

**Investigation into the death of a man
whilst in the custody of HMP Belmarsh
in June 2010**

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

August 2011

This is the report of an investigation into the death of the man. The man was found hanging in his cell at HMP Belmarsh and was pronounced dead by paramedics and the prison doctor. He had been in custody for nearly six months and was waiting to be sentenced. The man was 25 years old.

I would like to offer my personal condolences to his family, friends and everyone affected by his death. I am sorry that my report has been delayed and I regret any additional distress which this has caused.

The investigation was undertaken by one of my investigators. In addition, the investigations manager from NHS Greenwich, and an independent General Practitioner, conducted a clinical review of the care received by the man. I am grateful for their contribution to the investigation. I also thank the Governor of Belmarsh and his staff for their participation in the investigation.

Having appeared in court on 25 January 2010, the man was remanded into custody at HMP Pentonville. There were immediate concerns that he would harm himself and suicide monitoring procedures were put in place to ensure that he was supported. The man complained that he heard voices and felt depressed. He was prescribed medication but refused to take risperidone because of the side effects. The support procedures were closed on 11 March.

On 22 March, the man transferred to HMP Belmarsh, where he appeared to settle well, with staff reporting no worries about his behaviour. On 2 June, he made two telephone calls to his ex-girlfriend (the victim of his offences) when they discussed their relationship problems. Later that day, at around 2.45pm, a fellow prisoner, who had noticed that the man had not come out of his cell for his cleaning job, went to check on him. The man was discovered hanging in his cell. The man had given no indication to staff or other prisoners that he intended to harm himself.

My report makes two recommendations relating to repeat prescribing and obtaining information at reception.

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

Thea Walton
Acting Deputy Prisons and Probation Ombudsman

August 2011

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SUMMARY

1. After appearing at court on 25 January 2010, the man was remanded to HMP Pentonville. He had a history of self harm and depression, and depended on both alcohol and cocaine. He had continually punched himself while he was at court and on the way to Pentonville, and suicide support procedures were put in place when he arrived to ensure that he was monitored and supported appropriately. A referral was also made to the mental health team. He said that he had nothing to live for and wanted to stop hearing the voices in his head. He was placed in a double cell and observed at regular and frequent intervals.
2. On 11 March, the support procedures were closed. During a post closure review, held a week later, the man said that he no longer had any suicidal thoughts and felt positive about the future.
3. The man attended Basildon Crown Court on 22 March, and was taken to HMP Belmarsh after the hearing. He went through the normal reception screening and induction process. It was noted that he had previous substance misuse problems, drug induced psychosis, had self harmed and had been supported under the suicide support procedures whilst he was at Pentonville. However at this time, he gave no indication that he might want to harm himself.
4. In the next few weeks, the man settled into the prison regime at Belmarsh. Staff reported no concerns with his general well-being and he went on to be employed as a wing cleaner.
5. On the morning of 2 June, he spoke to his ex-girlfriend on the telephone. Having reviewed the content of these conversations after his death, he and his ex-girlfriend seem to have been having relationship problems. Another prisoner saw how upset the man was after speaking to his ex-girlfriend, but did not think that he would harm himself.
6. Later that morning, the man collected his lunch as usual. He was in his cell alone during the lunch time break (approximately 11.30am -12.15pm) and was seen in his cell by staff when they carried out a routine check. At around 2.45pm, a fellow prisoner looked through his cell door flap as he had not seen him after the cells were unlocked. He saw the man hanging by a ligature from the ceiling light fitting in his cell and immediately called for staff assistance. Staff went into the cell and called for medical assistance. Cardio pulmonary resuscitation (CPR) began and the paramedics arrived to take over. However, the man was pronounced dead at 3.21pm.
7. I make two recommendations as a result of this investigation. They relate to obtaining information at reception and repeat prescribing of medication.

THE INVESTIGATION PROCESS

8. The investigation into the man's death was opened at HMP Belmarsh on 8 June 2010 by one of my investigator, assisted by the manager of Greenwich. They met the Governor of Belmarsh and some of his staff. Notices of investigation and terms of reference had already been sent to the prison, inviting anyone with any information to contact the investigators.
9. They later met and formally interviewed a number of prison staff. They visited all parts of the prison including the house block where the man lived. They also met representatives from the Prison Officers' Association and the Independent Monitoring Board and met the prison liaison officer. I thank her for her assistance throughout the investigation.
10. Regrettably the investigation was delayed throughout because of difficulties arranging suitable interview times for staff working at the prison. This has already been brought to the attention of the Governor. Also some staff were not available to be interviewed and information was obtained from alternative sources.
11. The man's prison records, including his medical record, were made available during my investigators and his assist's initial visit to the prison. Additional documents were provided on their return visits to the prison to interview staff.
12. A clinical review of the man's medical care was commissioned from NHS Greenwich. Although there was a delay in its completion, I would like to thank the investigations manager from Greenwich and the clinical reviewer for their contribution to the investigation. Their report has been disclosed to the Primary Care Trust.
13. One of my senior family liaison officers contacted the man's family to inform them of the investigation. My family liaison officer and my investigator subsequently visited the man's mother at her home where she raised the following concerns:
 - Some items of the man's personal possessions were missing when his property was returned to the family.
 - A letter that was sent by the family to the man in prison was later returned to them through the post and marked "PB not here". The family were upset by this lack of sensitivity.
 - Why did the prison contact the man's partner to inform her of his death as she was not his next of kin?

