Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Belmarsh, in February 2007

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of my investigation into the death of a man on 10 February 2007. The man was found hanging in his cell at HMP Belmarsh in the early hours of the morning. He was aged 22.

I wish to offer my sincere condolences to the man's family and friends for their loss.

The investigation was conducted on my behalf by two of my investigators. I would like to extend my thanks to the Governor and her staff at Belmarsh for their help and co-operation.

In addition to my investigation, a clinical review was undertaken by the Greenwich Primary Care Trust into the medical care that the man received in custody. I am grateful to the clinical reviewer and his panel for that review.

This young man was charged with a number of serious offences including murder. According to a letter he left for his parents, the shame he felt for his crimes apparently led to a decision to end his own life.

I have made three recommendations in addition to the learning points emanating from the clinical review panel all of which have been accepted by the Prison service.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2007**

CONTENTS	**PAGE NO.**
Summary	1
The investigation process	2
HMP Belmarsh	4
Key events	5
Issues considered during the investigation	9
Recommendations	12

SUMMARY

1. In November 2006, the man was arrested and charged with a number of serious offences, including murder. He was remanded into custody on 27 November to await his trial.

2. The man was initially sent to HMP Wandsworth, but as a potential category A prisoner he was transferred to HMP Belmarsh on 30 November. He was described as a 'model prisoner', well behaved, quiet and polite. None of the staff, nor other prisoners nor members of his family noticed any change in his mood over the next two months. His sister visited him the day before his death and later said that he appeared to be his normal self.

3. However, in a letter dated 9 February 2007 and timed at 11.00 pm, the man wrote to his parents about his shame for what he had done and his feelings about ending his life. At about 5.15 am on the morning of 10 February, he was discovered hanging from the window bars of his cell. Despite the efforts of staff and paramedics, he was pronounced dead at 5.44 am. The man was just 22 years old.

THE INVESTIGATION PROCESS

4. My investigators opened this investigation at Belmarsh on 19 February 2007. The Governor and her staff produced the man's core record and a number of other documents for examination. Notices were distributed around the establishment notifying staff and prisoners of the investigation. As part of the investigation process, a number of staff were formally interviewed.

5. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist with his enquiries into the man's death.

6. A clinical review of the man's treatment in custody was undertaken on behalf of the Greenwich Primary Care Trust.

7. One of my Family Liaison Officers contacted the man's family to inform them about my investigation and to offer the opportunity to raise any concerns and questions that they would like explored and addressed. They chose not to meet with my investigator or Family Liaison Officer at that time. The family felt the prison had been open and honest with them about what had happened and did not have any significant matters to raise. However, they were concerned that, where possible, lessons should be learned to prevent the same thing happening in the future. Members of the family had spoken with prisoners who had known the man. The prisoners raised an issue about potentially vulnerable category A prisoners being allocated a single cell.

8. The man's sister told the family liaison officer that she and her son had visited the man on his birthday (the day before his death). The man had seemed his normal self and had not given any indication of feeling low or depressed. The family felt, although it was incredibly difficult, it was important to recognise that ultimately this was the man's decision.

HMP BELMARSH

9. HMP Belmarsh opened in 1991. It is a local prison within the high security estate and can hold category A prisoners.

10. In common with many other prisons, Belmarsh is overcrowded. Most of the prison's population are accommodated on four residential houseblocks.

11. In the introduction to an unannounced follow-up inspection report published in December 2005, Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, writes:

12. 'Belmarsh is a complex prison. Most of its prisoners are short-term, relatively low-risk prisoners who could be found in any local prison; but it also holds higher-risk prisoners in security category A, some within the main prison and some in its special and high security units. In addition, it has a significant population of young adults and life-sentenced prisoners.

13. At our last inspection, we described Belmarsh as "struggling to provide a regime and an environment that met the basic needs of its prisoners". Since then, the complexity of its task had, if anything, increased. The number of category A prisoners and of young adults had grown. Life-sentenced prisoners were spending longer in Belmarsh because of difficulties in transferring them within an overcrowded system. And the prison's high security and special security units were at full stretch, holding, among others, those suspected of the failed suicide bomb attempts of July.

