Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lewis Brown, a prisoner at HMP Birmingham, on 27 May 2024

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 His Majesty's Prison and Probation Service (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 Lewis Brown was found hanged in his cell at HMP Birmingham, on 27 May 2024. He was 37 years old. I offer my condolences to Mr Brown's family and friends.

Mr Brown took his life less than 72 hours after arriving at Birmingham. He had some risk factors for suicide and self-harm, not all of which staff were aware of. Not all of those interviewing Mr Brown as part of the reception and first night process had sight of the important documentation that helped identify his risk, and they said that they did not expect to. This investigation found that prison and healthcare staff placed too much emphasis on how Mr Brown presented, rather than considering all his known risk factors.

Mr Brown was the third prisoner to take his life at HMP Birmingham since May 2021. Up to the end of November 2024, there have been three further deaths, one of which was self-inflicted. While the causes of the other two deaths are unascertained, both also happened within a few days of arrival at the prison.

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 **February 2025**

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Summary

Events

1. On 21 May 2024, Mr Lewis Brown was released on licence from HMP Ranby to Astral Grove Approved Premises. On 24 May, he was recalled to prison for breaching his licence conditions and sent to HMP Birmingham.

2. Mr Brown had a history of self-harm, suicidal thoughts and a diagnosis of complex personality disorder. He had previously been admitted to psychiatric hospitals under the Mental Health Act. Mr Brown's Person Escort Record (PER) detailed that he was at risk of suicide and self-harm and (incorrectly) that he had schizophrenia.

3. On his arrival at Birmingham, prison and healthcare staff assessed that there were no factors to indicate that Mr Brown was at increased risk of suicide and self-harm and told us that he presented well. They did not start suicide and self-harm prevention procedures (known as ACCT). Healthcare staff did not make a referral to mental health services.

4. A reception custodial manager (CM) identified that Mr Brown was a high risk to others and therefore allocated him a single cell. Over the next few days, Mr Brown engaged with the prison regime and did not raise any concerns to staff or other prisoners.

5. At around 4.30am on 27 May, an officer conducted a routine check. He found that Mr Brown's observation panel was covered and knocked on the door. He told the investigator that he heard a faint response from the cell and moved on.

6. At around 9.30am, an officer found Mr Brown hanged in his cell. Healthcare staff identified clear signs of rigor mortis. At 9.55am, paramedics confirmed that Mr Brown had died.

Findings

7. Mr Brown had some risk factors for suicide and self-harm when he arrived at Birmingham, some of which were significant. Not all staff who interviewed him as part of the reception process were aware of all of his risk factors, relying considerably on his presentation to determine whether to start ACCT procedures. Not all reception staff saw the PER and other documents that highlighted Mr Brown's risk factors.

8. The morning that Mr Brown died he had covered his observation panel. The officer conducting the early morning check noted this but did not challenge it.

9. The clinical reviewer found that Mr Brown's care was not of the required standard or therefore equivalent to that which would have been received in the wider community. She found that, given his history, healthcare staff should have referred Mr Brown to the mental health team on his arrival at Birmingham.

Recommendations

- The Governor and Head of Healthcare should review the training for reception and induction staff to ensure they understand how to identify prisoners at risk of suicide and self-harm, including that all relevant risk information, including the PER, is properly shared and examined as part of the reception/first night process.

- The Head of Healthcare should review the quality and compliance with policy of reception and secondary health screens in the previous 12 months, ensure that prisoners are referred to the mental health team when appropriate, and identify any improvements required.

- The Governor should ensure that staff understand local policy around covered observation panels, that prisoners are appropriately challenged, and blockages removed, and that there is not a culture in which prisoners routinely cover observation panels.

The Investigation Process

10. HMPPS notified us of Mr Brown's death on 27 May 2024.

11. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator visited Birmingham on 4 June. She obtained copies of relevant extracts from Mr Brown's prison and medical records. She also obtained body worn video camera footage of the emergency response, the HMPPS Early Learning Review and West Midlands Ambulance Service records.

13. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison. The investigator and clinical reviewer jointly interviewed seven members of prison and healthcare staff in July 2024.

14. The investigator interviewed an additional seven members of prison and probation staff and four prisoners between June and August 2024.

15. We informed HM Coroner for Birmingham of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's office contacted Mr Brown's mother to explain the investigation and ask if she had any matters she wanted us to consider.

