

**Investigation into the circumstances surrounding the death
of a man at HMP Belmarsh,
in December 2005**

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

January 2007

This is the report of an investigation into the death a man who died at hospital, in December 2005, having been taken there from HMP Belmarsh the previous day, after being found hanging in his cell.

I wish to offer my sincere condolences to his family for their loss.

The man, who was 45 years of age, had been in custody for less than two months. He was awaiting trial at the time of his death, but was also serving a sentence as his licence for a previous offence had been revoked.

This investigation was conducted by two of my investigators. They and I are grateful to the Governor of Belmarsh and her staff for their help and co-operation during this investigation. I regret that one interview with a prisoner Listener was not conducted as it should have been with a member of the Samaritans present.

The local Primary Care Trust was asked to carry out a clinical review into the medical care that the man received in accordance with protocol agreed between my office and the Department of Health. Unfortunately, the review was not available at the time of preparing this report.

The man had been on an open F2052SH until three weeks before his death. I judge that the closure of the F2052SH was justified by the circumstances at the time. In common with many apparently self-inflicted deaths I investigate, in the period immediately before his death the man had given neither staff nor fellow prisoners any cause for concern over his wellbeing.

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Prisons and Probation Ombudsman

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Contents

Summary

Investigation methodology

HMP Belmarsh

Events prior to the man's death

Events surrounding the man's death

Findings and conclusions

Recommendations

Summary

1. The man was arrested in October 2005 for offences of theft and racially aggravated assault. He was remanded into custody on 14 October to HMP Belmarsh.
2. There were concerns at that stage about the man's mood and possible thoughts of self-harm, but these were not judged sufficient to warrant the opening of a F2052SH booklet (the Prison Service documentation for those at risk of suicide or self-harm).
3. On 17 October, the man was assessed by the detoxification medical officer. She became aware of his low mood and that he was expressing suicidal thoughts, and opened a F2052SH.
4. The man remained on the F2052SH until 10 November when it was decided by staff and the man himself that the crisis period was over. His mood had lifted, he said that he did not have thoughts of self-harm, and he was happy with his two cellmates.
5. At a court appearance on 18 November, it was discovered that the man's licence granted in December 2004 following early release from a five year custodial sentence had been revoked on 24 October 2005.
6. On 30 November, when his cellmates returned from a period of exercise, they saw the man hanging by a strip of bed sheet from the cell toilet door. Staff swiftly entered the cell and took him down. Cardio Pulmonary Resuscitation was started and an ambulance called.
7. Eventually, after the arrival of the paramedics, some cardiac output was detected and the man was transferred to hospital. Sadly, he died the following day without regaining consciousness.
8. Given the order of events outlined in this report, I do not judge that the man's attempt on his life could have been predicted or directly prevented. The decision to close his F2052SH three weeks earlier was justified by the circumstances at the time, and he had given neither staff nor fellow prisoners any further cause for concern.
9. I make four recommendations.

Investigation methodology

10. The investigation was opened at HMP Belmarsh on 4 December 2005. The Governor and her staff produced the man's core record and a large number of other documents for examination. Notices were distributed around the prison notifying staff and prisoners of the investigation. A number of prison staff and prisoners were formally interviewed.
11. My investigators liaised with the investigating officer from the Metropolitan Police to discuss the circumstances surrounding the man's death.
12. On 9 January 2006, in accordance with my Terms of Reference, jointly agreed with the Department of Health, the Primary Care Trust were contacted and agreed to carry out a clinical review of the care the man received whilst he was in custody. Unfortunately, the review was not available when I completed this investigation report.
13. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
14. One of my family liaison officers contacted the man's family. The man's brother asked for a letter to be written explaining the role of the Ombudsman and a similar letter was sent to the man's wife. After receiving the draft copy of this report, the man's brother requested extra time before responding. Our normal 28 day limit was extended on two occasions but in the end this report has had to be issued without any feedback from the man's family.

