SO said that he could not investigate without names of the perpetrators, but he planned to move Mr Cope and submitted a security intelligence report.
54. On 17 November, the SO spoke to Mr Cope’s key worker, an officer and a SO, who agreed to relocate Mr Cope to another cell on a different wing. The SO told Mr Cope but he refused to move. The SO told the investigator that he could not remember why Mr Cope refused.

### **Monday 18 November**

55. On 18 November, at around 10.45am, a SO spoke to Mr Cope who still refused to move cells. Mr Cope did not want to leave his cell that morning. The SO told the investigator that Mr Cope had stayed in his cell over the weekend as well. The SO told the investigator that he did not think that Mr Cope was at risk of suicide or self-harm that morning.
56. One of Mr Cope’s cellmates also told the investigator that Mr Cope had not wanted to leave the cell over the previous weekend. He also said that both he and his other cellmate were concerned about Mr Cope’s behaviour in the days leading up to his death and asked officers to check Mr Cope, but they did not do anything. He did not remember who he spoke to. He said that he was worried about Mr Cope, who he remembered would look at pictures of his children for long periods.
57. At around 11.00am, Mr Cope’s cellmate returned to his cell from an education session. Mr Cope had stayed in his cell with their other cellmate. He said that he spoke to Mr Cope on his return and he did not raise any concerns.

58. At around 2.45pm, an officer went to unlock their cell so that they could go to their afternoon activities. Mr Cope's cellmates left the cell, but Mr Cope asked to be locked back in the cell because he was 'on conflict'. The officer said that Mr Cope seemed otherwise fine. The officer locked Mr Cope back in his cell.
59. The officer and one of Mr Cope's cellmates told the investigator that a prisoner is considered 'on conflict' when he cannot move around the prison safely because of issues with other prisoners, including debt, gang-related matters or violence. Prisoners on the conflict list can only go to the healthcare centre or visits, escorted by an officer, but not to workshops or activities. The list of prisoners 'on conflict' is saved in a shared computer drive for all staff to access. An officer from the safer custody department told the investigator that Mr Cope was never on the conflict list.
60. At around 4.10pm, an officer finished his key worker sessions with other prisoners and offered to help unlock cells for those prisoners who had not attended activities on Mr Cope's wing to get their dinner. Mr Cope's cellmates were still in their education sessions.
61. At around 4.45pm, an officer arrived at Mr Cope's cell and opened the observation panel. He told the investigator that he could not see anything inside because "the whole place was dark". The officer opened the door and saw that Mr Cope was hanging from a ligature made of bedsheets, attached to the top of his bunk bed. The officer shouted "staff". (Another officer said that this is widely understood by officers as calling a general alarm.) The officer said that he did not have a radio because he was originally asked to do key work and was not therefore expected to have one.
62. An officer was nearby and went straight into the cell. The other officer also went in and cut the ligature. They placed Mr Cope on the floor. Another officer attended following the call and saw that Mr Cope was on the floor, looked blue and thought that Mr Cope was dead.
63. Body-Worn Video Camera (BWVC) footage shows that at 4.46pm, a SO attended and called a code blue over the radio. (A code blue emergency indicates that a prisoner is unconscious or having difficulty breathing.) At 4.47pm, an officer started cardiopulmonary resuscitation (CPR). One minute later, the SO brought a defibrillator and an Operational Support Grade (OSG), the control room officer, called the ambulance. At 4.49pm, two nurses arrived and placed the defibrillator on Mr Cope's body. Two other nurses also attended. At 4.51pm, nurses took over resuscitation procedures.
64. Ambulance service records indicate that the ambulance arrived at the prison gate at 5.01pm. Paramedics reached Mr Cope in his cell at 5.09pm. They took over CPR but pronounced Mr Cope dead at 5.48pm.

### **Suicide Notes**

65. Mr Cope had written suicide letters to his mother, partner and daughter. Mr Cope wrote that he could not live without them. Mr Cope also wrote to an ex-cellmate at Pentonville. Mr Cope told him about his recent fight with his previous

cellmate and complained that he had not had a job at Belmarsh, although he was attending maths classes.