17. Mr Brown's mother explained that a few days before Mr Brown died she had called his probation officer and informed her that the restrictions on Mr Brown's life were too severe and that he was at serious risk of suicide. She asked whether the probation officer took any action as a result. She asked whether Mr Brown was monitored under ACCT procedures and whether he received the right mental health care. Mr Brown's mother also raised that the final call she had with him was not normal and asked if the prison had noted that he was at risk.

18. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

19. We also shared the initial report with Mr Brown's family. They did not make any comments.

Background Information

HMP Birmingham

20. HMP Birmingham is a category B reception prison. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contracts Birmingham Community Healthcare NHS Trust to provide primary care services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Birmingham was in January and February 2023. Inspectors noted significant improvements at the prison since the previous inspection. They found that the leadership team, which was well motivated and supportive of the Governor's priorities, had helped to improve stability.

22. They found that the number of prisoners going through reception had halved since their last inspection but found that prisoners moved through the reception area over 1,000 times a month. Inspectors reported that the initial screening was thorough, and staff considered prisoners' presentation and any prior risk factors for suicide and self-harm. They found that nurses screened new arrivals in a dedicated room in reception and, where appropriate, referred patients to services.

23. Inspectors found that safety checks which should have happened on prisoners on the first night did not always take place. They also reported that time out of cell on the induction wing was very limited and that the induction process lacked structure.

24. Inspectors reported that the rate of self-harm at Birmingham was lower than average for reception prisons and was decreasing. Despite staff shortages, leaders had prioritised safety related training, and in the previous year, 193 staff had been trained in suicide and self-harm prevention. They found an up-to-date safety strategy, relevant to Birmingham, was in place.

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 2023, the IMB reported that the prison had continued to build on the earlier successes and improvements. They noted that there was a drive in the prison for self-evaluation and improvement.

26. The IMB found that the reception area was an ordered and calm environment, and most prisoners received their property on the night they arrived. They noted that HMIP had identified several areas of good practice relating to safety which had been cited in a recent document issued to all prisoners. They found that relationships between prisoners and staff were generally good. They found that 90 minutes a day out-of-cell was inadequate.

Previous deaths at HMP Birmingham

27. Mr Brown was the thirteenth prisoner to die at Birmingham since May 2021, and the third to take his own life. Until the end of November 2024, there have been three further deaths. One of these deaths was self-inflicted and the causes of the other two have not yet been established.

28. In previous investigations we made recommendations that staff should all have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm and, in particular, the need to record, share and consider all relevant information about risk. We have also made a recommendation for the Governor to review the PER system to ensure that reception staff have access to all relevant information.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

30. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Person Escort Record (PER)

31. A PER must be completed for all prisoners before any escorted movement or transfer. They provide escort staff and receiving prisons with relevant information on a prisoner and the risks they may pose during and after the movement. The PER is not itself a risk assessment, however it conveys information about a prisoner's assessed risks to those who may need to know about them. Prisoner Escort Custody Services (PECS) generally use a digital PER to transfer prisoners from police custody or court to prison.

Key Events

Background

32. In October 2020, Mr Lewis Brown was charged with stalking, making threats to kill and breaching a restraining order. He was remanded to HMP Birmingham. Upon arrival, staff began to monitor Mr Brown under ACCT procedures as he said that he heard voices telling him to harm himself or others. Staff closed the ACCT in November 2020. In June 2022, he was released on licence to an Approved Premises (AP).

33. In September 2022, Mr Brown was recalled to prison for breaching his licence conditions.

34. Mr Brown had a history of self-harm and attempted suicide by hanging in the community. In March 2023, Mr Brown was monitored under ACCT procedures when he cut the end of his right ear off. He shared with officers that he had done this as he felt low and depressed. Staff closed the ACCT procedures in April.

35. Mr Brown had a diagnosis of complex personality disorder. (He had initially been given a diagnosis of schizophrenia, but subsequent assessments considered that his presentation was of complex personality disorder.) Mr Brown had been admitted to psychiatric hospitals on several occasions and had been under the care of community psychiatric services. In the past, Mr Brown had received depot injections (a slow-release form of antipsychotic medication) but had stopped taking this in 2023, due to experiencing various side effects.

36. In June 2023, Mr Brown was sentenced to a further 22 months in custody for threatening to kill a family member, an offence he committed while in prison.