HMP Belmarsh

15. HMP Belmarsh became operational on 2 April 1991. It is a local prison within the Prison Service's high security estate. Belmarsh serves the Central Criminal Court and its feeder Magistrates' Courts in South East London, as well as Crown and Magistrates' Courts in South West Essex.
16. Prisoners at Belmarsh are offered regular access to education or workshops. The jail has two gymnasiums, one focusing on accredited courses and one on recreational gym, with use of a sports hall and a weights room.
17. A comprehensive detoxification and CARATs service is available to all prisoners. (CARAT stands for Counselling, Advice, Referral, Assessment and Throughcare.) Everyone coming into prison who is identified as having a drug problem is assessed, given advice about their misusing, and referred to the specific drug service they need.
18. Short term prisoners are offered help to resettle by a range of voluntary and statutory agencies including seconded staff from the Department of Work and Pensions, St Mungos (who offer a housing advice service) and St Giles (who offer a peer support service for advice on housing related issues).
19. A Listener scheme for prisoners at risk from suicide or self harm is in operation. (Listeners are volunteer prisoners, trained by the Samaritans.) A foreign national support group is also in operation.
20. From April 2005 Greenwich Teaching Primary Care Trust assumed responsibility for commissioning healthcare services within HMP Belmarsh and required that services met normal NHS standards, however responsibility for provision of healthcare within Belmarsh remained with the prison.
21. A three-storey building provides facilities for inpatients, outpatient clinics, Primary Care Services and a purpose built Mental Health Day Care Unit. Medical Primary Care and Psychiatric Services are contracted in from local NHS providers on a full-time basis. The inpatient unit has 33 beds, mainly used for psychiatric care with all cells having integral sanitation. The Head of Healthcare leads the multidisciplinary team comprising Nursing Grades, Healthcare Officers, Discipline Officers and Nursing Assistants in conjunction with the Mental Health Inreach Team and General Practitioners.
22. The Inreach Team provides a multi-disciplinary service across the prison. Outpatient facilities include daily GP clinics and nurse-led clinics (including for asthma, diabetes, coronary heart disease, HIV and hepatitis). All new prisoners receive a comprehensive health screen on reception. The Cass Unit (named after a former member of staff)

provides facilities for inpatients, discharged patients and outpatients on a multi-disciplinary basis led by a Senior Occupational Therapist.

23. In the latest Prison Performance Ratings (first quarter 2005/06), Belmarsh was rated as reaching performance level three (of four) which is defined as 'Meeting the majority of targets, experiencing no significant problems in doing so, delivering a reasonable and decent regime.'
24. The death of the man is the first apparently self-inflicted death to have occurred at Belmarsh since the introduction of independent investigation by the Prisons and Probation Ombudsman.

Events prior to the man's death

25. The man was arrested in October 2005 for shoplifting and a racially aggravated assault. It was documented that, when he was charged at the Police Station, he said that he would try and self-harm.
26. When the man arrived at Belmarsh on Friday 14 October, a First Reception Health Screen was completed. He said that, although he had previously tried to harm himself two years ago by jumping in front of a car, he did not have thoughts of self-harm at the present time. Nevertheless, he was referred for a mental health assessment.
27. A urine test showed positive for cannabis and benzodiazepines. The man was put onto a detoxification programme consisting of a chlordiazepoxide reduction regime to manage his withdrawal from alcohol.
28. A secondary health assessment was carried out the following day when the man answered further questions about his health. When asked about his current mood he admitted that it was low. A one to one interview questionnaire was completed, and he again stated that he did not feel suicidal at that time.
29. On Monday 17 October, the man was seen by the detoxification medical officer. During that interview, he stated that he had suicidal ideation, meaning that he was actively thinking of harming himself. The doctor opened a F2052SH, the Prison Service's self-harm at-risk form designed to record the support plans put into place and the observations of and interactions with the prisoner. The doctor decided that the man should remain on normal houseblock location in a shared cell and that he should be regularly monitored.
30. Later that day, at 9.50 pm, the man was seen in his cell trying to break up a plastic razor to separate the blade. That was the only overt act of potential self-harm noted by staff during his time on the F2052SH.
31. A review was held on 19 October when the man stated that he thought that he might have killed himself the previous night if it had not been for the presence of his cellmate. He told the review team of two previous attempts he had made outside prison, by jumping from a bridge and jumping in front of a car. He said that he had major problems with alcohol and became very tearful towards the end of the review. It was decided that he should remain on the F2052SH and that he should have access to education in addition to the other measures already in place.
32. On 21 October, the man returned to the Magistrates' Court and was further remanded on the theft and assault matters until November.

