

**Investigation into the circumstances surrounding the death of
a man at HMP Belmarsh in July 2004**

Prisons and Probation Ombudsman for England and Wales

October 2005

This is the report of an investigation into the circumstances of the death of a man who was found dead on the floor of his cell at HMP Belmarsh on 4 July 2004. He was just 24 years old.

It is hard to cope with any family loss and the sudden death of a loved one whilst they are in custody is especially difficult. My colleagues and I would like to extend our condolences to the man's family and to all those touched by his sad and untimely death.

Since 1 April 2004, the Prisons and Probation Ombudsman's office (PPO) has been responsible for investigating all deaths of prisoners in custody, including those who have died from apparently natural causes. During a transitional phase, which included the time of the man's death, I did not conduct all investigations directly but oversaw the work of experienced Prison Service investigators who worked under my supervision. The investigation into the man's death was carried out on my behalf by a Governor at HMP Full Sutton. I am most grateful to him for his work. The Governor was assisted by one of my investigators.

A clinical review of the health care the man received whilst at Belmarsh was requested from a Teaching Primary Care Trust in August 2004 but has not yet been received. The absence of a clinical review does leave some gaps. However, I do not believe we should delay the finalisation of this report any longer.

I would like to thank the Governor and staff of HMP Belmarsh for their co-operation and assistance during the course of this investigation. In particular, I would like to thank a member of staff at Belmarsh's Secretariat.

Whilst it is unusual for my investigations to include the circumstances of a prisoner's arrest before they come into custody, I am mindful in this case that the man's family were concerned about the chain of events before his arrival at Belmarsh, and whether this might have been linked to his death. I have therefore broadened the approach of this report to take account of the family's concerns.

Stephen Shaw CBE
Prisons and Probation Ombudsman

October 2005

CONTENTS

1. Summary
2. Investigative Process
3. HMP Belmarsh
4. Events leading to the man's death
5. The discovery of the man
6. Post Mortem and Clinical Review
7. Contact with the man's family
8. Responses from prisoners at Belmarsh
9. Health Care Centre
10. Conclusion and Recommendations

Summary

The man was stopped by police on 10 May 2004. He allegedly resisted arrest and indecently assaulted one of the police officers. He was taken to the police station, where it was noted in the custody record that he had a bruise under his left eye. He was charged on 11 May. On 12 May, he was taken to the Magistrates' Court and, whilst in the cells, he committed two apparently unprovoked assaults by punching another prisoner and a Prison Custody Officer. He was remanded into custody and taken to HMP Belmarsh.

Health Care staff saw the man on his initial reception and the relevant health screening was completed. It was noted that he had a black eye and said that this injury was sustained during a fight at court. Subsequent enquiries indicate that this injury was sustained prior to the man being seen by the doctor when he was received into police custody. There were no other issues raised by the man or staff during this screening.

The day after arriving at Belmarsh, the induction officer noted that the man was vague, showed little eye contact and his demeanour did not appear to be normal. After consultation with a member of the mental health team, it was decided to relocate him to Belmarsh's Health Care Centre for assessment.

During his time in the Health Care Centre, the man did not interact much with other prisoners, nor participate fully in regime activities such as exercise, preferring to remain in his cell or take a bath. He was not prescribed medication. The man remained in the Health Care Centre during his time at Belmarsh. Reports from staff and prisoners interviewed indicate that he kept himself to himself, was not perceived as a control problem and asked very little of staff. There is little evidence of staff attempting to encourage the man to participate in the limited regime activities on offer.

At about 5:15am on 4 July, an officer was conducting a roll check and found the man lying on his cell floor. He could not get a response so he called for assistance. Staff attended and attempted to resuscitate him. Despite the prompt attendance of paramedics, the man could not be revived. He was taken to a nearby hospital but was pronounced dead shortly afterwards.

While the regime and environment of H2 unit could have been improved, the man's death appears to have occurred through natural causes and cannot be attributed to the standard of care he received at Belmarsh.

Investigative Process

The Senior Investigating Officer, accompanied by two investigators from my office, conducted a preliminary visit to HMP Belmarsh on 19 July 2004 and returned on two subsequent occasions. They were given access to the man's prison records including his medical record. My investigation team met the Governor of Belmarsh, the Family Liaison Governor and representatives from the Independent Monitoring Board and Prison Officers' Association to offer them the opportunity to raise relevant issues. They visited the cell where the man had died and spoke to staff on duty in the Health Care Centre.

Notices to staff and prisoners announcing the investigation were displayed around the prison. As a result, one response was received from a prisoner. No responses were received from staff.