#### **Contact with next of kin and further Information:**

66. On 18 November, a prison chaplain went to Mr Cope's sister's home to break the news of Mr Cope's death. Mr Cope's funeral took place on 21 December. The prison offered support and paid for the funeral costs, in line with national instruction.
67. Mr Cope's sister told the chaplain that Mr Cope had been in debt in prison and that she had paid money into a bank account on his behalf. She wrote down the name of the prisoner and a phone number and the chaplain submitted a security intelligence report with this information. He also made a note of his interactions with her in the family liaison log which, disappointingly, was not disclosed to the investigator.

#### **Post-Mortem report**

68. The post-mortem examination found that Mr Cope died as a result of suspension (hanging).
69. The toxicology examination found a low therapeutic level of sertraline (an antidepressant) and a non-fatal concentration of methadone, both medications Mr Cope had been prescribed. No other drugs or alcohol were detected.

#### **Support for prisoners and staff**

70. After Mr Cope's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
71. The prison posted notices informing other prisoners of Mr Cope'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 Cope's death.

# Findings

## Assessment and management of risk

72. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, provides a non-exhaustive list of a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. These require staff to take appropriate action, such as starting ACCT procedures or referring prisoners to the mental health team.
73. Although we recognise that Mr Cope received good support from the substance misuse team and adequate psychological input, we consider that staff at Belmarsh prematurely closed Mr Cope's ACCT before all his issues had been addressed.
74. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and their triggers of distress and they should be updated following every case review. Mr Cope's caremap at Pentonville highlighted three issues: stress, drug use, and lack of purposeful activity, but did not include any support for the other issues he had raised: his concerns about his trial and sentence, contact with his daughter and mental health. Nothing further was added to the caremap at Belmarsh. On 4 September, a SO and a nurse assessed that Mr Cope was no longer at risk of suicide and self-harm and closed the ACCT without considering supportive actions to address his outstanding issues. In practice, this meant that the ACCT did not serve to reduce any of Mr Cope's risk factors.
75. PSI 64/2011 requires the post-closure interviewer must review the prisoner's risk levels after the ACCT was closed before deciding whether it should remain closed or be re-opened. On 11 September, Mr Cope told a SO his risk factors remained unresolved but there is no evidence that the SO explored these issues any further. We are concerned that the SO told the investigator that he did not check any documentation for the post-closure interview, including the caremap, and that he simply followed a template questionnaire. Post-closure interviews are an important opportunity to further assess the risk of suicide and self-harm. This opportunity should not be underestimated.
76. We consider that if staff had reviewed and monitored Mr Cope effectively, they might have concluded that he remained at raised risk of suicide or self-harm while at Belmarsh. His cellmate told the investigator that Mr Cope struggled throughout his time at the prison. In the event, no staff at Belmarsh supported him to manage his anxiety about his sentence, family contact and fear of violence, which remained risk factors until his death.
77. We are also concerned that staff from other disciplines did not share important information with prison officers. On 3 September, before Mr Cope's ACCT monitoring was stopped, Mr Cope talked about having suicidal thoughts with a mental health nurse during an assessment. Just five days before he died, on 13 November, Mr Cope told a substance misuse worker that he had suicidal thoughts. Neither considered Mr Cope to be at imminent risk of suicide or self-harm, but neither shared this information with officers. Suicidal thoughts are a key indication of an individual's risk and healthcare staff should actively share such information with officers.

78. We make the following recommendations:

**The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that:**

- **they identify all risk factors and assess a prisoner’s risk using all relevant information;**
- **they complete and update caremaps at case reviews, setting out specific and meaningful actions, identifying who is responsible for actions and reviewing progress at each review;**
- **they ensure that the ACCT is not closed until the prisoner’s concerns have been fully addressed; and**
- **post-closure reviews are carried out thoroughly.**

**The Head of Healthcare should ensure that healthcare staff and substance misuse share all risk information with those involved in a prisoner’s care.**

### **Meaningful support and the key worker scheme**

79. We are concerned that following the ACCT closure, there is no evidence that wing staff had any meaningful interaction with Mr Cope during the 11 weeks he spent at Belmarsh. The only record of note in his prison record was a SO’s retrospective entry on 16 November that Mr Cope had told him “a few days ago” that he had been assaulted.

