

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Belmarsh, on 20 January 2014

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

The man died of a heart attack, caused by anaemia due to blood loss from self-inflicted wounds, at HMP Belmarsh on 20 January 2014. He was 43 years old. I offer my condolences to his family and friends. There was initially some uncertainty about the cause of his death and the investigation was suspended until the post-mortem and toxicology examinations were concluded. I regret the consequent delay in issuing this report.

The man was a very challenging prisoner. Prison staff assessed him as at very high risk of suicide and self-harm, and he spent the last year of his life constantly supervised in a self-contained unit of the prison, apart from other prisoners. He rarely engaged with staff and spent much of his last year living naked in a dirty cell, often eating his own faeces and drinking his own urine. Psychiatric assessments concluded that he was feigning mental illness.

This is a sad and troubling case involving a very challenging prisoner, but I am concerned that the prison did not comply with some of the basic requirements of Prison Service suicide and self-harm prevention procedures. In particular, there was a lack of effective care planning to help address the man's risk and enhanced care management procedures, designed to help manage complex prisoners such as he were not used. He was also effectively kept in solitary conditions for very long periods without the usual safeguards that would apply when a prisoner is formally segregated.

As the man's behaviour was extreme, it is difficult to know whether proper implementation of the relevant procedures would have made a difference, but they should at least have been tried. I am also concerned that, on the night he died, healthcare staff failed to identify and act on abnormal clinical observations, which might have led to a different outcome. Finally, as I have noted in previous investigations at Belmarsh, there were weaknesses in the emergency response.

An enormous amount of staff time and effort went into managing the man, but too often this was poorly directed. Lessons need to be learned at Belmarsh from his case so that prisoners with complex needs can be better dealt with in future.

This 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.

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Summary

Events

1. In April 2012, the man was remanded to prison to await extradition to Albania where he had been convicted, in his absence, of multiple murders. He transferred to HMP Belmarsh a few days after his initial remand. Prison staff managed him under Prison Service suicide and self-harm prevention procedures (known as ACCT) for most of the following eight months, after assessing him as at high risk. He was initially admitted to the healthcare inpatient unit. He frequently banged his head on the wall, he made ligatures and attempted to hang himself, and sometimes cut his arms. He told prison psychiatrists that he had visions of a woman who told him to kill himself. In December 2012, he was admitted to Broadmoor Hospital, a high security psychiatric hospital, for assessment.
2. Specialists at Broadmoor concluded that the man was pretending to be mentally ill in order to avoid extradition. When he was sent back to Belmarsh in January 2013, he said he intended to kill himself. Staff began ACCT procedures and judged his risk to be so high that he should be constantly supervised. This did not change for the rest of his life.
3. The man continued to harm himself periodically. In March, he seriously cut his neck and needed hospital treatment. After he got back from hospital, he became almost permanently uncommunicative. He spent most of the time naked. He often ate faeces and drank urine and smeared it around his cell. He spent nearly all of the remainder of his life living in these conditions.
4. In May, staff moved the man to a self-contained unit in the prison, known as the contingency unit, designed for one prisoner who cannot be accommodated elsewhere in the prison. He lived in this unit for most of the rest of his life. An operational manager reviewed his location once a fortnight initially, and then once a month, and did not recommend any changes. His behaviour remained much the same.
5. In October, specialists from Broadmoor reassessed the man. As before, they concluded that he was feigning mental illness.
6. On 12 January 2014, the man made significant cuts to his neck and leg. Two days later, he made a ligature, which was taken from him. On 17 January, he was moved to the healthcare inpatient unit, in the hope that a change of location might alter his behaviour. This had no effect and, on 19 January, he was taken to hospital after making another serious cut to his neck.
7. The man got back to the prison from hospital at around 6.00pm on 19 January. He was unresponsive throughout the journey and during the night. A nurse checked his clinical observations twice in the night. Both times, his oxygen saturation level was very low, but the nurse did not take any action. Around 5.15am, the two officers monitoring him became concerned for his health and thought he might have stopped breathing. They telephoned for help but no one went into the cell or called an ambulance for approximately ten minutes. Prison

and healthcare staff attempted to resuscitate him. Paramedics arrived and took him to hospital. Shortly afterwards, hospital doctors recorded that he had died.

Findings

8. We recognise that managing the man's complex and difficult behaviour presented staff at Belmarsh with enormous challenges. However, we are not satisfied that enough was done to address his issues and reduce his risk of suicide and self-harm. A number of key aspects of ACCT procedures aimed at reducing risk, including setting caremap actions and holding enhanced case reviews, were not fulfilled. There was no consistent case manager. We found failings in the management of the contingency unit. He was effectively segregated and we consider that the same safeguards that apply for prisoners held in the segregation unit should have applied. We are concerned that healthcare staff did not take appropriate action when his clinical observations suggested that he was very ill on the night of his death. When officers became concerned about him they did not use an emergency code, it took too long to call an ambulance and too long to go into his cell and begin emergency treatment.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions and guidelines, including using the enhanced ACCT case management approach for suicidal prisoner with complex needs who are subject to constant supervision.
- The Governor should ensure that the provisions and safeguards of PSO 1700 apply to all segregated prisoners, wherever they are held in the prison, including those held in the contingency unit.
- The Head of Healthcare should ensure that all healthcare staff fully understand the significance of the clinical measurements they are responsible for, and take appropriate action, including urgent hospital admission, when indicated.
- The Governor should ensure that all prison staff are made aware of PSI 03/2013 and Governor's Notice to Staff 36/2013 and that they understand their responsibilities during medical emergencies, including:
 - Using the appropriate emergency code, by radio where possible, to effectively communicate the nature of the medical emergency;
 - Ensuring there are no delays to calling, directing or discharging ambulances;
 - Ensuring staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