37. In November 2023, a psychiatrist review outlined a treatment plan for Mr Brown which included accepting his medication. The psychiatrist noted that if Mr Brown did not accept medication, they would make a referral to a Regional Secure Unit. In December, the psychiatrist held a follow up review where it was noted that Mr Brown had expressed a preference for a depot injection but had then changed his mind and continued to refuse this.

38. In December 2023, Mr Brown transferred to HMP Ranby. While at Ranby, Mr Brown continued to decline his depot medication or comply with psychiatric appointments. The clinical reviewer noted that a psychiatrist's assessment at Ranby did not identify any conditions that suggested a referral to a specialist secure facility was required.

39. In January 2024, in a mental capacity assessment, Mr Brown disclosed that he heard three voices telling him to hurt himself and others. He did not attend his follow-up psychiatric appointment and, in March, chose to stop engaging with anyone in the mental health team. In April, Mr Brown signed a disclaimer refusing any mental health input or a referral to community mental health services on release.

Astral Grove Approved Premises (AP)

40. On 21 May, Mr Brown was released on licence to Astral Grove AP in Nottingham.

41. AP staff conducted an induction with Mr Brown, who said that he felt fine and that he had never harmed himself. Mr Brown shared that he had no thoughts of self-harm or suicide. Staff recorded that there were no current concerns regarding self-harm and suicide.

42. On 23 May, Mr Brown did not return to the AP at 3.00pm as set out in his curfew. Probation staff therefore completed emergency recall paperwork. His community offender manager (COM) noted in the recall paperwork that Mr Brown had a history of self-harm and suicidal behaviours and had previously been admitted to psychiatric hospitals. She also noted that he had emotionally unstable personality disorder.

43. At 8.48am on 24 May, police arrested Mr Brown after he attended a police station to hand himself in.

44. At around 10.00am, Mr Brown's mother called his COM. Mr Brown's mother told us that during this conversation she informed his COM that Mr Brown was at severe risk of suicide, and that his licence conditions were too strict.

45. The COM recorded in her notes of the conversation that Mr Brown's mother had explained that Mr Brown had handed himself in and shared that it may not be a bad thing for him to be in prison until the end of his licence as the restrictions were too strict. She noted that Mr Brown's mother said that this was "playing havoc with his mental health". She told the investigator that she was not told that Mr Brown was at risk of suicide or self-harm and had understood that the comments concerning his mental health were in relation to his licence restrictions rather than going into prison.

HMP Birmingham

46. A member of police staff recorded in Mr Brown's Person Escort Record (PER) that he had schizophrenia and was at risk of self-harm and suicide. The PER noted that Mr Brown was observed at least every 30 minutes in police custody. The police officer noted that Mr Brown had a history of self-harm, including that he been monitored under ACCT procedures in 2023. They also recorded a number of other warnings, including that Mr Brown was violent and that prison staff should hold him separately to others.

47. At around 11.56am, Mr Brown arrived at HMP Birmingham. Reception officers noted that they had viewed the PER and Mr Brown's previous prison records. We do not know if reception officers viewed and examined Mr Brown's recall paperwork.

48. At Birmingham, a reception officer reviews the relevant documentation, including the PER and previous prison records and highlights any alerts or markers – including any relating to the risk of suicide and self-harm - on the cell sharing risk assessment document (CSRA, to identify the risk of violence that a prisoner poses to a cell mate). The Reception Custodial Manager then conducts an interview with

the prisoner based on the risk factors set out on the CSRA. Reception officers noted on Mr Brown's CSRA that he was a risk to females, was on the sex offender register and that he was violent. (They did not record any of his ACCT or self-harm history.) A Custodial Manager (CM) completed a CSRA interview with Mr Brown. He concluded that Mr Brown was high risk and therefore should be placed in a single cell. He could not recall if he had been made aware of Mr Brown's history of self-harm or if he had spoken to him about this.

49. A nurse completed Mr Brown's initial health screening. She recorded that Mr Brown had paranoid schizophrenia, was not prescribed medication for this, and that he had been admitted to a psychiatric hospital in the past. She noted that Mr Brown had harmed himself in April 2023 by cutting part of his ear. She noted that he strongly denied any suicidal thoughts. At interview, she reported that Mr Brown seemed very happy and was joking and talking. She did not refer Mr Brown to the mental health team.

