Investigation into the circumstances surrounding the death of a man in August 2010 at hospital whilst in the custody of HMP Birmingham

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the death of a man. He was found in his single cell at HMP Birmingham in August 2010. He had apparently cut his throat with a razor blade. He was taken to hospital and died the following day at 12.49pm. At the time of his death he was on remand awaiting trial for murder. He was 52 years of age and it was his first time in prison.

I extend my condolences and those of my colleagues to the man's family. I hope this report goes some way to answering any questions they may have. I regret that my report is delayed and apologise for any additional distress that this may have caused.

The investigation into the man's death was undertaken by my investigator who was assisted by an Assistant Ombudsman. In addition, a clinical review was conducted by the clinical reviewer on behalf of the local Primary Care Trust (PCT). I am grateful to him.

During his time in custody, the man had frequent contact with mental health services at Birmingham prison, but had never expressed or committed any acts of self harm in custody. However, he frequently expressed anxiety over his forthcoming trial and cancelled hernia operation. It was noted that he would require additional support during his trial but this information was not communicated satisfactorily to officers on his wing. Although officers were aware of some of his concerns, he neither expressed nor displayed any overt signs that he was at risk of committing suicide.

During 2010, there were six self inflicted deaths at Birmingham prison, including that of the man. I note that several of the issues which are dealt with in this report have similarly been raised in previous investigations by this office. Three reports considered the lack of an emergency code system at the prison and one investigation highlighted the inadequate staffing levels in the mental health team. I also make recommendations with regard to communication of information between the mental health team and officers.

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.

Thea Walton
Acting Deputy Ombudsman **November 2011**

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SUMMARY

1. The man was remanded into the custody of HMP Birmingham on 26 August 2009, having been charged with murder. Due to his offence, he was described as vulnerable. During the reception process he was assessed by medical staff. He reported no physical health concerns, or expressed any thoughts of harming himself. However, due to having previously been admitted to psychiatric hospital he was referred for assessment by a member of the mental health team.

2. Over the following months, the man settled into prison life reporting no concerns or problems to staff. However, in December 2009, as a consequence of his father's death, Assessment, Care in Custody and Teamwork (ACCT) procedures were started. However, following a case review the following day the ACCT was closed. (ACCT procedures are used to assess, observe and support prisoners at risk of harming themselves. They highlight problems and possible trigger points of a prisoner at risk of harming himself and make a multidisciplinary plan to give support and help through a period of crises.)

3. Throughout the first few months of 2010, the man was assessed regularly by the prison's mental health team. During these meetings, he expressed concerns that he might receive a long prison sentence and expressed anxieties over his forthcoming trial. It was noted by staff that he would require additional support at this time. However, during these meetings he expressed no thoughts of harming himself or committing suicide.

4. During this time the man also reported a number of physical ailments, including back pain and an inguinal hernia for which he had previously been treated. (An inguinal hernia is a lump that results from a part of the intestine (bowel) slipping through a weakness in the abdominal wall.) He was referred to hospital for treatment. He was seen by a consultant at the hospital in May 2010, and a pre-admission appointment was made for surgery in June. However, due to testing positive for meticillin resistant staphylococcus aureus his surgery was cancelled. (MRSA is a bacterial Infection which mainly occurs in people who are already ill in hospital. It can be difficult to treat as MRSA bacteria are resistant to most types of antibiotics. Many people are carriers of MRSA without even realising it, as MRSA often does not cause symptoms in healthy people.)

5. On 19 June, the man approached a Community Psychiatric Nurse (CPN) and a member of the mental health team on the wing. He again expressed anxieties about his forthcoming trial and how he felt he was "not up to" his cleaning job. However, he continued to deny any thoughts of harming himself. During a meeting on 25 June, Nurse A reported again of the man's concerns regarding his trial and of his hope that his hernia would be operated upon before the trial began. He also said that he benefited from attending the sessions he had with mental health staff at the prison.

6. A second pre-admission appointment was made for the man to attend hospital with regard to his hernia at the end of June. However, this appears to have been cancelled for security reasons after consultation with one of the prison doctors, who was content that the appointment could be postponed to a later date.