14. There had undoubtedly been progress since the last inspection. This was most marked in relation to resettlement, which had been reorganised and coordinated. Drug treatment services had developed, and there was an excellent visitors' centre. There were still, however, no effective custody or rehabilitation plans for the short-term and remanded prisoners who formed the bulk of the population.'

15. Shortly after the man's death, the Governor introduced a new regime at Belmarsh. One of its aims is to reduce the period of time prisoners spend in their cell.

16. In April 2005, Greenwich Teaching PCT assumed responsibility for commissioning healthcare services in the prison. The Head of Healthcare leads a multi-disciplinary team of nurses, healthcare officers, discipline officers and nursing assistants, and there is input from a Mental Health In-reach Team (MHIRT), visiting GPs and a consultant forensic psychiatrist.

17. The man's death was the third apparently self-inflicted death to have occurred in Belmarsh since I began investigating fatal incidents in April 2004. (There has since been one other apparently self-inflicted death at the prison.) I have made recommendations in two other investigation reports regarding record keeping training for staff.

KEY EVENTS

18. During the night of 5/6 November 2006, two very serious offences were committed - one of which resulted in the death of a woman. The man was first arrested on 18 November on suspicion of being involved in those offences. He was released after interview but re-arrested on 23 November as the result of DNA evidence. The man was charged with the murder and other serious offences.

19. The man appeared at the City of Westminster Magistrates' Court on 27 November. He was remanded into custody at HMP Wandsworth and committed to the Central Criminal Court with a trial date of 5 March 2007.

20. The man arrived at Wandsworth and underwent the standard reception procedures. He was considered a low risk to others during the cell sharing risk assessment. However, he was identified as a potential category A prisoner due to the nature of the charges he was facing. (A category A prisoner is someone whose escape would be highly dangerous to the public or the police or the security of the State and for whom the aim must be to make escape impossible.)

21. The first reception health screen was completed and the man told the nurse that he had seen a doctor recently for a groin abscess. He had been given antibiotics to treat the abscess whilst at the police station. No other medical or mental problems were identified other than ongoing treatment for his acne. However, due to the nature of the crime that the man was charged with, he should have been referred for further psychiatric assessment. That was not done.

22. The man was transferred to HMP Belmarsh on 30 November due to his potential category A status. On 1 December, a secondary health assessment was completed. Again, no medical or mental health problems other than the abscess and acne were either mentioned or indicated. The man said that he was emotionally 'ok' and that he was aware of the Listeners service and the Samaritans. (The Listeners are volunteer prisoners who are trained by the Samaritans to perform a similar role within prison.)

23. A prison officer conducted a one to one induction interview with the man the same day. He confirmed the low risk cell sharing risk assessment, and explained the procedures at Belmarsh for visits and telephone calls for potential category A prisoners. The prison officer also gave the man literature explaining life sentences. When asked how he was managing with being in prison, the man said that he was coping at present but finding it hard. He confirmed that he did not have any suicidal or self-harm thoughts. The prison officer completed the 'Identification of Potential Life Sentence Prisoner' form. In the section entitled 'What is the prisoner's initial reaction to his/her remand in custody?' The prison officer wrote, 'Coping at present, but finding it hard. Aware that the charge of murder can result in a mandatory life sentence. Accepts move to Belmarsh, but it may cause problems with visits.'

24. The man was allocated a single cell on houseblock 3. It is normal for category A prisoners to be allocated a single cell for reasons of security. An exception to the rule is sometimes made if there are concerns about the prisoner self-harming. There were no such concerns raised in relation to the man and therefore the allocation of a single cell was in accordance with the local policy.

25. The man did not come to notice of staff during the remainder of his time at Belmarsh. He was polite and complied with any instructions he was given. Neither staff nor prisoners saw any change in his mood or behaviour which would indicate potential self-harming thoughts or behaviour.

26. The man was seen by healthcare staff on 1 December, 12 December, 4 January 2007 and 8 February, when he was prescribed various medications for his abscess and his acne. However, there are no entries in his continuous medical record relating to these dates.

27. The man's sister visited him on his 22nd birthday (9 February 2007), and later said that he appeared to be his normal self and had not given any indication of feeling low or depressed. At interview with my investigators, the night duty officer said that he had spoken with a prisoner in the next cell to the man who had been talking with him that evening. The prisoner said that the man did not 'give anything away'.