50. Between 3.54pm and 4.09pm, Mr Brown attempted three phone calls to his mother, none of which were answered. (All prisoners are offered a two-minute welfare call in reception.)

51. An induction officer carried out Mr Brown's first night interview in reception. She told us that she only has sight of the CSRA form. She did not review Mr Brown's PER or previous prison records and would not usually expect to examine these. She recorded that Mr Brown told her that he had never self-harmed and that he did not feel at risk of self-harm at that time. She could not recall this conversation in any detail, but said she believed that Mr Brown was polite, not very chatty and had said he was tired. She said that Mr Brown did not present with any risk factors and that she did not consider starting ACCT procedures.

52. At 5:20pm, Mr Brown moved onto P Wing (the induction wing where all prisoners who enter the prison initially live). An officer recorded that Mr Brown said that he had no current thoughts of self-harm.

53. At 7.06pm, Mr Brown called his mother using the general phone on P Wing and they had a two-minute conversation. (All prisoners' telephone calls are recorded. Prison staff listen to some at random and others are listened to if security staff have intelligence that information about the safety of individuals or the prison might have been discussed. No one listened to Mr Brown's calls until after his death.) During this conversation, Mr Brown spoke about not having some of his clothes and trainers. Mr Brown asked his mother to tell a number of people that he was sorry and that he had just wanted to see them.

Saturday 25 May

54. On 25 May, Mr Brown completed parts of his induction. This included a second day induction presentation, delivered by prisoners, which goes into detail about prison life.

55. At 12.15pm, an officer conducted a second day induction welfare check and key worker session. She recorded that she had checked Mr Brown's prison record (which identified his ACCT history and previous self-harm in prison). She asked Mr Brown how his first night had been and he responded that he had slept well and

was feeling alright. She explained the induction process and what to expect. They discussed that Mr Brown had had no answer from his mother in his welfare call and she advised him to try again. (As noted, Mr Brown had actually spoken to his mother the evening before.) Mr Brown explained that he wished to keep in touch with his family and friends and they spoke about the process to obtain a phone account so that he was able to use his in-cell telephone. (Prisoners have to put in an application for numbers to be added to their account – as Mr Brown was under public protection arrangements this is likely to have taken longer. We also understand that due to a backlog at Birmingham it can often take some time to add numbers to an account.) The officer recorded that Mr Brown had not raised any other issues during this conversation, engaged well and appeared in a good mood.

56. That day, Mr Brown submitted an application via the digital kiosk (a machine which prisoners can use to make requests to different departments). He wrote that he would like to move to HMP Oakwood as soon as possible but did not give any further details. Prisoner A on the wing told us that Mr Brown had shared that he wanted to move to Oakwood as he liked it there and wanted to be there for the rest of his sentence. (A prison offender manager responded via the kiosk the following day saying that they would try to get him a transfer.)

57. Prisoner B on the induction wing told us that in the afternoon he had a general conversation with Mr Brown. He told us that on a number of occasions he saw Mr Brown cover his observation panel with tissue.

58. Prisoner A told us that at some point over the few days, Mr Brown asked him to get him some quetiapine (medication for schizophrenia) and a phone wire. (We understand that this means a charging cable for a mobile phone.) He said that he did not get Mr Brown either of these items.

59. All prisoners we spoke to as part of this investigation told us that Mr Brown did not show any signs that he intended to take his life and none of them noticed any change in Mr Brown's behaviour over the few days he spent at Birmingham. They did not see Mr Brown share any concerns with staff.

Sunday 26 May

60. At 10.48am on 26 May, an officer facilitated Mr Brown making another call to his mother, lasting two minutes. (Mr Brown did not yet have the numbers set up on his phone account.)

61. Mr Brown explained to his mother that he was going to see the nurse as his ears were infected. (There is no evidence that Mr Brown sought healthcare input for this, including at his second health screening that morning.) Mr Brown's mother told him that she would put money into his account. They talked about Mr Brown being owed some money and that this would come into his account after the bank holiday. (Monday 27 May was a bank holiday.) Mr Brown ended the call by saying that "his head was in a bit of a mess" and he needed to sort it out but did not know how to yet. The officer told us that he did not listen to the call. He did not observe any change in Mr Brown's behaviour and said that Mr Brown was thankful for helping him make the call.