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 visited Belmarsh on 23 January 2014. He obtained copies of relevant extracts from the man's prison and medical records.
11. The investigator interviewed 18 members of staff at Belmarsh in March and April 2014. He gave the Governor initial feedback about the preliminary findings of the investigation.
12. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer joined the investigator for some of the interviews.
13. We informed HM Coroner for Inner South London of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. We suspended our investigation, as initial post-mortem tests were unable to establish a cause of death. We reopened the investigation on 24 August 2015 when the coroner provided the cause of death. We regret that this has delayed the publication of this report.
15. One of the Ombudsman's family liaison officers contacted the man's niece to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She said that she found it difficult to understand how her uncle could die when prison staff were monitoring him constantly. She thought that healthcare staff should have checked him more frequently during the night after he got back from hospital on 19 January.
16. The man's niece received a copy of the initial report. The solicitor representing her wrote to us pointing out some factual inaccuracies. The report has been amended accordingly.

Background Information

HMP Belmarsh

17. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds over 900 men. Care UK provided healthcare services at the prison until April 2015. Oxleas NHS Trust is now the healthcare provider. There is 24-hour healthcare cover, including an inpatient unit. There are healthcare facilities on each of the houseblocks, as well as in reception, and the first night centre.
18. There is a “contingency unit” on the ground floor of the healthcare centre. It consists of two cells, a staff office, an exercise room and a bathroom. Local policy describes its purpose as for prisoners who:

“... following assessment cannot be located in any other part of the establishment, due to the risk they pose to either the good order of the establishment or to themselves to the extent that they require constant supervision.”

HM Inspectorate of Prisons

19. HMIP inspected Belmarsh in September 2013, four months before the man’s death. Inspectors reported that living conditions in the contingency unit (where he was at the time) were poor, with unclear operating protocols and governance arrangements. They noted that none of the standard segregation safeguards were in place for prisoners held in the unit.
20. The most recent inspection of Belmarsh was in February 2015. Inspectors reported that prisoners assessed as at risk of suicide and self-harm received good care, with some very good assessments and multidisciplinary case reviews. They reported that the contingency unit had been used only very briefly in the year before the inspection and its governance arrangements now seemed sound.

Independent Monitoring Board

21. 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 June 2014, the IMB reported a drop in the incidence of self-harm. They noted that there was a high percentage of foreign national prisoners and some of them had spent a long time in the prison after their sentence had expired, due to difficulties arranging their deportation.

Previous deaths at HMP Belmarsh

22. We investigated four self-inflicted deaths at Belmarsh in the three years before the man died. In all four of the investigation reports, we raised issues about medical emergency response protocols: either the use of the appropriate local emergency code or ensuring that an ambulance is called immediately when a code is used.

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. 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. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. The man was born in Albania. He moved to the United Kingdom in the late 1990s and lived under another name. He was remanded to HMP Pentonville under this name on 1 March 2011, but was released eight weeks later, when the charges against him were withdrawn.
25. The man's correct identity was discovered after his release and it was revealed that, in 1997, he had been convicted by an Albanian court of three murders. He was also wanted in Italy for other offences. He was arrested again and, on 11 April 2012, was remanded to HMP Wandsworth, to await extradition to Albania.
26. Prison officers began Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures when the man arrived at Wandsworth. He told prison staff that he had tried to stab himself four years previously, had been detained in a mental health institution in Kosovo in the 1990s, and took antipsychotic medication. (His community GP records, obtained later, showed no record of psychiatric issues or that he took regular medication.) Prison staff assessed him as at high risk of suicide or self-harm and constantly supervised him – the highest level of monitoring, which means the prisoner must be watched at all times.
27. As he was regarded as a category A prisoner (the highest security classification), the man transferred to HMP Belmarsh on 16 April. Over the next eight months, he was often constantly supervised, but there were also some periods when he was monitored less frequently. In August, staff ended ACCT procedures for two weeks. He lived in the healthcare inpatient unit, sometimes in a single cell and sometimes on a ward. He frequently self-harmed; he banged his head on the wall, sometimes made ligatures and attempted to hang himself, and sometimes cut his arms. He often said that he wanted to end his life, but there were also periods when he appeared more settled.
28. Two prison psychiatrists frequently reviewed the man. He often told them, and other staff, that he had visions of a woman who told him to kill himself. At other times, he said that he banged his head on the wall because of a persistent headache. He said that he feared he would be killed if he returned to Albania. The psychiatrists prescribed chlorpromazine (an antipsychotic medication) and, later, mirtazapine (an antidepressant).
29. As a result of his behaviour, and the difficulty they found reaching a diagnosis, the prison psychiatrists referred the man to Broadmoor Hospital, a high security psychiatric hospital. After an initial review at Belmarsh, specialists at Broadmoor accepted him for further assessment. He was admitted on 11 December 2012.
30. Specialists at Broadmoor concluded that the man did not have a mental illness. They considered that he was pretending to be mentally ill, in order to avoid extradition. They explained their conclusions to the man.
31. On 23 January 2013, the man was taken back to Belmarsh. When he arrived, he said that he did not want to live and intended to kill himself. A reception officer began ACCT procedures and he was admitted to the healthcare inpatient unit and constantly supervised. On 23 January, an officer assessed him as part of

ACCT procedures. He said he had no reason to live because all his family, except his niece, were dead. (In fact, the man had an ex-partner, children and sister in London, as well as his niece.) He said he would kill himself by any means.