The man's family were offered, and accepted, the opportunity to contribute towards the investigation process. My investigator and one of my family liaison officers visited the man's mother and aunt. They also spoke to other family members. As a result of concerns raised by the man's family about his arrest and detention prior to arriving at Belmarsh, his police custody record and documents from the Magistrates' Court were obtained.

A clinical review was requested from the Teaching Primary Care Trust on 23 July 2004. Unfortunately, it is not yet complete and has not been made available in time for this report.

All interviews with staff were tape recorded.

HMP Belmarsh

HMP Belmarsh is a high security local prison, serving the courts over a wide catchment area. It is located near Woolwich in south-east London and opened in 1991. On the day the man died, the capacity of the prison was 921 prisoners - including those on remand, those awaiting sentence, and those convicted and sentenced.

Belmarsh contains a substantial Health Care Centre catering for prisoners with physical and mental health needs. The Centre is staffed 24 hours a day and has continuous nursing cover. The Oxleas NHS Trust is responsible for the mental health provision.

The most recent report on Belmarsh by HM Chief Inspector of Prisons (HMCIP) was published in 2003. In summary, it said 'in spite of valiant efforts, the regime for most prisoners was impoverished and unsatisfactory.'

The last full security and standards audit took place in January 2003. Belmarsh was rated as "good" in security and "acceptable" on standards.

Events leading to the man's death

The man's arrest

My colleague met with a Detective Constable (DC), of the Metropolitan Police, to discuss the circumstances of the man's arrest. She was told that, on 10 May 2004, police officers had stopped the man whilst he was walking along the street, because a woman had reported that she was being followed by a man fitting his description. The man was approached by the officers and, when they attempted to find out why he had a bulge in his jacket, he began to fight with the officers and groped the female officer between her legs. He was restrained with handcuffs with the help of other officers who arrived at the scene. The man was found to be carrying a 12-inch kitchen knife.

He was arrested at 4:45 pm and taken to the local police station. A Custody Sergeant noted in the Custody Record:

"D/P [detained person] has a slight bruise below left eye. No other apparent injuries ... D/P appeared to feign a faint whilst standing before me. Fell forward on to plastic computer surround. No injury. D/P was unwilling/unable to support himself ... possible mental condition and lack of understanding of proceedings."

A Custody Officer wrote along the edge of the Risk Assessment for medical care or other special help that the man was "not capable of coherent response". He was placed in a CCTV monitored cell and the Forensic Medical Examiner (FME) called to assess him. His clothing was retained for preservation of evidence. At 5:45pm he was examined by the FME who noted that the man appeared unsteady. He had denied having a mental health problem or taking drugs but said that he had drunk some alcohol earlier and fell down and hurt his head. The FME concluded that he was fit to be detained but not fit for interview. The next day, a different FME examined him and noted the man had a black left eye.

On 11 May, the man was interviewed by officers. According to the Detective Constable, the man told the officers that he had been out walking, saw the knife and picked it up as he thought it would be useful for cooking. He said that he was unfamiliar with the area he had been arrested in but, having checked his home address, police were satisfied that he did know it. He was charged with two counts of assaulting a police officer, possession of a bladed article, and indecent assault. His clothing was returned to him at 7:10am on 12 May before he was taken to court.

The Magistrates' Court

The man was taken from the police station to the Magistrates' Court on 12 May. He was placed in a cell with another prisoner at about 9:30am. Shortly afterwards the Prison Custody Officer (PCO) heard shouting coming from the cells area and when she went to investigate with her supervisor she saw the man and the prisoner fighting in the cell. According to the supervising PCO,, The man punched the other prisoner in his face. As he was being moved to another cell, the man - who had been walking backwards - turned around, struck the PCO on her left shoulder and kicked her right ankle. The man was placed in another cell. During his court hearing, he was refused bail and remanded in custody.

Initial reception at Belmarsh

The man arrived at Belmarsh at 5:40pm on 12 May. His Prisoner Escort Record (PER), which accompanies all prisoners when they are escorted outside of a secure custodial building, shows the risk categories for violence and concealed weapons were ticked. His possessions were recorded on a property card but there was no mention of his blue denim

jeans which, according to the police custody record, had been returned to him at the police station.

The man was asked on arrival to give the name and address of someone to be contacted in an emergency or next of kin. In his Core Record (completed on arrival to prison), section B of page 2 asks for the name and address of next of kin. There is a line drawn across it. Section C asks for the name and address of any other person to be notified in an emergency. It contains the words "stated none".