BACKGROUND

HMP Belmarsh

14. HMP Belmarsh opened on 2 April 1991 and is a local prison, serving primarily the Central Criminal Court and its feeder magistrates' courts in south east London. In addition, the establishment serves Crown and magistrates' courts in south west Essex. Belmarsh has a dual role, in that it also holds category A prisoners. There are four residential house blocks and a High Security Unit within the prison.

HM Chief Inspector of Prison's report

15. The most recent inspection of Belmarsh by Her Majesty's Chief Inspector of Prisons was an unannounced full follow-up inspection in April 2009. In a report published in December 2009, her comments included:

"Suicide and self-harm prevention was taken seriously, and there was some good work, but with a tendency to over-medicalise the issue. Over half the prisoners at Belmarsh said that they had at some time felt unsafe there, and the prison's own bullying survey had revealed low levels of confidence in the anti-bullying system.

"Relationships between staff and prisoners had improved, but were still mixed. Most interactions we observed were good, particularly on the first night and drug treatment units, and more prisoners said that there was a staff member they could turn to.

"Healthcare services had deteriorated since the last inspection, and there was an urgent need for re-engagement between the prison and the primary care trust (PCT). Mental health provision had decreased considerably, and the excellent and much-needed Cass unit was under-used and under threat. Primary healthcare in general was in some disarray, with the ending of the current GP contract, poor management of clinical records and some serious deficiencies in pharmacy services."

Cell Sharing Risk Assessment (CSRA)

16. In order to make sure that unsuitable prisoners do not share cells, a cell sharing risk assessment is completed by reception staff when a prisoner first arrives at the prison.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

17. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes, and can offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary, by application.

Critical debrief

18. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, review their feelings and reactions after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment.

Cut down tools

19. Each officer and member of healthcare staff who is in contact with prisoners carries an anti-ligature knife. They are knives which are specially designed to cut through ligatures in a safe manner.

Emergency response codes

20. Emergency codes are used to summon staff to deal with a particular situation. If there is a medical emergency, the call "Hotel 99" (which refers to healthcare) is put over the radio. This refers to life threatening situations such as hanging, severe blood loss or cardiac arrest. Such emergency situations require immediate attention from healthcare staff as the prisoner cannot normally be escorted to the healthcare centre for treatment.
21. Healthcare staff have emergency bags located around the prison. They contain life support equipment which includes airways, ambu bags (breathing aid), oxygen, needles and syringes. There are 12 defibrillators located around the prison.
22. The general alarms are linked to the Control Room. When the button is pressed (the buttons are found on the wing landings), the Control Room broadcasts the location across the radio network throughout the establishment so that staff from other areas can respond.

Listeners and Insiders

23. Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners at risk of self harm.
24. Insiders are prisoners who volunteer to work in the First Night and Induction wing and Reception, welcoming new prisoners and explaining the processes they will encounter in the early days of custody.

Mental Health In-Reach Team

25. The In-Reach team offers a mental health service for all prisoners who have enduring mental illnesses. They also treat and support prisoners who have mental health problems, offering intervention in crisis situations. The team supports prisoners who are at risk of harming themselves and attend most of their review meetings.

Person Escort Record (PER)

26. The police, courts, escort and prison services have an agreed procedure for sharing information about prisoners as they are moved between their establishments. It is essential that those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular it is essential that known risks of escape, assault, suicide or self harm or harassment are communicated to those with responsibility for the prisoner; to protect prisoners, staff and the public. It is also essential that any new risks that arise during a movement are recorded and flagged up. The PER is the key method for ensuring that information about the risks posed by is always available to those responsible for their custody.

Reception and induction

27. A Cell Sharing Risk Assessment (CSRA) is opened by a reception officer who completes the basic details. The form is handed to the First Night Centre staff where a confidential interview is conducted. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells. While primarily aimed at establishing the level of risk of prisoners sharing cells, it also includes other occasions when space may be shared, for example when a prisoner asks to see a Listener.
28. Reception staff do not routinely have access to a prisoner's past records and so the prisoner is the main source of information. If a prisoner has transferred from another establishment, his past record usually arrives with him which should include the PER form.
29. The initial healthcare screen concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.
30. All new prisoners are located on the induction wing. They are asked whether they have any immediate concerns, such as disability, their offence and general well being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, and telephone pin numbers and visiting arrangements are explained.

Roll check

31. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct. Staff carry out a physical head count to ensure that the prisoner is in his cell and the cell door is locked. If they cannot see the prisoner, staff must open the door to investigate further until they are satisfied that the person is in the cell.

32. Local procedures at Belmarsh state that roll checks should be conducted at the following times:
- 6.00am by the night staff before handing over to day staff
 - 12.30pm (11.45am on Fridays) at lunchtime lock-up
 - 5.15pm at the end of the core day, following activity/association
 - 8.30pm (Monday to Thursday) at the end of the association
 - 9.00pm at the end of the working day by the late patrol officer

Suicide and self harm monitoring procedures

33. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individual care and support before, during and after a period of crisis. Once the ACCT procedures are closed, a post closure review should take place within seven days.
34. Since my office took responsibility for investigating deaths in custody in 2004, there have been seven previous self-inflicted deaths at Belmarsh. Recommendations relating to record keeping have been raised in two of these reports.