32. A duty manager chaired the first case review later that morning, with a psychiatrist and an officer. The man said he was scared of returning to Broadmoor and said he did not have any medication. (Doctors at Broadmoor had stopped his previous antipsychotic medication.) The panel assessed him as a high risk of harming himself and agreed he would remain on constant supervision.
33. No case manager was named at the first case review. A Supervising Officer (SO) was named as case manager on the front cover of the ACCT document, but his first recorded contact with the man was not until 10 February. The SO told us that he was never formally appointed as case manager and that whichever qualified person was available at the time of a case review would take the lead.
34. A 'care and management plan' (caremap) should be completed at the first case review. The caremap is an essential part of the ACCT management plan as it highlights the key issues which affect the prisoner's risk of suicide or self-harm and identifies what actions should be completed, when, and by whom, to address them. All future case reviews should consider the prisoner's progress against the recorded actions of the caremap and, if appropriate, add additional action points. A caremap was not completed at this review, or at any time later.
35. On 25 January, a duty manager chaired an ACCT case review, at which the man said that wanted to die. She noted that he had recently banged his head against the wall. He remained constantly supervised and this continued for the rest of his life.
36. Later in the week, the man smeared faeces on the wall of his cell. He repeated this several times in February. During February, staff held case reviews around once a week and the man often said that he wanted to die. He argued that he was mentally ill and said he still saw visions of the woman who told him to kill himself.
37. On 5 February, staff moved the man to the contingency unit because of repair works in the inpatient unit. His niece visited him on 10 February. The visit reportedly went well, but the man banged his head on the wall soon afterwards. The next day, he tried to make a ligature. He returned to the inpatient unit on 11 February.
38. The man's niece told us that she visited her uncle several times at Belmarsh, but sometimes she was told that he could not come to the visit because he was on "dirty protest".
39. On 2 March, the man made a significant cut to his neck with a razor blade, while he was being constantly supervised. There is no record of how he obtained the blade. He was taken to hospital for treatment. During the few hours he was in hospital, he reportedly tried to take some scissors from a nurse.

40. After he got back from hospital, the man became almost permanently uncommunicative. For the rest of his life, he rarely spoke to prison staff or acknowledged their presence. He often smeared urine and faeces on the walls and floor of his cell and he spent much of the time living in a dirty cell. He also ate faeces and drank urine. Although this was not recorded every day, as local policy requires, prison staff frequently asked him to stop his dirty conditions and have a shower, but he rarely responded. He spent much of the time naked. He did not always eat his meals and began to lose weight.
41. Case reviews took place at varying frequencies during the remainder of the year, usually around every week to ten days but more frequently if the man had harmed himself. Case reviews usually involved a custodial manager or supervising officer, a prison nurse, and the officer who was constantly supervising him at the time. The SO listed as case manager, a custodial manager and a mental health nurse were the most consistent and frequent attendees. Prison psychiatrists attended three case reviews in the year after he got back from Broadmoor. Most case reviews usually noted a combination of his recent behaviour, that he did not participate in the review, and that he would remain on constant supervision. Prison staff rarely recorded any discussion of the reasons behind his behaviour or any plans to address it.
42. The prison psychiatrists saw the man at weekly healthcare ward rounds and carried out more detailed assessments at varying intervals. He very rarely engaged with these reviews. A psychiatrist told us that the man was a very complex man but he agreed with Broadmoor's view that the man was pretending to be ill. This was because his behaviour was very goal driven (to avoid extradition) and that there were a lot of inconsistencies in his presentation. The psychiatrist gave the investigator examples of these inconsistencies when he interviewed him and had also recorded them in the man's medical record at the time he observed them. He noted that the man stopped his dirty conditions and showered if someone external to the prison, such as a Home Office caseworker, was visiting him. He also observed that the man was very specific when he dirtied his cell and he never put faeces on or around his bed.
43. During the course of the year, the man sometimes banged his head on the cell walls or door. He occasionally made cuts to his arms, legs or neck, or made a ligature. There were also periods of several weeks at a time in which he did not harm himself, although he continued to live in dirty conditions.
44. On 30 May 2013, the Head of Residence and Safety (a role which includes management of the healthcare centre), in consultation with the Governor and deputy governor, decided to move the man to the contingency unit. He completed a local form called 'Authority for use of Contingency Unit', in which he explained the reasons.
45. The Head of Residence and Safety said that the man was moved because he had lived in dirty conditions in the inpatient unit for so long. He said they had been unable to use all the constant supervision cells fully, because the man had to move between two cells every three days due to the need to clean the cells thoroughly. (Records show that the man did not always move cells every three days, in either the inpatient or contingency units, and sometimes stayed in the

same cell for over a week before moving.) He said that flies had infested the inpatient unit, creating a health risk, and other inpatients were badly affected by the smell created by the conditions in which the man lived.