The man was interviewed by the Health Care Officer (HCO) and a First Reception Health Screen form was completed. The man said that he had not seen a doctor in the last few months, had no outstanding appointments, was not in receipt of prescription medication, had not used drugs and was a social drinker. He did not express any concerns about his physical or mental health. It was noted that he had a black eye. The man told the officer that he had sustained it some 24 hours earlier in a fight. On interview the HCO said that he put the man down to see the doctor because he was not entirely sure how the man's black eye had been obtained and he wanted to clarify that there was no police involvement. Subsequently, the prison obtained a copy of the Forensic Medical Examiner's report from the police, which stated that the man already had a black left eye. Other than that, there were no concerns about him. No other significant issues were raised and the man was fitted for normal location, work and any cell occupancy.

A Cell Sharing Risk Assessment (CSRA) was completed on reception. The CSRA indicated that, whilst the man said he had no concerns about sharing a cell and that he would not describe himself as a person who gets angry or frustrated quickly, he had shown unpredictable/unexplained aggression and had assaulted staff and others. His risk was assessed as "High" which means there is a clear indication that a prisoner is a potential threat to their cell mate. As a result, it was decided that the man should be located in a single cell. He was given a cell by himself on Houseblock 3, an ordinary residential unit.

Induction process

The man was seen the next day, in common with all newly received prisoners, to make sure that he understood how Belmarsh operated and to find out what concerns he might have had. One of the induction staff, went to see the man. According to the officer, he went to collect the man from his cell and noticed that he seemed extremely quiet and withdrawn. He asked the man questions about his history and, described his answers as "very very vague". When asked by the investigators to describe the man's behaviour, the induction officer gave an example of returning the man to his cell and finding that when he collected him again at least 20 minutes later, he was standing in exactly the same place he had left him without moving. The man did not engage in eye contact and said very little. The officer was concerned about the man's demeanour and the lack of response when he tried to engage him in conversation, so he referred him to the Houseblock Nurse. The Induction Officer noted in the man's Record of Events, in which any occurrences of note should be recorded, "This inmate is extremely volatile please treat with caution."

The Houseblock Nurse said that she too was concerned. When the man was seen at the prison's Well Man Clinic, his Record of Events was noted as follows: "quite hostile/poor eye contact/vague, guarded on questioning only answering with yes or no. Contacted crisis team."

The Community Psychiatric Nurse (CPN), who saw the man subsequently, shared the Induction Officer and Houseblock Nurse's assessment. Her entry in the man's medical record (IMR) read:

"Staff on houseblock 3 are concerned about him: vague, perplexed, fixed stare, limited eye contact. He sexually assaulted a female police officer when arrested and was found carrying a knife. He assaulted another prisoner at court yesterday - stranger and unprovoked ... had a blank facial expression: unreactive. He was reluctant to answer my questions, giving me simple yes, no answers. He did say he was NFA (homeless) and could not give any information about his history or next of kin."

She confirmed that the man should be located in the Health Care Centre (HCC) for further assessment of his mental state. The man was located in the HCC on the afternoon of 13 May.

The man's stay in the Health Care Centre

The man was interviewed by a doctor on his admission to Health Care on 13 May. According to his IMR, he stared at the wall and his answers to many of the questions were "ok" or "can't remember". When asked about his black eye, he said that he had been involved in a scuffle.

The man was placed into cell 16 in the Health Care Centre, a single cell. The Health Care Senior Officer wrote in the man's Record of Events:

"Female staff in particular need to be aware due to previous sexual assault [of] a female police officer this week. SIR [Security Information Report] submitted."

She also made a note to that effect in the Health Care staff observation book, adding that female staff should not unlock him alone. There are no other entries in the observation book concerning the man. The following is an account of the written documentation my investigators found concerning the man's stay in the Health Care Centre.

14 May - "I tried to talk to him but was ignored. He just looked at me. STAFF BE AWARE." (Record of Events)

15 May - "Came out to collect his meals no threats to staff expressed or reported." (IMR)

15 May - See page of Care Plan below (IMR):

Patients Problem/Need	Aim of Care/Goal	Nursing Action	Review On
Unprovoked aggressive behaviour	1. For the man to stop being aggressive. 2. To create a safe environment for the man	1. Locate in single cell 2. Give medication as prescribed. 3. Monitor and record observation of behaviour	21/05/04

16 May - "Came out for his meals. No threats to staff expressed or reported. No interaction with staff or other inmates." (IMR)

18 May - "Had shower but declined exercise, behaviour remains strange, doesn't communicate well with staff." (Record of Events)