28. The night duty officer was on duty on houseblock 3 that night. Part of his duty was to check the category A prisoners four times during the night. There were 18 such prisoners (including the man) on spur one, and he checked them all at around 10.30pm, 1.30am and 3.30am. The night duty officer did not notice anything untoward during his checks.

29. At about 5.00am, the night duty officer began his final count, making sure that all of the prisoners in houseblock 3 were still in their cells. When he got to cell 36 on spur one (the man's cell), he switched on the night light. He could not see the man in his bed or in the toilet area. He saw that the table and chair had been moved to the middle of the cell and it was then he noticed the man. The man had apparently tied a ligature made from his bed sheet to the window bars and around his neck. He was slumped down as if sitting on the heating pipes underneath the window.

30. The night duty officer kicked the door several times to get a response, but without success. He radioed a 'level one' emergency call to the control room, and then ran to the office (referred to as 'the bubble') to contact the control room again by telephone. He told them that he had a level one emergency, gave the details, and then returned to the cell. The call was logged at 5.15 am. (A level one call indicates a serious medical emergency.) The control room called for an ambulance at 5.17 am.

31. A second prison officer was the first to arrive. He opened the cell door and he and the night duty officer entered. The second prison officer immediately supported the man to relieve the pressure on his neck, while the night duty

officer returned to the ‘bubble’ to get the cut down scissors. The night duty officer cut the ligature and the officers laid the man down on the cell floor. The second prison officer then cut the ligature from around the man’s neck. The ligature was thin and had left a deep mark in the man’s neck. It was so deep that some officers who arrived later thought it was the ligature itself.

32. The second prison officer noticed that there was a quantity of toilet paper in the man’s throat and he had difficulty removing it. The night orderly officer arrived as the second prison officer began Cardio Pulmonary Resuscitation (CPR). Other staff arrived. They included a healthcare worker who also attempted to remove paper from the man’s airway. The healthcare worker applied the ambu-bag to introduce air into the man’s lungs and the second prison officer continued with the chest compressions.

33. An automatic external defibrillator was applied to the man’s chest but it indicated not to shock. CPR was continued by the staff until the ambulance crew arrived and took over at 5.27am. Sadly, despite the efforts of staff and paramedics, at 5.44am the ambulance crew confirmed to the control room that the man had died. At 8.26am, the prison doctor, who had been called in from home, certified that the man was dead.

34. When the cell was searched, a letter written by the man was found dated 9 February and timed at 11.00pm. In the letter the man talks about his shame for his offence and says goodbye to his family. Towards the end of the letter there is a passage which reads, ‘It’s meant to be my birthday, but all I can think about is ending my life!’ A diary was also found in the cell. The head of healthcare at Belmarsh, saw the printed proverb for the 10 February which read ‘man shall not live by bread alone’. The head of healthcare noted that the words ‘shall not live’ had been highlighted.

35. The man’s family was informed of his death by the police and a member of the prison chaplaincy. They have since had the opportunity to visit the prison, see the man’s cell and speak to staff and prisoners who knew him. I was pleased to learn that, in line with Prison Service policy, the Governor provided a contribution towards the funeral costs.

36. On 13 February, an officer put in a Security Information Report relating to the man’s death. Having heard about the particular circumstances of how the man had apparently ended his life, in particular the use of toilet paper, the officer recalled an interview with another prisoner. Whilst sitting in on a medical interview he had heard the prisoner, who had recently transferred in from another prison, almost boasting about the way he had tried to kill himself. The prisoner had said that he tried to hang himself after stuffing toilet paper in his mouth. The officer was struck by the similarity with the way that the man had died.

37. The prisoner concerned had been on the same houseblock as the man for a few days, so it is possible that he heard the man’s story and decided to use that method. Unfortunately, like other prisoners my investigators wished to speak to, this prisoner declined to be interviewed for my investigation. (Under

my current non-statutory Terms of reference, I have no power to compel potential witnesses to assist my inquiries.)