46. In the document, the Head of Residence and Safety noted that he had considered a move to the segregation unit but ruled this out because of works taking place there, which limited the space. He told the investigator that the same reasons why the inpatient unit was no longer suitable also applied to the segregation unit, and national instructions said that prisoners being managed under ACCT arrangements should not be held in segregation units except in exceptional circumstances. He therefore concluded that the contingency unit was the only realistic option for the man.
47. The Head of Residence and Safety and a custodial manager reviewed the man's location once a fortnight. They never recommended a change as there was no change in his conduct. The Head of Residence and Safety completed 'Authority for continued use of Contingency Unit' forms after each review. For the first three months, each form contained, exactly the same words as previously.
48. On 29 August, the deputy governor chaired an enhanced case review with the Head of Residence and Safety, a psychiatrist and the Head of Safer Custody, a manager and several prison nurses. The deputy governor told us that she held an enhanced case review at this stage because she wanted to see whether there was anything more they could do to encourage him to change his behaviour. He was silent throughout the case review. The review decided that prison staff would no longer complete his prison shop orders (known as canteen) for him and would not give him an order form unless he was clean. This meant that he could not buy tobacco while he remained in dirty conditions.
49. Removing the man's canteen privileges had no effect on his behaviour. He continued to live in dirty conditions and very rarely acknowledged or spoke to prison staff.
50. On 31 August, the man opened a wound in his leg. He told the nurse who treated him that he wanted to kill himself, as he thought he would be killed if he returned to Albania and the authorities would make it look like an accident. He banged his head on the wall several times in September. On 20 September, a psychiatrist wrote to Broadmoor asking for another assessment.
51. From this point, the Head of Residence and Safety reviewed the man's location in the contingency unit every month. He updated the 'Authority for continued use of the Contingency Unit' form to reflect the outcome of the enhanced case review, but there was little change after that. He noted that there was "no option but to keep the man in the contingency unit for the foreseeable future". There were two short periods, from 6 September to 10 September and from 27 September to 6 October, when the man returned to the inpatient unit but the reasons for this were not recorded.
52. The review with Broadmoor specialists was scheduled for 9 October and a Home Office immigration caseworker was due to interview the man about his application for asylum in the United Kingdom on 10 October. The Home Office

had written to him in advance and warned him that they would reject his application if he could not be interviewed due to him being on a “dirty protest”.

53. On 8 October, the man had his first shower for several months and moved to a clean cell. He attended an ACCT case review that morning and again said that he had visions of a lady who told him he had to die. He said he had no future and he was determined to kill himself.
54. On 9 October, a psychiatrist from Broadmoor assessed the man. He reached the same conclusion as before and did not consider that he had a mental illness.
55. On 10 October, a Home Office immigration caseworker interviewed the man. (The outcome of his asylum application was still outstanding when he died.) Two days later the man dirtied his cell again and stopped communicating with prison staff. He lived in these conditions for the rest of his life. Later in the month, he banged his head on the wall. There is no record that he harmed himself during November. At an ACCT case review on 28 November, the Head of Residence and Safety told him that they would now charge him for cleaning his cell if he dirtied it. This had no effect on the man’s behaviour.
56. On 2 December, the man made a ligature, which he tied to the cell bars. The officer who was constantly supervising him removed it. (The officer recorded that the ligature was made from a “strip of nylon”. There is no record of where the material came from or how he got it.) He would not participate in the ACCT case review held afterwards. The manager who chaired the review noted that the man had recently told him that he fully intended to kill himself rather than be deported. He recorded that the next review would be a full (enhanced) case review, but this did not happen.
57. On 12 December, the man broke the smoke alarm in his cell and used the shards to cut his neck and thigh. The officer who was supervising him went into the cell and prevented him from making anything more than superficial cuts. A prison nurse treated his wounds afterwards.
58. In early January 2014, the man continued to live in dirty conditions and still rarely communicated with prison staff. On 12 January, he told an officer who was supervising him that his name was incorrect and he was from Macedonia rather than Albania. He said he had lost his wife because he was in prison and he wanted to kill himself. Later that afternoon, he made serious cuts to his neck and left leg with a razor blade, and reportedly lost a lot of blood. He was taken to hospital for treatment. He returned to Belmarsh that evening.
59. The next evening, the man banged his head on the cell door and, later, opened wounds on his neck and right leg. A prison nurse treated him in his cell.
60. On 14 January, the man again opened a wound on his leg. A prison nurse treated him in his cell. The man banged his head on the cell door several times during the day. He made a ligature in the afternoon (what he used for this is not recorded), and tried to assault the officer who went into his cell to remove it. A prison manager held an ACCT case review afterwards. She recorded nothing other than that the man refused to discuss his actions.

61. On 17 January, the man was moved from the contingency unit to a cell in the inpatient healthcare unit, and two officers now supervised him. The deputy governor told us that the move was because the man had self-harmed more frequently at the time, and they wanted to do something different to try to change his behaviour. She said that the increase to two officers supervising was to help monitor him better, as he had often tried to hide under blankets or in the corner of his cell. It also provided an additional member of staff to intervene and help immediately, if the man harmed himself again.
62. A case review was held after the man moved. The manager who chaired the case review thought that the man appeared much the same as always at the review, but an SO thought he seemed more cheerful. The man attended but did not contribute to the review and dirtied his new cell shortly after moving into it.
63. On 18 January, the man behaved much the same as usual. He spent time banging on the window, threw faeces at the wall and largely ignored prison staff. At night he spoke to the officers supervising him for around ten minutes and said that he wanted something to make him sleep.
64. On 19 January, an officer supervised the man on his own, as prison managers had asked the officer who was scheduled to work with him to escort another prisoner to hospital, after an incident elsewhere in the prison. At around 3.05pm, the man made a deep cut to the side of his neck. It is not clear how he did this, but the officer speculated that he might have used his fingernail. Officers found no implement when they searched the cell afterwards. A nurse noted that he was lying in a pool of blood, indicating that he had lost a lot of blood. A prison doctor noted that the man had bled substantially. The nurse requested an emergency ambulance but one was not immediately available and paramedics did not arrive at the prison until 4.05pm. The man remained conscious throughout this time. Paramedics took him to hospital, where he received three stitches to his neck. The officer who was supervising him, who was one of four officers who escorted him to hospital, said that he was conscious in hospital but appeared agitated.
65. The man was assessed as fit for discharge, but was unresponsive when prison officers took him to the prison van to return to Belmarsh. The officer supervising him said that they had to lift him from a hospital bed onto the van. He said that the man appeared to be, or was pretending to be, asleep. The officer told us that he and the other officers concluded that the man was playacting, based on his previous behaviour, although they were not certain of this. They did not ask a hospital clinician to assess him. A custodial manager, who was also part of the escort, told us that the man's limbs were unnaturally stiff when they lifted him onto the van, which made him think that he was being purposefully obstructive.
66. The van arrived back at Belmarsh at around 6.00pm. The man still did not respond to the officers, and they pushed him to the healthcare centre in a wheelchair. The nurse who accompanied them said that the man appeared to be asleep. She took clinical observations at the healthcare centre, which were within the normal range. She told us that this included his oxygen saturation levels, although she did not record this result in the medical record. The

healthcare manager asked nurses to check the man's clinical observations every four hours during the night.