20 May - Attends the Magistrates' Court. (Court warrant)

22 May - "Remains quiet and not a management problem" (Record of Events)

24 May - "Remains settled and appeared quite cheerful this pm" (IMR)

26 May - "Remains settled. No management problem. No concerns expressed." (IMR)

1 June - "Remains the same. No problems voiced and seems quite cheerful." (IMR)

3 June - "Mental health management round. Review and consider referral to hospital." (IMR)

9 June - Committed for trial at the Crown Court, date to be fixed. (Court warrant)

11 June - A more detailed report in IMR of session with a Nurse. It comments on the man's poor self care, limited eye contact, monotone voice and brief answers. The outcome of the meeting was that the man would remain in Health Care and a doctor contacted concerning a referral.

14 June - Psychiatric review. The man said he had been concerned on his arrival to Belmarsh about his court case and being in prison. However, he felt okay and wanted to go back to the main prison. He talked more about his housing situation, saying that he had been of no fixed abode for about two years and had spent two years prior to that in hostels. His speech was described as "rather wooden" and he was "vague and perhaps evasive about home address". The outcome of the review was for him to remain in Health Care, contact would be made with the appropriate mental health unit, his solicitors would be contacted and he would be seen again on 8 July.

16 June - See Care Plan below

Patient's Problem/ Need	Aim of Care/Goal	Nursing Action	Review On
Can display aggressive behaviour	To reduce aggressive behaviours	Encourage patient to express how he feels to staff and Listeners. Encourage patient to engage in more appropriate coping behaviour.	26/6/04
Tendency to isolate himself	For patient to interact socially with others	Encourage patient to attend Cass unit and take part in exercise. Encourage patient to take part in association. Monitor and record patient's mood and behaviour, record how he	26/6/04

		interacts with others.	
--	--	------------------------	--

16 June - "Care Plan review. Care plan updated, no longer displays aggressive behaviour towards staff. Reported by discipline staff that prisoner complies well with regime and is always polite. Does go out on exercise but keeps himself to himself. Will continue to monitor and record interactions. Next review 26/06/04."

17 June - Mental health review took place. Outcome was to refer the man to the Johnson unit and to remain in Health Care.

Observations in IMR over the next week report that the man ate well, slept adequately, took exercise and was settled.

21 June - "Remains the same, quiet and not a control problem to staff" (Record of Events)

23 June - Bed Manager at the local mental health unit confirmed that the man was not known to two psychiatric hospitals. (IMR)

24 June - Attend Cass unit.

26 June - Care Plan review. "[The man] remains settled in mood and behaviour, compliant with ward regime. No display of aggression, continues to keep to himself. Next review 10-7-04."

27 June - "Eating and drinking sufficiently, appears settled. No problems voiced."

30 June - "Declined cell clean. Preferred to remain in bed." (Record of Events)

1 July - Psychiatry management round

2 July - "Very quiet, does not really interact with anyone, watches TV, not a management problem."

3 July - "Next Cell Sharing Risk Assessment due on 03 OCTOBER 2004" (Record of Events)

3 July - "Had a bath this am and did his washing whilst he was in the bath! Not currently a management problem." (Record of Events)

3 July - A Cell Sharing Risk Assessment review was carried out. It confirmed that the man should remain High Risk and that his status would be reviewed in three months time by a psychiatrist.

3 July - Was asked if he wanted exercise but he did not. Asked why, he replied "just don't want to go out ..." (Interview transcript - Officer arranging exercise)

The man was not prescribed any medication whilst at Belmarsh. When asked about his family, he was "vague". There is no evidence that he made any telephone calls or received any letters or visits whilst at Belmarsh.

The discovery of the man

On 3 July, the Night Duty Officer in the Health Care Centre, conducted a roll check of prisoners when he took over from day staff. Roll checks are carried out at set times throughout the day to confirm that the number of prisoners is accurate. At Belmarsh, staff on night duty perform a roll check when they come on duty to a unit, at approximately 12:30am, 5:15am and when the day staff take over duty. The Night Duty Officer said he saw the man watching television in his cell between 8:00pm and 8:30pm. He last remembered seeing him at about 12:30am on the morning of 4 July, lying in bed still watching television.

At approximately 4:30am, the nurse was conducting a round of H2 unit, where the man was located, checking the patients who needed to be observed at regular intervals. The man was not under any particular observational requirements but, according to the nurse doing the round, as there were several patients who were, she took the opportunity to observe all of them on her rounds. She saw the man in his bed asleep at that time.