ISSUES CONSIDERED DURING THE INVESTIGATION

Clinical Review

38. The panel concluded that:

- the medical record appeared to be incomplete
- the level of care the man received whilst in custody was comparable to the care he could have expected in the community
- no suicide or self-harm indicators were identified prior to his death
- the clinical response to the emergency call appeared appropriate.

39. The panel has identified a few learning points that the Prison Health Partnership may wish to consider for future service improvement. A copy of the full clinical review is included in the annexes to this report.

Record keeping

40. Upon arrival at Wandsworth, the man went through the standard Reception procedures which included a First Reception Health Screen. The form was completed by a reception nurse. After the section on the form that asks questions about the prisoner's past and present mental health, there is a paragraph in underlined capital letters which reads: 'If yes to questions 12-14 or charged with homicide, refer to CPN for further psychiatric assessment and record details in IMR'.

41. During his interview with my investigator, the reception nurse said that the man was not referred as required due to an oversight, even though the reception nurse was aware of the charges that the man faced. The reception nurse is a registered CPN (Community Psychiatric Nurse) and said that the man's presentation on the 27 November did not give him any cause for concern. Whilst I do not feel it would have altered the outcome in this case, healthcare staff at Wandsworth should be reminded of the importance of completing the reception procedures correctly.

42. **The Prison Health Partnership at HMP Wandsworth should remind all healthcare staff of the importance of correctly completing the reception procedures and ensuring the timely referral of prisoners when required.**

43. The prisoner's medical record should contain a chronology of interactions with healthcare staff, treatments and medication prescribed. There were no entries on the man's continuous medical record by Belmarsh staff until the day of his death.

44. A Secondary Health Assessment form was completed the day after the man arrived at Belmarsh (1 December) when he said that he felt emotionally ok. The prescription chart shows entries on 1 December and 12 December 2006 and 4 January and 8 February 2007. There should be entries on the continuous medical record to document the prescribing of this medication.

Poorly completed or incomplete medical records are highlighted in a significant number of my reports and accompanying Clinical Reviews.

45. **Healthcare staff should take steps to ensure they adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.**

Anti-ligature knives

46. When the officers entered the man's cell they had no means of cutting the bed sheet ligature. The night duty officer returned to the 'bubble' to get the cut-down scissors from the emergency box. The time delay in this case was minimal. Nevertheless, Prison Service Instruction (PSI) 32/2006, issued on 20 November 2006, introduced the personal issue of cut down tools. All establishments are required to have a local protocol on the procurement, issuing, carrying and use of cut down tools. The PSI says:

47. 'All unified and uniformed staff in closed and semi-open establishments must be provided with and carry on duty their own personal issue cut-down tool. It is not sufficient for cut-down tools to be held in a box in the office for 'grab-and-go' purposes, nor for staff to collect 'any' cut-down tool upon commencement of duty.' (Emphasis in original.)

48. **The Governor must ensure local compliance with Prison Service Instruction 32/2006.**

Prisoner/staff interaction

49. A copy of the relevant section of the Staff Observation Book for houseblock 3 was given to my investigators at the start of their investigation. My investigators were impressed with the quality of the entries made by staff, particularly with regard to any concerns they had about prisoners self-harming. The quality of these entries demonstrates a good level of interaction between staff and prisoners, enabling changes in an individual's behaviour or emotional state to be recognised. Furthermore, such entries enable effective continuity of care and safety of individuals who may be at risk.

Conclusion

50. The man was a young man with no experience of adult prison life. Because of the nature of the charges against him, he faced a very long custodial sentence if convicted.

51. It is clear from the letter the man wrote to his parents on the late evening before his death that he felt ashamed of what he had done, and he appears to have taken a decision to end his own life.

52. During his two months in custody the man was seen both by medical and uniformed staff. Neither the staff nor fellow prisoners noticed any deterioration in his mood. It is also telling that the man's sister, who visited him on his birthday the day before he died, also saw no signs that he intended to take his own life.

RECOMMENDATIONS

HMP Wandsworth

- **The Prison Health Partnership at HMP Wandsworth should remind all healthcare staff of the importance of correctly completing the reception procedures and ensuring the timely referral of prisoners when required.**

HMP Belmarsh

- **Healthcare staff should take steps to ensure they adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.**

- **The Governor must ensure local compliance with Prison Service Instruction 32/2006**