67. As his cell in the inpatient unit was dirty, officers took the man back to the contingency unit. A SO and an officer were responsible for his constant supervision. At 6.45pm, an entry was made in the ACCT record at 6.45pm:

“He has been placed ... [on] a mattress on the floor. He has been unresponsive to staff throughout. Breathing can be heard although he is not moving.”
68. At 6.50pm, another custodial manager held an ACCT case review from outside the man's cell. He recalled that the man was lying down in his cell throughout the review and did not contribute to it. The manager told us that the man was already on a two officer constant supervision so there was nothing more he could do to ensure his safety. He scheduled another review for two days later.
69. A Supervising Officer (SO) and an officer, the officers responsible for constantly supervising the man that night, arrived just after 8.00pm. The evening staff explained the day's events. The man was lying face down on his mattress, underneath a blanket and with his head away from the door. Around 8.30pm, the two night staff, and an SO who had not yet left, went into the cell as they could see the man's arms moving underneath the blanket and wanted to check that he was not harming himself. The man did not acknowledge them and the night SO said that he appeared to be asleep. The officers moved his arms so that they were visible, and moved his head so it was on the mattress rather than the concrete floor.
70. The evening SO finished his shift shortly afterwards, leaving the night SO and the officer to monitor the man. The SO told us that the man began to make a very loud snoring noise after they left the cell, which he made throughout the night. The officer also said that the man made a heavy breathing or loud snoring noise during the night, although he thought that it started before they went into the cell at 8.30pm.
71. At 10.35pm, two nurses visited the cell to check the man's clinical observations. They were accompanied by three members of the overnight 'Oscar Unit' (a group of officers who respond to incidents around the prison): n SO and two officers. The manager in charge of the prison that night did not come at that time as she was busy elsewhere.
72. Closed circuit television (CCTV) coverage shows that the two nurses and the three Oscar Unit officers spent around three minutes in the man's cell. A nurse said that the man was in a deep sleep throughout this time and made a normal snoring noise. He took the man's clinical observations and said they were all within the normal range except for his oxygen saturation level, which was 79 per cent (a normal oxygen saturation level is at least 95 per cent). Nurse A said that the man was asleep and did not appear to be having difficulty breathing. He therefore did not think he needed to take any further action at the time. The man did not react to any of the tests carried out on him, which included, taking his blood pressure and pulse rate, as well as his oxygen saturation levels.

73. The nurses and Oscar Unit officers came back to the contingency unit at around 2.50am. This time, the manger also attended. The two nurses, the SO and the officer went into the cell and were there for around eight minutes. Nurse A said that the man was asleep and appeared to be breathing normally. The officer and Nurse B said that the man was still making a loud snoring noise. Nurse A checked his oxygen saturation level, which was still 79 per cent. He did not react to the examination. Because his oxygen saturation level had been below the normal range for at least four hours, Nurse A decided to telephone the on-call doctor for advice.
74. Nurse A telephoned the doctor at around 3.15am. He said that he told the doctor that the man's oxygen saturation level was 79 per cent and that he appeared to be asleep. The nurse could not remember if he had told the doctor that the man's oxygen saturation level had also been low, at 79 per cent, at 10.35pm. He said that the doctor advised that 79 per cent was normal for someone who was asleep and that he should ensure that his airway was clear. (The nurse said he had already done this when he visited the cell.)
75. The doctor recalled the conversation differently. He thought that the nurse had said that the man's oxygen saturation level was 89 per cent, that he seemed fine and that he was fast asleep and snoring. He said that he had assumed that the reading had only just become this low, although he did not specifically ask what it had been earlier. He said that he told the nurse that a reading of 89 per cent was not unusual if the patient was asleep but that he ought to check it again. No further check took place.
76. The SO and officer said that the man stopped snoring at around 5.00am. At 5.02am, the officer stood at the cell door and looked in for around three minutes. (The door was a barred gate with a Perspex screen the width of the cell to allow full visibility. The officers spent most of the night sitting on chairs around two metres away, opposite the cell door.) The officer said he could see the man's head move slightly and that he was breathing. The SO said that they wanted to see if he had woken up and, if so, that he was not harming himself. He also said that they could see him moving and breathing.
77. At 5.16am, the SO climbed onto the bars of the gate to look in. He said that he could not hear the man breathing and wanted to change the viewing angle to see if he could detect any movement. The SO and officer spent around five minutes looking into the cell from the door. The SO said he could see and hear nothing. He told us that he thought the man had stopped breathing and might be dead. The officer also said they could not see any sign that the man was breathing.
78. At 5.21am, the SO went to the staff office (next door to the man's cell) and telephoned the control room. He asked for the Oscar Unit and the first response nurse to come to the contingency unit. He did not use an emergency code and did not ask for immediate or urgent assistance. He also telephoned Nurse A and asked him to come to the contingency unit. The nurse thought that the SO had told him that the man was struggling to breathe. The manager telephoned the contingency unit around 30 seconds later and asked why she was needed. The SO told her he was concerned that the man was not breathing.

