Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Birch, a prisoner at HMP Whitemoor, on 26 September 2019

A report by the Prisons and Probation Ombudsman

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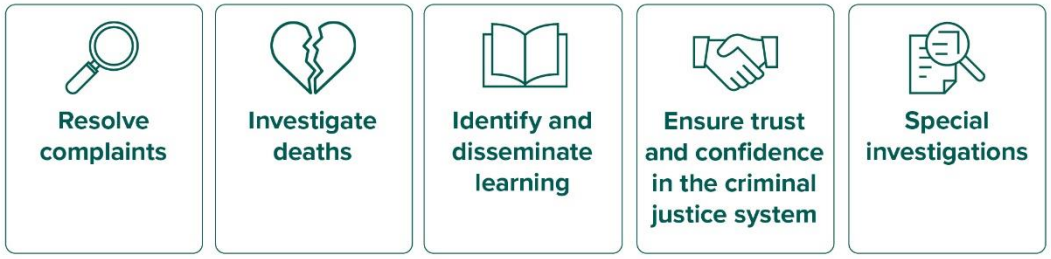
OUR VISION

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jason Birch died on 26 September 2019 in Peterborough Hospital after being found hanging in his cell at HMP Whitemoor on 24 September. Mr Birch was 46 years old. I offer my condolences to Mr Birch's family and friends.

Mr Birch had spent a long time in custody, in prison and in a high secure psychiatric hospital. He was transferred from Rampton Secure Hospital to Whitemoor's segregation unit on 28 June 2019. Within days, his paranoia and self-harm escalated severely. Rampton refused to readmit him, so prison healthcare staff and prison managers tried to arrange a transfer to another secure mental health setting.

While they were trying to do this, Mr Birch spent most of his time at Whitemoor being managed under suicide and self-harm prevention procedures (known as ACCT), subject to constant supervision. On 24 September, a multidisciplinary team agreed to reduce his observations. That evening, he was found hanging and died two days later in hospital.

Although it is clear with hindsight that the decision to reduce Mr Birch's level of observations was a mistake, I am satisfied that it was made in line with national guidelines and with Mr Birch's best interests in mind. I do not consider that it was an unreasonable decision to have made in the circumstances.

Mr Birch's extreme presentation and severe and repeated self-harm meant that the prison used measures of last resort to manage his risk on a number of occasions. I consider that this was reasonable in the circumstances. However, our investigation found that the prison did not always follow procedures correctly in some respects.

Although there is learning for Whitemoor about the management of risk, use of body belts, segregation and record keeping, I am satisfied that prison and healthcare staff worked hard to try to care for Mr Birch. However, I am very concerned that prison was not the right setting for someone with Mr Birch's complex needs.

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

Sue McAllister CB
Prisons and Probation Ombudsman **November 2020**

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Summary

Events

1. In 2012, Mr Jason Birch was convicted of burglary and sentenced to five years imprisonment. In 2014, he was convicted of attacking another prisoner and was sentenced to a further 12 years. In August 2016, he was transferred to Rampton Hospital (a high secure psychiatric hospital). On 28 June 2019, he was discharged from Rampton to HMP Whitemoor.

2. Mr Birch had an extensive history of aggressive, violent and disruptive behaviour, both in the community and in custodial settings. He had attacked staff, prisoners and fellow patients in hospital.

3. Before he arrived at Whitemoor, the prison agreed that Mr Birch would be segregated while he was assessed by the mental health team. Mr Birch soon began to display paranoid behaviour and cut his arm. Staff started suicide and self-harm prevention measures.

4. While at a hospital appointment in July, Mr Birch tied a ligature (noose) around his neck and escorting officers had to restrain him.

5. Over the following weeks, Mr Birch displayed increasingly paranoid behaviour. He said that his food was being tampered with and that other prisoners were threatening him because he had been talked about in the national news. (There is no evidence for either.) He repeatedly aggravated the cut in his arm, turning it into a serious wound.

6. Mr Birch was managed under suicide and self-harm prevention procedures (known as ACCT) and was put under constant supervision in a gated cell, and remained under the care of the mental health team. He refused to move from his bed, frequently soiling himself, and rubbed faeces into his wound. On several occasions, Mr Birch damaged his arm so badly that staff put him into a body belt to prevent him from harming himself further. The mental health team tried to secure a transfer back to a secure hospital.

7. In September, healthcare staff escalated Mr Birch's referral to a secure hospital. In the meantime, they and prison staff considered how best to care for Mr Birch while he remained in Whitemoor. On 19 September, a multi-disciplinary meeting developed plans to reintegrate him slowly into a normal regime, initially by moving him to a non-gated cell.

8. On 24 September, Mr Birch moved from a constant supervision cell to a standard cell in the healthcare unit. At a multidisciplinary meeting, it was agreed that his level of observations should reduce to at least four times per hour and his risk level was assessed as low.

9. When a prison officer was conducting an ACCT check that evening, he found Mr Birch hanging. Staff entered the cell, lowered Mr Birch to the floor and attempted to revive him. Mr Birch was transferred to hospital and placed on life support, but he died two days later.

Findings

10. Although there is learning for Whitemoor about the management of risk, use of body belts, segregation and record keeping, we are satisfied that staff at Whitemoor worked hard to try to care for Mr Birch.

11. We are very concerned that prison was not the right setting for someone with Mr Birch's complex needs.

Mr Birch's mental health

12. Mr Birch displayed deteriorating mental health almost from his arrival at Whitemoor. The healthcare team worked with prison staff to manage Mr Birch's risk of suicide and self-harm. They assessed his capacity, and managers and healthcare staff worked together to try to arrange a transfer back to a high security mental health setting to meet his needs.

Mr Birch's ACCT management

13. Mr Birch's risk of self-harm remained acute while he was at Whitemoor, and we are satisfied that the prison took a multidisciplinary approach to managing his risk. However, we are concerned that the caremap was not used effectively to record, monitor and review the actions to reduce this risk.

