Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sundeep Ghuman, a prisoner at HMP Belmarsh, on 19 February 2020

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Sundeep Ghuman died in hospital of a head injury on 19 February 2020, having been assaulted by his cellmate at HMP Belmarsh. Mr Ghuman was 36 years old. I offer my condolences to Mr Ghuman's family and friends.

On 16 May 2022, Mr Steven Hilden was found guilty of Mr Ghuman's murder and later sentenced to life in prison. Mr Hilden had a history of racist and violent behaviour but prison staff at Belmarsh failed to identify his risk. This meant that Mr Ghuman, who was a British Asian man, was placed in a cell with him. If prison staff had properly identified the risk, it is highly likely that Mr Ghuman's death could have been avoided as Mr Hilden should not have shared a cell with him.

Mr Ghuman's death has terrible echoes of the racist murder of Zahid Mubarek in 2000. I am dismayed that, despite the learning and change to have come from Mr Mubarek's death and the subsequent inquiry, basic errors allowed for such a similar event to happen again twenty years later.

Although the clinical reviewer found that healthcare staff managed the resuscitation efforts well, there were delays in calling an emergency code red immediately and further delays in providing sufficient information to the ambulance service for an ambulance to be dispatched and then for paramedics to be escorted to Mr Ghuman's cell.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

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Summary

Events

1. On 18 September 2019, Mr Sundeep Ghuman was recalled to HMP Belmarsh for breaching his licence conditions. He had a history of substance misuse but did not always engage with the prison's substance misuse team.

2. On 5 November, Mr Steven Hilden was transferred to HMP Belmarsh from court, having previously been at HMP High Down. He had a history of racist and violent behaviour and was only allowed to share a cell with a prisoner of the same ethnicity at High Down. However, there is no record that staff at Belmarsh identified his risks when completing his cell sharing risk assessment (CSRA).

3. On 13 February 2020, prison staff moved Mr Ghuman to a cell which he was to share with two other prisoners, one of whom was Mr Steven Hilden.

4. At 5.30pm on 18 February 2020, a prisoner looked through Mr Ghuman's cell door observation panel and saw him lying on the floor, with blood coming from his head. He shouted out for prison officers to attend.

5. At 5.31pm, a prison officer looked through the cell observation panel and saw blood splattered on the walls and Mr Ghuman slumped over a broken table. He shouted for staff to attend and went into the cell with other prison officers.

6. A prison officer told Mr Ghuman's cellmates to leave the cell, shouted for an emergency medical code red, which indicates that a prisoner has severe bleeding, and removed a broken table from the cell. At 5.32pm, an officer radioed a medical code red and an ambulance was called.

7. Officers tried to attend to Mr Ghuman, but he was bleeding profusely from the head and ear and rolling around on the floor, groaning and trying to grab the staff attending to him. Several healthcare staff, including a GP at Belmarsh, arrived to help but they were unable to stop the bleeding.

8. At 7.14pm, paramedics took Mr Ghuman to hospital by ambulance. He was admitted to the intensive care unit and treated for a severe head injury. At 6.10pm on 19 February, Mr Ghuman died in hospital after life support was withdrawn.

9. On 16 May 2022, Mr Hilden was found guilty of Mr Ghuman's murder. He was sentenced to life in prison on 15 July.

Findings

10. Mr Hilden had a history of racist and violent behaviour which prison staff at Belmarsh failed to identify as a risk. This led to Mr Ghuman, a British Asian man, sharing a cell with him. Had this risk been identified, it is highly likely that Mr Ghuman would not have shared a cell with him. We therefore consider that Mr Ghuman's death was avoidable.

11. We are concerned that there was a nine-minute delay between when the prison first called for an ambulance and the second call, when an ambulance was dispatched. We are also concerned that there was a further 15-minute delay in escorting paramedics to Mr Ghuman's cell.

Recommendations

- The Governor should write to the Ombudsman, setting out what action she has taken to assure herself that CSRA processes at Belmarsh are robust and consider all relevant information.