62. That morning, a pharmacy technician conducted Mr Brown's second health screening. She told the investigator that during the screening Mr Brown was chatty and co-operative. She asked Mr Brown how he was feeling, and he told her that he was fine and did not have any mental health issues. She therefore did not complete the mental health template as she should have done or ask any questions about this.

63. At around 3.30pm, Prisoner A went to see Mr Brown, and they had a general conversation. The prisoner went back to his cell at around 4.00pm and noted that there was a tissue over Mr Brown's observation panel.

64. At around 4.15pm, an officer opened Mr Brown's door to let him out to get his food. Mr Brown's observation panel was covered, and the officer said that he told Mr Brown that he would "kick his fucking door at night" if he did not uncover it and that they had a laugh and a joke about this. The officer said that Mr Brown laughed, apologised and understood why he had asked him to remove it. Mr Brown returned to his cell after getting his food. The officer then locked his cell and wished him a good evening.

65. At 9.00pm, officers signed for a routine check. They did not note any issues with Mr Brown or his cell.

Monday 27 May

66. The CCTV on P Wing was not working at the time of Mr Brown's death. (It had not been working since March 2024, but had been fixed when we issued this report.) The following account has been drawn from staff statements, interviews, body worn video camera (BWVC) footage and ambulance service records.

67. At approximately 4.30am, Officer A completed a routine check. He told the investigator that when he reached Mr Brown's cell, he noticed that the observation panel was covered. He said that he banged on the door to gain a verbal response and heard a faint response. He said that, on reflection, this could have been from a neighbouring cell. He took no further action.

68. At around 9.30am, Officer B began unlocking cells for prisoners to spend social time with their peers. Prisoner B told us that he was let out of his cell before Mr Brown and saw that a tissue was covering Mr Brown's observation panel.

69. At around 9.33am, Officer B opened Mr Brown's cell and told the investigator he looked round the door and saw Mr Brown suspended by a ligature tied to a medication safe on the table. He did not switch on his body worn camera. (Staff who arrived later activated their cameras.)

70. Officer B told the investigator that, on seeing Mr Brown, he went to push the general alarm (an alarm to notify all staff of any emergency) as he was not carrying a radio at the time. (Not all wing officers are assigned a radio as there are not enough for the current staffing model. Radios are assigned as a priority to staff in particular roles, such as those responsible for moving prisoners on and off the wing.) He also shouted for staff to come up to the fourth landing.

71. Prisoner B told us that Officer B did not look into the cell, and he had to shout for him to come back to the cell. The prisoner told the investigator that he pressed the general alarm.

72. Officer B went into the cell and cut the ligature. At 9.34am, a CM and Officer C arrived at the cell. A few seconds later, the CM called a medical emergency code blue (used to indicate when someone is unresponsive or not breathing). Officer B told the investigator that Mr Brown's tongue was swollen and that he was purple and rigid. The CM directed staff to start cardiopulmonary resuscitation (CPR), which Officer B did immediately.

73. At 9.35am, two nurses arrived at the cell. One nurse noted that Mr Brown's body was rigid and there were clear signs of rigor mortis and hypostasis (two conditions which are unequivocally associated with death). Healthcare staff therefore advised Officer B to stop CPR.

74. At 9.50am, paramedics arrived and confirmed that Mr Brown had died. The duty governor recorded that paramedics said that they believed that Mr Brown had been dead for four to six hours.

75. Mr Brown left a note in his cell telling his mother that he was truly sorry. He asked her to tell everybody that he loved them, and he was sorry. He asked to be cremated and for a number of songs to be played at his funeral.

Contact with Mr Brown's family

76. At 10.40am on 27 May, the prison appointed a family liaison officer (FLO). At 1.08pm, the FLO attended Mr Brown's mother's address, with police support. Mr Brown's mother was not at home, so he rang her phone number but was unable to get through to her. He therefore decided to speak to her neighbour. He asked if she knew where Mr Brown's mother was, and they responded that they believed she was at work. He asked the neighbour to pass on the message to call HMP Birmingham when she returned home.

77. At 4.50pm, the FLO spoke to the duty governor, and they decided to deliver the news via phone, as there was no other FLO available to accompany the FLO, and they did not want information reaching her through other means. The FLO called Mr Brown's mother shortly afterwards, and informed her of his death.