79. Another SO and officer arrived at the contingency unit just over a minute after the first SO had telephoned the control room. Another officer and both nurses arrived in the next minute. At 5.24am, they opened the cell and went in. A SO checked the man's pulse but could not find one. An officer began cardiopulmonary resuscitation.
80. The manager arrived at the contingency unit at 5.25am and, around 40 seconds later, radioed for an emergency ambulance. An officer brought a bag of emergency medical equipment from the healthcare centre on the floor above at 5.26am and Nurse A administered oxygen to the man. Nurse B attached a defibrillator, which found no shockable heart rhythm, so they continued to attempt cardiopulmonary resuscitation.
81. At 5.35am, paramedics arrived at the cell and took over emergency treatment and care. At 6.09am, they took the man to the ambulance and then to hospital. At 6.59am, a hospital doctor recorded that he had died.

Contact with the man's family.

82. The man had listed his niece as next of kin. The Head of Safer Custody telephoned his solicitor later in the morning that the man died to confirm that this was correct. The prison's family liaison officer and a custodial manager visited the man's niece around midday and informed her that he had died. They offered condolences and support. In line with Prison Service instructions, the prison offered to contribute to the costs of the funeral.

Support for prisoners and staff

83. After the man's death, the duty manager debriefed the staff involved in the emergency response to offer her support and that of the staff care team.
84. The prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by his death.

Post-mortem report

85. A post-mortem examination established that the cause of death was cardiorespiratory arrest, due to anaemia caused by blood loss from multiple incised wounds.

Findings

Management of risk of suicide and self-harm

86. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It advises that prison staff should consider constant supervision when a prisoner makes serious attempts or compelling preparations for suicide, or makes a credible expression of a wish to die. When the man got back from Broadmoor Hospital in January 2013 he said that he wanted to kill himself. The staff assessed him as high risk and began constant supervision. We are satisfied that with his history of self-harm and suicidal behaviour at the prison in 2012, and his circumstances at the time, this was a reasonable decision.
87. It is a mandatory requirement of PSI 64/2011 that constant supervision “must only be used at times of acute crisis and for the shortest time possible”. We appreciate that the man was a very challenging prisoner who showed little motivation to change his behaviour and did not respond to any of the initiatives that were occasionally tried. However, we found that there was no effective plan to address his issues, reduce his risk and, ultimately, get him to the stage where he would not need constant supervision.
88. The instructions of PSI 64/2011 aim to ensure consistent case management and to give prison staff the best opportunity of reducing the risk of prisoners at risk of suicide or self-harm. However, we found that prison staff did not follow many of the instructions, including some specifically for prisoners judged to be in acute crisis. We list our concerns below and then discuss some in more depth:
- No caremap was ever completed - a mandatory requirement of PSI 64/2011.
 - There was no evident case manager.
 - PSI 64/2011 requires multi-disciplinary case reviews daily for the first 72 hours that a prisoner is managed on constant supervision. Only two case reviews were held in this period.
 - Prisoners subject to constant supervision for more than eight days should be managed under the enhanced case management process. There was only one enhanced case review in the year that the man was constantly supervised.
 - Records of case reviews contained little information other than there was no change in the man’s behaviour. They were not always multi-disciplinary.
 - Few of the staff had read, or were familiar with, the specific requirements of PSI 64/2011 for prisoners subject to constant supervision.
 - A doctor did not see the man each day, which is a mandatory requirement for a prisoner subject to constant supervision. (This is also a requirement of Belmarsh’s dirty protest policy.)
 - There was no emergency access plan, another mandatory requirement for a prisoner subject to constant supervision.
 - There was little consideration of how to involve the man’s family.
89. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner’s needs, the triggers of their distress, and must aim to address the

issues identified at the assessment interview. The caremap should set time bounded actions and be aimed at reducing the risk the prisoner presents to themselves. No caremap was completed, either at the first case review in January 2013 or at any time in the remainder of the man's life. This was a major omission. As well as being a mandatory requirement, the caremap is a key tool in planning how to address a prisoner's issues and it is hard to see how prison staff could have made any coherent plan for him without one.

90. PSI 64/2011 instructs that a case manager must be appointed at the first case review. An SO was named as case manager on the front cover of the ACCT plan, but did not have any contact with the man until almost three weeks after ACCT monitoring began. He told us that he was never formally given the role of case manager and whichever qualified member of staff was available would normally take the lead. Two more staff were also listed as the case manager at various stages, but neither considered themselves to have any formal oversight role in managing the ACCT procedures and ensuring the man's needs were met. The lack of clear case manager meant there was little managerial ownership of the case and it seems this contributed to the lack of care planning.
91. PSI 64/2011 states that prisoners should be managed under the enhanced case review process if they have been subject to constant supervision for more than eight days. These should be chaired by a senior manager, and should include more specialists and a higher level of operational management than a standard ACCT case review. The aim of enhanced case management is to provide a flexible but consistent approach to achieve the desired changes in a prisoner's behaviour. During the year that the man was subject to constant supervision, prison staff held just one enhanced case review, seven months after ACCT procedures began. The routine case reviews did little to address his issues and often the records of the reviews said nothing more than that his behaviour had not changed. We consider that he fully met the criteria for the enhanced case management, which would have ensured that senior managers at Belmarsh and other relevant specialists took an active part in his care planning.
92. PSI 64/2011 also instructs that, for prisoners subject to constant supervision, the case review team must document "how the prisoner will engage ... and contact with family and friends". This is also a requirement of the enhanced case management process. One of the very few occasions in the last year of his life when the man changed his behaviour, was in February 2013 when his niece visited him. Several members of staff told us that visits or phone calls with his niece were motivating factors for the man, yet no one took the initiative to involve her further. His niece said that her visits to him were sometimes cancelled by prison staff as he was on "dirty protest".
93. The man was a very challenging prisoner. Managing his behaviour and risk presented enormous difficulties to prison staff. However, we consider that he did not receive sufficient and meaningful support through appropriate use of the ACCT process and staff did not always follow national instructions for managing ACCT procedures. We consider he should have been managed under the enhanced case review process. His behaviour was so extreme that we cannot say that this would have made a significant difference. Nevertheless, it would have given prison managers and staff a better chance of producing a coordinated