- The Head of Healthcare should establish a clear policy to ensure that healthcare staff share with prison staff any concerns expressed by prisoners about sharing cells.

- The Governor should write to the Ombudsman, setting out what improvements have been made to ensure that:

    - control room staff call an ambulance immediately and provide all possible information required, remaining on the line until an ambulance is dispatched; and;
    - there are no delays in escorting ambulance and paramedics in an emergency.

The Investigation Process

12. 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.

13. The investigator visited Belmarsh on 3 March 2020. He obtained copies of relevant extracts from Mr Ghuman's prison and medical records.

14. The investigator interviewed eight members of staff from Belmarsh between 9 September and 6 October 2022.

15. NHS England commissioned a clinical reviewer to review Mr Ghuman's and Mr Hilden's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed six members of staff. The purpose of examining the clinical care Mr Hilden received is to establish that there were no actions or inactions in relation to his physical or mental health that contributed to the death of Mr Ghuman.

16. We had to suspend our investigation between February 2020 and May 2022 while the police investigated the circumstances of Mr Ghuman's death and his murder trial concluded. The investigator remained in regular contact with the police, who shared information with him about Mr Ghuman's murder.

17. We also had to suspend our investigation between June and August 2022 while we waited for the prison to provide significant documentation and between October 2022 and January 2023 while we waited for the clinical reviewer's reports.

18. We informed HM Coroner for Southwark of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

19. The Ombudsman's family liaison officer contacted Mr Ghuman's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Ghuman's mother wanted to know:

    - whether anyone saw or heard anything;
    - if CCTV footage was available for the investigator to view;
    - who raised the alarm when Mr Ghuman was found;
    - how was he taken to hospital; and
    - where he died.

    We have addressed these questions in this report.

20. Mr Ghuman's mother 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. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Belmarsh

22. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and a 32-bed inpatient unit.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Belmarsh was in July and August 2021. Inspectors reported that rates of violence had risen since their last inspection despite COVID-19 restrictions limiting the time most prisoners were out of their cells. They found that one in four prisoners said they felt unsafe, that the violence reduction strategy did not address the specific issues relevant to Belmarsh and that there was inadequate use of data to support the development of effective strategies for safety or equality.

24. In April 2022, inspectors conducted an independent review of progress at Belmarsh. They found that the management of violence had much improved and there was some early evidence of improving outcomes. However, inspectors also found that there had been very little progress in increasing the effective use of body-worn cameras.

Independent Monitoring Board

25. 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 2022, the IMB reported that prisoner on prisoner violence remained at very similar levels to the previous year, despite strict regime changes and new conflict reduction initiatives. However, they considered that more time would be needed for the changes to become embedded before judgements could be made on their efficacy. The IMB also reported that prisoners with substance misuse issues were well supported by prison staff and external agencies.

Previous deaths at HMP Belmarsh

26. Mr Ghuman was the eighth prisoner to die at Belmarsh since February 2018. There have been two deaths from natural causes, one self-inflicted death and one death awaiting classification since Mr Ghuman’s death. In one of the investigations, we were concerned about the quality of family liaison.

Psychoactive Substances (PS)

27. PS are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy

levels, a high tolerance of pain and a potential for violence. Besides evidence of such risks to physical health, PS may precipitate or exacerbate the deterioration of mental health and has been linked to suicide and self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

29. HMPPS has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drug testing arrangements.

The murder of Zahid Mubarek and subsequent public inquiry

30. In March 2000, Mr Zahid Mubarek, who was an Asian teenager and prisoner at HMYOI Feltham, died from head injuries inflicted by his cellmate, Mr Robert Stewart. Mr Stewart was a known racist and attacked Mr Mubarek with a broken table leg while he slept. In November 2000, Mr Stewart was convicted of Mr Mubarek's murder and sentenced to life in prison. Over the following four years, Mr Mubarek's family campaigned for the Government to hold a public inquiry into his death and in July 2004, the then Home Secretary, The Rt Hon. Lord David Blunkett, announced a public inquiry to be chaired by The Honourable Mr Justice Keith.