At 5:15am, the Night Duty Officer was carrying out another roll check of the prisoners in the Health Care Centre. He looked through the observation panel of the man's cell, H2-16. He saw the man lying on the floor of the cell between the bed and locker. The Night Duty Officer noticed a small amount of froth around the man's mouth and thought that he might have had some sort of fit. According to the Night Duty Officer, the man's bed sheet was underneath him and he was lying flat out and face down as if he had rolled out of bed. He called out to the man several times but did not get a response. The Nurse who conducted the round heard the Night Duty Officer repeatedly calling the man's name and went to investigate. She too looked through the door hatch and saw him face down. She spoke to him but there was no response. The Night Duty Officer tried to summon assistance using his radio but his battery was flat. He therefore went to the unit office and telephoned the Emergency Control Room (ECR) to call the Assistant Night Orderly Officer (ANOO) and the Night Orderly Officer (NOO) - the most senior officers on duty during the night. The Nurse who conducted the round went to fetch some oxygen.

A Senior Officer (SO), the ANOO, arrived at the man's cell within a minute as he was nearby, as did a Health Care Officer (HCO). The SO, a former paramedic, unlocked the cell door and with the help of other staff moved the man into the corridor to allow staff to attempt resuscitation as he did not appear to be breathing. He asked the Nurse on scene to fetch an ambu bag to help resuscitate the man, whilst the HCO began Cardio-pulmonary Resuscitation (CPR). The SO checked the man's pulse and began chest compressions. There was no ambu bag on H2, so the Nurse went downstairs to fetch it. She also went to get the defibrillator but, as she did not carry the key for it, the Night Duty Officer retrieved it and the Nurse attached it to the man. The Night Duty Officer said a member of staff said the defibrillator did not quite function properly though it was not clear to him why. A Principal Officer, the NOO, arrived at the man's cell and called for an ambulance at 5:25am. A Fast Response Unit (FRU) and an ambulance were dispatched by London Ambulance Service at 5:28am and 5:29am respectively. They arrived at the prison at 5:32am and 5:35am.

Belmarsh staff continued CPR until the paramedics took over. According to the staff present, at no time did the man show any signs of life - no pulse, no respiration and he was cyanosed (turned blue) around his lips and mouth. The man was moved from H2 to the ambulance on a stretcher. He was re-intubated once he was in the ambulance and CPR was maintained. The ambulance left Belmarsh at 6:02am and alerted the nearby hospital of its imminent arrival. It arrived at 6:07am but the hospital staff were unable to revive the man. He was pronounced dead at 6:21am.

Staff involved in the incident took part in a hot debrief lead by the Duty Governor, to go over the facts of what had happened to the man. During interview the Nurse who conducted the

round and the Night Duty Officer were asked by my investigators whether they had heard any cell bells, shouting, banging or prisoners calling out on the night the man. Both said that they had not heard any noises to indicate a prisoner in distress and that, up until the man's death, it had been a settled and quiet week. The Nurse who conducted the round was asked if the man had pressed his cell bell, whether she had heard any other person raising an alarm concerning the man or whether she had heard any noise that had given her cause for concern and she replied that she had not.

The police attended Belmarsh and examined the man's cell for clues as to his possible cause of death. They were satisfied that there were no suspicious circumstances.

Contact with the man's family

As the man did not provide details of his next of kin, Belmarsh asked the Metropolitan Police to assist in tracing them. The prison's Roman Catholic Chaplain, visited the man's mother, on 4 July to deliver the news of her son's death. The prison appointed a governor to liaise with the man's family.

My investigator contacted the man's sister on 21 July, to find out whether she had questions or concerns about her brother's death. The man's sister asked about her brother's health care and whether he had been given a mental health assessment. Asked if she suspected he had mental health problems, she said that she had been worried at one point and had mentioned it to her father as she had noticed a change in the man's behaviour some nine months before he died. He had seemed slightly "odd", but she could not pin-point exactly why. She had asked him whether he had been using drugs, but he denied doing so.

My investigator spoke to the man's mother on 9 August and visited her with one of my Family Liaison Officers on 15 September. The man's mother was concerned that the police had not been forthcoming with her about the details of her son's arrest and that she still needed more information from the prison about how her son had seemed before his death. The man's aunt raised concerns about the medical records that were kept on her nephew as there did not appear to be any on-going assessment of his mental health and there was no proper care plan. She asked why he had remained in the Health Care Centre instead of being integrated back into the main prison.

Both the man's aunt and mother were concerned that a visit arranged by Belmarsh to show the man's family where he died went ahead without the two of them being present. They said that when they did eventually make a visit, they found some of the Health Care staff had been less than sensitive when speaking about the man.