and effective care plan aimed at addressing his issues and reducing his risk. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions and guidelines, including using the enhanced ACCT case management approach for suicidal prisoner with complex needs who are subject to constant supervision.

The man's location in the contingency unit

94. The man moved to the contingency unit on 30 May 2013. Other than a few brief periods in the healthcare inpatient unit, he remained there for the rest of his life. Belmarsh's local policy for the management and operation of the contingency unit names the Head of Residence and Safety as the lead manager for the unit. The latest policy was issued in October 2013 but is an identical copy of the previous version, dated October 2010, and contains some references that are out of date. (For example, the policy refers to Prison Service Order 2700 as providing guidance on managing prisoners at risk of suicide or self-harm. PSI 64/2011 replaced this document in April 2012.)
95. Local policy describes the purpose of the contingency unit as to house prisoners who:

“... following assessment cannot be located in any other part of the establishment, due to the risk they pose to either the good order of the establishment or to themselves to the extent that they require constant supervision.”
96. The policy states that use of the contingency unit is not a punishment, but to maintain the prisoner's safety. It says that only prisoners meeting the following criteria should be located in the unit: (1) Prisoners subject to constant supervision; (2) High public interest prisoners whose safety can only be maintained by preventing contact with other prisoners; (3) Prisoners subject to protective witness procedures.
97. The man moved to the unit because the dirty conditions he created and lived in meant that it was unsustainable for him to remain in the healthcare inpatient unit any longer. We appreciate that the long-term nature of these conditions had a negative effect on other prisoners in the inpatient unit and think it was reasonable at the time to move him.
98. However, we were concerned about the operation of the contingency unit. Her Majesty's Inspectorate of Prisons inspected Belmarsh in September 2013, while the man was living in the unit. The Inspectorate found that the unit had unclear operating protocols and governance arrangements. They also found that none of the standard segregation safeguards operated for prisoners held in the unit. We share these concerns.
99. The man was, in effect, segregated in the contingency unit and had no contact with other prisoners for several months. We are concerned that senior managers at Belmarsh did not consider location in the contingency unit as segregation,

even though it is only used for one prisoner at a time and he did not mix with any other prisoners while he was held there. The Head of Residence and Safety told us that the contingency unit was part of the healthcare centre and not a segregation unit. However, segregation units are used to keep prisoners apart from other prisoners which is, effectively, the purpose of the contingency unit. It is undoubtedly the case that he had been segregated from other prisoners without the usual safeguards that would apply in a segregation unit. In fact, he was effectively in solitary confinement and the authority for this was not clear.

100. Prison Service Order (PSO) 1700 about segregation notes that, 'Research into the mental health of prisoners held in solitary confinement indicates that for most prisoners, there is a negative effect on their mental well being and that in some cases the effects can be serious. A study by Grassian & Friedman (1986) stated that, "Whilst a term in solitary confinement would be difficult for a well adjusted person, it can be almost unbearable for the poorly adjusted personality types often found in a prison." The study reported that the prisoners became hypersensitive to noises and smells and that many suffered from several types of perceptual distortions (e.g. hearing voices, hallucinations, and paranoia). The study also found that many of the prisoners were prone to losing their temper easily and committing random acts of violence against themselves and others. Most prisoners had not experienced any of the above observations prior to entering solitary confinement.'
101. In a PPO thematic report, published in June 2015, about segregation, we found that lengthy periods of segregation may cause deterioration in a prisoner's health and well-being and should be avoided. When this cannot be avoided, Segregation Review Boards should be held regularly to assess how the prisoner is coping and plan for their move to more appropriate accommodation.
102. To counter some of the negative effects of segregation, PSO 1700 sets out the mandatory requirements and guidance for segregation and the procedures to follow when segregating prisoners. A qualified healthcare professional (nurse or doctor) should complete a Segregation Safety Algorithm (safety assessment) for all segregated prisoners. The purpose is to take a snap shot assessment of a prisoner's mental health when deciding whether to segregate them. The aim is to exclude very mentally unwell, suicidal prisoners from segregation, in all but the most exceptional of circumstances. Belmarsh's contingency unit policy document also states that a health safety screen must be completed within two hours of placement in the unit (although the nature of this screen is not detailed). No one completed any form of health screen when the man moved to the contingency unit.
103. PSI 64/2011 instructs that staff should only segregate prisoners subject to ACCT procedures in exceptional circumstances. The Head of Residence and Safety told us that this was one of the reasons why they did not think the prison's segregation unit was suitable for the man but, as we have noted above, no one considered that by moving him to the contingency unit they were effectively segregating him. There is no evidence that anyone formally considered the effects of segregating him on his mental health and risk of suicide or self-harm.