31. In response to Mr Mubarek's death, the Prison Service introduced the Cell Sharing Risk Assessment (CSRA), a formalised process aimed at identifying prisoners who cannot safely share a cell with others, and several additional systems to improve information flow. The Zahid Mubarek Inquiry highlighted the importance of reviewing documents such as the PER to inform the management of a prisoner and made 88 recommendations to address what it considered systematic failings within the Prison Service.

Key Events

Mr Sundeep Ghuman

32. On 8 September 2011, Mr Sundeep Ghuman was sentenced to five years and four months in prison for arson with intent to endanger life. He was released on licence from HMP The Mount on 7 January 2014.

33. On 18 September 2019, Mr Ghuman was recalled to HMP Belmarsh for breaching his licence conditions.

34. At an initial reception screen, a nurse recorded that Mr Ghuman had a history of mental health issues and substance misuse and took citalopram (an antidepressant). He referred him to the mental health and substance misuse teams and arranged for a GP at Belmarsh to see him. The GP increased his citalopram, and noted Mr Ghuman's history of anxiety and depression.

35. That day, an officer completed a cell sharing risk assessment (CSRA) and temporarily assessed Mr Ghuman as high risk (which meant he needed a single cell) due to his arson conviction while staff checked his Police National Computer (PNC) record. He also put a note on NOMIS, the prison's case management system, stating that Mr Ghuman asked to share with non-Muslims as he was a Sikh.

36. On 19 September, a nurse conducted a secondary health screen and recorded that Mr Ghuman reported a history of alcohol, cannabis, and cocaine use. He referred him to the substance misuse service. He noted that Mr Ghuman said that he was a Sikh and was only happy to share a cell with "like-minded people and old white males".

37. Later that day, a custodial manager (CM) reviewed Mr Ghuman's CSRA and noted that having checked his PNC record, he posed a standard risk and was therefore suitable to share a cell.

38. On 22 October, staff submitted an intelligence report which stated that Mr Ghuman was under threat from prisoners on the wing and had asked his mother for money. The next day, an officer checked on Mr Ghuman as his mother had raised concerns about his safety with the Probation Service. He noted that Mr Ghuman said that nobody had threatened him and that he would contact the safer custody team if he had concerns.

39. On 26 November, an officer, Mr Ghuman's keyworker, introduced himself and conducted their first session. He noted that Mr Ghuman felt that prisoners who were supplying psychoactive substances (PS) on the houseblock were targeting him, and he said he wanted to leave Belmarsh.

40. On 19 December, staff submitted an intelligence report saying that Mr Ghuman was seen under the influence of PS on the wing and had accepted it from his cellmate for agreeing to move out. In the report, staff suggested that Mr Ghuman and two other prisoners should have a mandatory drug test (MDT) and that the custodial manager on the houseblock should talk to Mr Ghuman to make sure he felt safe.

However, there is no record that prison or healthcare staff reviewed Mr Ghuman or that he had an MDT.

41. On 29 December, staff submitted an intelligence report which said that Mr Ghuman was being bullied in relation to PS. In the report, staff suggested that Mr Ghuman should have an MDT. There is no record that this took place.

42. On 30 December, Mr Ghuman's keyworker saw Mr Ghuman for a keywork session, and they spoke about his recent PS use. Mr Ghuman said that he was no longer using PS and was paying off his debt weekly.

43. On 8 January 2020, a substance misuse worker visited Mr Ghuman to discuss his poor attendance at group work for substance misuse. They also spoke about his PS use and he said that he had not used for a while and was "on top" of his debt. She said that she would refer him to the cannabis, PS, and alcohol groups.

44. On 10 January, Mr Ghuman's keyworker noted that he saw Mr Ghuman for a keywork session, and he said that he had not touched PS or hooch (prison-brewed alcohol) for 10 days and had reduced his debt. Mr Ghuman also said that he would like to move to HMP Rochester to take part in a drug rehabilitation course.

45. On 30 January, a prison offender manager (POM) visited Mr Ghuman to discuss his parole hearing. She told him that the Probation Service would not recommend his release to the Parole Board as he had not engaged with the substance misuse and mental health teams.