My investigator spoke to the man's father. He raised concerns about whether his son had called for help by pressing his cell bell before he died. He said that he had collected his son's belongings from the prison but his trousers had not been included.

All the family members welcomed the opportunity to participate in the investigation process. None of them had known that the man was in custody until they were told of his death.

After seeing the draft report, the man's father raised several points concerning some interview transcripts, Belmarsh's response to the man's black eye, the operation of the defibrillator and the Night Duty Officer's radio, whether the staff on duty on the night his son died heard him call for help and clinical issues. I have altered some paragraphs to clarify some of his concerns. Unfortunately, I have been unable to answer his clinical questions due to the lack of a clinical review.

Post Mortem and Clinical review

A post mortem examination of the man took place on 6 July. Whilst the casualty doctor said he had found petechial haemorrhages and congested conjunctival surfaces, this was not confirmed in the post mortem which "found no evidence of assault in general or particularly that which might cause asphyxial changes."

There was no deep bruising or fracture of the man's facial neck structures. There was evidence of internal bleeding in his stomach and some sickled cells in his brain but these were not thought responsible for his death. There was no evidence of the presence of alcohol and drugs (other than traces of atropine which was used by medical staff in efforts to resuscitate him).

The pathologist concluded that the man's death was due to natural causes, caused by pulmonary oedema and congestion and "dilated cardiomyopathy which is known to be related to arrhythmias and sudden death".

I understand the man's family commissioned a second post mortem which was inconclusive about his cause of death.

A clinical review of the health care the man received was requested from the Teaching Primary Care Trust in August 2004. It is still not available. The Prison Service commented, after seeing the draft report, that they considered the report incomplete without the clinical review. I share their reservations but I am unable to delay this report any longer. The length of time it has taken to produce the clinical review is unsatisfactory and I am sorry that, as a result, I have been unable to provide the man's family with answers to some of their questions.

Responses from prisoners at Belmarsh

After a Notice to Prisoners was displayed telling prisoners of the investigation, one response was received. This was from a prisoner who had been in the Health Care Centre at the time of the man's death. In his letter to my investigators, the prisoner said that "Stephen Shaw", as he termed the man, had died at around 2:45am and had been shouting for about an hour beforehand. On interview, the prisoner said that at about 2:00am he saw the man through his window banging on his cell door and heard a cell buzzer going. The banging continued for about 20 minutes then stopped: "I saw him seem to bend over his sink and either sit down or drop to the floor." He said he did not alert staff to what he saw, his reasoning being that if staff would not respond to the man banging why would they respond to him? Asked to describe the man, the prisoner said he "had a beard, he appeared to be like Mediterranean origin, he was dark ... I suppose he was in his thirties." The prisoner said he had seen the man a couple of times previously and spoken to him across the courtyard as his cell window was opposite the man's. He said that if staff had responded to the man's banging, his death probably would not have happened.

My investigators interviewed, the prisoner who was in the cell H2-17, next door to the man. The prisoner next door said that he had talked to the man at the window of his cell. The man generally appeared to him to be quiet, stayed in his cell and did not go on association with other prisoners or on the exercise yard. The prisoner next door said he used to encourage the man to get out and take some fresh air but he would decline and say " ...he's stressed out, he don't want to come out, he's really down, he wants to kill himself, stuff like that you know?" Asked if the man had said that he wanted to take his own life, the prisoner next door maintained that the man told him "he'd had enough". On the evening before the man died, the prisoner next door said he could hear him playing with his cup against the cell wall. He spoke to the man through the window and, when he asked him how he was, the reply was that he was "not too bad, just stressed out". The prisoner next door said he was awake in the early morning of 4 July as he was unable to sleep. He remembered seeing the Night Officer doing regular checks but he did not hear any noises coming from the cell next door apart from the man playing with his cup at about 3:00am.

Health Care Centre

H2 unit is the inpatient unit within Belmarsh. It accommodates 33 prisoners in 21 single cells and two six-bed wards in the shape of an H with four spurs leading off a central corridor. It also looks after prisoners with mental health problems. The unit is managed by a healthcare management team under the direction of the Head of Healthcare. There are clinical staff from Oxleas NHS Trust and a mix of officers, Health Care Officers, nursing staff employed by the Prison Service and clinical staff directly employed by the local Primary Care Trust.