33. On 24 October, the licence on which the man had been released in December 2004 was revoked. That revocation appears to have come to light when he returned to court in November.
34. Another F2052SH review was held on 26 October at which the man was present. It was noted that he spoke in a monotone and did not make a single positive response.
35. On 28 October, he was seen by an occupational therapist. During the extensive interview, he again spoke of his very low mood but said that he had no motivation to act on his thoughts of self-harm. At the end of the session it was decided that he should attend the Cass Unit (occupational health) three times a week. This would enable his mood and mental state to be monitored whilst he was participating in constructive activities. It was also planned that the occupational therapist would liaise with the psychiatrist about an out-patient's appointment.
36. During an F2052SH review held on 2 November, the man said that he still had thoughts of self-harm due to his family not wanting any contact with him. He also said that he would not self-harm whilst he was in a shared cell. His detoxification medication had been extended and, with the support of that medication, he was coping.
37. The man was seen by one of the prison's psychiatrists on 7 November. Again, it was an extensive interview during which he told the psychiatrist about his drug and alcohol abuse and his relationship problems. The outcome of that assessment was that the psychiatrist decided to review the man in the outpatient's clinic in four weeks time, for him to attend the Cass unit and continue on the anti-depressant medication. The psychiatrist was content for the F2052SH reviews to continue unchanged as there had been no changes recently in his mood and he appeared to be coping well in the house block.
38. On 10 November, another F2052SH review was held. The man was in a noticeably better mental state and, now that his detoxification was completed, he said that he felt much better. He also said that attending education had helped him. The review team, with the man, agreed to close the F2052SH booklet. He was reminded that he still had support that he could access on the houseblock.
39. During his time on the F2052SH, the man had spoken to a Listener a number of times. He had got on well with him as he spoke Punjabi as well as English. During an interview with my investigators the Listener agreed that the man was happy to come off the F2052SH and was in a much better frame of mind.
40. On 18 November, the man attended the Magistrates' Court and was again remanded into custody, this time until December. As previously noted, it appears that it was during this court attendance that the

revocation of his licence was discovered. My investigators have not seen any documentation apart from the copy of the revocation document itself. No action appears to have been taken regarding the licence revocation and no reassessment of the man was undertaken.

41. On 24 November, the man was spoken to regarding a cell move to spur one in order to be near the Listener. He declined the move saying that he was happy in the cell he currently occupied.
42. His cellmates told my investigators that the man gave them no cause for concern. He was friendly, talkative and would watch TV with them as well as making tea for them or accepting tea made by them. As far as they were concerned, what subsequently took place was totally unexpected.

Events surrounding the man's death

43. On 30 November 2005, at about 9 am, the cells on Houseblock 2 were opened for the prisoners to go to exercise. The man's two cellmates left the cell, but he decided that he did not want to go. It was not the first time that he had been left alone in his cell since coming off of the F2052SH. The cell was re-secured.
44. At about 9.30 am, one of the houseblock cleaners heard a noise from the man's cell and, despite regulations prohibiting the cleaners approaching the cell doors, he looked into the cell. Although he did not know at the time who he was, he saw the man apparently standing with his back to the toilet door. Another prisoner suggested that he was probably meditating.
45. At 9.55 am, the man's cellmate's returned from exercise and looked into their cell. It was dark but they could see the man apparently standing with his back against the toilet door. They looked closer and believed that he was hanging. They alerted the nearest officer. The officer looked into the cell and opened the door. He shouted for other staff and entered the cell. The man had tied a strip of torn bed sheet to the kettle which he had placed over the top of the toilet door. He had then fashioned a loop in the remaining strip and, after placing his head in the loop, had leaned forward thereby constricting his neck.
46. Two officers ran to the cell and removed the ligature around the man's neck, whilst the officer first on scene, supported his weight. They laid the man on the cell floor and one of the officers called a level one emergency over her radio whilst checking the man's airway. The officer first on scene felt for a pulse, but could not find one.
47. A nurse arrived in the cell and began mouth to mouth resuscitation, while the officer first on scene did the chest compressions. An ambulance was called by the control room at 10 am. A second nurse heard the radio call and responded with another officer. The second nurse took over from the nurse on scene and called for the defibrillator, which is kept on the houseblock. He attached the machine which advised 'No shock' and they continued Cardio Pulmonary Resuscitation (CPR).
48. A doctor arrived at the cell at 10.13 am, as the ambulance was reversing up to the houseblock. The paramedics took over CPR and, after intravenously administering some drugs, established cardiac output.
49. Escort staff had been arranged and a risk assessment completed. Two officers accompanied the man in the ambulance when it left Belmarsh at 10.30 am. He was unconscious and was not restrained in any way.