78. The prison contributed toward the cost of Mr Brown's funeral in line with national policy.

Support for prisoners and staff

79. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

80. After Mr Brown's death, the Head of Reducing Reoffending debriefed the prison staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The healthcare staff did not attend this debrief, although the Head of Healthcare provided support afterwards. The staff care team and TRiM team (TRiM is a trauma-focused peer support system designed to help staff working in prisons who have experienced a traumatic event) also offered support to all staff involved.

81. The prison posted notices informing other prisoners of Mr Brown's death and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Brown's death. Staff visited those close to Mr Brown to check on their wellbeing and provided tailored support for Prisoner B. Listeners were deployed to support prisoners in P Wing.

Post-mortem report

82. A post-mortem examination found that Mr Brown died of hanging. Toxicology tests identified no illicit substances.

Findings

Identifying the risk of suicide and self-harm

83. Prison Service Instruction (PSI) 64/2011, on safer custody, which was in place at the time of Mr Brown's death, required staff who had contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. The PSI recognised that prisoners are at increased risk of suicide and self-harm in their first days in custody.

84. PSI 07/2015 'Early Days in Custody' sets out guidance and mandatory actions for prison staff regarding reception, first night in custody and induction procedures. It sets out that the completed Person Escort Record (PER) and any other available documentation must be examined, and the prisoner interviewed in reception, to assess the risk of suicide and self-harm. Staff are required to be aware that particular groups are at a higher risk of suicide/self-harm. Annex D of PSI 07/2015 lists the categories of prisoners who may be especially vulnerable to suicide or self-harm.

85. When Mr Brown arrived at Birmingham he had a number of risk factors for suicide and self-harm: he was on licence recall, had a mental health diagnosis, had previously been an inpatient at a psychiatric hospital, and he had a history of self-harm (in prison and the community) and suicidal behaviour.

86. Mr Brown's PER noted that he was at risk of self-harm and suicide, including that he had been managed under ACCT procedures in April 2023. It noted that he was observed every 30 minutes prior to arriving at Birmingham. It also recorded that he had a diagnosis of schizophrenia. Mr Brown's emergency recall paperwork noted that he had a history of self-harm and suicidal behaviours, had emotionally unstable personality disorder and had previously been admitted to a psychiatric hospital.

87. A CM interviewed Mr Brown in reception. He was not able to recall this conversation in any detail, including whether he spoke to Mr Brown about his history of self-harm or whether he looked at the PER or the recall paperwork. He told the investigator that the process followed is that an officer in his team would look at documentation, including the PER and previous prison records and would highlight any alerts or markers on the CSRA document before the CM conducted the interview. He said that normally any history of self-harm would be put into the CSRA document (there was no mention of Mr Brown's history of self-harm in the document). He said that sometimes he would look at the other documentation if he needed further information about a particular risk factor.

88. The CM said that, had he known, the observation level of at least 30 minutes would have prompted him to have further conversations about Mr Brown's vulnerability and to give greater consideration to starting ACCT procedures. Another reception CM we spoke to as part of the investigation said he would usually ask the prisoner as part of the CSRA interview whether they have a history of self-harm and would glance at the PER to see if there was any self-harm risk noted. He told us that no one had specifically said that he should look at the PER but that this was good practice.

89. A nurse saw the PER and Mr Brown's previous medical history. She told the investigator that she did not consider starting ACCT procedures at the time as she said that Mr Brown did not present as though he was suicidal or at risk.

90. The first night interviewing officer told us that the only information she reviews as part of the interview is the CSRA document. A CM informed us that while everyone can get access to the PER, the first night interviewing officers would not normally have access to computer terminals to look at this. The officer was not aware of Mr Brown's history of self-harm and suicidal behaviours. She did not consider starting ACCT procedures, explaining that Mr Brown was polite and friendly during the interview.

91. We found that not all staff interviewing Mr Brown as part of the reception and first night process were aware of his risk factors and the process for identifying and logging risk factors was flawed. Certain staff based their assessment of Mr Brown's risk on how he presented, rather than examining and considering all the relevant risk information. Had they been able to review all risk information, this might have altered reception and first night staff's decision not to start ACCT procedures. It is important for all staff to have considered all the necessary information to reach an appropriate decision.

92. The first night interview document lists four risk factors and says that anyone who has these multiple risk factors should be referred to the Safer Custody Team, regardless of whether ACCT procedures are started. While this is positive, the list is not comprehensive and does not include some very significant risk factors, including a history of self-harm or a mental ill-health diagnosis. It is also not clear on the form whether a prisoner needs all four risk factors listed or a combination of them for staff to consider contacting Safer Custody. (Mr Brown had one risk factor listed on the form, a licence recall.) In addition, the first night interviewing officer will need to have access to all risk information to make this assessment.

93. In our report into the death of a prisoner at Birmingham in February 2022, we recommended that the Governor ensure that reception staff have access to all relevant information, including from the PER. In response, Birmingham reported that they would review the reception process to ensure that all reception and healthcare staff have access to the digital PER system (which had been recently introduced at the time). Our investigation into Mr Brown's death found that some key staff did not have access to or did not review important information on his PER and that there was an over-reliance that one single officer would identify all risks and log them on the CSRA.

94. The Head of Safety has informed us that, since Mr Brown's death, they have introduced a safety questionnaire. This involves a safer custody officer going to see a prisoner within a few days of entering the establishment (the goal is to conduct this in the first few hours of being in custody but is not possible at this time due to staffing within the safer custody team) to ask a number of questions. This is a positive step, although the questions on the form are not comprehensive and if the questionnaire cannot be completed quickly, it will not identify risk in arguably the riskiest time for new arrivals. It is also important that it is seen as an additional safeguard to complement other reception and first night interviews, rather than as a substitute for these. The Head of Safety will wish to ensure that staff consider a wider range of risk factors, based on those included within the new Safety Policy

Framework and Annex D of PSI 07/2015. Reception and safety staff should have access to all relevant information to make these considerations, including the PER.

95. We have repeatedly raised concerns about staff using relevant documentation to inform risk assessments when prisoners first arrive. We raised our concerns with HMPPS colleagues who, in collaboration with NHS England colleagues, have agreed to consider what more can be done to ensure that Governors and Heads of Healthcare have robust processes in place to identify risk on reception.

96. Having again identified particular issues at Birmingham, we make the following recommendation:

The Governor and Head of Healthcare should review the training for reception and induction staff to ensure they understand how to identify prisoners at risk of suicide and self-harm, including that all relevant risk information, including the PER, is properly shared and examined as part of the reception/first night process.

Mental health provision

97. The clinical reviewer concluded that the clinical care that Mr Brown received at Birmingham was not equivalent to that which he could have expected to receive in the community.

98. Mr Brown had a significant mental health diagnosis and history of psychiatric inpatient care, as well as a history of self-harm, all of which he disclosed at his reception health screen. He was not referred to the mental health team at his reception or secondary health screen (at which important questions about mental health were not asked) or at any other time.

99. The Head of Healthcare told us that Birmingham has trained a range of healthcare professionals, including pharmacy technicians, to complete second health screenings. This includes developing a standard operating protocol and in-house training and assessment before they are permitted to undertake screenings without supervision.

100. The clinical reviewer found that healthcare staff should have based their referral decisions on Mr Brown's history, rather than relying on his presentation. She found that any referral would have been a non-urgent referral under local policy (meaning that he would have been assessed within five days and would not have been seen by the mental health team before he died). The Head of Healthcare has informed us that Birmingham is now re-delivering competency training for reception nurses and staff who complete secondary health screens. Nevertheless, Mr Brown's history meant that he should have immediately been recognised as someone for whom a mental health referral was appropriate, and it is not clear that training is sufficient to ensure staff understand their responsibilities. It is important that similar prisoners are not missed in future.

101. We make the following recommendation:

The Head of Healthcare should review the quality and compliance with policy of reception and secondary health screens in the previous 12 months, ensure

that prisoners are referred to the mental health team when appropriate, and identify any improvements required.

Emergency response

Early morning roll check

102. Birmingham's Local Security Strategy states that during the night a roll count must take place between 5.00am and 6.00am and that the purpose of this check is to confirm the number of prisoners as well as the wellbeing of each prisoner. It sets out that night patrol officers should satisfy themselves that breathing or movement is noted. Where observation panels are blocked the prisoner must be ordered to remove the blockage immediately and failure to comply with this should result in the night manager attending the scene to assess the need for opening the cell door.