There was no visible timetable of day-to-day activities on display on any of the occasions my investigators were present on H2. The Supervising Principal Officer, a manager in the Health Care Centre until September 2004, was asked about the regime there. He said that he had created a new association area for prisoners and encouraged staff to get prisoners out of their cells, but had faced resistance from some staff including managers, who were reluctant to engage with difficult prisoners. He alluded to conflict between discipline (uniformed prison officers) and clinical nursing staff and the difficulties in running the unit with differences in approach and priorities.

The Duty Governor on the day the man died, said that his impression of the Health Care Centre was that the clinical and discipline staff did not seem to mix sufficiently. That the regime could be described as impoverished was an understatement.

When the prisoner in Healthcare was asked by my investigators to describe his time in the Health Care Centre he said:

"I have been in here before and it was better then, it was very good and now it is poor. We very rarely get exercise or any other regime activity. The staff are at odds with each other and what I mean by that is the nurses and the officers, there is a power struggle between them. There is very little interaction between staff and prisoners and we are locked in our cells most of the day ... When the day staff come on, we are given hot water through the flap ... I didn't have a shower for nine days. No association whilst there. I got access to the phone about every other day but it depended who was on duty. I did not have a TV or radio. I submitted numerous complaints about the HCC but none were answered correctly and I raised it with the IMB as well."

The officer who conducted the roll check was also asked to describe the regime during the day and evening. He replied:

"Evening, none. Of a daytime, it's a very limited regime, we run with an MSL [Minimum Staffing Level] of three staff and then there's a nurse and a senior. Patients within the Health Care tend to be unkempt so every day we have to go round, clean them out, get them bathed, get them sorted which takes two staff, so you've got a spare member of staff which is normally the cleaning officer. Exercise, we try ... if not we have to push it over to the afternoon depending on the staffing figures. We can't actually run a full regime because if you get a doctor come in to see someone, they're normally come in to see a three man unlock or something like that but all three staff are used. It is a limited regime. We give them the basics but we can't give them much more ..."

When my investigators visited the Health Care Centre, they noted that although the unit was clean it appeared dark and drab and there was no floor covering in the man's cell. On the days they visited, they did not observe association or exercise taking place.

Each cell or ward contains a call button that can be pressed to attract the attention of staff. It should only be used for emergencies but, in common with many prisons, is routinely rung by prisoners for non-urgent requests. A light is activated outside the room and a buzzer is sounded until the bell is answered. Each time the bell is pressed, it is registered by the electronic Cell Call System. My investigators obtained a printout of the system covering 3 and 4 July 2004. It shows that the bell in the man's cell, H2-16, was pressed on 3 July at 08:05:47 and was answered at 08:13:47. The printout shows that the bell in cell 16 was reset again on 3 July at 09:43:11. No other activations of the bell are recorded for 3 and 4 July.

Staff impressions of the man prior to his death

Staff who had come into contact with the man in the Health Care were asked to describe him. The consensus was that the man was "not a control problem", had limited interaction with staff or other prisoners, rarely spoke and kept a low profile. The opinion of the officer arranging exercise "he was just ... another face behind a door ..." The officer who conducted the roll check said that the man kept conversation to a minimum and was very quiet, but if he was offered the opportunity of having a bath he would become animated. Asked by my investigators if he thought that the Health Care Centre was an appropriate place for the man, the officer who conducted the roll check said the man did not look out of place in Health Care as he appeared to have difficulties with communication, kept himself to himself and might have been perceived by some prisoners as a problem.

Conclusion and Recommendations

When the man was received into custody at Belmarsh, he was treated as one would expect a newly received prisoner to be. The First Reception Health Screen was completed and his black eye was noted. It is evident from the man's police custody record that his injury was sustained before he arrived at the police station and therefore before he arrived at Belmarsh. Belmarsh obtained a copy of the police's Forensic Medical Examination to ascertain where the injury had been caused. Nothing I have seen during the investigation has led me to the conclusion that his injury contributed towards his death and the results of the post mortem are consistent with this view. The Induction Officer was concerned about the man's mental health and, given the man's unexplained violent behaviour whilst in the court cells, he asked the Houseblock Nurse and Community Psychiatric Nurse to assess the man. Both agreed that he should be located in the Health Care Centre for assessment. I was impressed by the induction process at Belmarsh which came across as caring and thorough.

Poor eye contact and seeming withdrawn might not have been distinct problems in themselves. But coupled with assaulting a prisoner and a Prison Custody Officer earlier that day, it was reasonable that, having displayed behaviour that staff considered unsettling, the man was located in a single cell and then moved to Health Care.