14. We are satisfied that there was a sufficiently good level of continuity, and that case reviews were sufficiently multidisciplinary, though they were not always recorded in Mr Birch's medical record.

15. We consider that the prison should have tried to involve Mr Birch's family in the management of his risk, and should have encouraged him to contact his family as a protective factor.

16. We agree with the clinical reviewer that the decision to relocate Mr Birch to a non-gated cell on 24 September was carefully considered, multidisciplinary and planned over several days. While in hindsight the decision was not right for Mr Birch, we consider that the decision to end his constant supervision was taken in line with national guidelines and with his best interests in mind. It was not an unreasonable decision in the circumstances.

17. We are, however, concerned that not all Mr Birch's risks were communicated to inform that decision, particularly Mr Birch's attempt to tie a noose around his neck in July.

18. When his risk was reviewed after he had relocated, the multidisciplinary team assessed that Mr Birch's level of risk had reduced to low. We do not consider that this was appropriate. However, we are satisfied that the support in place and the frequency of observations remained at a higher level than that normally associated with someone at low risk of suicide or self-harm.

Segregation

19. Mr Birch spent almost all his time at Whitemoor in segregation, either in the segregation unit or alone in his cell. We are concerned that there is no record that the required health screen was conducted to ensure that he was sufficiently well to be segregated.

20. Mr Birch was subject to suicide prevention measures for most of his time at Whitemoor. Although we understand the reasons for segregating Mr Birch, we are concerned that there is no evidence that alternative locations were considered, in line with national guidelines.

Use of body belts

21. Body belts should only be used in extreme circumstances. We do not consider that it was unreasonable or inappropriate for them to have been used to prevent Mr Birch's extreme self-harm.

22. However, we are very concerned that decisions about the use of body belts were not always made with the required level of authority or well recorded. As a measure of last resort, the decision to use a body belt should be subject to the highest level of scrutiny.

Mr Birch's physical healthcare

23. Despite Mr Birch's reluctance to engage with medical staff, they consistently offered appropriate physical care. The clinical reviewer highlighted some failings in record keeping.

Recommendations

- The Operational Manager and the Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
    - reviewing and update the prisoner's caremap at every case review;
    - involving the prisoner's family in the ACCT process when appropriate, and including family contact issues in the caremap;
    - recording all relevant ACCT information in the prisoner's medical record, including the outcome of all case reviews;
    - communicating all known risk factors and incidents of self-harm to all those involved in the prisoner's care;
    - considering all known risk factors when determining the prisoner's level of risk.
- The Operational Manager should ensure that when managers authorise segregation of a prisoner under ACCT management, they record what alternative locations have been considered.

- The Head of Healthcare should ensure that segregation algorithms are completed for all segregated prisoners, and that medical records reflect an assessment of the prisoner's mental wellbeing.
- The Operational Manager should ensure that the correct procedures for the use of body belts are followed and their use is recorded in line with PSO 1700.
- The Head of Healthcare should ensure that physical observations are recorded for all prisoners on arrival at Whitemoor.

The Investigation Process

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

25. The investigator obtained copies of relevant extracts from Mr Birch's prison and medical records.

26. The investigator interviewed seven members of staff at Whitemoor in December 2019 and February 2020. NHS England commissioned a clinical reviewer to review Mr Birch's clinical care at the prison. They interviewed healthcare staff.

27. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

28. One of the Ombudsman's family liaison officers contacted Mr Birch's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked whether Mr Birch had been under threat, and whether he had been prevented from contacting his family. We have addressed these questions in this report. We provided Mr Birch's mother with a copy of our report.

Background Information

HMP Whitemoor

29. HMP Whitemoor is a high security prison, which holds around 450 men serving long sentences. Northamptonshire Healthcare NHS Foundation Trust provide healthcare services.

HM Inspectorate of Prisons

30. The most recent inspection of HMP Whitemoor was in March 2017. Inspectors reported that care for those susceptible to self-harm was appropriate. Relationships between staff and prisoners were good and observations during the inspection indicated that many staff knew about the personal circumstances of the prisoners in their care. Inspectors had concerns about the length of time some prisoners were held in segregation. Operation of ACCT procedures was reasonable, although many prisoners being monitored under ACCT were held in segregation without clear exceptional circumstances. Transfers to secure hospitals were consistently delayed.

Independent Monitoring Board

31. 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 31 May 2019, the IMB reported a caring approach by staff for some complex prisoners. The Board was concerned that the time taken for referrals for transfer to secure hospitals was excessive, leaving local staff and facilities to cope with prisoners whose challenging needs they were not trained or equipped to meet. They noted that healthcare staff were frequently absent from ACCT reviews.

Previous deaths at HMP Whitemoor

32. Mr Birch was the fifth prisoner to die at Whitemoor since the beginning of 2017. One of the previous deaths was due to natural causes, one was self-inflicted and two were related to drug use. In a previous report, we raised the issue of staff not sharing information about a prisoner at risk of self-harm, something we repeat here.

Assessment, Care in Custody and Teamwork (ACCT)

33. 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.

34. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The

ACCT plan should not be closed until all the actions of the caremap have been completed.

35. 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.

Constant supervision

36. If staff consider a prisoner to be at very high risk of suicide or self-harm, they can implement constant supervision, which means the prisoner must be watched at all times. PSI 64/2011 requires that prisoners should be subject to constant supervision for as short a time as possible.

Segregation units

37. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

Key Events

38. In 2012, Mr Jason Birch was convicted of burglary and breaching licence conditions from a previous sentence (during which he had spent some time detained under the Mental Health Act in Rampton Secure Hospital). He was sentenced to five years imprisonment.

39. In 2014, he was convicted of wounding with intent after attacking another prisoner at HMP Full Sutton, and sentenced to a further 12 years. In August 2016, he was transferred back to Rampton where he was located in the Dangerous and Severe Personality Disorder (DSPD) unit for individuals diagnosed with a personality disorder.