103. On 27 May, Officer A conducted the early morning roll check, which he said was at around 4.30am (outside of the expected times).

104. Officer A told the investigator that Mr Brown had his observation panel covered and that he knocked on the door and told us that he got a faint response. He said that, on reflection, this could have come from a neighbouring cell. He said that, generally, if he could not see a prisoner, he would try to get a verbal response. As he believed he had a response from Mr Brown, he did not consider calling the night manager and removing the observation panel. Birmingham has conducted a local investigation into this incident, which recommended a disciplinary hearing. This hearing had not yet taken place when we issued our report.

105. While conducting our investigation, other staff members told us that when they found an observation panel covered, they would seek a verbal response. While staff generally knew the local policy, some said that receiving a verbal response would be sufficient. One prisoner told us that staff "do nothing" when observation panels are covered. We make the following recommendation:

The Governor should ensure that staff understand local policy around covered observation panels, that prisoners are appropriately challenged, and blockages removed, and that there is not a culture in which prisoners routinely cover observation panels.

Welfare checks

106. Staff checked on Mr Brown around five hours after the roll check, when they found him hanging. Birmingham has now introduced an additional welfare check every morning where staff are required to check on every prisoner before unlocking the wing and obtain a physical response. A prisoner told us that these welfare checks happened for a week and had not happened since. In our investigation into the death of a prisoner around a month after Mr Brown died, some staff told us that they did not complete the welfare check. This is disappointing and demonstrates the need for robust quality assurance processes to ensure that measures have been embedded. The Governor will want to assure herself that these welfare checks are taking place.

Body worn video cameras

107. The Prison Service Body Worn Video Cameras Policy Framework states that staff responding to an incident should start recording at the earliest opportunity. This includes incidents involving injury or illness to a prisoner (which would include incidents of hanging).

108. The first responding officer did not switch on his body worn video camera. In interview, he explained that he had not activated it because it was the spur of the moment. This means that we have not been able to accurately confirm what happened upon finding Mr Brown, including whether Officer B or Prisoner B's version of events was more accurate. The Head of Safety at Birmingham has confirmed that a notice has been sent to staff reminding them of the importance of activating body worn video cameras, in line with national policy. As with welfare checks, the Governor will wish to assure herself that staff behaviour has changed as a result.

Informing Mr Brown's family of his death

109. PSI 64/2011 says that, wherever possible, the family liaison officer and another member of staff must visit the next of kin in person to break the news of the death. It notes that where face to face notification is not possible, a follow up visit must be arranged as soon as possible.

110. When the FLO arrived at Mr Brown's mother's address, she was not home, and he was unable to reach her on the phone. He decided to ask a neighbour to pass on a message to Mr Brown's mother.

111. While PSI 64/2011 gives advice for family liaison officers after a death in custody, it does not set out what to do when the next of kin is not at the home address. The FLO told us he was unsure what to do when Mr Brown's mother was not at home, and the police officers who were with him suggested going to speak to the neighbour.

112. Later that day, and following discussion with the duty governor, the FLO decided to call Mr Brown's mother, rather than attend the address. He told us that the rationale for this was the timeframe which had already elapsed and the risk of information getting out to Mr Brown's mother before his attendance.

113. The HMPPS Safety Group are currently reviewing the training provided to family liaison officers. This includes producing a toolkit, which we understand will include guidance on what to do when the next of kin is not at the home address. We do not therefore make a recommendation.

Governor to note

First night welfare checks

114. When a prisoner arrives at Birmingham, staff should conduct three welfare checks throughout their first night. These should be recorded on the prisoner's record.

115. On Mr Brown's first night in custody, there are no welfare checks recorded and we do not know whether these took place. While this did not have a direct impact on his death, it is important that these are appropriately conducted and documented.

Cell sharing risk assessment

116. PSI 20/2015 'Cell Sharing Risk Assessments' sets out that a day two assessment should take place when Police National Computer (PNC) records are not available on the day of reception. Reception officers noted that they had not reviewed the PNC records as part of the CSRA. No day two assessment was carried out for Mr Brown. We do not know if this would have impacted whether Mr Brown shared a cell – which might have been a protective factor – but it is important that this second day assessment is carried out to determine whether the risk is appropriately considered.

Inquest

117. The inquest into Mr Brown's death concluded on 21 March 2025, and recorded a verdict of suicide.

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