46. On 12 February, staff submitted an intelligence report saying that Mr Ghuman had stolen a television from a cell and sold it for a 'bit of gear' (taken to mean PS). He was placed on report. Later that day, Mr Ghuman's keyworker saw Mr Ghuman for a keywork session, but he refused to talk to him.

47. On 13 February, the POM and a community-based probation officer saw Mr Ghuman to conduct a parole report interview. She noted that wing staff told her that Mr Ghuman's behaviour had not been great and that he had been taking PS more often, but would see if he would speak to them. Mr Ghuman agreed to the meeting but did not particularly engage and said he would wait until his sentence expired. Later that day, prison staff moved Mr Ghuman to another cell which he was to share with another prisoner and Mr Steven Hilden, who were cousins. They recorded the reason for the move as 'administrative' (which is a catch-all term).

Mr Steven Hilden

48. On 18 January 2011, while Mr Steven Hilden was at HMYOI Feltham, an officer submitted an intelligence report stating that staff had overheard Mr Hilden telling his peers that he was a member of the Racist Army of Woolwich and that they went on attacks in Brixton, Peckham, and Vauxhall.

49. On 7 October 2018, while at HMP Brixton, Mr Hilden started to present with signs of psychosis (he was hearing voices in his head) and was started on olanzapine (an antipsychotic). However, he never had a formal psychiatric assessment.

50. On 27 June 2019, staff at HMP High Down submitted an intelligence report stating that Mr Hilden told staff that another prisoner had assaulted him. It is noted in the report that the prisoner who assaulted Mr Hilden told staff that he had been making racist remarks towards him.

51. On 18 July, Mr Hilden was released from HMP High Down.

52. On 8 October, Mr Hilden was remanded to HMP High Down, charged with theft. An officer completed a cell sharing risk assessment (CSRA) and assessed him as standard risk (which meant that he could share a cell) but noted that he was to 'share with his own ethnicity only' (due to the February 2011 report of his membership of the Racist Army of Woolwich).

HMP Belmarsh

53. On 5 November, Mr Hilden was transferred to HMP Belmarsh from court. On the Person Escort Record (PER – which accompanies prisoners on all journeys between police stations, courts, and prisons to communicate risk factors) it was noted that Mr Hilden was a known racist and had a history of assaulting other prisoners.

54. At 4.27pm, a nurse conducted an initial reception screen and recorded that Mr Hilden had a history of substance misuse and was prescribed methadone to treat opiate dependence. She also recorded that he reported a diagnosis of paranoid schizophrenia, personality disorder and bipolar disorder.

55. At 5.25pm, an officer recorded that he had completed Mr Hilden's CSRA and that he was a standard risk for cell sharing pending a Police National Computer (PNC) check. Despite indicating that he had reviewed the PER, there is no record that he considered Mr Hilden's history of racist behaviour and violence towards other prisoners. There is also no record that he considered his CSRA from High Down which explicitly said that he should only share a cell with prisoners of the same ethnicity as him.

56. At 6.34pm, a GP at Belmarsh reviewed Mr Hilden and recorded that he did not have a copy of his summary care record (a summary of his community medical record). He noted that Mr Hilden said that he did not feel that 150mg of quetiapine (an antipsychotic) was sufficient because he had been prescribed 600mg in February. The GP recorded that it sounded like Mr Hilden had had psychotic episodes, increased his quetiapine, and referred him to a psychiatrist.

57. At 10.56am on 6 November, an officer noted that he had completed Mr Hilden's full induction, that he had seen his PNC record and assessed him as standard risk. (We have seen Mr Hilden's PNC report which had no markers or indicators of racism or anything that might have caused concern in terms of his cell sharing risk.)

58. At 1.43pm, a nurse conducted a secondary health screen and noted that the mental health team had reviewed Mr Hilden's medical record and established that he was not known to secondary mental health services. (Secondary care services generally need a referral from a GP and include mental health hospitals and community mental health teams).

59. On 8 November, a mental health nurse reviewed Mr Hilden on the wing and recorded that he said he was known to community mental health services and that he should be prescribed a higher dose of quetiapine. She noted that Mr Hilden looked dishevelled and that she would ask for his community mental health record.

60. On 12 November, the mental health nurse received an email from Greenwich East Mental Health Team confirming that Mr Hilden was not on their caseload. They acknowledged that he had been referred in the past but was not deemed suitable for their service.

61. On 29 November, prison staff submitted an intelligence report stating that Mr Hilden had been involved in conflict with other prisoners on houseblock four. In the report, it is noted that Mr Hilden was frightened of a group of bullies and was in debt to them. It is also noted that Mr Hilden had an alert for being a member of the Racist Army of Woolwich. The reference to membership of the Racist Army of Woolwich was not 'new' information and did not trigger a review of Mr Hilden's CSRA under the policy.

62. On 13 December, a consultant psychiatrist reviewed Mr Hilden's medical record and recorded that during a psychiatry review in November 2018, he reported persecutory beliefs and was started on olanzapine (an antipsychotic), which was later changed to quetiapine. He noted that Mr Hilden was prescribed 300mg of quetiapine and that prison staff were concerned about his medication-seeking behaviour.

63. On 16 December, Mr Hilden failed to attend a psychiatry appointment the consultant psychiatrist. A review was subsequently scheduled for 20 January.

64. On 15 January 2020, the GP saw Mr Hilden for an emergency review after he said he slipped and hit his head the previous night. Mr Hilden said that he had "spat out blood" and that he thought it had come from holes drilled in his palate to fix a plate in his brain. The GP assessed him but concluded that there was no sign of a significant head injury.

65. On 21 January, another GP at Belmarsh reviewed Mr Hilden and noted that he had requested a reduction in his methadone dose. He added that Mr Hilden appeared alert and agreed to reduce his methadone by 5ml a week. Later that day, Mr Hilden failed to attend a psychiatry appointment with the GP. There is no reason recorded.

66. At 11.49am on 28 January, a nurse requested a GP review as Mr Hilden had refused methadone during the morning medication round. He explained to Mr Hilden that a rapid reduction in methadone could result in withdrawal symptoms or illicit drug use but Mr Hilden said that he had done it before.

67. At 3.26pm, an officer saw Mr Hilden for a keywork session, but he refused to engage. The officer recorded that he suspected Mr Hilden's reluctance to engage in keywork was due to him self-isolating. He noted that he had explained to both Mr Hilden and his cellmate that that there was not much he could do to help them if they refused to leave their cell. He added that he would try to provide them with in-cell activities at their next session.

68. At 4.16pm, a GP recorded that he discussed Mr Hilden's methadone refusal with a nurse, and they planned to reduce his dosage to 20ml. It is not clear whether Mr Hilden accepted this.

69. On 30 January, a nurse recorded that Mr Hilden refused methadone and asked a GP to prescribe sleeping tablets. Later that day, a GP at Belmarsh stopped Mr Hilden's methadone and prescribed several medications, including zopiclone (a sleep medication).

70. On 1 February, staff carrying out advanced accommodation checks found two improvised weapons in Mr Hilden's cell. Staff placed them on report and submitted an intelligence report.

71. On 9 February, a nurse noted that Mr Hilden had been discharged from the substance misuse service as he was no longer receiving opiate-based treatment.

72. On 17 February, staff submitted an intelligence report stating that Mr Ghuman asked his cellmates to turn the television down during a call and they appear to have ignored his request.

Events of 18 to 19 February

73. At 5.04pm on 18 February, CCTV footage shows that Mr Hilden arrived at the door to the cell he shared with Mr Ghuman and another prisoner and looked through the cell observation panel. Both Mr Ghuman and the other prisoner were inside the cell. At 5.05pm, an officer unlocked the door and Mr Hilden went into the cell.

74. At 5.24pm, CCTV footage shows that a prisoner opened the observation panel on Mr Ghuman's cell door. In his police statement, he said that he spoke to Mr Ghuman about attending the chapel. He said that Mr Ghuman was sitting on his bed at the time, reading a book. Around 30 seconds later, an officer walked towards the cell and the prisoner walked down the wing.

75. At 5.30pm, CCTV footage shows that the prisoner went to Mr Ghuman's cell again and looked through the observation panel. In his police statement, he said that a bearded prisoner (taken to mean Mr Hilden) told him to go away. However, he said that he remained at the cell door and that as Mr Hilden moved, he saw that Mr Ghuman was lying on the floor with blood coming from his head. He said that he then shouted out for prison officers to attend.

76. At 5.31pm, CCTV footage shows that an officer arrived at Mr Ghuman's cell and looked through the observation panel. In his police statement, he said that he saw blood splattered on the walls and Mr Ghuman slumped over a broken table. The officer shouted for staff to attend and reached for his cell key as another officer arrived at the cell, followed by several other officers.

77. Five officers went into the cell. Mr Ghuman was bleeding from his ears and mouth, and he had several large lumps on his head. An officer shouted at Mr Hilden and the other cellmate, and asked them what had happened. In his prison statement, he said that Mr Hilden was sitting on his bed, looking relaxed, and that he said that Mr Ghuman had tried to kill himself by jumping off the top bunk bed. He said the other prisoner was shaking, looked terrified, and did not say anything. Another officer told

the prisoners to leave the cell, shouted for a medical emergency code red (which indicates severe bleeding) to be called and removed the broken table. An officer radioed a code red at 5.32pm.

78. Three officers tried to attend to Mr Ghuman, but he was rolling around on the floor, screaming. He could not communicate but tried to grab the staff attending to him. In the meantime, other officers ordered the other prisoner and Mr Hilden to stand up against the wall outside the cell. They noticed blood on Mr Hilden's tracksuit bottoms. Four officers then escorted them to the segregation unit. On route, Mr Hilden told an officer that Mr Ghuman had asked to swap positions with him so he could "smoke out the window". He then stated that Mr Ghuman fell from the top bunk on to the table. He said that Mr Ghuman "jumped up after falling on to the table and started going crazy", "he ripped the toilet door off and started smashing his head with it". He blamed Mr Ghuman's behaviour on PS.

79. At 5.34pm, two nurses arrived at the cell. A prison officer informed them that there was a lot of blood in the cell. At 5.35pm, two more nurses arrived and assisted with the emergency. Other members of healthcare staff and a GP attended, but they were unable to stop the bleeding. In her police statement, one nurse said that staff could not take Mr Ghuman's clinical observations as he was very distressed, so they kept him safe from further harm until paramedics arrived.

80. Ambulance logs show that a call connected at 5.32pm. On the recording, a member of control room staff said to the ambulance call handler, "LAS code 2, code red, that's all I can tell you". She then asked for the names of the crew member and said, "can you call back, you usually call back, we just can't let anyone in the prison".

81. At 5.41pm, a member of control room staff called the ambulance service back and provided additional information about Mr Ghuman's condition. She said that Mr Ghuman had been hit on the head, was bleeding profusely from the ear and was unconscious. The ambulance log shows that an ambulance was despatched at 5.41pm.

82. The ambulance log shows that the first paramedics arrived at the prison at 5.55pm and at Mr Ghuman's cell at 6.10pm. A helicopter emergency medical service team arrived at 6.26pm and moved Mr Ghuman onto the wing landing for easier access. At 7.14pm, paramedics took Mr Ghuman to hospital by ambulance. Two officers went with him, and no restraints were used.

83. Later that evening, houseblock staff submitted an intelligence report outlining what had happened to Mr Ghuman. In response, security staff noted that Mr Hilden's prison records indicated that he was a member of a racist gang and that the attack on Mr Ghuman might have been racist, despite them having shared a cell for some time.

84. At 9.40am on 19 February, the Deputy Head of Healthcare contacted the hospital for an update and noted that Mr Ghuman was in the intensive care unit with a serious head injury. Later that afternoon, hospital staff told prison escort officers that they intended to withdraw Mr Ghuman's life support. At 6.10pm, a hospital doctor pronounced that Mr Ghuman had died.

Contact with Mr Ghuman's family

85. A short while after prison staff found Mr Ghuman a prison manager was appointed as the Family Liaison Officer. When the investigator asked for the family liaison log, it could not be found, and the FLO had left the Prison Service. Staff at Belmarsh told the investigator that once Mr Ghuman's death was considered a homicide, the police took the lead on family contact. We do not know what kind or quality of support Belmarsh offered to Mr Ghuman's family, but they did not raise any direct concerns about the quality of the family liaison they received during our investigation.

Support for prisoners and staff

86. After Mr Ghuman's death, a Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

87. The prison posted notices informing other prisoners of Mr Ghuman's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Ghuman's death.

Post-mortem report

88. The post-mortem report found that Mr Ghuman died of a head injury. Toxicology analysis of Mr Ghuman's blood did not detect any alcohol or illicit drugs.

Events after Mr Ghuman's death

89. On 20 February, prison staff at Belmarsh submitted an intelligence report stating that Mr Ghuman, Mr Hilden and their cellmate were in their cell when a prisoner from a nearby cell shouted from behind his cell door that Mr Ghuman owed him money for PS. Mr Hilden overheard the prisoner and asked how much Mr Ghuman owed. Intelligence records show that the prisoner said £10.00, and in response, Mr Ghuman became abusive towards Mr Hilden. It is noted that Mr Hilden then proceeded to attack Mr Ghuman and that this led to his unintentional death.

90. On 16 May 2022, Mr Hilden was found guilty of Mr Ghuman's murder. On 15 July, he was sentenced to life in prison, with a minimum term to serve of 17 years. (The other cellmate was acquitted of Mr Ghuman's murder in December 2021.)

Inquest

91. At an inquest between 20 October and 7 November 2025, the Coroner recorded Mr Ghuman's cause of death as a head injury.

92. The Coroner concluded that the following facts made a material contribution to Mr Ghuman's death: Mr Hilden's CSRA was not carried out appropriately on 5 and 6 November. It failed to consider known information, including a racist marker on his electronic prison record. If Mr Hilden's CSRA had been carried out appropriately, he would not have been placed in a cell with Mr Ghuman and Mr Ghuman's death could have been avoided. Prison officers had not recorded adequate training in how

to complete CSRAs and officers providing training through shadowing did not understand what they were required to do in line with policy. Mr Ghuman was unlawfully killed.

Findings

Cell sharing risk assessment

93. Prison Service Instruction (PSI 20/2015) on assessing cell-sharing risks states that the CSRA is an essential tool to identify prisoners at risk of seriously assaulting or killing a cellmate in a locked cell. Governors of all closed prisons must satisfy themselves that staff are aware of the CSRA process, and that it is being followed, including that all evidence sources are checked in reception or the next working day and that risk indicators from the evidence sources are taken into account in making decisions about risk.

94. When Mr Hilden arrived at Belmarsh, two officers failed to identify that he had a history of racially motivated behaviour and violence towards other prisoners. Mr Hilden's prison records (known as NOMIS) had a racist alert dated 9 February 2011, a gang member alert dated 8 January 2016 and a violence alert dated 7 October 2016, following an assault on another prisoner. The PER also clearly indicated that Mr Hilden was a racist and had previously displayed violent behaviour towards other prisoners. However, there is no evidence that prison staff considered this information when they assessed Mr Hilden's risk to a potential cellmate.

95. Mr Hilden's CSRA states that he had a 'standard risk transfer in as High Down [sic]'. This suggests that at least one of the officers had seen Mr Hilden's risk assessment from High Down. However, there is no evidence that they considered that while Mr Hilden was assessed as a standard risk, he was only to share with an occupant of the same ethnicity as him. There is also no evidence that they considered the information contained in the PER, despite indicating on the CSRA form that the PER had been reviewed as part of the process.

96. We are also concerned that Mr Ghuman shared with the nurse who conducted the secondary healthcare screen that he only wanted to share a cell with like-minded people but there is no record that the nurse shared this information with prison staff. While we cannot know whether this would have had an impact on where prison staff located Mr Ghuman, we consider that the information should nonetheless have been shared.

97. We are appalled that Belmarsh allowed Mr Ghuman, a British Asian prisoner who was clearly vulnerable due to his substance use, to be in a cell with a known racist (and his cousin, who might not have felt able to raise concerns if he had any or who might have colluded in any abuse) and failed to keep him safe. The Prison Service introduced the CSRA in response to Zahid Mubarek's murder by his racist cellmate and we find it deeply troubling that Mr Ghuman died in such similar circumstances, 20 years later.

98. The information about Mr Hilden's risk was readily available to staff at Belmarsh. We found no good reason for staff to have missed the risk information and their errors had fatal consequences. (At the beginning of our investigation, the prison told us that the officers responsible for assessing Mr Hilden's cell-sharing risk no longer work at Belmarsh. We therefore did not interview them. Following our initial report which was shared with HMPPS and the legal representatives of Mr Ghuman's mother, both parties told us that in fact, one of the officers still worked at the prison.

We decided not to interview him as we had sufficient information to make a finding without this and HMPPS has subsequently accepted all the recommendations in this report.) Although the investigator flagged his concerns about the officer's actions to the police before Mr Hilden's conviction, the police did not pursue the errors that led Mr Ghuman to share a cell with Mr Hilden or the potentially racist nature of the attack.

99. Given what was known about Mr Hilden, it is simply not acceptable that he shared a cell with Mr Ghuman. We consider that Mr Ghuman's death was preventable. We have not received sufficient assurance from Belmarsh that lessons have been learnt from Mr Ghuman's death or that any changes have been made to make the CSRA process more robust. We make the following recommendations:

The Governor should write to the Ombudsman, setting out what action she has taken to assure herself that CSRA processes at Belmarsh are robust and consider all relevant information.

The Head of Healthcare should establish a clear policy to ensure that healthcare staff share with prison staff any concerns expressed by prisoners about sharing cells.

Emergency response

100. There was a nine-minute delay from when the prison first called for an ambulance to their second call providing further information, which resulted in an ambulance being dispatched. While we have been unable to fully establish the reason for the delay, there appears to have been a communication breakdown and a reluctance from the prison's perspective to allow immediate access to the prison. We appreciate that security is a priority for a high security prison such as Belmarsh, but arranging immediate ambulance access for a prisoner with serious life-threatening injuries, like those sustained by Mr Ghuman, must take precedence.

101. The first ambulance arrived at the prison nine minutes after it was dispatched. It then took 15 minutes to escort the paramedics to Mr Ghuman's cell. PSI 03/2013 on medical emergency response codes states that staff should follow local instructions to facilitate the swift entry and exit of emergency vehicles by giving them priority and minimising waiting times. We have been unable to establish a reason for the delay due to the elapsed time between the incident and our investigation, but we consider it likely to be related to security concerns.

102. While we cannot know whether swifter access to emergency paramedics would have changed the outcome for Mr Ghuman, there should not be avoidable delay in an emergency. Given the length of time that has passed since Mr Ghuman's death, we make the following recommendation:

The Governor should write to the Ombudsman, setting out what improvements have been made to ensure that:

- **control room staff call an ambulance immediately and provide all possible information required, remaining on the line until an ambulance is dispatched; and**

- **there are no delays in escorting ambulance and paramedics in an emergency.**

Mr Hilden's clinical care

103. The clinical reviewer considered that the clinical care Mr Hilden received at HMP Belmarsh was equivalent to that which he could have expected in the community, and there were no obvious omissions or failings in the care he was provided that might have contributed to his subsequent attack on Mr Ghuman. Healthcare staff made appropriate mental and physical health referrals and effectively managed his methadone substitution therapy. However, the clinical reviewer found that the clinical response was limited when Mr Hilden presented with psychotic symptoms on 15 January. While this should have warranted a mental health assessment and this did not happen, the clinical reviewer concluded that this also often happens in the community.

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