40. Mr Birch had an extensive medical history. He had hepatitis C, asthma, diabetes, borderline personality disorder (which can include self-destructive behaviour including self-harm, and extreme changes in emotion), antisocial personality disorder (including impulsive behaviour and a lack of empathy), and paranoid personality disorder (characterised by mistrust, which can lead to isolation). Mr Birch had a history of aggressive, violent and disruptive behaviour, both in the community and in custodial settings. He had attacked staff, prisoners and fellow patients in hospital.

41. In 2019, Rampton staff decided to discharge Mr Birch from the hospital because he had assaulted other patients and was not engaging with the therapy programme offered. It was agreed that he would be discharged to HMP Whitemoor.

42. A care planning meeting was held at Rampton on 18 June 2019, attended by, Whitemoor's Head of Segregation, and Whitemoor's mental health team manager. It was agreed that when Mr Birch was discharged to Whitemoor, he would be held in the segregation unit while he was assessed by the prison's mental health team to determine the most appropriate location for him in the prison.

43. On 28 June 2019, he was discharged from Rampton to Whitemoor.

44. When he arrived at Whitemoor, a nurse noted on his medical record that Mr Birch was fit to be segregated. He said that he had no thoughts of self-harm. There is no evidence of an Initial Segregation Safety Screen, which should be completed for all prisoners held in segregation units to ensure that they are sufficiently well to be segregated.

45. Nurses could not complete a reception health screen because Mr Birch was verbally aggressive. During a health screen on 29 June, Mr Birch told a nurse that he had not self-harmed for 12 months, and she noted that he had no physical injuries. He said that he had not used illicit substances recently and declined a referral to the substance misuse team. He refused to give a urine sample for testing. Staff assessed that it was not safe for him to have his medication in his cell, and that he was not fit for normal location.

July – in the segregation unit

46. On 1 July, Mr Birch cut his arm. When a nurse attended, prison officers said that his unpredictable behaviour meant that it was not safe to open the cell door. The

nurse looked through the observation panel and assessed that he did not need treatment. The nurse passed a dressing to Mr Birch under the cell door. Staff started ACCT monitoring. Mr Birch said that he did not feel safe in his cell, so he was moved into a 'safer cell'. (Safer cells are designed to make suicide or self-harm by ligaturing (hanging) as difficult as possible by reducing known ligature points and by installing specialist "anti-ligature" furniture and fittings.)

47. During an ACCT assessment on 2 July, an officer recorded that Mr Birch was highly anxious and paranoid. Mr Birch said that he was concerned that social media had exposed him as a child killer, and that he and his family were in danger. He said that he was being threatened by Muslim prisoners in cells around him. (There was no evidence of either.) Mr Birch said he would refuse all medication apart from that used to treat his diabetes. He would not eat any food that was not delivered in a sealed container because he was concerned it could be poisoned. The officer arranged for Mr Birch to have sealed kosher meals.

48. That afternoon, having spoken to the officer, a Supervising Officer (SO) (the segregation unit manager) chaired an ACCT review with Mr Birch, a nurse, a custodial manager and representatives from the IMB and the Chaplaincy. Mr Birch was upset about being in the segregation unit. His risk to himself was assessed as "raised" and staff were to check on him at least three times per hour. The ACCT document noted that he had been moved to a safer custody cell in the segregation unit the previous day, but there is no evidence of a discussion about the exceptional circumstances that meant he should continue to be segregated while being assessed as at risk of suicide or self-harm. His caremap noted that he was to see the mental health team about his paranoia. That evening, Mr Birch used the Samaritans telephone.

49. At a secondary health screen on 4 July, the mental health team manager noted Mr Birch's physical and mental health history, and that if his mood deteriorated, this could lead to self-neglect. Mr Birch denied any substance or alcohol misuse, though records indicated a long history of both. Despite having cut his arm on 1 July, he said he had not hurt himself. The mental health team manager scheduled Mr Birch's care to be discussed at a healthcare multidisciplinary team meeting and thereafter with the visiting psychiatrist.

50. Mr Birch asked a member from the chaplaincy team to help him retrieve some telephone numbers so that he could add them to his telephone account. He said he would check and get back to him. There is no evidence that the chaplain did so. Later that day Mr Birch flooded his cell. Staff turned off the water supply, but assessed that they were unable to go into the cell because Mr Birch was paranoid and aggressive.

51. On the morning of 5 July, Mr Birch pressed his cell bell. When staff responded, he showed them that he had aggravated the cut on his arm. Eventually Mr Birch allowed a prison GP to treat the wound. Staff moved him into the constant supervision cell (with a gate instead of a door, so they could keep him under continuous observation).

52. That afternoon, a Custodial Manager (CM) chaired a multidisciplinary ACCT review. A nurse from the mental health team told Mr Birch that he had an appointment with the mental health team the next week, and Mr Birch said he might not be alive. He

said that he felt safe in the gated cell, and it was agreed that he should remain there under constant supervision. His risk was assessed as "high".

53. During the night, Mr Birch removed the stitches from his arm, then refused treatment. The following morning a senior prison manager chaired an ACCT review, with a CM from the safer custody team, the officer on constant supervision duties, and Mr Birch. No healthcare staff were present. Mr Birch continued to be highly paranoid and they assessed that his risk remained high. He was to remain under constant supervision, with a further review the following day.

54. Mr Birch aggravated the wound in his arm several times over the following days. At an ACCT review on 7 July, he told the senior prison manager, that he was fearful of leaving the gated cell as he thought he would be assaulted. On 8 July, he had made the wound so serious that he could get his vape pen under his vein. He told officers that he had packed the wound with faeces. Officers called a code red medical emergency (meaning serious bleeding), but Mr Birch refused all treatment, saying that staff were going to attack him.

55. That afternoon, Mr Birch agreed to let a nurse dress the wound. A prison GP explained to him the risk of sepsis, which could be fatal. He noted that Mr Birch had the mental capacity to decide whether he wanted to accept treatment. He advised Mr Birch to go to hospital. Mr Birch agreed, but on the way to hospital became aggressive and refused to get out of the escort vehicle so was taken back to prison. That evening, Mr Birch complained of chest pains and went back to hospital, where he was eventually admitted.

56. On 8 July, the Acting Operational Manager sent an email to a senior manager in HMPPS headquarters with responsibility for complex prisoner management saying that Mr Birch had deteriorated shockingly since arriving at Whitemoor, with serious self-harm and paranoia. Healthcare staff had begun procedures to refer him back to Rampton, but as he had been discharged less than 28 days before, the Acting Operational Manager asked whether he was still technically under the care of Rampton's mental health team and whether a full referral was necessary. The senior manager forwarded the query to the Prison Service's head psychologist for the Long-Term and High Security Estate (LTHSE).

57. In hospital, Mr Birch was given a psychiatric assessment. He said he was thinking about killing himself. On 11 July, Mr Birch tried to hang himself in the toilet using his dressing gown cord. Prison officers intervened and stopped him. The officers then held an ACCT review, noting what had happened and that Mr Birch remained at high risk of self-harm.

58. Mr Birch was discharged back to prison that same day. There is no note in his healthcare record that healthcare staff were told about his attempt to hang himself. Healthcare staff noted in his medical record the following day that he remained constantly distressed and paranoid.

59. Between 11 and 18 July, healthcare staff saw Mr Birch 14 times to offer him medication, offer to assess and redress his wound, and to help him shower. On most occasions, Mr Birch refused care.

60. On 16 July, during a psychiatric review with a doctor, Mr Birch said he thought he was being poisoned with medication and that he would be tortured by prison

officers. He said he could not tolerate it anymore and would kill himself. The doctor assessed Mr Birch as suffering from persistent delusional disorder (beliefs conflicting with reality, reinforced by misinterpretation of events). The doctor concluded that Mr Birch should be transferred to a secure psychiatric hospital. The mental health team manager told Mr Birch this during an ACCT review that afternoon, chaired by a CM. A segregation risk assessment noted that staff were attempting to refer Mr Birch back to a secure hospital and in the meantime the segregation unit was the best place to manage his complex needs.

61. On 18 July, Mr Birch cut his arm and smeared excrement in the wound. Prison officers called a code red emergency and healthcare staff cleaned the wound, but Mr Birch refused to have it dressed. He also refused his medication and to allow staff to take his physical observations.

62. Later that day he pulled at the veins in his wound, and prison officers called a further code red emergency. Mr Birch refused any care, and was put in a body belt to stop him from aggravating the wound further. This was authorised by the operational manager. Ambulance staff attended, but Mr Birch refused to see them. The orderly officer in charge of the day to day running of the prison), held an ACCT review, with attendees including a nurse. They agreed that Mr Birch remained at high risk and should remain subject to constant supervision.

63. The next day, 19 July, Mr Birch was hitting his arms against the wall and pushing excrement into his wound again. Officers once again used a body belt and called healthcare staff, but Mr Birch refused treatment. A multi-disciplinary healthcare meeting that afternoon discussed Mr Birch's ongoing management. They agreed that if Mr Birch's behaviour escalated to the point that he posed a risk to himself, use of a body belt was appropriate. They noted that Mr Birch had been drinking fluids, but not eating.

64. On 19 July, the Prison Service's head psychologist emailed two member of staff. She had contacted Rampton, who would not automatically accept Mr Birch back as he was no longer sectioned under the Mental Health Act. Rampton staff had told her that Mr Birch's behaviour at Whitemoor was similar to his behaviour in Rampton, and it was their view that he was not mentally ill. Whitemoor would therefore need to make a full referral, providing Mr Birch's full medical and mental health history, including any previous psychiatric assessments. She recommended that Whitemoor's psychiatrist refer him as soon as it could be arranged. She also suggested that the mental health team review his mental capacity.

65. Over the following days, Mr Birch continued to cause serious damage to his arm, pulling at his veins, exposing cartilage, as well as stuffing paper into his throat. He was put into a body belt on several occasions to stop him causing further harm to himself and his risk was reviewed through ACCT procedures.

66. On 22 July, the acting Operational Manager forwarded an email to the Prison Service's head psychologist from the mental health team manager giving the healthcare team's view that Mr Birch ought to return to a secure psychiatric hospital. They considered that his paranoia was delusional and that he needed more specialist care than could be provided at Whitemoor. He was very distressed, displaying extreme behaviour, frequently declining his medication, and was at serious risk of self-harm. Mr Birch did not want to go back to Rampton, which

meant that his placement needed consideration. He was judged to still have capacity to make his own decisions, but needed ongoing support.

67. The Prison Service's head psychologist responded that the prison should refer Mr Birch to a mental health secure setting as soon as possible.

68. On 23 July, the mental health team manager reviewed Mr Birch's mental health during an ACCT review, chaired by a CM. He was paranoid, believing that staff were going to kill him. He had refused to let officers help him shower that morning. The plan was to move him to a gated cell in the healthcare centre where he would have more frequent interaction with clinicians and could build supportive relationships. There would also be fewer people walking past his cell, something that had been fuelling his paranoia.

69. Later that day, he opened the wound on his arm and lost a lot of blood. A CM who was the orderly officer, authorised a body belt to stop him hurting himself further. A SO chaired an emergency ACCT review, but Mr Birch was too ill to participate. He was taken to hospital, but was disruptive so was taken back to prison.

70. The following morning, he was seen biting his wound and trying to pull his veins out, and was put into a body belt again. Healthcare staff cleaned and dressed the wound. A CM chaired an ACCT review, with Ms Leach present, and noted that Mr Birch was correctly located in the gated cell. That evening, Mr Birch again opened his wound and sprayed blood around his cell. Officers called a code red emergency. Mr Birch allowed them to put him into a body belt, but refused treatment.

71. Between 27 July and 31 July, Mr Birch had to be stopped from aggravating his wound several times, and often refused treatment. Authorisation was given to put him into a body belt on further occasions, sometimes at Mr Birch's own request, to stop him hurting himself more. ACCT reviews were held after the most serious incidents. His risk continued to be judged as high, and he remained under constant supervision.

August – in the healthcare unit

72. On 1 August, staff relocated Mr Birch to the gated cell in the healthcare centre. Mr Birch was agitated during the move. A CM chaired an ACCT review with the senior prison manager and the mental health team manager present. Mr Birch, however, refused to engage and became confrontational.

73. Staff applied a body belt again on 3 and 5 August to stop Mr Birch reopening his wound. Multidisciplinary ACCT reviews were held after each occasion.

74. On 8 August, a GP assessed Mr Birch. He said that he felt safe in the gated cell, but did not want to go to Rampton. The GP did not consider that Mr Birch was at risk of suicide, but recorded that he remained paranoid about staff wanting to kill him.

75. Mr Birch refused to engage in ACCT reviews on 9, 13, 20 and 27 August. He aggravated his wound again on 12 August, and refused to let the doctor assess it. He said he had not been sleeping as he was worried about his own safety. During a daily mental health review on 16 August, Mr Birch was less delusional. On 19

August, he once again was afraid that staff wanted to kill him. On 21 August staff arranged for Mr Birch to have a mental health review on a wing with the mental health team manager while his cell was cleaned of dirt and faeces. When the time came, however, Mr Birch was aggressive and refused to speak to the mental health team manager. The GP tried to assess Mr Birch on 23 August, but he refused to engage.

76. On 28 August, staff persuaded Mr Birch to have a shower and, while doing so, have his cell cleaned. Mr Birch had been refusing to leave his bed, so had little strength in his legs. Three prison officers had to help him get to the shower and back. Within minutes of returning to his clean cell, he defecated on the floor. On 29 August, the GP tried to review Mr Birch, but he refused to engage.

77. Between 13 August and 6 September Mr Birch refused all medication, wound care, and any physical observations.

78. On 5 September, The GP, a nurse and the senior prison manager held a video link meeting with staff at Rampton, including the psychiatrist and ward manager who had worked with Mr Birch while he was there. The psychiatrist at Rampton said that Mr Birch's delusions were not new and he had behaved similarly when in segregation in Rampton. Staff at Rampton were concerned that if he returned there, he would self-harm to prevent him from ever returning to prison. It was agreed that the mental health referral would assess Mr Birch for transfer to a secure hospital, but not Rampton.

79. On 6 September, a GP reviewed Mr Birch's physical health because he refused to stand. He was suffering from muscle wastage, so the GP referred him for physiotherapy.

8 September – move to the Bridge Unit

80. On the morning of 8 September, a CM held an ACCT review to tell Mr Birch that a multidisciplinary team meeting had decided that he might benefit from a move from the gated cell in the healthcare unit to the gated cell in the Bridge Unit (a unit next to the segregation unit, used to reintegrate prisoners into the prison's regime). Mr Birch refused to leave his bed, saying he wanted to be left to die. He said he was going to soil his bed because he could not walk, but refused offers of assistance. He said he would refuse food, so officers conducting constant supervision were instructed to record his food intake. The following day, the prison dietician prescribed Fortisips (a nutritional, high energy drink).

81. During a mental health review on 10 September, a nurse incorrectly noted that Mr Birch had last self-harmed over three months ago (it had only been three weeks). He had been refusing to stand up, so staff arranged for him to go to hospital for tests. Blood tests were all normal, so he returned to prison. At an ACCT review the next day, it was noted that Mr Birch's physical condition was deteriorating because he refused to move or eat. A GP's referred him for social care for pressure sores and to get a specialised mattress.

82. A healthcare multidisciplinary meeting discussed Mr Birch's situation on 12 September. They agreed that his secure hospital referral needed escalation. A GP assessed Mr Birch's mental capacity and concluded that he retained capacity to make his own decisions. If he lost consciousness or became delirious, then it

should be assumed that he had lost capacity and should be treated by emergency services.

83. On 17 September, the healthcare team referred Mr Birch for assessment for a secure hospital.

84. Between 12 and 24 September, Mr Birch continued to refuse most medication, medical treatment, assistance with his personal hygiene, and food or drink. He occasionally accepted Fortisips. He declined a mobility assessment on 16 September, and an ACCT review had to be abandoned when he became confrontational.

85. On 19 September, a GP reassessed Mr Birch's mental capacity. He concluded that Mr Birch had impaired capacity because of delusional beliefs. The GP noted that Mr Birch was extremely distrustful of staff and this was affecting his decisions to accept physical care and medication, as well as food. The GP requested an independent capacity assessment. Mr Birch appeared unable to stand, and was physically weak. The GP told Mr Birch he had been referred to Rampton.

86. A CM, the senior prison manager, two GPs and a nurse then held a multidisciplinary meeting to consider Mr Birch's care. They agreed that Mr Birch's physical needs could be better met in a standard cell in the healthcare centre and that he would benefit from being moved out of a gated cell. They noted that he was not at risk of ligaturing because he did not have the strength to move and (incorrectly) that he had no history of ligature making. They planned to move him on Monday 23 September, so he would be well-supported over the weekend (when staffing levels would otherwise be reduced). They planned that he would have daily healthcare checks, mental health checks three times a week, and a psychiatric review weekly. Mr Birch's risk was still judged to be high. Those present agreed that in order to try to reintroduce Mr Birch into a more normal routine, he could come off constant supervision after his cell move.

87. On 23 September, healthcare staff offered Mr Birch a mobility assessment, which he declined. A note on Mr Birch's ACCT document from the CM noted that the move to the standard cell in the healthcare centre would take place the next day.

Events of 24 September

88. On 24 September, staff moved Mr Birch from the constant supervision cell to a standard cell in the healthcare department. They reassured him that he would still get a high level of support, and initially Mr Birch was content with the move and got out of his bed into a wheelchair. When he arrived in his cell, however, he became anxious. He rolled off his bed onto the floor, and began to put his fingers into his wound. Staff restrained him, and he became calmer and allowed staff to put him onto his mattress on the floor. Healthcare staff cleaned and dressed his wound, but Mr Birch would not allow them to take any physical observations and refused Fortisips.

89. At 10.30am, after the move, the senior prison manager chaired an ACCT review. Mr Birch was present, with an officer (who had been on constant supervision duty), the deputy Head of Healthcare, Mr Birch's offender supervisor, a nurse, a SO, another SO (healthcare/Bridge Unit manager), and an officer (healthcare/Bridge Unit officer). The note of the review stated that Mr Birch was not in a safer cell as

there was no evidence of ligaturing. Staff would check on Mr Birch at least four times per hour.

90. Although Mr Birch was no longer under constant supervision, an extra prison officer was detailed to work on the healthcare unit so additional support was available if either Mr Birch or staff needed it. He would be given his food at meal times, and staff would record food and fluid intake. Staff would be expected to have positive dialogue with him and encourage him to join in the prison regime.

91. The acting Head of Safer Prisons noted that Mr Birch continued not to stand, which was making his legs weak, so his food would be brought to him and he was to be provided with urine bottles. She noted that if he self-harmed it should not be assumed that he should go directly back onto constant supervision, but his risk should be reassessed. He would be reviewed again the following day. His risk was reduced to low. Staff were to check on him at least four times per hour, with a minimum of four entries per session (i.e. morning, afternoon, evening and night).

92. Mr Birch's ACCT document showed that staff continued to check him, but he did not engage with them. At midday, a member of the chaplaincy team visited. Mr Birch was given lunch, and a nurse dressed his wound. His keyworker spoke to him, and asked if he was okay. Mr Birch replied "no", but did not explain why.

93. An officer came on duty for a night shift and was allocated to the healthcare wing. He knew Mr Birch, having conducted constant supervision duties in the past. He said in interview that when he first checked Mr Birch, he was uncharacteristically polite. In further checks, he observed Mr Birch standing up, something that he had not done for several weeks.

94. At 8.30pm, a nurse noticed Mr Birch standing by the observation panel in his door. She asked him if he was alright, and he said he was. She asked if he wanted anything to eat or drink, but he did not. She told him that she was surprised to see him standing as she thought he was unable to walk, it being so long since he had done so (she said in interview that he had apparently not stood up for approximately three weeks, and had muscle wastage). He said he could walk but was in pain. She offered him painkillers but he declined. The nurse said in interview that she had no concerns about him, though she ended the conversation when he became rude. She told an officer that she had seen Mr Birch standing up and asked him to make a note in Mr Birch's ACCT document, which he did.

95. At 8.41pm, the officer checked Mr Birch, and found him hanging by a ligature made from a bed sheet attached to the television shelf. He called a code blue emergency (a life-threatening emergency when a prisoner is not breathing), which prompted the control room to call for an ambulance (ambulance service records showed that the call was received at 8.42pm). Another officer joined him and they opened the cell door and went in. The officer used his anti-ligature knife and they lowered Mr Birch to the floor.

96. Other staff, including a nurse had responded to the emergency call and the officers moved Mr Birch out of his cell onto the landing where there was more room to provide medical aid. The officer checked Mr Birch for signs of life and, when he could not find any, a nurse told him to begin cardiopulmonary resuscitation (CPR) while she applied a defibrillator to Mr Birch. It advised to continue with CPR. Staff

did so until ambulance paramedics arrived and took over. Mr Birch began to breathe, and was transferred to hospital.

97. Mr Birch was placed on life support in hospital. He was confirmed to be brain dead the next morning and died in hospital at 10.06am on 26 September.

Contact with Mr Birch's family

98. An officer was appointed as family liaison officer, and identified Mr Birch's parents as his next of kin. He went to their home on the evening of 24 September and explained what had happened. He drove Mr Birch's mother to the hospital to be with him, and drove her home later that night. The following morning, he drove both Mr Birch's parents to the hospital and they were with him when he died.

99. In line with Prison Service guidance, Whitemoor offered a contribution to the cost of Mr Birch's funeral.

Support for prisoners and staff

100. After Mr Birch's death, a CM 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. The healthcare team had a separate debrief.

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

Post-mortem report

102. The post-mortem found that Mr Birch died as a result of a lack of oxygen to the brain due to hanging. Post-mortem toxicology tests showed no drugs or alcohol.

Findings

103. Mr Birch had complex needs, which presented exceptional challenges to those caring for him. As soon as he arrived at Whitemoor, he expressed deep paranoia and his self-harm escalated rapidly. The IMB raised serious concerns about his continued detention in prison, and it is clear that Whitemoor devoted a good deal of time and consideration to his care.

Mr Birch's mental health

104. The clinical review concluded that the healthcare team had a multidisciplinary approach to Mr Birch's mental health care. The psychiatrist, the GP, the psychologist, general nurses, mental health nurses and team managers were all involved, and advice was sought from external professionals.

Assessment for transfer to a secure psychiatric hospital

105. A mental health team manager said in interview that a week after Mr Birch arrived, she contacted Rampton and said that his presentation had changed. He was paranoid and suspicious, and was self-harming. She said she was told that this was how he had been in Rampton, and that he needed to be in prison. She did not note this conversation in Mr Birch's medical record.

106. On 16 July, a GP noted that a multidisciplinary meeting had agreed that Mr Birch needed to transfer to a psychiatric hospital. He noted this again on 8 August. After some difficulty in arranging it, a video link conference was held with Rampton staff on 5 September. The conclusion was that Mr Birch should be assessed for a secure hospital other than Rampton, but Rampton agreed to continue the assessment process for the wider high security mental health estate. The doctor sent a referral on 17 September.

107. On 19 September, a GP reported to a multidisciplinary team meeting that Rampton had asked for Mr Birch to be referred as a new patient, and that they did not believe that he had a mental illness or that he was psychotic. The GP noted that it was the view of staff in Whitemoor that Mr Birch was mentally ill and needed hospitalisation. He agreed to refer Mr Birch as a new patient for transfer to a high security mental health setting.

108. Alongside the mental health team's efforts, the acting Operational Manager emailed HMPPS and asked for support to transfer Mr Birch back to a secure mental health setting. HMPPS eventually advised that the prison should arrange a psychiatric review and refer Mr Birch to a secure mental health setting as quickly as possible.

109. The clinical reviewer concluded that the initial timeliness of the referral was appropriate, and the healthcare team consistently followed up the process. We are satisfied that the mental health team and prison managers tried to expedite Mr Birch's transfer back to a mental health setting.

Mental capacity

110. The clinical reviewer noted that the mental health team had prepared for Mr Birch's arrival at Whitemoor in advance. While Mr Birch frequently refused to engage in his care and treatment, all healthcare staff were committed to engaging with him.

111. Mr Birch's mental capacity was assessed by a GP on 8 July, when the doctor concluded that he had capacity to make his own decisions. It was assessed by a GP on 12 September and subsequently discussed at a multidisciplinary team meeting that afternoon, with the same conclusion. When the GP reassessed him on 19 September, he judged him to have impaired capacity about his refusal of food, medication and treatment, due to delusional beliefs. The same day, he requested an independent capacity assessment.

112. The clinical reviewer noted that Mr Birch's capacity was appropriately reviewed, assessed and documented during his time at Whitemoor, with plans underway for independent assessment.

Food refusal

113. Mr Birch's paranoia affected his acceptance of food. He believed it had been tampered with and he would sometimes only accept food if the prison officer delivering it tasted it first, or if it was in a sealed container. A food refusal log was opened in August and initially filled in, but from the end of August the record became intermittent. When a GP saw Mr Birch on 12 September, he was not sure that Mr Birch's fluid intake was being properly recorded. The GP discussed the risks of food and fluid refusal with Mr Birch. Mr Birch was aware of the possible consequences of his decision.

Mental health care overall

114. The clinical reviewer concluded that the absence of physical observations on reception, the lack of the segregation algorithm, and some omissions from his records meant that Mr Birch's care was not equivalent to that which he would have expected in the community. She said, however, that none of these had a direct impact on his death.

115. The clinical reviewer has made some related recommendations about record keeping that we do not repeat here, but that the Head of Healthcare will need to address.

Mr Birch's ACCT management

116. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* sets out the Prison Service's framework for delivering safer custody procedures. From early August onwards, Mr Birch would not go to ACCT case reviews.

117. The caremap was completed when the ACCT was opened, and revisited on 7 July, 6 August, and 10 September. The PSI requires that the caremap is revisited at each ACCT case review. We are concerned that this was a missed opportunity to

record, monitor and review the steps that staff were taking to manage Mr Birch's self-harm and risk of suicide.

118. The prison held 29 ACCT case reviews. PSI 64/2011 requires the appointment of a case manager to ensure continuity of care throughout a prisoner's risk period. The case manager was a CM on seven occasions, the acting Head of Safer Prisons on six occasions, and another CM on eleven occasions. While not strictly in line with the requirements of the PSI, we consider that this provided sufficient continuity to manage Mr Birch's complex needs.

119. When Mr Birch arrived at Whitemoor, he did not have his family's contact numbers on his telephone account. A member of the chaplaincy said that he would help, but there is no record that the issue was ever resolved. Family contact is often a protective factor for prisoners assessed as at risk of suicide or self-harm. PSI 64/2011 says that "where appropriate, procedures must be in place to encourage family engagement in managing and reducing the risk of prisoners who harm themselves". Family contact or family involvement could have been a supportive factor for Mr Birch and for those that were trying to manage his risk and we are concerned that the prison did not explore this further.

120. Healthcare staff were represented at 23 of the 29 reviews (the mental health team also went to 19 reviews). If healthcare staff could not attend, the prison scheduled a review the following day. We are satisfied that healthcare staff were represented in ACCT reviews wherever possible, and that Whitemoor did their best to ensure a multidisciplinary approach to the management of Mr Birch's risk. However, we are concerned that the outcomes of some of the ACCT reviews were not recorded in the medical record.

121. When Mr Birch tied a ligature around his neck while in hospital on 11 July, escort officers held an ACCT review, but did not tell healthcare staff about the self-harm. This meant that healthcare staff did not know that Mr Birch presented a risk of hanging. As a result, healthcare staff later wrongly assessed that he was not at risk of tying ligatures because he had no history of doing so.

122. At the multidisciplinary planning meeting on 19 September, it was agreed that Mr Birch should move to a standard (non-gated) cell. We agree with the clinical reviewer that the cell move was carefully planned and other options considered. Mr Birch had not self-harmed in the recent past. We are satisfied that the reasons for moving him, including to reduce his distress and paranoia, were reasonable and that the decision was taken with his best interests in mind. We are concerned, however, that staff wrongly concluded that Mr Birch was not a ligature risk because the self-harm incident in July had not been effectively communicated.

123. On 24 September, after Mr Birch's move to a standard (non-gated) cell, it was agreed that Mr Birch's observations should reduce to four times an hour. This was decided by a multidisciplinary review attended by eight members of staff, including two from the healthcare team.

124. PSI 64/2011 sets out that constant supervision should be used for the shortest possible time because it can be de-humanising and therefore increase risk. While in hindsight, the reduction in observations was not the right decision for Mr Birch, we consider that the decision was taken in line with guidance and with the best of intentions.

125. However, we are concerned that Mr Birch's level of risk was reduced to "low" at this meeting. We consider that the level of risk did not reflect the severity of Mr Birch's risk factors or the complexity of his needs. We are satisfied that the management of his risk and the frequency of observations continued to reflect a higher risk level, but we remain concerned at the outcome of this assessment of his risk.

The Operational Manager and the Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **reviewing and updating the prisoner's caremap at every case review;**
- **involving the prisoner's family in the ACCT process when appropriate, and including of family contact issues in the caremap;**
- **recording all relevant ACCT information in the prisoner's medical record, including the outcome of all case reviews;**
- **communicating all known risk factors and incidents of self-harm to all those involved in the prisoner's care;**
- **considering all known risk factors when determining the prisoner's level of risk.**

Segregation

126. Mr Birch spent almost all his time at Whitemoor in segregation, either in the segregation unit or locked alone in his cell. Throughout this time, he was largely under ACCT management.

127. Segregation is an extreme and isolating form of custody used for prisoners who have misbehaved or who cannot be kept safely in normal prison accommodation. It inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others, and for this reason should only be used in exceptional circumstances for those known to be at risk of taking their own life.

128. This can leave prison staff with some very difficult decisions about where prisoners managed under ACCT procedures should be held, to minimise the risk of harm to themselves as well as to others. As a result, there will sometimes be exceptional circumstances to justify holding prisoners at risk of suicide or self-harm in segregation units. However, PSO 1700 emphasises that this should only happen when all other options have been considered and exhausted.

129. We recognise that Mr Birch was a very challenging prisoner with exceptionally complex needs and presentation. However, although managers at Whitemoor were aware that healthcare staff were working to have Mr Birch transferred to a secure hospital, there is no documentation to say that they had considered alternative locations to segregation. Mr Birch's location was clearly something they had in mind, as he moved between the gated cell in the healthcare centre, the gated cell in the Bridge Unit and, finally, a standard cell in the healthcare centre. There is, though, little written evidence of the decision-making process or of senior managers ratifying the decision that he remain segregated while under ACCT management.

130. Prison Service Order (PSO) 1700, Segregation, sets out the rules governing segregation. When prisoners are segregated, healthcare staff are required to complete an algorithm to confirm that segregation will not have a detrimental effect on their health. There is no evidence of an initial safety screen when Mr Birch was segregated.

131. The clinical reviewer noted that daily segregation reviews were held in line with guidance, but daily mental health reviews were not always documented, so records do not fully reflect the deterioration in his mental health. We make the following recommendations:

The Governor should ensure that when managers authorise segregation of a prisoner under ACCT management, they record what alternative locations have been considered.

The Head of Healthcare should ensure that segregation algorithms are completed for all segregated prisoners, and that medical records reflect an assessment of the prisoner's mental wellbeing.

Use of body belts

132. PSO 1700 says that a body belt must only be used in extreme circumstances to prevent life-threatening behaviour when all other options have failed or are considered unsafe. Its use must be a last resort, where other methods such as de-escalation techniques or the use of special accommodation have been considered.

133. The PSO requires the Governor's authority to put a prisoner into a body belt. In an emergency, the duty governor can authorise, but the Governor's authority must be sought as soon as possible. A doctor or nurse must assess the decision using the Initial Segregation Safety Screen. If a prisoner is under ACCT management, the Governor must chair a case review within 60 minutes of the decision being made, and the prisoner must have a mental health assessment. The ACCT document must make clear what alternatives have been considered. A manager must review the use of a body belt at least hourly. The Governor must chair a reassessment review within four hours with a doctor or nurse. A prisoner must be taken out of a body belt as soon as the reasons for its use no longer exist. The form for authority for location in a body belt must be used for all decisions.

134. Mr Birch was put in a body belt on several occasions. On each occasion, it was to prevent him harming himself. We recognise that Mr Birch's reluctance to engage would have made the use of de-escalation techniques extremely challenging. The body belt was applied several times at Mr Birch's request or with his compliance and effectively stopped his self-harm. The clinical reviewer noted that healthcare staff attended and reviewed Mr Birch when a body belt was applied. His mental and physical health were monitored in line with the PSO.

135. However, we are concerned that documentation for use of the body belt was not always completed. On occasions when Mr Birch had requested the belt, this was not always made clear on the documentation. Managers did not always carry out the required four-hour reviews, even when Mr Birch was in a body belt for extended periods.

136. The IMB raised concerns on 11 August, and were told that managers had not been aware of what they needed to do, but had since been trained. On 22 August, the IMB again raised concerns that the four-hour check documentation was still not being completed.

137. Whitemoor provided the investigator with their records of using body belts in 2019. Staff did not use body belts with any other prisoner in 2019. The Acting Head of Safer Custody said in interview that when concerns were raised, the relevant forms were checked and they found that Whitemoor's forms did not include the paperwork for the four-hour check. Once this was realised, the correct forms were used. She had also circulated the body belt guidance to all managers.

138. The use of a body belt is an extreme method of control and must, therefore, be subject to thorough scrutiny. It is essential that when they are used the proper processes are followed and documented, and that appropriate staff are trained in how to ensure this. We are satisfied that staff used body belts for Mr Birch as a measure of last resort. However, we are very concerned that staff did not always properly record, review and justify all key decisions, in line with the requirements of the PSO. We make the following recommendation:

The Governor should ensure that the correct procedures for the use of body belts are followed and their use is recorded in line with PSO 1700.

Physical healthcare

139. The clinical reviewer said that despite Mr Birch's reluctance to accept physical healthcare, his frequent refusal of some or all his medication, healthcare staff consistently offered what they felt he needed. He was taken to hospital when it was warranted. The clinical reviewer was satisfied that overall, Mr Birch's physical healthcare was well-coordinated and of a good standard, demonstrating good practice, and was equivalent to that which he could have expected in the community.

140. She did, however, identify one concern. At reception and secondary healthcare screenings, healthcare staff did not take Mr Birch's physical observations. This, and, in particular, not having a note of his weight, meant that it was difficult to monitor his ongoing health when he subsequently refused food. We make the following recommendation:

The Head of Healthcare should ensure that physical observations are recorded for all prisoners on arrival at Whitemoor.

Inquest

141. The inquest, held from 21 to 25 October 2024, concluded that Mr Birch died as a result of hanging from a ligature that he placed around his neck. It was not possible to determine whether he intended the outcome to be his death.

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