104. PSO 1700 requires prison staff to review a prisoner's segregation at least every two weeks. The review panel should be multidisciplinary and consist of an operational manager (who chairs the review), healthcare representative (mandatory), segregation and wing officers, chaplain, psychologist, the ACCT case manager and, if possible, a member of the IMB. Belmarsh's contingency unit policy document says prison staff should review the prisoner's location in the unit, but only for high public interest or protective witness prisoners. The 'Authority for continued location in the contingency unit' form (which constitutes the record of the review) indicates that staff should review all prisoners held in the unit. The contingency unit policy document says that reviews should happen every week and the panel should consist of the duty manager, a security manager and a member of the IMB. Prison staff reviewed the man's location in the contingency unit every two weeks from June to mid-September and every month from then on. The panel was usually just the Head of Residence and Safety and a manager and each review was virtually identical to the last. We are concerned that there was no effective review of the man's location in the contingency unit and whether his continued detention there had led to a deterioration in his mental health.
105. We understand that the contingency unit might have been the most suitable location for the man when he moved there in May 2013. The conditions he created meant it was very difficult to keep him in an environment with other prisoners. However, we consider that holding him in the contingency unit for months at a time, effectively segregated, was inappropriate. While he seemed determined not to change his behaviour, as we have noted earlier, there was no fully considered plan to address the underlying issues and reintegrate him gradually back to normal location. We make the following recommendation:

The Governor should ensure that the provisions and safeguards of PSO 1700 apply to all segregated prisoners, wherever they are held in the prison, including those held in the contingency unit.

Clinical care on the night of 19-20 January 2014

106. The man did not respond to officers or healthcare staff at any time after his hospital admission on 19 January. Officers had to carry him from a hospital trolley to the van to return to Belmarsh, and then push him in a wheelchair from the van to the healthcare centre and, subsequently, the contingency unit. A nurse took clinical observations, which she recorded as within the normal range, but these would not establish that he was conscious.
107. The officers we interviewed, who escorted the man to hospital, thought he was being deliberately obstructive by pretending to be asleep. The nurse and the officers who took over the constant supervision thought that he was in a deep sleep. The clinical reviewer considered it possible that he was unconscious rather than asleep.
108. At 10.35pm, Nurse A took clinical observations. The officers and nurses who attended the man's cell thought he was in a deep sleep. The observations were in the normal range, except that his oxygen saturation level was very low. Anyone with an oxygen saturation level below 90 per cent might require

additional oxygen, and levels below 80 per cent can compromise organ function. Continued low oxygen saturation levels might lead to respiratory or cardiac arrest.

109. The results were the same when Nurse A returned at 2.50am. The nurse telephoned the on-call doctor for advice. The nurse and the doctor gave different accounts of what was said but, significantly, no action was taken afterwards, even though the man's oxygen saturation levels had been low for some hours.
110. The clinical reviewer commented that these events constituted a basic failure of care. He considered that Nurse A should have acted on the low oxygen saturation level when he first recorded it, by making a full assessment of the man's airway, breathing and level of consciousness and, if necessary, organising hospital admission. He concluded that the care the man received was of an unacceptable standard and that appropriate medical care might have resulted in a different outcome. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff fully understand the significance of the clinical measurements they are responsible for, and take appropriate action, including urgent hospital admission, when indicated.

Emergency response

111. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes*, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.
112. Belmarsh's local instruction on emergency response codes (Governor's Notice to Staff 36/2013) instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which code blue should be used are when the prisoner has difficulty breathing, is unconscious or is fitting or concussed.
113. A SO and an officer said that the man made a loud snoring noise during the night of 19-20 January, which stopped at around 5.00am. They both looked into the cell at this time and both said they were satisfied that they could see him breathing and moving slightly. They then spent around five minutes looking into the cell from 5.16am. At that point, neither thought he was breathing. The SO told us he thought the man might be dead. They should therefore have radioed a code blue alarm at this time, which would have alerted staff throughout the prison, including the emergency response nurse, and signalled to the control room to call an ambulance immediately. Instead, the SO telephoned the control room at 5.21am and asked for the Oscar Unit staff and the response nurse to attend the contingency unit. He did not ask for an ambulance and did not say that the situation was urgent.

114. It was a further three minutes before any staff went into the man's cell. At night, staff do not carry standard keys but have a cell key in a sealed pouch for use in an emergency. National instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Prison staff are not expected to take action that they feel would put themselves or others in danger and should first make every effort to get a verbal response from the prisoner. What they observe and any knowledge of the prisoner should be used to make a dynamic risk assessment of the situation.
115. The SO and officer's accounts indicate that they had assessed the situation as life threatening. The SO told us that he did not open the cell because he had informed the Oscar Unit and nurse and knew they were close by. While we understand that it is difficult for staff in such situations to make immediate decisions, when someone is in a potentially life threatening situation it is essential to act quickly. In such circumstances we would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life. As there were two members of staff present, we would have expected them to go in immediately rather than wait for support, as the risk to the man's life at the time outweighed any risks to themselves.
116. PSI 64/2011 states that the ACCT case review team should provide an emergency access plan, which provides authority for staff to intervene when a prisoner subject to constant supervision engages in potentially fatal self-harm or attempts suicide. The plan must detail actions for the supervising member of staff to take, including how to raise the alarm and instructions for entering the cell at day and night. As we have noted above, there was no emergency access plan and therefore the SO and officer did not have its guidance to rely on. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of PSI 03/2013 and Governor's Notice to Staff 36/2013 and that they understand their responsibilities during medical emergencies, including:

- **Using the appropriate emergency code, by radio where possible, to effectively communicate the nature of the medical emergency;**
- **Ensuring there are no delays to calling, directing or discharging ambulances;**
- **Ensuring staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.**

**Prisons &
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