KEY EVENTS

Events at HMP Pentonville prior to the man's arrival at HMP Belmarsh

35. The man appeared at Havering Magistrates' Court on 25 January 2010 and was remanded into HMP Pentonville. He was charged with wounding and grievous bodily harm and his ex-girlfriend was the victim of the alleged offence. He was assessed by a prison doctor who noted that the man had a history of self harm, depression and depended on both alcohol and cocaine. The ACCT suicide and self harm support procedures were put in place as the man had continually punched himself at court and on the way to Pentonville. He had also hit his head with his fist and the wall whilst at the police station.
36. The following day, an ACCT review and care plan was completed. The care plan said the man should be located in a double cell with hourly observations by staff, and he should have unlimited access to the telephone and listeners if he requested them. The man said that he had "nothing to live for" and wanted to stop the voices he heard in his head. He was homeless and said his relationship with his ex-girlfriend was in trouble. Staff made a referral to the mental health team. In addition, the man agreed to apply to St Mungo's (a housing charity) for help with housing, to contact his family regularly and to see the doctor for medication. The ACCT was to be reviewed on 2 February.
37. Later that morning, the man poured hot water on his leg, which he had also cut. Staff took him to the healthcare treatment room where the cuts were dressed and plastered and he was seen by the doctor. The man said he had been having auditory hallucinations since before Christmas, the symptoms having started after his relationship with his ex-girlfriend came to an end. The doctor noted that the man was sleeping poorly, had lost his appetite and had lost weight since Christmas.
38. The man was assessed by a Counselling, Assessment, Referral, Advice and Throughcare (CARAT) worker on 27 January. The CARAT records stated that he started using cocaine in October 2009 due to the breakdown of his relationship. He said that he used between £251 and £500 of cocaine every week and drank 25 units or more of alcohol a day. Although the man was not thought to require further formal CARAT intervention, he was referred to Alcoholics Anonymous and the alcohol workshop. The CARAT worker noted that the man should be referred immediately because he had harmed himself. She contacted the healthcare department with these concerns.
39. The man was subsequently assessed by a member of staff from the psychology department. He said that he felt very low and had nothing to live for, although he had no current plans or intent to harm himself. A referral for counselling was made. Hourly observations continued and he was prescribed risperidone (which is commonly used to treat schizophrenia and schizoaffective disorder) and fluoxetine (an antidepressant).
40. The man was seen the following day by a CARAT worker who said that he appeared more relaxed. He told the CARAT worker that he had been given

sleeping tablets by the doctor but was worried they were being stopped that night and he might start hearing voices again.

41. On 29 January, prison Doctor A conducted a mental health review with the man and described him as stable. The man said he was not sleeping well, which usually led to him to hearing voices. He talked about his background and family life and denied having had any previous contact with a psychiatrist or psychologist. The doctor increased his risperidone prescription and planned a further review for two weeks time.
42. The ACCT support procedures remained in place for the man. At his next review, held on 2 February, he talked about his family circumstances and life history. He was still taking his medication. He was very talkative in the meeting, said that he accepted that his relationship had ended and wanted to get on with his life for his children's sake. At the end of the review, it was agreed that the ACCT document should remain open and his observations were to be reduced to every two hours.
43. The man completed his alcohol detoxification on 5 February. He told staff during the day that he was annoyed because his ex-girlfriend had sold his work tools. After talking to staff, the man calmed down and started to slowly come to terms with the news. He saw a doctor that day as was still suffering from poor sleep and was prescribed zopiclone (used to treat insomnia).
44. On the evening of 8 February, during the ACCT checks, the man was found attempting to commit suicide. He had made a ligature from bed sheets to hang himself. He was taken out of his cell and an ACCT review was carried out immediately with the man, a senior officer (SO) and a principal officer on the wing. The man was very tearful, distressed, and said he wanted to "end it all". He was moved into healthcare where, to keep him safe, he was constantly watched by a single member of staff.
45. On 9 February, the man discussed the previous day's events with a healthcare worker. He told the nurse that, when he was in the community, if he took alcohol and drugs he would usually "blank out" and find himself in a police station the next day. He disclosed that he had previously been admitted himself to hospital. The man added however that he wanted to get help now as he had two children to look after.
46. Later that day, another SO and a doctor completed an ACCT review. The man appeared to be relaxed and settled but the doctor wanted the constant watch to continue due to his attempt to harm himself the day before. Also, he had not yet been properly assessed by the mental health team. The doctor increased his risperidone prescription and his other medication was to be reviewed. An ACCT review was planned for the following day, and a doctor from the mental health team was asked to attend.
47. At the ACCT review the next day, it was noted that the man demonstrated a good understanding of his self harm attempt which had led to his healthcare admission. He said that he wanted to get better. The doctor noted that the

man had no major problems and was eating and sleeping well. He was concerned about the pending court case and his relationship with his ex-girlfriend, but he denied having any active thoughts of harming himself. The doctor advised that the ACCT support should continue with the man's observations reduced to every four hours. The next ACCT review was scheduled to take place on 17 February.

48. On 10 February, the man was reported by staff as eating and drinking well and they did not see any more incidents of self harm.
49. A mental health review took place on 15 February. The doctor said that the man appeared depressed, had a history of alcohol and substance abuse and continuing auditory hallucinations. His risperidone medication was increased again and his antidepressant medication was to be reviewed in due course.
50. In the ACCT review on 17 February, the man said that he was hearing voices which occasionally told him to harm himself. He said however that he had no intention of doing so. He was participating in association and agreed to attend cookery classes. The man said that he appreciated the monthly visits from his family. The ACCT remained open and a review was scheduled for 24 February.
51. On 19 February, it was noted on the ACCT form that the man had red marks on his cheek and forehead. He had made them with a broken plastic fork, which he had thrown away. He said that his medication was working but, when it wore off, he saw "little men".
52. Five days later, on 24 February, the man was interviewed by a CARAT drug worker. He spoke about wanting to get fit and overcome his drug problems for the sake of himself and his children. He wanted to complete the relapse prevention work and was given work by the CARAT worker to do in his cell. However, as the man was in healthcare, he was unable to attend the relapse prevention workshop.
53. Later that day, an ACCT review was conducted. The man and two members of staff, including a nurse, attended. The man discussed his concerns about having access to his children. He admitted to hearing voices but said that the medication was helping. His medical records noted that he continued to hear voices which brought on panic attacks, and his dreams caused him to have an erratic sleep pattern. The man was however keeping himself occupied by helping to paint the ward. The next ACCT review date was set for 3 March
54. On 1 March, the man had a mental health review. He was reported as having an erratic sleep pattern, agitation, low mood and ongoing suicidal thoughts (although he said that he had no plans to act on them). He said that he was having fewer auditory hallucinations and asked for a test for Attention Deficit Hyperactive Disorder (ADHD). He said that he was missing his children as he had not seen them for about six weeks.

55. Later that day, the man smeared himself with faeces and told staff that he was worried about his forthcoming court appearance on 3 March. He was given support and reassurance by the healthcare staff. The following day, his records noted that he was tearful and anxious.
56. The man appeared at Havering Magistrates' Court on 3 March and was remanded back to Pentonville later that day. He was seen by a doctor on his return, who noted that the man remained unpredictable and easily irritable if his needs were not met. The doctor continued his current medication and the man remained on the healthcare wing. Later that day, he seemed positive, believing that he would not get a long sentence. After another ACCT review that evening, the next review was set for 10 March and a mental health worker was invited to attend.
57. On 10 March, the man complained that his risperidone medication was causing him side effects. He was due to have an ACCT review, but this was postponed as staff were not available.
58. The postponed ACCT review took place on 11 March. The man, a senior officer, a prison officer and two nurses attended. The man was friendly and approachable and said he had not harmed himself for a long time. He wanted to complete an anger management course and move on, as he believed that he would not benefit in any way from being located in healthcare wing. The staff were content with the man's well being and so the ACCT document was closed.
59. At a mental health review the next day, the man again denied having any psychotic symptoms or thoughts of wanting to harm himself. He had refused to take his risperidone medication for two days and this was discussed at the meeting. The man said that it made him feel anxious and asked for valium to be prescribed instead.
60. Over the next couple of days, the man continued to refuse his night medication. He also became more vocal about his opinions of healthcare staff. He said that there was nothing wrong with him or his behaviour and he wanted to leave healthcare. A follow up mental health review took place on 15 March where it was noted that the man's behaviour had become more challenging since he had refused his risperidone. He was still receiving fluoxetine.
61. On 17 March, the man was seen by a doctor who noted that he had not taken his risperidone for seven days because he said it caused side effects. He was not hearing voices anymore, nor did he have any thoughts of wanting to harm himself. The doctor assessed the man as fit to leave healthcare and move to a residential wing and his risperidone was to be discontinued.
62. The man was moved from healthcare to a residential wing the following day. The ACCT post closure review was held the same day with two senior officers present. The review noted that he had no suicidal thoughts and was positive about his future. The ACCT therefore remained closed.

The man's transfer to HMP Belmarsh

63. On 22 March, the man was escorted from Pentonville to appear at Basildon Crown Court. He was convicted of wounding and grievous bodily harm but not sentenced. Following his court appearance, he was transferred to HMP Belmarsh.
64. He was interviewed in reception by Officer A. (Officer A was one of the staff who was unavailable to be interviewed by the investigators.) Officer A carried out the initial reception interview with the man. He also completed a cell sharing risk assessment (CSRA) on which he assessed the man as "medium" risk. He noted "Smoker stated that he would harm other prisoners if he had to share with them. SIR [Security Information Report] submitted". The SIR also noted that the man "stated that he had medical issues".
65. As part of the reception process, the man was interviewed by nurse A. Nurse A told the investigators that he would have had the man's medical records with him and interviewed him to check his immediate medical needs.
66. The man said that he was being prescribed fluoxetine. However, as he had left Pentonville that morning, he had not received his daily dose. Nurse A said that this was not an immediate concern as fluoxetine builds up in the system so a patient could miss one dose without suffering any adverse effects. He referred the man to the doctor to ensure that fluoxetine was prescribed and because he had previously been prescribed risperidone.
67. Officer B was the diary officer on duty. She checked the prisoner's core records for any relevant risk indicators (drugs, self harm, violence, which are then written into their history sheet on duty). She did not meet the man but she checked his core records and Prisoner Escort Records (PER) for anything of relevance. The man's PER mentioned violence and Officer B added this to his prison history sheet. When asked by the investigators if she recalled receiving information about the ACCT procedures, Officer B said that she did not. She said that, had she received such information, she would have noted that he "was on an open ACCT now closed", thus making sure that other staff knew what had happened previously. (The man's ACCT paperwork was not received at Belmarsh until eight days later on 30 March.)
68. The man was taken to the induction wing, house block three. He was interviewed by Officer C, who completed an induction passport by collecting information about his immediate needs. She highlighted mental health issues as he said he was suffering from depression. She also noted that he had been taking risperidone but had stopped because of the side effects. The man said that he had tried to hang himself in January and had been supported by the ACCT procedures whilst he was at Pentonville. However, he said that he had no current thoughts of harming himself. From her assessment, Officer C said she had no concerns that the man was at risk. She did not, therefore, open an ACCT although she did tell the nurse on duty about these matters.

69. The healthcare officer on duty, Nurse B, interviewed the man next and referred him to the mental health team. (Nurse B was unavailable for interview during the course of the investigation and the investigator could not find a copy of the reception healthscreen.) The reason for referral was noted as the man's statement that he had schizophrenia and was taking risperidone and fluoxetine. The nurse noted that the man had misused drugs in the past and questioned whether he was experiencing a drug induced psychosis. Nurse B also noted that the man had attempted suicide and had previously burnt his right foot.
70. The man was seen by the prison doctor and reassured. Shortly after this screening, he would have been taken to his cell. There were no concerns noted about his first night at Belmarsh.
71. All new prisoners have an induction talk to familiarise themselves with the prison. The man's induction continued the following day, 23 March. He was seen by Officer D who completed a cell sharing risk review as the man's CSRA had been assessed as a "medium" risk when he arrived. The man maintained that he did not want to share with prisoners such as "substance abusers". The CSRA subsequently remained as medium risk. Officer D noted that the man had attempted suicide at Pentonville but had no current thoughts about harming himself.
72. The man also had a secondary health assessment but his medical records, do not identify which healthcare officer carried it out. The record was made by an IT data summariser employed by NHS Greenwich PCT. From the investigator's enquiries, it is likely that the secondary assessment was also carried out by Nurse B. The entry noted that the man had depression and was taking fluoxetine and zopiclone. Nurse B noted that the man felt emotionally unstable.
73. The investigators interviewed Nurse C, the Mental Health In-Reach Manager. The man's mental health referral was discussed by the mental health team on 23 March. They were doubtful about the diagnosis of schizophrenia, noting that it was rare for risperidone to be stopped and fluoxetine (an anti-depressant) to be substituted. Nurse C attempted to see the man on 24 March to obtain further information. However, he was unavailable as he was having an induction talk.
74. Nurse C telephoned Pentonville's mental health in-reach team and was told that the man had been assessed but that schizophrenia had not been diagnosed. His symptoms were described as due to poor coping skills and occasional anxiety problems rather than schizophrenia. Nurse C knew that the man had been supported by the ACCT procedures even though his medical documents and ACCT documents were not yet available.
75. Nurse C referred the man to the Occupational Therapy Department so that he would receive support and help with effective coping skills. (The occupational therapist later made an appointment to see the man, but he failed to attend.)
76. On 26 March, the man referred himself to the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team. A CARAT worker, told the

investigators that he interviewed the man on 9 and 27 April when he made both an initial and a comprehensive substance misuse assessment.

77. The man told the CARAT worker that he had last used cocaine in January 2010. He said that feeling stressed and being in a low mood were triggers for taking the drugs. The assessment suggested that the man had high treatment needs and an increased risk of taking drugs. A care plan was drawn up to address these risk factors and increase his understanding in order to prevent a relapse. The CARAT worker referred the man to the prisons drug treatment programme, a Short Duration Programme (SDP) and the integrated drug treatment system (IDTS) group work. (Although he was assessed as suitable for the SDP on 19 May, he would have been unable to attend as he was due in court.)
78. Prison Doctor B continued the prescription for fluoxetine, as well as prescribing nytol (a sleeping tablet) for the man. He told the investigators that he wrote repeat prescriptions at the request of nursing staff, and did not see or examine the man. The doctor said that it was impossible to review the whole medical record each time that a repeat prescription was requested and he would follow the initial treatment plan decided at the reception healthscreen by the doctor and nurse. Any necessary referrals would also have been made at that stage.
79. Senior Officer A (SO) had frequent contact with the man on house block three. He described the man as a quiet young man who presented no problems to staff. He settled on the wing and soon became employed as a wing cleaner. Officer E concurred with the SO A's view of the man, describing him as a happy and polite individual. The man also worked in the servery where he interacted well with both staff and other prisoners. Due to his work activities, the man was out of his cell a lot of the time and Officer E said there was never an issue about his behaviour.
80. The man's first cellmate who shared the cell with the man for about four weeks until about a week before the man's death. He described the man as a "bubbly fellow" who everyone knew. He did not speak about his time at Pentonville, including the suicide attempt, and the man's cellmate did not know if he took any prescribed medication. The man did confide about his relationship problems with his ex-girlfriend and his worries about losing his children. The man was also concerned about the length of sentence which he might have to serve.
81. On 27 May, the man telephoned his mother at 4.29pm. (The prison provided the investigators with the typed transcript of the man's telephone calls which were not monitored at the time.) They had a five minute conversation about his ex-girlfriend and their children. The following day, at around 4.40pm, the man telephoned his ex-girlfriend and they spoke about their relationship and its problems. The man said that he missed both her and their children.
82. Five days later, on 1 June, the man made two more telephone calls to his ex-girlfriend at 2.57pm and 3.17pm, both for about ten minutes. The first call sounds light hearted and the man spoke to his children. During the second

conversation, the man said that he had seen an officer from the public protection unit. His ex-girlfriend had notified the police that he had written to her, something he was not allowed to do as she was the victim of his crime. The letters were returned to him. His ex-girlfriend told him that she had given this information to the police some months ago. She said that she was happy to receive correspondence from the man now, so that he could send letters and cards for their children. Their conversation appeared to be friendly and the man said that he hoped that she did not forget him whilst he was in prison.

Events on 2 June 2010

83. The man's second cellmate was moved to house block three around the beginning of May where he shared a cell with the man after cellmate A moved to another wing. He was employed in the reception area, where he worked each day between 9.00am to 8.00pm, remaining there during the lunch period.
84. Officer F was the officer in charge of spur 1 that day. She told the investigators that at about 8.00am, as soon as the man was unlocked from his cell, he asked her to contact the public protection unit. He said that he was worried about what they had told him about ending the contact with his children. The man also submitted three applications to attend courses, namely the Thinking Skills Programme, Victim Awareness and Anger Management. Officer F sent off his applications that morning. She also telephoned the public protection unit and was told that the man could have contact with his children because he had now been convicted. This information was passed to him later that morning, which he was happy about.
85. The cleaners' cells, including the man's, are left unlocked until lunchtime and they can leave their cells and use the telephones whenever they wish. The man's second cellmate said that he and the man had a cup of tea together when they woke up and the man said that he intended to telephone his ex-girlfriend. The cellmate knew they were having relationship problems and, the previous night, the man was "ranting and raving" about things which he intended to resolve after being released. The cellmate talked to him about the situation and, after a while, he appeared to calm down. The man also said that he had had an argument with his mother a few days ago about his relationship with his ex-girlfriend. However, when the cellmate left their cell for work at about 9.00am, he had no concerns about the man who seemed "absolutely fine".
86. The man made two consecutive telephone calls to his ex-girlfriend that morning timed at 11.06am. He said that he was getting help with his substance misuse problem and thought that he might receive a six year sentence. In the second conversation, the man learnt that his ex-girlfriend had a relationship two months previously with someone who he knew. Although he was upset, their conversation appeared to end on a more positive note, with talk of a possible reconciliation.
87. After speaking to his ex-girlfriend, the man went to prisoner A's cell (which was on the same landing near the telephones) to speak to him. The prisoner told the

investigators that the man was angry and, whilst complaining about his ex-girlfriend, kicked the cell toilet door in frustration. The prisoner managed to calm him down and they both returned to the man's cell. Here, the prisoner made them both a cup of coffee and they played a game of cards. The man remained angry for a while but calmed down by the time when lunch time approached.

88. Prisoner B saw the man after he spoke to his ex-girlfriend on the telephone. The man told him about their conversation. He said he and other prisoners spoke to him about how he felt and tried to advise him. The prisoner said that he did not think the man was suicidal and "it was a major shock" when he heard that he had died.
89. Prisoner C lived in the cell next door to the man and had spoken with him that day. The man told him that he had spoken to his ex-girlfriend and explained what they talked about. Prisoner C said he did not ask too many questions but thought that the man seemed alright. He later walked behind the man to collect their lunches from the servery. They both returned to their respective cells which are locked over the lunch period. The man was alone as his cellmate B, stayed at work.
90. Between 12.00pm and 12.30pm, Officer G completed a roll check of all the prisoners on that spur. He said that he looked into the man's cell and saw him sitting watching the television, with his back to the door. Officer G said that he did not notice anything untoward and the man raised no concerns with him when he opened the cell observation flap. Officer G told the investigators that, after completing the roll check, he left the prison as he had finished his shift.
91. Officer H told the investigators that he began his shift on houseblock three either at 12.15pm or 1.30pm. He explained the procedure for unlocking prisoners after lunch. At 1.50pm, staff start unlocking prisoners on the top landing, at cell number 42, and then work their way round unlocking prisoners who are listed for activities such as work, gym or visits. If a prisoner is not listed for an activity, their cell stays locked.
92. The prisoners who are going to an activity gather on the middle landing, from where they leave the spur, and staff secure their cells. The prisoners are searched before they leave the house block and then make their way to their designated places (called free flow) whilst staff wait to deal with any issues. Officer H said that this would normally be concluded by 2.30pm, after which staff would return to their spur and unlock the cleaners and other prisoners who have appointments. All the other prisoners remain locked in their cells until the evening association period, which begins at around 5.45pm.
93. Officer H and Officer F were responsible for carrying out the unlocking duties on spur 1, houseblock three, but they did not unlock the man's cell even though he was a cleaner. Officer F said that she did not see the man after talking to him earlier that morning. Both described the spur as busy in the afternoons and they dealt with requests from prisoners.

94. Prisoner A left his cell at about 2.30pm after it was unlocked. He walked past the man's cell, which he noticed was closed. He went and talked to other cleaners on the spur for a while and then walked past the man's cell again, still noticing it was locked. As he had not seen the man, he decided to lift the cell observation flap to look inside. When he did so, Prisoner A initially thought that the man was standing over his bed. He soon realised that he was hanging and told Officer I who was sitting nearby to come to the cell.
95. Officer I immediately shouted for staff assistance, unlocked the man's cell door and went inside. He held the man up and waited for other staff to come to assist by cutting the ligature. Officer I told the investigators that the man had used the green bedding sheet as a ligature, which was tied around his neck. The bedding had been put through the ceiling light fitting. The man was cold and the officer saw no signs of life. Officer H had followed Officer I into the cell and tried to take the sheet off the light. Prisoner B also came into the cell and tried to help remove the bedding.
96. Officers E and Officer J responded and made their way to the man's cell. When Officer E went into the cell, he saw the two prisoners and Officer J lifting the man and trying to loosen the ligature from around his neck. Officer E used his anti-ligature knife to cut the ligature and the man was lowered to the floor. Officer F had also responded to the call for staff and she too helped lower the man to the ground. She then radioed the Control Room asking for an ambulance to be called urgently. The alarm was raised at 2.45pm.
97. SO A arrived at the cell as the ligature was being cut. He ushered the prisoners out of the cell and asked a member of staff to inform the house block nurse. He then heard the general alarm over the radio net.
98. Officer H responded to the call for assistance. He had been in the middle landing office dealing with a prisoner's query. When he arrived at the cell, staff were already inside dealing with the incident and so he began escorting other prisoners away from the cell.
99. Nurse D had been walking along the middle landing on house block three when staff shouted to her to come to the man's cell. She told the investigators that she quickly made her way to the cell. She examined the man who showed no signs of life. However, she decided that cardiac compressions should be carried out and called for further healthcare assistance.
100. Officer I had completed only three cycles of cardio pulmonary resuscitation chest compressions (CPR) before Nurse E arrived and took over. He shouted for a defibrillator machine to be brought to the cell.
101. The Physical Education Instructor (PEI) had heard the general alarm and arrived at the cell. He was informed by staff that the incident was a medical alarm rather than a general alarm. The two officers then continued to administer CPR with Nurse D and the PEI (a trained first aider and instructor) started to perform rescue breaths. The PEI also requested the defibrillator machine (a life-saving machine that can detect electrical activity in the heart and

deliver an electric shock if appropriate) and was told that someone had already gone to collect it. (Each wing has a defibrillator machine.)

102. Nurse E was in the medical treatment room when the general alarm was broadcast over the radio. As she had the Hotel 99 emergency response radio, it was her responsibility to respond to the alarm straightaway. Whilst she was on her way to the cell, she was told by a prison officer that the defibrillator machine was needed so she collected it with the oxygen and emergency bag. On arrival at the cell, Nurse E gave the oxygen to the PEI and asked for more oxygen and the ambu-bag to be collected. Nurse F also arrived at the cell just before Nurse E.
103. The Developing Prison Service Manager A (DPSM) was the officer in charge of the prison that day and he responded when the general alarm was broadcast over the radio. He passed someone who was going to get the defibrillator which told him that it was a medical alarm. The DPSM said that at some point it was clarified over the radio that it was a medical alarm not a general one. When the DPSM arrived, the PEI and Nurse D were giving CPR to the man. The DPSM asked the staff and prisoners who were not required to leave the cell.
104. The PEI operated the defibrillator. The machine advised that 'no shock' should be given five times, and so the PEI and Nurse D continued carrying out chest compressions and rescue breaths. A paramedic attended, which was recorded as at 2.55pm, bringing another defibrillator machine which was attached to the existing leads and pads. The prison doctor arrived at the same time. The defibrillator advised 'no shock' a further four times and so CPR continued in between each assessment. Three further paramedics also arrived within minutes. CPR continued until 3.21pm when the doctor and the first paramedic pronounced that the man had died.

After the man's death

105. The duty governor arrived and activated the prison's death in custody contingency plans with the DPSM A. All the necessary agencies were informed that there had been a death in custody.
106. The DPSM held a hot debrief meeting on the house block with staff involved in the resuscitation of the man and invited the staff care and welfare team to attend. He also met the prisoners who had helped the staff, using a Samaritan and a Listener to offer support to them and to the man's friends.
107. The man had named his next of kin as his mother who lived in Southampton. The prison family liaison Officer, and DPSM B left Belmarsh at 5.50pm to make their way to Southampton. They arrived at about 8.15pm and broke the news to the man's mother, stepfather and sister.
108. The man's mother was offered a visit to the prison and given information about what would happen next, including contacting the Coroner. The officers also gave information about how the prison could assist with the cost of the funeral.

109. The man's ex-girlfriend had telephoned the prison that evening and she spoke to the duty governor. After her identity was confirmed, she was informed of the man's death.
110. The prison family liaison officer kept in contact with the man's family about the funeral arrangements. She visited the man's mother and stepfather on 15 June to return his personal possessions. The man's mother later told the investigator that some of his personal belongings were missing. My investigator spoke with officers on the wings and was told that, as far as they were aware, all of his property had been collected and passed to the prison's FLO to return to his family.
111. The man's mother told the investigator that they had written to the man before his death. The letter was returned from the prison through the post and marked "PB Not here". The prison family liaison officer apologised on behalf of the prison service for this lack of sensitivity. The investigators made a number of enquiries as to how this might have occurred but were unable to establish how this had happened.
112. The investigator was given by the prison, a letter, a poem and a card (addressed to the man's children). The man had written these at some point prior to his death. Within the contents of these documents he expresses his love for his ex-girlfriend and his children. However no reference was made to him harming himself.
113. The prison held a critical debrief meeting a few weeks after the man died and the staff who attended said they benefited from the discussion.

ISSUES

114. The clinical review was conducted by the clinical reviewers and makes ten recommendations. I note that it raises a number of concerns about prison doctor B and some of the prison healthcare practices and policies. However, these are not directly related to the circumstances of the man's death and I do not repeat them here.
115. The review also states that the care delivered to the man by the mental health team at Belmarsh was prompt and comparable with what he might have expected to receive in the community.

The man's arrival at Belmarsh

116. The man received the normal reception and induction screening. However, the initial health screen record, which should have been completed on 22 March, has not been provided for the investigator. There does not seem to be a record of his past alcohol or substance misuse, his mental illness or having been on an ACCT.
117. His ACCT document had been closed ten days before the man came to Belmarsh and he was no longer considered to be at risk of harming himself. The closed document did not travel with him to Belmarsh and only arrived eight days afterwards. Reception staff made no enquiries with Pentonville as to when the document was closed.
118. Prison Service Order 2700 mentions that, when transferring to another prison, the safety and well being of prisoners require that any existing support and care plans are maintained in the new environment. I appreciate that the ACCT monitoring had ended 11 days before the man's arrival at Belmarsh. However, he had since appeared in court, been convicted and subsequently transferred to Belmarsh to wait to be sentenced. These are factors which I think staff should take into account when assessing the level of risk which a prisoner might pose to himself.
119. That said, I was pleased to note that there was very good and prompt communication between the mental health specialist in Belmarsh and relevant colleagues in Pentonville about the man's mental health, following the referral made at reception.
120. The initial assessments, completed when a prisoner arrives at a prison, are vital to ensuring that their immediate needs are met and determining how their care and treatment should be delivered. If the assessments are not completed properly, and relevant information is omitted or overlooked, subsequent decisions will not be as informed or effective. Although these issues arose in March, three months before the man took his life, and do not appear to directly relate to his death, I make the following recommendation.

The Governor and Head of Healthcare should remind reception staff of the importance of recording significant contact with prisoners. Where

reference to a prisoner's previous risk has been identified, staff should ensure that these records are obtained at the earliest opportunity.

Repeat prescribing system

121. The Belmarsh doctor repeatedly prescribed medication for the man but without making his own assessment to ascertain whether his needs had changed. The clinical reviewers noted that Belmarsh had no written repeat prescribing procedure to ensure that patients taking long term medication are regularly reviewed. To ensure that medication is prescribed appropriately and safely, it is imperative that regular assessments are made.

The Head of Healthcare should identify safe systems for repeat prescribing and to recall patients for tests and review.

Transferring medical information from paper to computer records

122. During May 2010, prisoner's clinical records were transferred from paper to computer. The PCT employed a data clerk to summarise the information written by clinicians and enter the summary on to the computer records. The data clerk's name appears in place of the clinician's name and the name of the clinician making the original entries is not recorded. Neither the investigator nor the clinical reviewer could find an audit trail as to whom conducted the assessments. This created difficulties in ascertaining who had contact with the man during his initial days in custody and should be interviewed for the investigation.

The process of transferring the paper records to the computer is now complete, and the omissions were identified many months ago. I therefore do not make a recommendation to the Primary Care Trust but I am sure that, if the process is ever repeated, they will want to ensure that it is undertaken correctly. The NHS Greenwich PCT should ensure that IT data summarisers record the name of the clinician who had made the entry in the manual record, so that the electronic record indicates that the entry was made by the summariser.

Emergency response

123. The general alarm call was used to alert staff when the man was found hanging. However, this did not indicate the nature of the emergency. Officer H told the investigators that pressing the general alarm is a faster method of summoning assistance, especially during free-flow, when there are a lot of radio transmissions. He said that pressing the general alarm guarantees that the Control Room are aware of an incident. Using a radio can be difficult as other transmissions can interfere, which means that it can take longer for assistance to arrive. Although the emergency medical response code, Hotel 99, was not immediately used, I am satisfied that staff arrived to assist very quickly.
124. Since this investigation, the clinical reviewer has noted that new guidance has been issued about raising alarms in emergencies which requires staff to indicate the nature of the emergency. As the prison has already changed its

system following the man's death, I do not make a further recommendation. The emergency response was, in fact, well managed. The staff attended promptly, had the necessary equipment which was all in good order, and did everything they could to resuscitate the man.

Contact with the man's next of kin

125. The man's family have asked me to explain why his ex-girlfriend was told of his death as well as themselves when they were the ones named as his next of kin. The Prison Service Order 2710, entitled "Follow up To Deaths in Custody", gives guidance for family liaison officers. In paragraph 3.4 of chapter 4, it states that "the Family Liaison Officer should be prepared to deal with different sections of one family if necessary". The PSO also gives a definition of "family", which includes the parents, children, spouses and partners, but also "others who have had a direct and close relationship with the deceased". I judge that the man's ex-girlfriend, as the mother of his children comes into this category, and, once the prison confirmed her identity, I believe they were right to tell her about his death.

CONCLUSION

- 121 The man had previously attempted to take his own life while he was at Pentonville. However, health assessments indicated that he had no severe enduring mental illness and there was nothing to support a diagnosis of schizophrenia or severe depression. The man did not show any signs of depression or suicidal intent whilst he was at Belmarsh. He had gained employment as a cleaner and did not come to the attention of staff in an adverse way.
- 122 There was nothing to indicate that the man was at risk of self harm prior to his suicide. It was evident that he regretted the offence which resulted in his imprisonment and he appeared to want to positively address his offending behaviour and substance misuse problems.
- 123 Even after the telephone call with his ex-girlfriend on the day he died, the man did not express any suicidal thoughts to other prisoners or staff. Indeed, after this telephone call, he saw several other prisoners, none of whom thought there was a risk of the man harming himself. They said that he was frustrated and worried about seeing his children but they did not think he was likely to harm himself. The man's conversation with his ex-girlfriend appears to have ended on a positive note. Unfortunately, It is impossible to say why the man chose to take his own life, and I have not found any evidence that his death could have been predicted or prevented.

RECOMMENDATIONS

- 1 The Governor and Head of Healthcare should remind reception staff of the importance of recording significant contact with prisoners. Where reference to a prisoner's previous risk has been identified, staff should ensure that these records are obtained at the earliest opportunity.

The Prison Service has accepted this recommendation.

- 2 The Head of Healthcare should identify safe systems for repeat prescribing and to recall patients for tests and review.

The Prison Service has accepted this recommendation.