50. The ambulance arrived at the hospital at 10.40 am. After a CT scan, the man was moved to the Intensive Therapy Unit.
51. The man's two cellmates were separately put into other cells with other prisoners. Both men were upset by this and would have preferred to remain together to talk about the man and what had happened.
52. A 'hot debrief' was held at the prison to give the staff involved the opportunity to discuss what had taken place. The prison care team also attended and spoke with the staff members. The man's cellmates and his former Listener were spoken to by senior staff and offered the opportunity to speak with the chaplaincy and/or the Samaritans.
53. A Governor and the prison Sikh minister, visited the man's brother and notified him of what had occurred. His brother provided contact details for the man's estranged wife and she was also informed.
54. The man died at the hospital at midday on 1 December 2005.
55. The Post Mortem examination took place on 2 December 2005. The cause of death was found to be hanging.

Findings and conclusions

56. The man arrived at Belmarsh during the afternoon of Friday 14 October 2005 with self-harm warning signals on his Prisoner Escort Risk (PER) form. During the initial reception procedures and the first and secondary health checks, he denied any thoughts of self-harm. When he was seen by the detox medical officer after the weekend, she was sufficiently concerned about the man's mood and suicidal ideations to open a F2052SH. Given that he was expressing thoughts of self-harm and displaying signs of low mood, I am sure this was appropriate.
57. The period that he was on the open F2052SH was well documented and he was properly supported. The reviews were conducted correctly, although I would have liked to have seen more input from healthcare staff on the review panels. The decision to close the F2052SH appears also to have been justified, taking account of the change in the man's mood. His cellmates and his Listener/friend all stated that they saw no sign of any intention on his part to self-harm at that time or after.
58. All of the staff responded quickly to the discovery of the man hanging in his cell. They are to be commended for their actions and the part they played in re-establishing cardiac output.
59. The man's licence was revoked on 24 October and that fact was recognised when he returned from court on 18 November. I am concerned that nothing appears to have been done in relation to the revocation. It is not clear from the documents disclosed to my investigators if he was aware of the revocation. The establishment is unable to clarify this matter any further. I would have expected the man to have at least been seen by a member of the mental health team upon return from court to assess the impact of the revocation on his mood, especially as he had recently been on an open F2052SH.
60. It was unfortunate that his cellmates were put into separate cells after the the man was discovered hanging. Both men understood the need to move from their shared cell but would have liked to have been re-housed together. Should a similar circumstance occur in the future, I hope that greater consideration be given to keeping cellmates together if they so wish and if security issues permit.
61. In the circumstances described in this report, I do not believe that the man's attempt on his life could have been predicted, or directly prevented.

Recommendations

The Governor should give consideration to the make-up of the F2052SH review teams with a view to incorporating healthcare staff on a regular basis.

The Governor should ensure that any significant changes in prisoners' circumstances are properly assessed, documented and acted upon.

The Governor should ensure that a robust system is in place to inform prisoners of any change in their status.

The Primary Care Trust was asked to undertake a clinical review into the care the man received whilst at HMP Belmarsh in accordance with the agreement between the Department of Health and the Prisons and Probation Ombudsman. The report has yet to be completed. Prison Health should arrange an urgent review into the care received by the man.