80. He did not have an allocated key worker until two months after he arrived at Belmarsh and Mr Cope’s key worker therefore only met him once two days before he died (although they did then have a good discussion).

81. The key worker scheme is designed to help officers identify prisoners’ needs and provide support. Belmarsh’s local key worker policy says that key workers will be allocated an average of 45 minutes each week for key worker duties with each prisoner on their caseload, including one-to-one contact. Mr Cope’s key worker told the investigator that he expected to speak to his allocated prisoners every fortnight. We consider that the prison needs to make it clear whether key workers are expected to have a discussion with their prisoners once a week or once a fortnight. We make the following recommendation:

**The Governor should ensure that:**

- **wing staff know what is expected of them in terms of engagement with prisoners and record these interactions;**
- **key workers have regular meaningful discussions with the prisoners on their caseload; and**
- **key workers are clear whether they should see prisoners weekly or fortnightly under the prison’s key officer policy.**

## Fear of violence and self-isolation

82. We are very concerned that, neither the officer nor the SO took meaningful action on 16 November to support Mr Cope after he said that he had been assaulted and was under threat. The SO should have considered opening a violence reduction support plan, or at least asking officers to monitor and support Mr Cope informally. He should also have considered whether Mr Cope was at risk of suicide and self-harm as a result of his concerns.
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. Belmarsh did not have a self-isolation policy at the time of Mr Cope's death with guidelines to staff on how to manage, monitor and support prisoners who isolate themselves.
84. In our investigation into a previous death at Belmarsh in April 2019, we recommended that the Governor issue a policy on managing prisoners who self-isolate. We are currently waiting for the prison's response. In the meantime, we repeat the recommendation:

**The Governor should ensure that there is a policy in place setting out how staff should manage, monitor and support prisoners who isolate themselves.**

## Mr Cope's debt

85. After Mr Cope's death, his sister told the prison chaplain that she was transferring money on behalf of Mr Cope to another prisoner in payment for a debt. She said that she had not told the prison about this before. The chaplain submitted an intelligence report which the Head of Security said was the first intelligence they had received that Mr Cope was being bullied.
86. The Head of Security said that the possible perpetrator of the bullying had been known to the security department since October 2018, shortly after he arrived at Belmarsh. Staff submitted reports related to his drug involvement, bullying and extortion of other prisoners. The Head of Security said that there had been nothing linking Mr Cope and the other prisoner before Mr Cope's death. Staff monitored the prisoner's calls and carried out searches of his cell on 19 September and 21 November 2019 but found nothing relevant. Because of Mr Cope's death and the information that followed, officers placed the prisoner on special monitoring on 28 November.
87. Belmarsh has a comprehensive debt management policy which includes methods for visitors and families to report debt, including the use of a helpline. The prison provides a national leaflet explaining the impact of debt on a prisoner's safety to families, and advising that families should never get involved in trying to pay back a prisoner's debts.
88. We are satisfied that the prison was not aware of Mr Cope's debt issues, but we recognise that this could have been an important risk factor for Mr Cope. The

prison's lack of awareness reinforces our findings in this report, in particular, the need for more meaningful officer-prisoner contact.

### **Clinical Care**

89. Mr Cope did not have a severe a diagnosed enduring mental health problem or a significant physical health problem. The clinical reviewer said that the care provided to Mr Cope both in relation to his substance misuse and his mental health issues was equivalent to the care he could have expected to receive in the community.
90. After reviewing BWVC footage, the clinical reviewer was satisfied that the emergency response, including resuscitation attempts, were carried out appropriately and in line with current guidance.

### **Learning Lessons**

91. In order to ensure that the lessons of this investigation are learned, we recommend:

**The Governor should ensure that a copy of this report is shared with staff named in this report.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations