

**Investigation into the circumstances surrounding
the death of a man in June 2010,
whilst in the custody of HMP Birmingham**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2011

This is the report of the investigation into the circumstances surrounding the death of a man. He was 28 years old when he died at hospital in June 2010. He had been a prisoner in HMP Birmingham for almost a year when he was found with a ligature around his neck in June. He had not harmed himself whilst he was in prison. He was allowed a single cell as he said that he could not share because he had obsessive compulsive disorder.

He was taken to hospital after he was found but his condition did not improve and, with his family's agreement, his life support machine was switched off two days later. He is survived by his parents and sister. I extend my sincere condolences to them.

The investigation was completed by one of my investigators. He visited Birmingham and interviewed discipline and healthcare staff. One of my Family Liaison Officers contacted the family to tell them more about my investigation and to find out what concerns and questions they had about his death. I am grateful to them for their contribution under what I appreciate are distressing circumstances.

A clinical review of the treatment which the man received in prison was undertaken by a clinical reviewer appointed by the local Primary Care Trust. He assessed whether the care that he received in custody was comparable to that he would have been offered in the community. I am grateful to the clinical reviewer for his assistance.

I would like to express my thanks to the Governor and the staff and prisoners at Birmingham for their full cooperation whilst the investigation was completed. I particularly thank the liaison officer for liaising with the investigator and helping to organise interviews.

The investigation has raised a number of areas of concern. Amongst other issues, I examine the provision of mental health treatment in Birmingham, the involvement of discipline staff in resuscitation efforts and allegations of bullying by staff and prisoners. The prison took these allegations seriously and commissioned its own investigations which have been made available to me.

I have struggled to reconcile the differing accounts of prisoners and staff, as well as the recollections of different staff members. I hope that the report provides as clear an account as possible of the circumstances surrounding the man's death. I endorse four recommendations from the clinical reviewer to address staffing levels in the mental health team, interruptions to cardiopulmonary resuscitation, healthcare induction and the provision of emergency equipment.

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

Jane Webb
Acting Prisons and Probation Ombudsman

March 2011

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SUMMARY

The man committed an offence of robbery in June 2009. He was arrested and appeared at Magistrates' Court on 1 July. He was remanded into custody and taken to HMP Birmingham. He had been in prison before. He did not report any concerns about self harm during the reception process. He said that he suffered from obsessive compulsive disorder (OCD) and so staff allocated a single cell because he said that he became stressed if others interfered with his belongings.

He said that he was being prescribed pain relief for a longstanding injury to his arm. However, his local surgery told the prison healthcare team that this was not the case. He asked the healthcare staff to confirm his prescription with the hospital, but, by the end of July, the team had not yet received a reply. He did not mention the pain again until the following April and the matter was not pursued at the time. He underwent a mental health assessment in July. He was offered further appointments but, after he chose not to attend three sessions, the primary care mental health team discharged him.

In early November, he moved onto M wing. He remained in a single cell even after the wing changed its function to become the Integrated Drug Treatment System (IDTS) unit. Staff took account of his OCD and thought that he would cope best if offered continuity and stability. He stayed on the wing even though he was not taking part in the IDTS programme. His cell sharing risk was regularly reviewed during the next few months. At different intervals, senior staff wanted to move him off the unit but the wing staff arranged for him to remain there. He was occasionally issued with warnings for not moving wings.

He asked for a mental health assessment in March 2010 because he was anxious that staff were going to move him to a different wing. Although a referral was made, an assessment had not been completed by the end of April. Nursing staff spoke to the mental health team again and reminded them of the referral. He chose not to attend the assessment scheduled for 9 June. Three days later he was assessed by a mental health nurse, who decided to offer cognitive behavioural therapy to address his OCD, starting in early July.

On 21 May, he received a sentence of five and a half years. He tested positive for Subutex (a heroin substitute) twice in Birmingham. After he died a number of prisoners told the investigator that he had been misusing Subutex and owed debts to a number of the men. He wrote to members of his family in early June, asking them to send in money to repay his debts.

He was found hanging in his cell at 7.55am in June after another prisoner looked in his cell and alerted the wing officers. Two officers went into the cell, cut through the ligature and lowered him to the floor. Nursing staff arrived in the cell and tried to resuscitate him. The paramedics attended and he was taken to hospital. However, he did not recover and died with his family present in the hospital. His funeral was held on 29 June. During the investigation, staff and prisoners disputed accounts of the resuscitation procedure. Some prisoners also alleged that an officer had been bullying him.

THE INVESTIGATION PROCESS

1. The investigator was formally notified of the man's death on 18 June 2010. Notices were subsequently issued to both staff and prisoners at HMP Birmingham, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information.
2. During the investigation, the investigator liaised with the liaison officer in Birmingham's safer custody unit. He visited Birmingham on 22 June and was provided with all documents relating to the man's time in custody. Whilst there, he spoke to four prisoners. He returned to Birmingham on 19 and 22 July to interview a total of 16 discipline and healthcare staff. He was also provided with a copy of the note the man left in his cell.
3. The investigator wrote to the local Coroner's office to inform them of the nature and scope of the investigation. HM Coroner will be provided with a copy of the report of the Ombudsman's investigation.
4. After he was notified of the man's death, the investigator contacted the local Primary Care Trust. He asked that a clinical review be carried out with regard to the man's healthcare at Birmingham. The purpose of the review is to establish whether the care that he was offered in prison was comparable with that he would have received in the community. The clinical reviewer completed the review.

The man's family

5. One of my Family Liaison Officers spoke to the man's family on the telephone on 14 and 23 July to discuss the investigation and any concerns they had about the treatment he received in prison. Both she and the investigator visited the family on 25 August to speak at length about the investigation. The family provided very helpful information and asked a number of questions.
6. The family said that he had made previous attempts to take his own life in the community whilst under the influence of alcohol. His mother said that her son had visible scarring on his left wrist. The family were concerned that prison staff did not recognise his history of self harm.
7. At the family liaison meeting, his family expressed concern that his community medical records would have provided valuable information about any suicidal thoughts he might be having. They asked whether efforts were made by the prison to request them from his local surgery.
8. His mother said that he complained about toothache for almost a year. The family are concerned that this was not treated and that any pain may have contributed to any feelings of despair that he experienced.
9. She also mother mentioned that, about six months before he was imprisoned, her son's community doctor wrote to the Probation Service about a recent

attempt to take an overdose. She wondered if this information was shared with staff at the prison.

10. His parents showed my investigator letters that their son wrote before his death asking them to send money to help pay off debts he had accrued at Birmingham. In his letters, he wrote that he was being beaten up by other prisoners. The family are concerned that prisoners whom officers thought were friends were actually bullying and intimidating him. They asked whether the extent of his debts was known to the staff at Birmingham. The family were worried that the burden of his debts would have affected his state of mind and wondered whether any action was taken to monitor the problem.
11. Other prisoners had been in touch with the family and told them that a prison officer had been bullying him. They wanted to know more about this.
12. The family also asked why, if he was being treated for OCD and depression, he was not subject to additional monitoring and checks.
13. Encouragingly, his mother spoke positively about the support she had received from the prison following her son's death, particularly from the prison Family Liaison Officer.
14. I hope that the report gives the family a better understanding of the year he spent in Birmingham. The investigation has sought to explore the concerns they raised.
15. After the draft report was published, the man's mother spoke to the family liaison officer to discuss my findings. I have included her response on page 47.

HMP BIRMINGHAM

16. Birmingham is one of the largest prisons in the country, accommodating a maximum population of 1,450 adult male prisoners. It accepts men from nearby courts in Birmingham, Stafford, Wolverhampton, Burton, Cannock, Litchfield, Rugeley, Sutton Coldfield and Tamworth. Its main function is to hold prisoners who are awaiting sentencing, being held on remand or facing a trial. Originally a Victorian prison, in recent years it has expanded and modernised. Many local people refer to the prison by its original name, Winson Green.

Market testing

17. At the time of writing, Birmingham is awaiting the outcome of a bidding process to determine whether it will be run by a private contractor. The decision is due in January 2011. By this time, the bidding process will have been ongoing for two years. Both Governor and staff acknowledged to my investigator that the uncertainty this has created has not been helpful to staff morale. .

Healthcare

18. Birmingham and Solihull Mental Health Foundation Trust provide mental health care at Birmingham. The In-Reach team at Birmingham should have three community psychiatric nurses and a social worker. However, as of July 2010, none of these posts were filled and had been vacant for some months. This has placed a drain on resources, with the five nurses from the primary care mental health team attempting to cover the In-Reach team's work in addition to their own.

19. The manager of both teams told my investigator that in spring 2010 it was not uncommon for a routine mental health referral to result in at least a six week wait for an assessment. She said that such a referral should ideally take two weeks if her teams were fully staffed. She said that she anticipated filling two of the roles in the near future. The Governor explained to my investigator that the prison has had difficulty recruiting mental health nurses because there are five hospitals in the local area.

20. The man was located on M wing for the majority of his time at Birmingham. The wing holds prisoners undergoing detoxification. He was not a 'detox' prisoner and should not really have been on the wing. Strictly speaking, he should have been relocated. However, he had OCD and staff did not want to distress him by moving him to another cell when the wing changed function and became the detoxification unit on 18 November 2009. The Governor told my investigator that the new wing was created to bring all the prisoners taking part in the Integrated Drug Treatment System (IDTS) together in one location. Previously, they were located in a number of pockets around the prison. The new arrangement allows the nurses to work more efficiently.

21. The majority of prisoners on the wing are prescribed either Subutex or methadone (both heroin substitutes). Approximately one fifth of the men are given Subutex.

Her Majesty's Inspectorate of Prisons

22. The former Chief Inspector of Prisons completed a full and unannounced inspection of Birmingham in December 2009. She found that:

‘... while some progress had been made, there was still a considerable amount to do to ensure a safe, decent and effective prison.’

23. With regard to self-harm and suicide prevention, she wrote:

‘There was a good senior management attention to safer custody, though some of the operational aspects of support for prisoners at risk of suicide needed strengthening.’

24. She commented on how Birmingham have responded to previous deaths in custody:

‘An up-to-date action plan consolidated recommendations from previous Prison and Probation Ombudsman investigations and there had been some investigations to learn from near-fatal incidents.’

Independent Monitoring Board

25. The most recent annual report published by the Independent Monitoring Board (IMB) at Birmingham covers the year from July 2007 to June 2008. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB praised the safer custody team's efforts.

Previous deaths at Birmingham

26. The Ombudsman assumed responsibility for investigating deaths in custody in 2004. Since that time, I have investigated 27 other deaths at Birmingham. Most recently, there have been seven deaths at the prison since December 2009. Of these, four (including the man) were self-inflicted, and three were the result of natural causes. A common theme to emerge from these investigations was the lack of a proper code system when officers needed to communicate with colleagues over the radio net in an emergency.
27. When I investigated the death of a prisoner in November 2008, I recommended that staffing levels in the mental health teams at Birmingham should be reviewed to ensure that mental health treatment could be properly delivered. I also asked the Governor to emphasise to all staff that any member of staff was able to call for an ambulance in the event of an

emergency. I return to both of these themes in the 'Issues' section of this report.

Performance

28. Prison quarterly ratings published by the Ministry of Justice on 24 March 2010 show that Birmingham scored 2 overall, indicating that its performance required development. The prison achieved the same score in the previous and subsequent quarters. The minimum score is 1 (serious concerns) and the maximum is 4 (exceptional performance). The rating takes into account 34 different aspects of the way the prison is currently operating.

Assessment, Care in Custody and Teamwork (ACCT)

29. Assessment, Care in Custody and Teamwork (ACCT) monitoring is started if a prisoner is thought to be at risk of harming himself. The prisoner is interviewed and a plan for his care is drawn up in response to his needs and concerns. The process is ongoing and the document remains open whilst the risk remains. An ACCT review should be held at least once a week. Any staff who have contact with a prisoner can make entries in the document. The frequency of observations by staff is set out on the front cover, for example, 'hourly'. Staff must check the prisoner at least this often, they should conduct their observations at random intervals and write down all the checks in the ongoing record. Some of the scheduled checks must be 'quality observations', meaning that the member of staff speaks to the prisoner at some length and has meaningful interaction with him in order to gauge his presentation and the risk he may present to himself.

KEY FINDINGS

30. The man received a 12 month Community Order at Magistrates' Court on 29 May 2009 for offences of common assault, criminal damage and breaching a conditional discharge. He was instructed to keep appointments with a probation officer for the next year. He committed a new offence of robbery on 21 June and was arrested on 30 June. He told the doctor in the police station that he was not dependent on drugs or alcohol and was not thinking of harming himself.
31. On 1 July, he was taken from the police station to Magistrates' Court. He was remanded into custody to await trial and taken to HMP Birmingham.
32. A member of staff carried out a 'Day One Interview' with him during the reception process. He said that he was not a drug user and only used alcohol 'occasionally'. He also said that he was not experiencing any withdrawal symptoms or misusing any substances and would not therefore benefit from a detoxification programme.
33. From the choices available on the form, he told the officer that he was 'not at all worried' about being in prison. He said that he had been expecting to be sent to prison and had served previous custodial sentences. He indicated that he had never tried to harm himself and was not currently considering doing so. He said that he had never been treated for either depression or any other mental health problems.
34. One of the officers completed a Cell Sharing Risk Assessment (CSRA). (This is a form used by the Prison Service to decide whether prisoners should be located together and to determine the risk they present to each other.) The officer assessed him as presenting a medium risk of harm to potential cellmates because he had assaulted another prisoner in the past. It was noted that he had concerns about sharing a cell and could get angry or frustrated quickly. The officer wrote that he 'claimed' to have Obsessive Compulsive Disorder (OCD). He said that he would assault anybody who made a mess of his cell. The officer recorded what he said about not misusing drugs or alcohol but noted that he was dependent on prescribed medication.
35. Mental Health Nurse A ticked the 'High risk' box on the CSRA and explained his assessment in the healthcare section of the form:

'Due to presentation and his statement to kill his cellmate if put in a shared cell.'
36. The locating officer placed him in a single cell on D wing and made the following comments on the CSRA:

'Claims he has an OCD disorder but that he has never seen a doctor about it. Advised he must report to our medical staff.'

'He must [original text] take responsibility and seek medical help. Reassess on induction unit.'

37. During the reception process, Nurse A completed his initial health screening. He said that he had been prescribed tramadol (a pain killer), gabapentin (another pain killer) and diazepam (a benzodiazepine commonly referred to as Valium used to treat anxiety) by staff at hospital. He also said that he was in receipt of mirtazapine (an antidepressant). He told the nurse that he was not having suicidal thoughts but did think about harming himself. He mentioned that he bought drugs such as diazepam on the street and said that he had 'mental health issues'. He told the nurse that he suffered from depression and OCD (which was diagnosed by his mother and ran in his family). He said that he had never been assessed by a psychiatrist or spent time in a mental health hospital.
38. He told the nurse that he needed to stay in a single cell because of his OCD. He said that he would kill any potential cellmate who left the cell in an untidy state. Because he was agitated, the nurse referred him for a mental health assessment. He also referred him to the doctor to discuss his medication. The nurse recommended that he stay in a single cell for the time being.
39. The next day, 2 July, he was assessed by a member of the Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) team. (There is a CARATS team in each prison working with substance misusers.) A CARATS worker interviewed him. Contrary to what he had said the previous day, he told her that he smoked heroin daily and crack cocaine weekly before arriving in prison. He indicated that he had misused drugs for 15 years but said that he did not misuse alcohol. The assessor noted that no further intervention would be given because he did not want to engage with the CARATS team. He signed a disclaimer refusing further help and she gave him harm minimisation advice (to reduce the risk associated with misusing drugs).
40. He also spoke to a prison chaplain the same day. During his 'Day Two Interview' with discipline staff, he said that he was unconcerned about being in prison, did not feel that he was at risk of harming himself and had no preference about where he was located in the prison. He moved to a cell on N wing four days later, on 6 July.
41. On 7 July, healthcare staff completed a 'Request for medical records' form and faxed it to his community surgery. They needed to know which drugs he was supposed to be prescribed. The next day, 8 July, a fax from the surgery confirmed that he was not being prescribed any medication. His prescriptions for tramadol and gabapentin were therefore cancelled by the prison doctor (although the medical record does not show that these prescriptions had been prepared).
42. He challenged the decision not to provide these drugs when he was assessed by Prison Doctor A on 13 July. He said that he had been regularly prescribed tramadol, gabapentin and diazepam for an injury to his arm (sustained when a

dog attacked him). He told the doctor that he had been operated on at hospital and continued to collect the medication from there. The doctor planned to contact the hospital to confirm this information, as the local doctor's surgery had no record of any prescriptions.

43. On 14 July, he underwent a mental health assessment with a community psychiatric nurse and the manager of the primary care mental health and In-Reach teams. He told her that he was not thinking about harming himself. He said that he had attempted to take his own life once in the past by taking an overdose. He told her that he was 'finding things extremely difficult' in prison. They talked about his OCD and his need to keep his cell clean. He said that he did not like other people going in his cell and he discussed how his OCD had affected his relationship with his family. He mentioned that he needed to complete all of the daily 'rituals' involved in tidying his cell in case he was escorted to court. He worried that, when he was away from his cell, other people would go in it.
44. He told her that his OCD had worsened ever since he was attacked by a dog. He described how the related anxiety kept him from sleeping. During the assessment, she noticed that he was sweating and seemed embarrassed. He said that he had suffered from depression, but did not find that mirtazapine had any effect. She booked a further mental health assessment for him on 5 August. She planned to speak to a psychiatrist about his medication. She obtained his consent to allow her to obtain information from his community healthcare provider. She wrote to his GP at the surgery two days later seeking information and advice about his current and previous treatment.
45. On 21 July, he attended the police station.
46. Five days later, an officer made an entry about him in his wing history sheet:

'He works well on the wing as a cleaner. He is polite to staff and gets on well with other prisoners.'
47. On 29 July, Prison Doctor B noted that the healthcare team had still not heard from the hospital about his prescriptions for tramadol, diazepam and gabapentin.
48. He refused to go to his next mental health assessment on 5 August. On the same day, an officer noted that he and three other prisoners were involved 'in the drug culture'. The information had come from another prisoner. A drug test was suggested but it does not seem that one took place because the information provided to staff was not sufficiently detailed.
49. On 23 August, his CSRA was reviewed by a senior officer and an officer. They noted that he suffered from OCD and found it difficult to share a cell. They recorded that the primary care mental health team were aware of his condition. The officers thought that the team might be able to teach him coping mechanisms which would allow him to share a cell. It is unclear from the form whether he was assessed as presenting a low or high risk to other

prisoners as both boxes are ticked. However, an officer wrote the following in his wing history sheet:

‘CSRA revisited. He is currently a cleaner and has raised no concerns to staff. Due to his mental health issues he is to remain on single cell status however his overall risk is to be reduced to low.’

50. Nearly a month later, on 2 September, he went to his next scheduled appointment with the primary care mental health team. He told a mental health nurse that he wanted to work on his OCD and alleviate the symptoms. She thought that he seemed settled.
51. On 4 September, he went to the Magistrates’ Court and his case was committed to the Crown Court. In the middle of September, an officer wrote in his wing history sheet:

‘Works well on wing helpful and polite to staff.’
52. He moved to a different cell on N wing on 23 September. His next assessment with the primary care mental health team was booked for 30 September, but he chose not to attend for a second time.
53. On 1 October, he attended an adjudication hearing. (Prisoners must go to a hearing in front of a governor if they are alleged to have seriously misbehaved or broken the prison’s rules.) He had tested positive for Subutex (a heroin substitute prescribed to drug misusers) and pleaded guilty to two counts of possessing illegal drugs in prison. Twenty one days were added to his prison sentence. He was referred to the CARATS team by an officer on the same day as a result of his failed drug test.
54. He was required to attend another adjudication hearing on 12 October. He had been found smoking drugs in another man’s cell. He pled guilty and received a caution on this occasion.
55. When he failed to attend a mental health assessment for a third time on 21 October, he was discharged from the primary care mental health team’s register and not offered any further appointments (as per the team’s local policy). The community psychiatric nurse explained to my investigator that he would have been given a letter explaining how to re-engage with mental health services if he wanted to do so.
56. He signed a disclaimer confirming that he did not wish to engage with the CARATS team on 28 October, stating that he was not misusing drugs. He told the CARATS assessor that he had taken Subutex by accident. He claimed that his cellmate had provided the drug and told him that the substance was pain relief for a headache.
57. On 30 October, he moved into a cell on C wing. Staff noted that he ‘remained high risk’ (as regards cell sharing). Four days later, an officer wrote in his wing history:

'States he needs to get off C wing due to threats from other prisoners. Declined a move to B wing wants a move to M wing.'

58. He moved into a cell on the fourth landing of M wing (then the healthy living wing) on 4 November. (Although staff moved him to a different wing, the threats he reported do not appear to have been formally investigated.) Because of his OCD, he remained in a single cell on M wing when it changed its function to the Integrated Drug Treatment System (IDTS) unit on 18 November 2009, even though he was not taking part in a detoxification programme.
59. On 20 November, he appeared at Crown Court. His supervising probation officer visited Birmingham and tried to interview him on 27 November, but wrote that he refused to meet him because he was working. He therefore based the assessment on his previous experience of him. The author recorded his drug and alcohol misuse and three suicide attempts in quick succession in 2008. He noted that, before his return to prison, he had said that he had not tried to harm himself since 2008, nor had he thought about doing so. The pre-sentence report did not identify a mental illness and the author did not recommend an alternative to a custodial sentence.
60. At the start of December, he moved into cell 15 on the first landing of M wing. On 23 December, he made another appearance at the Crown Court. His probation officer had prepared a report for the hearing, although he was not actually sentenced on this occasion.
61. He applied for enhanced status under the Incentives and Earned Privileges (IEP) Scheme on 28 January 2010. (The IEP scheme is intended to encourage and reward good behaviour. Additional entitlements, such as more visits, can be gained in return for good behaviour. However, the entitlements can be lost if behaviour deteriorates. Prisoners can be moved between a basic, standard and enhanced regime.) His application was supported by two officers who wrote that he was a 'polite and respectful' prisoner.
62. On 2 February, his CSRA was reviewed again. His risk both before and after the review was set as 'medium'. His OCD, difficulty in sharing a cell and need for mental health support were recorded.
63. As a result of his IEP application, he was placed on the enhanced regime on 7 February. It was noted that he had 'applied himself well and now deserves the opportunity'.
64. He was issued with a warning under the IEP scheme on 5 March for refusing to move off M wing (which is intended only for prisoners who are participating in the IDTS detoxification programme). Senior staff were keen to move him from the wing as he was not supposed to remain there. However, staff recalled that he refused to move because he did not want to leave his single cell, where he felt he could remain in control of his OCD.

65. On 16 March, he told Nurse B (a substance misuse nurse with mental health training) that he wanted to re-engage with the mental health team. He was anxious that staff had been trying to relocate him to another wing because he was not being prescribed any detoxification medication (a criterion for being on M wing). He had settled in his cell on M wing and thought that he would not be treated as sympathetically on another wing.

66. He told her that he did not think he could cope with a move to another wing because his OCD made it difficult to adapt to change. He said that he washed his legs so much that they bled. He told her that he had tried to harm himself in the past, but was not having these sorts of thoughts at present. She completed a referral to the mental health team and took it over to them on the same day. She also spoke to a SO about his OCD.

67. The referral form asks staff to assess seven aspects of a person's mental health and mark the level of concern as 'none', 'mild', 'moderate', 'severe' or 'very severe'. She marked three criteria as 'none' and three as 'mild'. She made the following comments at the bottom of the form:

'OCD, prisoner has been asked to move wings, [heightened] anxiety state, related to OCD. Feels unable to cope on other wing.'

68. She told the investigator that she thought her remarks at the bottom of the form would trigger a relatively rapid assessment, because a possible transfer to another wing was imminent and this was the source of his anxiety. On the day, she felt that the issue was a 'high concern' because of the imminence of the proposed move. However, the form does not require staff to indicate a timescale for assessment.

69. On 6 April, an officer made the following entry about him in his P-NOMIS contact log:

'He continues to be no problem to staff apart from his refusal to move – now working as a wing servery worker, working well. He has never been a detox prisoner – we inherited him on the last move.'

70. He received a warning about his behaviour three days later. Another officer wrote:

'When collecting kit from the CES stores he did take a forage cap [a type of peaked cap used in catering] without permission. This is not acceptable or in keeping with his position of responsibility as a wing worker. Rules explained.'

71. On 21 April, he received a warning under the IEP scheme when he refused to move to I wing. An officer wrote:

'IEP warning – refused to relocate to a different wing. He has informed me that he has an agreement between the M wing SOs and mental

health team that he should remain on M wing in a single cell due to his OCD and mental health issues.'

72. Officer A told my investigator that he was asked to issue the warning by SO A (who did not normally work on M wing). The SO was apparently unfamiliar with the man's OCD which was the reason he was still held on M wing and decided he should move to another wing. When he refused, the SO told the officer to issue the warning. The officer protested and told my investigator that he personally decided to withdraw the warning minutes after it was issued, after the SO had left the wing. He thought that the SO should have consulted previous entries made by M wing staff, which clearly indicated that he should not be relocated. The officer said that he never formally issued a warning to him. However, before he made an entry on the P-NOMIS system, he explained to him that he would, effectively, have to issue and then retract an IEP warning.
73. On 22 April, he complained of pain in his right forearm to Prison Doctor C. This was the result of an injury sustained a couple of years previously when he was attacked by a dog. The doctor prescribed 56 tablets of naproxen (an anti-inflammatory drug used to reduce pain) which he was to keep and take one twice daily. The doctor noted that he had not told staff about the pain since first mentioning it when he came into prison nine months earlier.
74. He failed a drugs test on 29 April when he gave a positive result for Subutex. No action was taken against him. On the same day, Nurse B was finishing her shift and asked her colleague, Nurse C, (another substance misuse nurse with mental health training who works on M wing) to check him and follow up the referral she had made to the primary care mental health team on 16 March.
75. They recalled in interview that they were prompted to pursue the planned assessment because the wing staff were again contemplating moving him to another wing and he was becoming anxious. She presumed that he had been assessed after her original referral, but realised on 29 April that he had not had any recent input from the mental health team.
76. He told Nurse C that he was depressed and wanted to be assessed by a psychiatrist. She assessed that he did not seem especially anxious and that his presentation was not 'out of the ordinary'. She confirmed on the computer that a mental health assessment was pending following Nurse B's original referral and also confirmed this by telephoning the primary care mental health team. She did not complete a new referral.
77. Officer B (his personal officer for about three months before he died) made the following entry in his P-NOMIS contact log on 1 May:
- 'He is acting a bit strange due to the fact that he could be moved to another wing. I am not sure how bad his OCD is. I have advised him to see a member of the mental health team, he said he would.'

78. The officer talked to him in his cell and told him that there was a chance he might be moved because staff needed the cell for a prisoner who was taking part in the IDTS detoxification programme. The officer advised him that he had not actually been formally diagnosed with OCD and that he needed to be assessed by the mental health team. Otherwise, the officer thought that he would probably have to move wings or face penalties under the IEP scheme.
79. He telephoned his mother on 2 May. This was the last time he made a telephone call from a prison PIN phone. A CARATS worker helped him complete a healthcare referral form on 4 May. On the same day, whilst receiving medication for his skin complaint, he mentioned to Nurse D that he had toothache.
80. Two days later, on 6 May, Prison doctor C assessed him again. The doctor told the investigator that he said that he was still experiencing pain in his forearm and that the naproxen the doctor had prescribed two weeks earlier was not helping. He prescribed a combination of two different pain killers (gabapentin and nefopam hydrochloride) to treat the pain that he was experiencing from his long standing arm injury (rather than the recently reported toothache).
81. On 17 May, Officer B made another entry in his P-NOMIS contact log:
- ‘Previous entries state that an agreement has been reached with him and wing so that he will not be moved due to his OCD, this is as far as I know not true. He has been told to seek medical guidance ref OCD. The main reason he hasn’t moved is the fact that he is a single cell. Continues to work well but isn’t indispensable as he seems to think.’
82. Two days later, he complained that the nefopam hydrochloride tablets he was taking for pain relief gave him indigestion. Nurse D prescribed Gaviscon tablets to settle his stomach.
83. He was sentenced at the Crown Court to five and a half years imprisonment on 21 May.
84. On 23 May, his CSRA was reviewed again by SO B. The risk he presented to other prisoners was assessed as high both before and after the review. He continued to live in a single occupancy cell. The SO recorded that he had threatened to kill any potential cellmate and noted his obsessive cleaning of his cell. He told the SO that he needed to have control over the layout of his cell. The SO recorded the following remarks in the ‘Cell sharing risk minimisation plan’:
- ‘Highly agitated about moving wings and thought of sharing cell. Cell is regimented and spotless. Genuine distress at prospect of sharing cell.’
85. A governor approved the plan. He told my investigator that he had wanted to move all prisoners who were not taking part in the IDTS detoxification programme off M wing. However, he said that the SO had persuaded him

that he had the potential to become very upset and unpredictable if he was moved. The governor thought in retrospect that the SO may have exaggerated the potential risk presented to other prisoners when he wrote the plan in order to strengthen his case for staying on M wing. He said that the distress the SO referred to was the upset he might experience if moved to a different wing. They believed that he would continue to cope with his OCD as long as he was allowed to stay in a single cell on M wing.

86. On 27 May, he passed a drug test. Officer B made the following entry in his P-NOMIS contact log on 29 May:

‘A good week for him. Working well on the servery but can become too involved. He gets upset if the others don’t work as hard as he does. Gets on OK with the other workers.’

87. He wrote a letter to his family on 1 June. (Only a small random sample of prisoners’ letters are checked and read by staff before they are posted.) He expressed relief that his recently imposed prison sentence was not as long as he thought it might have been. He expected to be released in March 2012. He commented that he had been assaulted the day before because he owed tobacco to another prisoner. He explained that he was currently having a more difficult time in prison than he had done previously. He had tried to appeal to his creditors, but that the debt would be doubled and he might be ‘beaten up’. He remarked that the debts were his own fault and that he would have to tolerate the situation.

88. The same day, he wrote another letter to his mother. He mentioned that his pre-sentence report had concluded that his behaviour was aggravated by alcohol misuse and that he might have a mild form of schizophrenia which was made worse by drinking. (Staffordshire and West Midlands Probation Trust provided my investigator with a copy of his pre-sentence report. His probation officer, the author, did not refer to a specific mental illness. He recorded that the man had not engaged with mental health services either inside prison or in the community. He noted that the man did not think that he needed mental health treatment.)

89. He wrote in his letter that he was ashamed to have to ask his family for help paying back debts he owed to other prisoners. (At the time he wrote the letters, staff were unaware that he was experiencing difficulties with his debts. The issue of bullying only arose after he died.) He explained to his mother that his debt had doubled because he had not returned the tobacco at the earliest opportunity. He stressed that his family should not tell the prison staff that he was being assaulted by other prisoners because he thought that doing so would only worsen his situation. He expressed the hope that he would be moved to another prison in the near future.

90. The next day, 2 June, he wrote to his mother again. He informed her that he had moved wings. (In fact, he had actually been on M wing for some months and, although staff talked about moving him, it never happened.) He explained that he could not give the tobacco he owed to a prisoner who was

now on another wing, that he had been 'beaten up' on his 'new wing' for this reason and that the debt he owed had doubled. He said that the first postal order his mother had sent was now insufficient to pay the debt and he asked her to send in another to another prisoner. Around this period, he also wrote to his sister asking for her help to pay off another debt, this time to another prisoner.

91. He was prescribed gabapentin again on 2 June and nefopam hydrochloride again on 7 June. On 8 June, Officer B made a further entry in his P-NOMIS contact log:

'A good week for him but again becomes too involved in the running of the wing cleaners offering unwanted advice. It may be down to his alleged OCD.'

92. On 9 June, he was supposed to go to a mental health assessment, but chose not to attend because he was working on the wing and did not feel that he could leave the job he was doing (this seems to have been an aspect of his OCD). He apologised to the nursing staff for failing to attend.
93. Nurse E (a registered Mental Health Nurse) carried out an Initial Mental Health Assessment of him on M Wing at 9.45am on Saturday 12 June. He went to speak to him because he knew that his assessment was due within a six week window following Nurse C's reminder to the mental health team in late April. (The nurse worked an extra shift on 12 June to help out because of staff shortages and took the opportunity to complete outstanding assessments.)
94. Before he carried out the assessment, he spoke to the senior officer on the wing, who explained the reasons the man remained on M wing and the measures staff had taken to address his OCD. He carried out the one-to-one assessment in his cell. It lasted about 45 minutes.
95. The nurse thought that his OCD was 'quite severe'. The man said that he had 'sleep issues', was losing weight and had episodes of reactive depression. He said that he could not relax and the nurse gained the impression that his life was ruled by OCD. He was having trouble sleeping because his mind 'refuses to switch off'. The nurse told my investigator that the man engaged throughout the interview and showed some flashes of humour.
96. He said that he had cut his wrists in 2008 after being attacked by a dog and showed the nurse the scars. The nurse asked him if he had any intention of harming himself, and he said that he was not planning to harm himself or having suicidal thoughts. The nurse wrote that he was not a risk to either himself or others and was not at risk from others. He rated his mood as 4/10. The nurse noted that he was living in a single cell because of his OCD.
97. The nurse told the investigator that the man's mood was stable, that he made eye contact and that he did not appear evasive. He talked with insight about his history of depression and OCD and his attitude was 'open and

forthcoming'. Of the five or six assessments the nurse carried out that day, he told the investigator that he was not one of the prisoners who caused him to worry unduly. During the interview, he did not refer to any pain (such as toothache) as something that was causing him particular concern.

98. Following his assessment, the nurse wrote in his clinical record that the following action would be taken:

'Plan 1) For [the Community Psychiatric Nurse] to discuss Cognitive Behavioural Therapy [CBT] on clinic appointment on 05/07/10.' (CBT is a form of talking therapy that encourages people to change the way they think in order to alter their behaviour.)

99. As well as booking him into the psychiatric nurse's clinic for CBT, the nurse planned to organise a doctor's appointment for him and discuss his case at the regular multi-disciplinary team meeting. He also wrote a letter to the man's local practice in the community to inform his doctor there that the healthcare team were planning to offer him CBT to address his OCD. The letter was placed in the out tray (although he said that it had not been posted before the man took his own life).

14 June

100. Prisoner A (one of the prisoners on M wing) told the investigator that the man did not go to work on 14 June. He said that he went to his cell and checked him. He remembered that he seemed drowsy and told him that he was sick and unhappy with how he was being treated.
101. At dinner time on 14 June, Prisoner B was standing behind him in the queue for food. He recalled afterwards that one of the men working on the servery told him that he did not look well, and he replied that he did not feel well. He staggered back and lost his balance. He steadied himself and he asked if he was 'OK'. He said that he would be 'in a minute'.
102. During the evening, Prisoner C said that he heard another prisoner shouting out to him that he owed money for tobacco. He did not remember him showing any signs of distress before lock up.
103. He was locked in his single cell as usual on the evening of 14 June. Prisoner D lived in the neighbouring cell. He told staff afterwards that they would talk through the walls at night. That evening, he recalled that he was 'laughing and joking' and gave no indication that he was thinking of harming himself.

15 June

104. Officer C was on duty on his own overnight on M Wing and completed roll checks of all the prisoners at about 8.30pm on 14 June and 6.00am on 15 June. He told the investigator that he remembered nothing out of the ordinary either overnight, when he checked the prisoners or when he handed over responsibility for the wing to the day staff. (During the roll check, staff switch

the cell light on if the light is not good enough and open the observation flap to account for the prisoner. Staff are not required to obtain a response.) The officer said that he had no other reason to check his cell (number 15 on the first landing of M wing) overnight as he was not subject to self harm monitoring.

105. A second roll check of M wing was carried out by two officers (the newly arrived day staff) between 7.05am and 7.10am. Both officers agreed the count and allowed Officer C to go home. Officer B told my investigator that he was responsible for checking the part of the wing where the man's cell was located. He said that he opened each hatch and looked in each cell to check that the prisoner was present. He did not specifically recall checking his cell, but he did not remember anything unusual or remarkable about the roll check and thought he had still been in bed. After the roll check, the other officer went to work in a different part of the prison.
106. Prisoner E, who lives in cell 16, thought he heard banging coming from the man's cell at about 7.15am. Prisoner F lives in neighbouring cell 14. Normally, the man would bang on his neighbour's wall at 7.30am to wake him up. On this morning, the prisoner said that he did not do so. The prisoner also apparently told others that he heard another prisoner stand outside the cell at about 7.00am and threaten him with reprisals if he did not pay a debt he owed.
107. Prisoner A found him hanging in his cell at about 7.55am. He said that the previous evening, the man had asked four or five of his friends, including himself, to collect him on their way to the gym. (This seemed strange to him because he did not normally use the gym.) In the morning, he was unlocked to collect his daily medication from the hatch. Once he had done this, he went as asked to his cell. The door was still locked so he looked inside through the observation hatch, saw him on the floor and immediately thought something was wrong. He banged on the door but he remained motionless.
108. He shouted to an officer, 'Officer, quick!' The officer was in charge of the wing cleaners and also temporarily in charge of the wing in the absence of a senior officer. He was standing at the far end of the wing by the door that leads to the exercise yard and was joined by another officer. They were discussing which prisoners were sick and which needed to be unlocked to go to the workshops.
109. Prisoner A attracted the attention of another prisoner who shouted, ran towards the officers and gestured with a motion indicating the use of a ligature. Officer D told the investigator that he ran directly to the cell as soon as he heard the prisoner and saw the other prisoner gesture. (Prisoner A told the investigator that the officer stared at him and did not immediately respond.) Officer E told the investigator that he reached the cell about 20 seconds after his colleague because the other officer is quite a bit younger. He remembered being alerted by Prisoner A waving his arms about and both he and the other officer went to the cell without delay. Another prisoner approached the cell.

110. Officer D looked through the observation hatch, unlocked the door, shot the bolt and went inside. The man had used torn bed sheets to fashion a ligature. He had made a hole in a waist-high privacy screen dividing the toilet from the rest of his cell and threaded the ligature through the hole. He had hanged himself facing away from the door and was partly obscured by the panel. He was found in a seated position with his legs flat out on the floor.
111. Both officers started shouting to attract the attention of their colleagues on the wing. The man was unconscious and there was blood around his mouth. Officer D used his anti-ligature knife to cut through the torn bed sheet around his neck.
112. During interview, both officers told my investigator that the former cut through the ligature whilst the latter supported his weight and helped lay him on the floor. Officer E told the investigator that he took a loose sheet from the bed to rest the man's head on. (Two prisoners both told my investigator that the officers were not supporting his weight at this stage and, as a result, he slumped heavily sideways onto the floor.)
113. Officer F was keeping watch on the second landing of M wing whilst two officers searched a prisoner's cell for illegally brewed alcohol, known as 'hooch'. He saw Officers D and E running to the cell. He ran down the back stairs and arrived at the cell door to witness Officer D cutting through the ligature. Officer F told the investigator that he saw Officer E support the man's weight with both hands and lower him to the floor, laying him on his back.
114. After he cut through the ligature, Officer D removed it and called for the emergency medical response nurse using his radio. (Officer E did not have a radio.) The control room incident log shows that the emergency response nurse was asked to go to M Wing at 7.56am.
115. Officer F witnessed his two colleagues discussing who would start CPR. He did not see Officer E start to give chest compressions because he then went to collect the wing manager from the office. He also went to find one of the substance misuse nurses who were dispensing medication on the landings. He thought that collecting one of the nurses already on the wing would be quicker than waiting for the emergency response nurse.
116. During the next minute or so, the prisoners my investigator spoke to claimed that the officers in the cell did not attempt to resuscitate him. Prisoner A said that the officers seemed shocked and stood staring at each other until a nurse arrived. He said that the officers shouted for a nurse and that he had implored them to 'do something.' He remembered Officer F telling him to calm down. However, he and Officer E both recalled Officer D checking the man to try to find a pulse.
117. The incident log shows that three officers started cardiopulmonary resuscitation (CPR). (Of the three, only Officer E told the investigator that he

performed CPR. He said that he had received first aid training once in his Prison Service career, about ten years previously.) He told the investigator that he started chest compressions as soon as he helped to lower the man to the floor. He remembered that he placed a towel on his chest to do so because he did not want to touch the blood on his T-shirt. He said that he did not give rescue breaths. He recalled in interview that he responded to resuscitation, producing a 'croaky sort of breathing'. Officer D told the investigator that Officer E gave chest compressions until a nurse arrived, whilst he communicated on the radio and shouted for help.

118. Officer E told the investigator that he continued to give chest compressions until he heard somebody say that a nurse had arrived. He said that he did not stop until he became aware of the wing manager and Nurse F in the doorway. He said that he was kneeling by the man when the nurse arrived and moved back from him as she approached.

119. However, the wing manager told my investigator that, when he reached the cell, none of the officers were either resuscitating him, moving away from where he lay or kneeling over him. He was quite clear that the nurse, who arrived just behind him, was the first person to try to resuscitate him, who was lying on his back on the floor with his feet towards the window. He told the investigator:

'... I recall thinking well nobody's here doing anything.'

120. The wing manager was 'absolutely clear' that the nurse did not take over from Officer E, because he would not have asked him to start a log of the emergency if he thought that he had just given CPR. He said that he considered starting CPR himself when he entered the cell, before he realised that the nurse was right behind him and was better qualified to do so.

121. The nurse was working by the hatch and about to dispense medication on the second landing. She told my investigator that a prisoner alerted her to the emergency. She said that she ran downstairs to find three or four officers gathered in the entrance to the cell, who told her that the man had hanged himself.

122. She was the first nurse to reach the cell, arriving at about the same moment as the wing manager. She told my investigator that, when she went into the cell, no discipline staff were inside. (Officer D told the investigator that he was standing at the back of the cell at this point.) She said that the man was lying flat on the floor with his head nearest the door and nobody was attending to him. She told the investigator that the ligature had been removed and that she did not take over CPR from anybody else.

123. During interview, Officer E found it hard to understand how they could not have seen him giving chest compressions when they arrived. He said that he stopped giving chest compressions and stepped away from the man when he saw the nurse coming into the cell. He explained that he wanted to get out of the way and let her get on with her job. He said that he did not give a direct,

uninterrupted handover to her. Both officers both remembered that Officer E did not speak to the nurse when he handed over to her.

124. Officer A told the investigator that he saw both officers going into the cell from the second landing. Having disposed of the bucket of the hooch he had found, he went downstairs and entered the cell. He told my investigator that he saw Officer E giving chest compressions to the man. However, Officer A said that the wing manager then arrived and told him to telephone the control room to request an ambulance. He went to the wing office and rang the control room to request that an ambulance be called. The control room incident log shows that an ambulance was called at 8.00am. When he returned to the cell, he said that the nurse was carrying out CPR.
125. Having entered the cell, the nurse knelt down and checked the man for signs of life. His face was blue and his skin still quite warm. She could not find a pulse. She told the investigator that she started CPR a minute or two before 8.00am. Officer D made further calls on his radio to ask for the emergency response nurse to come to M wing.
126. An officer went to the fourth landing and alerted Nurse G to the emergency. Officer F met her coming down the stairs and directed her to the cell. Within about a minute of Nurse F's arrival in the cell, Nurse G joined her and helped her to give CPR. Nurse G shouted at the officers to call for an ambulance. The wing manager used one of the officers' radios to summon the duty governor and remind the control room to call an ambulance.
127. Nurse H was working on the second landing of M wing when she noticed staff running around below her. She asked a prisoner what was happening and he told her that a prisoner had hanged himself. She went to collect the emergency medical bag from the fourth landing and met Nurse G (who had left Nurse F giving CPR in the cell in order to collect the bag) on the stairwell. She took the emergency bag from Nurse H and they both went back to the cell.
128. The wing manager asked Officer F and some of his colleagues to lock prisoners who had gathered on the landing back in their own cells. The officer made sure to place Prisoner A with several other prisoners in a holding room because he knew that he had found the man and did not want him to be alone. The wing manager directed staff to check any prisoners subject to self harm monitoring.
129. After the call had gone out over the radio net, the duty governor, Governor (in charge of the prison) and Principal Officer (PO) (the leader of the staff care team) went to M wing and took charge of the emergency. Both Governors were together in the reception area at the time the call came through and met the PO on their way to M wing. As an experienced care team representative, the Governor asked the PO to accompany them.
130. The wing manager (in charge of the response to the emergency until the three men arrived) told my investigator that both Governors took over running the

emergency without seeking a briefing from him. He said that they did not speak to him.

131. The Governor confirmed during interview that he arrived with the duty governor and PO and did not ask the wing manager for a briefing. He said that he spoke to one of the officers who had found the man and saw the nurses trying to resuscitate him. At the nurses' request, the Governor took an anti-ligature knife from one of his officers and cut through his top to allow them access to his chest.
132. The three nurses continued CPR. Nurse I (the designated emergency response nurse) reached the cell at about 8.05am. She and Nurse F continued to give chest compressions whilst the other two nurses gave rescue breaths.
133. Nurse I attached a defibrillator to the man several times during the next few minutes. (A defibrillator is a small portable machine that searches for an irregular heart rhythm. If one is found, the defibrillator can deliver an electric shock to reset the rhythm.) However, on each occasion, the machine instructed the nurses that he should not be shocked because a heart rhythm could not be found. Instead, the nurses continued to give CPR. Nurse H remembered that he was still warm but that he did not respond to their efforts to resuscitate him. She thought that he had died at this point.
134. The PO asked another officer to take over recording the emergency log from Officer E. He wanted to remove both Officer D and E from the wing because they were in a state of shock following the incident.
135. The control room incident log shows that a first response car carrying emergency medical staff arrived at the prison gate at 8.07am. An ambulance followed, arriving five minutes later. Control room staff checked for a doctor in the prison, but none had yet reported for duty. Paramedics from the response car reached the wing at 8.15am. Two further members of the prison healthcare team also arrived on the wing at around this time.
136. At the paramedics' request, the Governor helped them to move him out of his cell onto the landing (where there was more space to treat him). The nurses moved alongside, carrying the defibrillator and the oxygen.
137. Nurse I and Nurse F continued to help the paramedics to give CPR. The paramedics inserted a plastic tube into his windpipe to keep his airway open. He was given oxygen using a bag and mask and he was attached to a cardiac monitor. At 8.22am, he was given adrenaline (a drug commonly given to patients when no heart rhythm is found). However, he did not respond and an electrocardiogram (ECG) monitor confirmed that his heart was not working.
138. The ambulance carrying him left the prison at 8.31am. The response car left six minutes later. He was taken to hospital. A Person Escort Record (PER) was not completed for the journey because the Governor wanted the staff to move him into the ambulance and out to hospital as quickly as possible. He

was not handcuffed to an officer at hospital because he was so unwell. He was revived but attached to a ventilator. A scan of his brain later that morning showed no sign of activity.

139. PO B and the duty governor left the prison immediately to visit the man's family and tell them what had happened. They took his parents and sister to the hospital.
140. A note that he had written to his family was found in his cell, placed in an evidence bag and kept by the Governor. In the note, dated 14 June, he wrote that he felt 'calm and at peace'. He expressed regret about his behaviour towards his family and apologised to them. He stressed that he had made a decision and wanted to take his own life.
141. A hot debrief meeting was held in the prison at 9.05am, chaired by the Governor. (A hot debrief takes place straight after an emergency. It allows staff to discuss the effect the incident has had on them and to identify any immediate lessons which need to be learnt.) Members of the care team came to the meeting to offer support to their colleagues. PO A was asked to organise a critical incident debrief (a more thorough and considered review of the emergency) within the next few weeks.
142. The man was treated in the hospital's Intensive Care Unit. A bedwatch log was begun by staff on the evening of 15 June. Early on 16 June, the SO told the escorting officers that the family could stay at his bedside for however long they wanted to without restrictions. At midday, PO B decided that the officers should move away from his bedside for the sake of privacy and out of respect for his family. A little later, the family were told by hospital staff that he would not recover. The hospital staff and the family discussed organ donation. In the early evening, the prison chaplain visited.
143. At the suggestion of their manager, Nurse F, Nurse B and a Healthcare Assistant visited the hospital and spoke to the family at about 3.00pm on 17 June. Family members told Nurse B that he had written them letters asking for money to be sent in to repay his debts to other prisoners. When she returned to Birmingham, she completed a Security Incident Report.
144. His condition did not improve and his family decided not to proceed with organ donation. Following a number of tests, the family agreed that the hospital staff should switch off his life support machine at 5.30pm. He died in the hospital with his family at his bedside 20 minutes later.
145. Following his death, the Head of Security and Operations was asked to complete a report about possible bullying on M Wing amongst the prisoners. Her enquiries focussed on the rumours that he had owed money to different prisoners and not on allegations of bullying by officers. The prison conducted a separate enquiry into the behaviour of Officer D after several prisoners made allegations against him following the death.

146. The funeral took place on 29 June. (Birmingham arranged to pay the costs, as per Prison Service policy.) A governor, PO B (the designated Family Liaison Officer) and the wing manager went to the funeral on behalf of their colleagues.
147. His property was subsequently returned to his family. A critical incident debrief was held at the prison on Friday 16 July. Nine members of staff attended.

ISSUES

148. All the staff and prisoners my investigator spoke to said that the man was a well behaved prisoner who worked hard and caused no trouble. He had been living on M wing when its function swapped with L wing and it became the IDTS unit. Although he was located on the detoxification wing, he was not receiving medication or taking part in the IDTS programme and was supposed to relocate elsewhere. Initially there was no room on L wing for him, so he stayed on M wing, even though he was not an IDTS prisoner. Staff then became largely reluctant to move him because of his OCD and the upset a transfer might cause. He became very settled and resisted several attempts by managers to move him.
149. Records confirm that he did not try to harm himself and was never subject to self harm monitoring. Although he had harmed himself in the past, all of the staff my investigator spoke to confirmed that he did not talk about having active suicidal thoughts during the 12 months he was at Birmingham. Without exception, staff said that his death came as a shock and seemed entirely unexpected. Nurse H commented that he had never shown any signs of depression or of there being anything wrong. Nurse B said that he was a 'placid' person who, she thought, did not disclose his feelings unless prompted. Aside from an alleged incident which I address below, the four prisoners my investigator spoke to on M wing also agreed that he was not somebody who ever indicated that he would harm himself.
150. Although he had OCD, he was not considered to have severe or enduring mental health problems. I explore below the reasons why his OCD had not been addressed by the time he died. I have been careful not to draw conclusions about any connection between his OCD and his decision to take his own life.
151. After he died, staff found a four page note in his cell addressed to members of his family. Unusually, he apparently asked Prisoner A and some other prisoners to collect him on the morning of 15 June. This was why the prisoner went to his cell and found him. Both prisoners and staff have speculated that he may have wanted to be found in the act of taking his own life and that his actions were a 'cry for help'. However, he left what is a very detailed and eloquent note with a decisive tone, which suggests that he carefully considered taking his own life and made a deliberate choice to do so. He did not write that he was being bullied by prisoners or staff, and did not allude to debts as being a reason for taking his own life. Nonetheless, I address the issue of bullying.
152. He was held on remand for nearly a year. Arriving in prison in July 2009, he was not sentenced until May 2010. However, despite the long wait for an outcome to his case, he indicated that he was initially relieved by the sentence of five and a half years imprisonment that he eventually received. Prisoner A remembered that he had been expecting a far longer sentence of ten years or more.

Mental health

153. He gave conflicting accounts of his history of mental health problems, self harm and substance misuse to different members of healthcare and discipline staff. Sometimes he would say that he did not have problems with drugs and alcohol, other times he would confirm that he did. He said that he suffered from OCD and healthcare and discipline staff agreed with this diagnosis. His mental health problems were not formally diagnosed or addressed until just before he died.

Community clinical records

154. The family asked if the prison healthcare team requested records from his community doctor when he arrived at Birmingham. I can confirm that they sent a fax to the surgery a few days after he entered the prison and received a reply the next day confirming that he was not in receipt of any medication.

The man's failure to go to healthcare appointments in autumn 2009

155. He failed to attend three appointments in the autumn of 2009 with the primary care mental health team and, in line with local policy, was discharged from their care. He effectively chose to disengage from the primary care mental health team. He also twice refused to work with the CARATS teams in 2009 and signed disclaimers refusing treatment for his drug and alcohol misuse. He did not accurately disclose his substance misuse and mental health problems to all involved.

Delayed mental health referral March – June 2010

156. Aside from the cell sharing risk reviews, he tried independently to re-engage with mental health services. He spoke to Nurse B on 16 March and she referred him to the primary care mental health team. She felt the referral was a priority at the time. She wanted the mental health team to assess him within the next day or two because a possible move to another wing was imminent. However, she only assessed his symptoms as being 'mild' on the referral form. She agreed in interview that the mental health team, being very short staffed, may therefore not have treated the referral as a priority.

157. The community psychiatric nurse confirmed that a patient would only be assessed the next day if one of the criteria on the referral form was marked as 'severe'. If two or more of the criteria are marked 'moderate' on the form, the patient would be assessed within a week. All other referrals are treated as routine and may be assessed up to six weeks later (at the current staffing levels) or ideally within two weeks if staff were in post. However, she added that all referrals are checked by the duty nurse and compared against the prisoner's clinical record. If the record raises additional concerns, the urgency of the referral may be raised.

158. No assessment took place in the next six weeks and, on 29 April, Nurse B asked Nurse C to speak to him again. She pursued Nurse B's original

concerns and telephoned the mental health team to check on the progress of the referral. However, an assessment by the primary care mental health team was not scheduled until 9 June (nearly three months after Nurse B first referred him).

159. Officer B told the investigator that, around this time, he rang the primary care mental health team and asked somebody to assess him. He thought that the mental health nurse had come to the wing the next day to check him. However, there is no record of such an assessment in the clinical record. The officer also advised him that he required a formal diagnosis of OCD if he wanted staff to properly recognise his condition. He suggested that he should submit an application to be examined by the mental health team.
160. The community psychiatric nurse told my investigator that severe staff shortages have left Birmingham's mental health provision seriously under-resourced. The primary care mental health team (made up of five nurses) are also having to cover all of the work of the In-Reach team (who deal with severe and enduring mental health problems), because none of its four team members are in post. She explained that, as a result, routine referrals to the primary care mental health team were resulting in an assessment more than six weeks later. She agreed that the gap between 16 March and 9 June was therefore not exceptional in the circumstances. She said that the delay was a consequence of staffing problems and expressed her disappointment that he was not offered an assessment more quickly.
161. An assessment was eventually arranged on 9 June, but he failed to go to the appointment. (He did not want to abandon the work he was doing at the time, something which may have been a result of his OCD.) Nurse E visited him on 12 June. He completed an initial mental health assessment and scheduled a follow-up appointment at the start of July. He planned for a colleague to begin cognitive behavioural therapy with him to address his OCD. In response to questions, he said that he was not thinking of harming himself and therefore there was no reason for the nurse to open the ACCT procedures.
162. When my investigator spoke to the family, they discussed the fact that the treatment he was due to receive related to his OCD, and not to depression or suicidal thoughts. (However, his family thought that the OCD might have been associated with depression. They considered that he might have benefited from CBT as both a diversion and an opportunity to talk to someone generally about being in prison.)
163. He repeatedly cited his OCD and fear of change as reasons for staying on M wing. His cell sharing risk was recorded and concerns noted. It is unfortunate that, despite the helpful attitude of staff, no diagnosis was reached and no constructive intervention (such as CBT or even the provision of some reading material) was offered after a year in custody. However, CBT was about to begin. The lack of progress is accounted for by his own disengagement in late 2009 and a subsequent three month wait for a mental health assessment in 2010.

164. I previously made a recommendation following the death of a prisoner in November 2008 about the urgent need to review staffing levels within the mental health teams at Birmingham. I am disappointed that the difficulties I observed on that occasion are still apparent. I am sympathetic to the various problems facing those responsible for managing the teams, such as sickness and unexpected resignations. Nonetheless, it is a concern that a large and busy prison like Birmingham has been unable to offer the mental health treatment that prisoners require.

165. I endorse the clinical reviewer's recommendation:

The Head of Healthcare should carry out an urgent review of the staffing levels of the Primary Care Mental Health Team and In Reach Team so the timeframe for an initial assessment is acceptable.

Dental treatment and pain relief

166. The family asked about the toothache he reported in May 2010. They think that the pain might have caused him considerable discomfort and are concerned that, if he were feeling depressed, this pain would only have added to his low mood. The clinical reviewer agrees in his clinical review that, if the man was in considerable pain, then this might well have contributed to any feelings of despair. I have explored the general issue of pain relief.

167. When he arrived at Birmingham, he told the nurse that he was being prescribed tramadol, diazepam and gabapentin directly from the hospital because of a historical injury to his arm. The nursing team checked with his community doctor a few days later, who indicated that the surgery was not issuing these medications to him. Prison healthcare staff therefore ceased prescriptions for tramadol and gabapentin. (Aside from the references made to these drugs during the first night assessment, it is unclear whether the tramadol and gabapentin were actually ever dispensed during these first few days.)

168. He subsequently insisted that he was being prescribed medication for the pain in his arm by staff at hospital. The healthcare team planned to contact the hospital and, at the end of July, noted that they had still not received a response. There is no subsequent indication in the clinical record as to whether the hospital got in touch about his pain relief. No pain relief medication was dispensed during this period. There is also no record of him complaining about being in any pain until April 2010.

169. When he complained of pain because of the long standing injury to his arm in April 2010, Prison Doctor C prescribed naproxen. (The clinical reviewer notes in his clinical review that this drug is similar to aspirin and would not have affected the likelihood of depression or mental health problems.) In early May, he told the doctor that the pain relief was not working, so the doctor prescribed different pain killers (gabapentin and nefopam hydrochloride) for the pain in his arm.

170. The clinical reviewer writes that, in studies, a small number of people (about one in 500) who took gabapentin developed suicidal thoughts. He comments:

‘In an ideal world the doctor should review the patient within 14 days [this did not happen in the man’s case] but in my experience [doctors] consider gabapentin so safe that this is rarely done. There is a patient safety warning issued with the drug, but I am not sure these written warnings are issued in HMP Birmingham.’

171. He adds:

‘On balance I think the timing of [the man] asking for help for [his] mental health condition and referral to the mental health team [in March 2010] does not suggest an association between medication issued [ie. gabapentin in April] and [any] exacerbation of symptoms.’

172. In early June, he was given repeat prescriptions of nefopam hydrochloride and gabapentin. Whilst Prison Doctor C has confirmed to my investigator that this pain relief medication was provided to address the arm injury, he also complained of toothache in May 2010. There is no clear reference in the clinical record regarding any action to address the toothache, or explain whether the drugs already dispensed would have relieved the toothache. He did not undergo any dental treatment before he died. There is no record of him reporting the toothache again in the period immediately before his death.

Remaining on M wing

173. Discipline staff were concerned about his OCD and the likelihood that he might become distressed if he shared with another prisoner or moved to another wing. They chose to keep him in a single cell for the entire year, for much of the time on a wing where he was not supposed to be. My investigator found that the staff were sympathetic and thought that his OCD was genuine. They cited examples of him having to clean and tidy the cell if an officer stepped inside. Nurse E (a mental health nurse) said that his OCD was ‘one of the clearest [cases] I’ve seen [at Birmingham]’.

174. I am satisfied that staff made a creditable and pragmatic decision based on common sense to prioritise his welfare and accommodate his needs. He became anxious if it was suggested that he move to another wing. Some senior staff who did not work on the wing or were not familiar with his problems tried to facilitate a move.

175. SO B and Officer D both spoke to a governor, who was minded to move any prisoners off M wing who were not taking part in the IDTS programme. They persuaded him that the man would become distressed if he was moved and the governor agreed that he should stay.

176. Officer A also argued that he should stay on M wing when SO A, inadvertently unaware of the issues, insisted that he should be given an IEP warning

because he refused to relocate. The officer retracted the warning because he did not feel it fair after staff had previously accepted his explanation.

177. Another SO tried sympathetically to organise a possible move, offering him the chance to clean a new cell on a different wing and prepare it in advance of a move. Officer B remembered that staff had even found him a job as a cleaner on the proposed new wing.
178. I commend M wing staff for acknowledging the potential risk, and keeping him in the single cell he asked for. They took him seriously and carried out regular cell sharing risk reviews. I gather that, when he died the issue of a move to another wing was not under consideration.
179. Officer B told the investigator that, by June 2010, staff had accepted that he would remain on M wing. Nurse E, who completed a 45 minute mental health assessment on 12 June, agreed that there was no pressure on him to move cells at that time. I do not believe that the prospect of moving cells was worrying him when he harmed himself.
180. I note that the concerns expressed about his mental health during cell sharing risk reviews did not seem to result in a referral to the primary care mental health team. He attended a cell sharing risk review on 23 August 2009. He then went to a mental health assessment on 2 September, but it appears that this was scheduled in any case and was not an outcome of the review.
181. He went to other cell share risk reviews on 2 February 2010 and 23 May. At the latter meeting, SO B noted his 'genuine distress' at the prospect of moving. Although a referral was not made for a mental health assessment, the governor (who approved SO B's assessment) explained to the investigator that staff were worried about his *potential* distress if he moved. They thought that he was coping and would continue to cope if he stayed where he was. In other words, staff managed the risk by allowing him to stay on M wing.
182. The governor also thought that M wing staff may have exaggerated the risk he presented to others in order to prevent a cell share and keep him in a single cell. There is no record of him ever making threats against anybody or harming another prisoner. However, given that a single cell was available, the governor agreed that it seemed prudent not to upset him by making him share.
183. When he approved the CSRA review in May 2010, the governor presumed that the mental health team were already treating him, because his issues were well known to wing staff and several cell sharing risk reviews had previously taken place.
184. The manager of the primary care mental health team told my investigator that she might have expected her team to be involved in the cell sharing risk reviews or to have been consulted as a result of his comments. She confirmed that her team sometimes attend reviews. Nurse E said that

members of the mental health team were not normally invited to cell sharing risk reviews unless the prisoner was actively threatening to harm his cellmate.

Subutex misuse and allegations of bullying by other prisoners

185. After the man died, prisoners and staff alike mentioned in interview that his misuse of Subutex had caused him difficulties. He tested positive for the heroin substitute twice, in October 2009 and April 2010. Toxicology tests carried out on his body after he died found traces of buprenorphine (another name for Subutex) in his blood and urine. The prisoners said that he paid the men who supplied him with Subutex by giving them his tobacco and also borrowing tobacco from other prisoners. He asked his family to repay his debts by sending in postal orders.
186. He wrote in his letters to the family that he was afraid of being assaulted if he did not repay his debts. There is no evidence in the clinical record that he was assaulted and he did not allude to his debts in the note he left in his cell. He did not tell any staff that he was worried about debts. Officer B (his personal officer) spoke to him regularly in the weeks before he died and told the investigator that he never expressed any such worries to him. If he had been anxious about repercussions from debts, he had several opportunities to move off the IDTS unit.
187. An officer expressed concern to my investigator that the man was not moved off M wing. (Most staff thought that keeping him on M wing was in his best interests but Officer B felt that staff could have acted more quickly to move him to a different wing.) He was worried that he had easier access to Subutex on the IDTS wing. Although staff took a common sense approach, keeping him on the wing to reduce his anxiety and provide him with continuity of care, it can be argued that the decision may have had a counter productive effect.
188. How much Subutex he was able to obtain is unclear. Although he tested positive twice, the Governor confirmed that he would have been drug tested at least once a month. Prisoner A thought that he may have used Subutex on 14 June, as he had felt unwell, seemed very quiet and had gone to lie down in his bed.
189. As a result of taking Subutex, he apparently built up a number of outstanding debts to other prisoners. A prisoner said that he had been using Subutex regularly, was in debt as a result and was paying 'silly' rates of interest to other prisoners. He thought he was a 'soft' target for the other prisoners and was easily bullied.
190. Several prisoners spoke to my investigator about his debts. Prisoner A said that other prisoners paid some of his debts for him. He thought that he did not have particularly serious debt problems but may have had 'many small debts'. He was not aware of him receiving any threats of violence as a result of the debts.

191. Prisoner C thought that he owed money to four or five different prisoners. He said that he had been 'borrowing from Peter to pay Paul' and that the situation had 'got out of hand'. He said that he had paid off some of his debts to keep him out of trouble, but he still had some outstanding debts when he died.
192. He said that another prisoner took his stereo as payment for a debt. He told the investigator that he gave his weekly canteen purchases (sweets, tobacco and such like) to other prisoners in order to pay off his debts, meaning that he never had any of his own. He also said that another prisoner 'slapped' him at one stage because he had not repaid the tobacco he had borrowed.
193. Another prisoner told the investigator that he helped him by paying some of his debts. He commented that he had been in debt from 'day one'. He said that the man's family had then sent him money to repay him. Although debts were an issue for him, he did not think they were uncontrollable or a sufficient reason for him to take his own life.
194. Subsequently, the prisoner wrote to my investigator to say that the man was in debt to two particular prisoners, and that one of them, Prisoner G, had forced him to hand over his stereo and trainers to cover part of the debt. He also wrote that this prisoner was unlocked early from his cell on the morning of 15 June and approached the man's cell at about 7.00am. He was told that Prisoner F (in the neighbouring cell to the man) overheard Prisoner G threatening him with violence if he did not repay his debts.
195. Another of my investigators spoke to Prisoner G who commented that he knew the man was using Subutex. He said that he was not in debt to him. He knew that he owed tobacco to other prisoners. He mentioned that the man had wished him good night on the evening before he took his own life. He denied speaking to him the next morning when Officer D unlocked him to take him to court.
196. The man wrote to his family asking for financial help, naming the prisoners who he wanted them to send money on his behalf. I am satisfied that the prison became aware of this when three of the healthcare staff visited the hospital on 17 June and spoke to the family, who mentioned their concerns. I gather that the police have interviewed prisoners about money which his relatives sent to them.
197. It is impossible to know to what degree his debts affected his state of mind, or whether they were sufficiently out of control to prompt him to take his own life. It is important to remember that his situation was not extraordinary, and that regrettably many prisoners owe money to others for the supply of illegal drugs. There are conflicting accounts about his attitude to his debts. He gave Nurse E the impression that he 'was well on top of things on M wing'.
198. Following his death and an increase in positive drug test results on M wing, the prison's intelligence unit carried out their own investigation of the possibility of increased bullying on the IDTS unit. Their investigation considered the relevance of illicit drug taking on the wing. The Governor

provided my investigator with a copy of the internal security report which was redacted to omit any confidential and sensitive information.

199. The investigation found that:

‘... a small number of prisoners who are prescribed Subutex on the wing were concealing tablets to trade on to other prisoners for profit or to facilitate them buying other illicit drugs.’

200. The intelligence unit established that none of the staff at Birmingham were aware of the man’s Subutex-related debts before he died. Their report identified an increase in the number of assaults on M wing in May 2010 (there were three that month). However, the number was comparable with other wings in the prison. There was a slight increase in the number of illegal drug finds by staff on M wing in May (doubling from one to two). Three anti-bullying documents were opened on the unit in May (one more than the previous month). Overall, the investigation gave the following finding:

‘Having interrogated the intelligence and evidence regarding bullying, illicit drug taking and the man, we conclude that there was no significant increase in the level of bullying on M wing in comparison to other wings and that the issues which exist in relation to it are around taxing and trading for Subutex.’

The conduct of Officer D

201. My investigator spoke to four prisoners on M wing when he initially visited Birmingham to open the investigation. The men made a number of allegations about Officer D’s behaviour. As the officer in charge of the cleaners on the wing, the officer had frequent cause to interact with the man. When my investigator returned to Birmingham, he interviewed the officer and had the opportunity to discuss each of the prisoners’ claims in turn.

202. Prisoner C said that the officer antagonised the man. He told my investigator that the man had come to his cell about five days before he took his own life. He said that the man was crying and upset, claiming that the officer was bullying him. Prisoner A told the investigator that the man complained to him repeatedly that the officer was bullying him. The prisoners mentioned that the officer threatened to move him off the wing and also moved his property around his cell in order to upset him (because his OCD meant that he did not like others to touch his belongings).

203. During interview, the officer told the investigator that he had enjoyed a ‘really good’ relationship with the man. He said that he had empathised with him, because he had also suffered from very bad OCD when he was younger. He remembered how they swapped stories about their experiences of OCD, saying that he took his condition seriously. He is in charge of the cleaners on M wing and employed him as both a servery worker and cleaner. He said that he was his hardest worker who he could trust to do a good job.

204. The officer tried to persuade senior staff that he should not be moved to a different wing, because he knew that it would upset him. A governor confirmed that the officer had gone out of his way to support the man's case for staying on M wing, where he said he felt safer. The officer said that he asked a nurse to assess him and spoke to a senior member of the healthcare team and a SO about his condition.
205. The officer said that the only time he had had cause to interfere with his cell was when, a couple of weeks before he died, he asked him to remove pornographic posters from his wall which were against prison policy.
206. When the investigator visited Birmingham, some of the prisoners told him that an incident took place in the servery which had upset the man. They claimed that he told them that the officer had shouted at him and demoted him in front of other prisoners in the days before he took his own life. Prisoner A said that he felt that the officer kept 'picking on him' and another prisoner remembered that he was upset by the incident. Another prisoner said he had been in tears. Prisoner G recalled him crying the night before he died because the officer disciplined him.
207. The officer told the investigator that he recalled an incident a week or two before the man died. He said that he needed to rebuke a number of prisoners who worked on the servery for taking too much bread back to their cells. He remembered that he protested, but that several of the other prisoners were also unhappy. He did not recall him being especially upset. He said that he issued the warning to all the prisoners and he was not singled out. He described himself as a 'firm' officer who treats prisoners on the wing fairly. The officer said that this was the only time he had cause to discipline him, who had otherwise been a good worker.
208. Prisoner C said that he became concerned about the man possibly harming himself a few days before he died. He claimed that he asked Officer D to check his in his cell in the evening after lock up. He recalled telling the officer that he was upset and had indicated that he might try to harm himself. He told the investigator that he asked the officer to check on him because he was the only officer present.
209. During interview, the prisoner said that he went to see him in his cell the next morning, whereupon he thanked him for sending the officer to intervene. The prisoner told the investigator that he said that the officer found him writing a suicide note to his family. He said that the man told him that the officer 'stopped him going through with it' and that he was 'really going to do it'.
210. When he spoke to my investigator, the prisoner expressed concern that he might have hidden a ligature he was making from the officer during the visit to his cell. He questioned why, if the officer saw him writing the note, he did not confiscate it and consider starting ACCT monitoring. Another prisoner said that the man told him that he and the officer had agreed that he would not begin ACCT monitoring or, as the prisoner put it, 'put him on an orange card'.

The prisoners alleged that the officer told him 'not to be stupid' and to 'man up' and threatened to sack him from his job if he did anything like it again.

211. Prisoner C said that the man looked vacant over the next few days and told him that he 'couldn't handle it anymore'. However, he remembered that he seemed less upset and did not talk about harming himself. On 14 June, Prisoner A told the investigator that the man said that he was 'sick of being spoken to like an idiot'.
212. When my investigator told the officer what the prisoners alleged, he replied that he did not recognise the events they described at all. He said that he had no knowledge of the man ever thinking about harming himself. The wing observation book shows no record of either the incident in the servery or the officer's alleged discovery of him in the process of writing a suicide note some days before his death. (There is no reference to him in the book from 7 June until he took his own life on 15 June.) An ACCT document was not opened. The wing manager expressed confidence that wing staff would begin ACCT monitoring if it was required.
213. Prisoner A wrote to my investigator about Officer D. He commented:
- 'He is at times harsh, loud and unpredictable ... [I have] only heard in rumour that the officer 'bullied' the man, which I think may be misinterpreted. I fully accept and believe he may have shouted at him, but [I do] not believe that the man killed himself over issues with staff. In no uncertain terms.'
214. My investigator interviewed a number of officers who work on M wing. They said that the relationships between staff and prisoners are good. Officer A said:
- '[The man] got on with all staff; all staff got on with him.'
215. If one accepts that he felt particularly persecuted by the officer, then he had several opportunities to move off M wing in the months before he died (his OCD notwithstanding). Various senior members of staff were keen to move him because he did not meet the criteria for the IDTS wing.
216. Officer D addressed all of the prisoners' allegations during his interview with my investigator. Whilst it is undoubtedly frustrating for the family, I am unable to do much more than outline the prisoners' concerns and the officer's responses.
217. The Governor told my investigator that his senior staff have carried out their own investigation into the officer's conduct. It found no evidence of wrong doing. The officer has returned to work and is working on a different wing.
218. None of the staff my investigator interviewed were aware of difficulties between the man and wing officers, either in the long term or shortly before he died. There are no records of any incidents of this kind in the wing

observation book or other documents. In the circumstances, I can draw no conclusions and do not make a recommendation.