Once in Health Care, despite there being evidence of a limited care plan to encourage the man to engage in activities, it is not clear which staff took ownership of making this happen. The accounts I have seen concerning the issues of staffing and job demarcation within the Centre would suggest that positive multi-disciplinary efforts to care for patients may have depended on the presence of particular members of staff. There was no evidence of a Personal Officer or named nurse scheme in place within the Health Care Centre, a fact that perhaps explains the lack of consistency or quality in entries within the man's Record of Events. Comments seem to be based on whether or not he was a 'control problem' rather than the reasons for which he found himself in the Health Care Centre in the first place.

The man spent seven weeks in the Health Care Centre, yet my impression is that very little positive seemed to have been known about him apart from the officer who conducted the roll check's observations. As he was not prescribed any medication, not considered at risk of self harm, received few if any letters or visits, and barely spoke, he faded into the background. In a Centre where patients spent the vast majority of their day in their cells or wards, it is unsurprising that, in the words of the officer arranging exercise, [The man became "just ...another face behind a door". This was a regime that lacked activity for the patients, and meaningful contact with staff, and which needed to be more open to change at all levels. Despite the efforts made by some staff, the physical appearance of the Health Care Centre and especially the lack of flooring in the man's cell, created in the minds of my colleagues a perception of a lack of care for the patients.

The prisoner in Healthcare said that on the morning the man died, he saw the man banging on his cell door and heard his cell bell ring for about 20 minutes at around 2:00am. Whilst the Healthcare prisoner's cell was opposite the man's, and it was possible for him to see into it, a number of points lead me to conclude that the prisoner in Healthcare was mistaken. The prisoner who was in the cell next door to the man said that he heard him tapping his cup against the wall at about 3:00am but no other noises. The Nurse conducting the round saw the man in his bed asleep at about 4:30am. Above all, the Cell Call System printout shows that his call button was not activated. Indeed no cell bells were activated after 12:43am on the night in question. Identification evidence can be unreliable but the prisoner in healthcare described the man as a bearded man of Mediterranean origin whereas the man was a bearded, dark-skinned man of African-Caribbean descent.

Apart from the prisoner in Healthcare's account, I have not found other evidence that conflicts with the accounts given by the Nurse who conducted the round, the supervising HCO or the officer who conducted the roll check .

The staff's response once the man was found was speedy and consistent. It is unfortunate that the officer conducting the roll check's radio battery was found to be flat and that he had to contact the communications room by telephone. Whilst it appears that the man was already beyond help when he was found, the seconds lost by going to the office to make the call might have been vital in different circumstances. Whilst there was a short delay of about a minute in entering the man's cell after he was found, it is clear the SO previous experience as a paramedic was invaluable. However, there was an initial problem with accessing and in the operation of the defibrillator.

Other Issues

The last inspection by HM Chief Inspector of Prisons in the summer of 2003 highlighted the impoverished and unsatisfactory regime for prisoners within the Health Care Centre. This was also identified in two recent death in custody investigations. There is no evidence that these recommendations have been acted upon, as the regime still remains unsatisfactory. This investigation has identified some specific problems:

- There was no published regime or any evidence of management checks to ensure that the limited regime in place happened consistently.
- There was a lack of team working and understanding of the differing roles of the discipline and clinical grades within the Health Care Centre.
- There was a lack of interaction between staff and prisoners in the Health Care Centre.
- Finally, the physical appearance of the HCC is not satisfactory and, although it is not dirty, it is in need of repainting and refurbishment to reflect a more caring environment.

The man's death appears to have been sudden, unexpected and a shock to all those who knew him. Subject to the findings of the clinical review which I am yet to receive, I am satisfied that his death could not have been foreseen and that, once he was discovered, staff made every effort to resuscitate him. Although I have been critical of some aspects of the regime and environment of the healthcare centre, the accounts I have seen of his time at Belmarsh do not indicate that the outcome could have been predicted. I do not believe that the man's death was brought about by the care he received at Belmarsh.

Recommendations

- I recommend that the Governor of Belmarsh in conjunction with the Primary Care Trust reviews the regime available to prisoners located within the Health Care Centre with a view to providing purposeful activity and better interaction between staff and patients.
- I recommend the Governor of Belmarsh in conjunction with the Primary Care Trust initiates a review of staffing in the Health Care Centre. The prison should promote a multi-disciplinary approach including the development of a more cohesive team ethos that meets the needs of staff and prisoners.
- The Healthcare Manager should produce and implement an action plan for the repainting and refurbishment of the Health Care Centre to promote a more caring environment.
- Regular checks should be made to ensure that the defibrillator is in full working order

1.