Response to the emergency

219. As I have already discussed, several prisoners made a number of allegations about Officer D. Amongst these, two prisoners alleged that he was slow to respond when Prisoner A raised the alarm. Officer D told my investigator that he was at the other end of M wing, but that he responded and ran to the cell as soon as he heard the prisoner shouting and saw the other gesturing. Officer E confirmed that Officer D ran quickly to the cell. He remarked that he was considerably older and arrived ten or 20 seconds after his colleague.
220. Both prisoners also claimed that Officers D and E allowed the man to fall unassisted to the floor after Officer D cut through the ligature. The prisoners alleged that the two officers left him where he fell rather than moving him into a comfortable position or beginning CPR. I am satisfied, from the accounts of other officers that this was not the case. Their evidence suggests that Officer E supported his weight and lowered him to the floor, ready for CPR.
221. When my investigator read the statements completed by staff, contradictions emerged regarding the attempt to resuscitate him. Unfortunately, interviews with the staff failed to reconcile the different accounts.
222. Officers D and E both told the investigator that Officer E was the first to try to resuscitate him after they lowered him to the floor. Officer E said that he gave chest compressions (but not rescue breaths) until he heard somebody say that a nurse had arrived and he became aware of the nurse in the doorway. He told the investigator that he moved away from him and did not speak to the nurse. He recalled that the handover was not seamless and that the resuscitation attempt was briefly interrupted.
223. Officer D said that he saw the officer give chest compressions (but not breaths) and also witnessed the handover between his colleague and the nurse because he was still in the cell at the time.
224. Officer F told the investigator that he saw the two officers lower him to the floor, but did not see Officer E begin chest compressions because he left the cell to collect other staff. Officer A told my investigator that he saw Officer E start compressions before he left the cell.
225. However, the wing manager and Nurse F were both clear that, when they reached the cell, the officers were standing in the doorway and nobody was giving CPR. They both said that Nurse F was the first person to attend to him and start resuscitation. Neither could remember anybody else tending to him or looking as if they were just getting up from giving chest compressions. They remembered that he was lying untended in the middle of the cell.
226. Both prisoners claimed that, having removed the ligature, officers stood in the doorway of the cell and left him where he lay until the nurse arrived. They

said that none of the discipline staff tried to resuscitate him or move him into an appropriate position.

227. People's recollections of emergency situations often differ with regard to details such as time. However, in this case the two versions of the resuscitation attempt are markedly different. My investigator asked everybody involved to recollect as precisely as possible what had occurred. They were unable to agree on a collective version of events.

228. Officers are not necessarily trained in first aid. The prison has 24 hour nursing cover and nurses are primarily responsible for giving CPR during an emergency in the daytime. Nonetheless, I am concerned about the inconsistent accounts of events and make the following recommendation to ensure that in similar circumstances, prisoners are properly attended to.

The Governor and the Head of Healthcare should remind all staff that, once begun, cardio-pulmonary resuscitation should continue during an emergency without interruption until paramedics take over or instruct otherwise. Handovers between staff should be seamless.

229. The lack of first aid training for discipline staff has been raised during previous investigations at Birmingham. It is a perennial theme in many of my investigations. Officer E said that he tried to give chest compressions to the man before Nurse F arrived. He told the investigator that he had only received first aid training once in his 30 year prison service career which was about ten years earlier.

230. Birmingham is a very large local prison. There are always nursing staff on duty during the day and they are expected to attend an emergency. At night, there is reduced nursing cover and the senior night shift staff have up-to-date first aid training. If this were not the case (for example, in a small training prison where nursing staff do not work 24 hours a day), then the Governor said he would consider training more prison officers in first aid. However, he told the investigator that he is content with the current level of first aid provision at Birmingham. In the case of the man, I am satisfied that nurses were available and responded promptly.

231. I would like to commend members of the nursing staff. They not only responded rapidly to the emergency and did their best to resuscitate him, but on 17 June, three members of staff visited him and his family at the hospital. Given the trauma Nurse F had experienced during the emergency, I thank her and her colleagues for the kindness they showed to the relatives.

232. Accepting that healthcare staff have an important part to play in responding to emergencies such as this, I am concerned about their induction. Nurse F told the investigator that she was not given formal training in how to respond to an emergency, despite being a member of nursing staff for six months. She said that she had received key training, but that she had needed to learn from experience where items such as the defibrillator were located. She said that she used her common sense during the emergency, but had not been

formally instructed how to respond. I endorse the clinical reviewer's recommendation:

The Head of Healthcare should review the induction policy for staff to include what to do if a prisoner is found in a collapsed state, where the medical equipment is and when to call for an ambulance.

Location of the emergency bag

233. Staff told the investigator that the emergency bag was located on the fourth landing of M wing. Nurse H collected the bag before making her way to the cell and I do not believe that this caused any undue delay. Nevertheless, I endorse the clinical reviewer's recommendation:

The Head of Healthcare should review the location and number of resuscitation equipment stations in conjunction with their staff.

Calling an ambulance

234. Approximately five minutes after the emergency began, Nurse F instructed the officers to call an ambulance. It is somewhat unclear from the evidence whether the wing manager told an officer to telephone the control room just before this happened. Nonetheless, given that the man, by the accounts of Officers D and E, had a discoloured face and had evidently hanged himself, I am concerned that the control room were not told to call an ambulance immediately after he was discovered. I would hope that officers would have more confidence to make a swift decision in the sure knowledge that they would not be wasting the ambulance service's time.

235. I note that delays calling an ambulance have recently been identified in two other investigations of deaths at Birmingham (both took place in March 2010). An operational order issued at Birmingham on 5 May 2009 regarding medical emergencies stated that:

"The officer (or other person) supervising the incident scene may request that an ambulance is called, prior to the arrival of [the emergency response nurse], [orderly officer] or [assistant orderly officer] if they believe that the prisoner's condition is sufficiently serious to warrant doing so. This is particularly important where the prisoner appears to be unconscious and/or not breathing."

236. I am aware that previous recommendations have been made about the need for any member of staff present to request an ambulance without delay. I commented on the issue both as a result of the death of a prisoner in November 2008 and very recently in relation to the death of a prisoner in March 2010. I am pleased to note that the recent recommendation was accepted, and therefore I do not repeat it.

Escort to hospital

237. When the man was taken to hospital on 15 June, a PER was not completed for the journey. The Governor told my investigator that he took responsibility for this decision because he wanted him to be escorted to the hospital without any unnecessary delays. This decision seems both wise and understandable in the circumstances. The decision not to handcuff him was also commendable.

238. However, I note that the bedwatch log itself does not begin until 8.00pm on 15 June, nearly 12 hours after he arrived at hospital. The paperwork seems to indicate that a handwritten, improvised log may have been kept in the initial hours, but my investigator has not seen the document.

Staff support

239. My investigator asked the different members of staff he interviewed about the aftercare they received following the emergency on 15 June. They all expressed satisfaction with the support they were offered. Officer D and Nurse F were deeply affected by the incident, and said that they received help to cope afterwards. The wing manager commented that, in his experience, good support is (and was in this case) offered initially, but he thought that additional checks on staff should continue to be carried out during subsequent months, as the impact of such a traumatic death can have an effect over time.

CONCLUSION

240. The man spent nearly a year in Birmingham. During this period, he did not tell staff that he was having suicidal thoughts, he made no attempt to harm himself and he was not subject to self harm monitoring. He reported his OCD and staff took practical measures on the wing to help him cope with this.
241. Although he initially disengaged from mental health treatment, he later requested an assessment. Almost three months passed from the referral to the eventual assessment, something the head of the team accepts was a result of short staffing. Nonetheless, he was being assessed for his OCD and did not give the mental health nurse cause to worry that he might harm himself. I have not found any direct connection between the delayed mental health assessment and his decision to take his own life.
242. As regards the alleged bullying by Officer D, and the possibility of debts and bullying by other prisoners, I have tried to include the accounts of all the parties concerned for the sake of transparency and fairness. Although I realise that contradictory accounts can prove frustrating, I hope that the report has provided the family with a greater understanding of the circumstances surrounding his death.
243. Following my investigation, I would ask the Governor and the Head of Healthcare to look again at the emergency response procedure. It is regrettable that staff cannot agree on a coherent version of events in the cell. In particular, a seamless transition during CPR is critical.

The family's response to the draft report

244. My family liaison officer spoke to the man's mother after I published my draft report. She said that her family thought that the investigation was thorough. On the whole, she felt that their questions had been addressed.
245. However, she commented that the varying accounts of different individuals made it difficult to be certain about what precisely had happened. She appreciated that distressing circumstances can affect people's ability to recollect events accurately. Nonetheless, the family are concerned that the evidence given by prison officers should differ so widely from that of the nursing staff and prisoners.
246. The family expressed concern about a comment the clinical reviewer made in his clinical review regarding the man's first reception health screening in July 2009. At the top of page three of the review, after recounting the medication that he told Nurse A he was taking, the clinical reviewer comments in brackets, 'This is not true'. The family are upset by the implication that he was lying.
247. His mother said that her son was being prescribed the drugs by a specialist at hospital rather than his community GP. She expressed concern that the prison did not manage to confirm the information her son provided with staff at the hospital. (As the 'Key events' section of the report shows, initial attempts were made to get in touch but no conclusion was reached.) The family are concerned that he did not receive gabapentin until shortly before his death.
248. The family also expressed concern about two other aspects of the clinical review. They told the family liaison officer that the table near the top of page two should read more accurately as follows:
- | | |
|-------------|--|
| '1998 -2001 | Heroin addiction. Methadone programme. |
| '2002 | Problematic alcohol use.' |
249. Additionally, the reference to self harm near the bottom of the same table dated 23 September 2008 should have been dated about two weeks later, a fortnight after he took an overdose.
250. I would like to thank the family for identifying the factual errors. I will ensure that the clinical reviewer receives a copy of my final report.

RECOMMENDATIONS

1. The Head of Healthcare should carry out an urgent review of the staffing levels of the Primary Care Mental Health Team and In Reach Team so the timeframe for an initial assessment is acceptable.

The prison accepted the recommendation and provided the following response:

‘Work has commenced in reviewing current staffing levels.’

2. The Governor and the Head of Healthcare should remind all staff that, once begun, cardio-pulmonary resuscitation should continue during an emergency without interruption until paramedics take over or instruct otherwise. Handovers between staff should be seamless.

The prison accepted the recommendation and provided the following response:

‘Seamless handovers during CPR should be the required standard and the head of healthcare will remind all staff of this requirement.’

3. The Head of Healthcare should review the induction policy for staff to include what to do if a prisoner is found in a collapsed state, where the medical equipment is and when to call for an ambulance.

The prison accepted the recommendation and provided the following response:

‘The Head of Healthcare will ensure the induction policy is reviewed.’

4. The Head of Healthcare should review the location and number of resuscitation equipment stations in conjunction with their staff.

The prison accepted the recommendation and provided the following response:

‘A partnership review has already taken place with regards to the location and numbers of resuscitation equipment. Their locations will be enforced to all healthcare staff and discussed during the adjusted induction programme for healthcare staff.’