7. In a meeting in early July, at which the man was not present, the prison psychiatrist discussed him with Nurse A. During the meeting it was noted that there had been a recent worsening of his mood, including his anxieties over his forthcoming trial. The doctor reported that there was no immediate risk of suicide or of him harming himself and he prescribed Diazepam for a period of four weeks.

8. At the end of July the man was transferred to the case load of another of the prisons mental health nurses, Nurse B. The nurse said that there was a marked difference between his presentations during clinical assessments compared to when he was on the wing. During his first assessment with him, the nurse noted that he was experiencing nightmares and could hear the voices of people “coming to get him”. The nurse wrote that he felt hopeless and confused and that during the assessment he spent his time looking at the floor and was difficult to understand. However, the nurse reported that he had no thoughts of harming himself.

9. The man was seen again by Nurse B on 23 August. The nurse noted that he appeared slightly low in mood, but communicated well and kept good eye contact. He complained to the nurse that his medication was not working but was informed that a prescription of sleeping tablets was not an appropriate way to manage his sleep and other anxieties.

10. Although not aware of his medical assessments, wing staff’s interaction in the days leading to the man’s death increased. Two senior officers on the wing had frequent contact with him during this time, spending considerable amounts of time speaking with him and talking through the anxieties over his trial. During this time, wing staff said they had no concerns about any increased risk of him harming himself.

11. On the morning of 29 August, during a routine check the man was found in his cell having apparently made cuts to his neck. Healthcare staff attended and started resuscitation attempts. Upon the arrival of paramedics he was transferred to hospital. However, the following day, his condition having deteriorated, he died.

12. My report into the man’s death raises a number of issues relating to the care he received whilst in the custody of Birmingham prison, including the sharing of information between mental health and officers, and mental health intervention in the weeks leading to his death. I also comment on staffing levels within the mental health team at the prison, the cancellation of his hernia operation and the use of emergency codes at the prison.

THE INVESTIGATION PROCESS

13. The investigation following the man's death was carried out by one of my investigators, assisted by an Assistant Ombudsman also from my office. He opened the investigation on 1 September 2010, when he visited HMP Birmingham. He met the then Governor of Birmingham and the Wing Manager. He also met a representative from the Prison Officers' Association (POA) and a member of the Independent Monitoring Board (IMB). (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The POA is the trade union for prison officers.)

14. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Birmingham. The notices were displayed around the prison and invited staff and prisoners to contact my investigator with any information relevant to the investigation. No prisoners came forward to speak with the investigator.

15. The investigator was shown the cell and wing where the man spent the last weeks of his life. The investigator reviewed his prison and health records and other documentation relating to the time that he spent at Birmingham and subsequently visited the prison on several occasions to interview staff. During the course of the investigation, the investigator and Assistant Ombudsman provided verbal and written feedback to the Governor. My investigator also had access to transcripts of telephone calls made by the man to members of his family. (The content of these telephone calls were not known to staff before his death. Only a small percentage of telephone calls made by prisoners are monitored. When calls are monitored they are usually for reasons of security or child protection. He did not fall into these categories.)

16. A clinical review was commissioned from the local Primary Care Trust (PCT). The clinical reviewer completed this on behalf of the PCT and I am very grateful for his assistance in this matter.

17. The investigator also liaised with a detective from West Midlands Police, who was acting on behalf of the Coroner. He has also been in contact with the Coroner's office and a copy of this report will be sent to the Coroner to assist him with his enquiries.

18. One of my family liaison officers contacted the man's mother to inform her of the Ombudsman's role and investigation. He also invited her to raise any concerns or questions about her son's time in custody that she wished to be addressed as part of this process. Although no feedback has been received I trust that this report helps his family better understand the events before and after his death.

HMP BIRMINGHAM

19. HMP Birmingham is a local prison serving the Crown Courts of Birmingham, Stafford and Wolverhampton in addition to local Magistrates' Courts. There are 11 accommodation units which include the original Victorian wings and additional modern accommodation, built in 2002, providing space for a further 450 prisoners. The prison can hold a maximum number of 1,450 prisoners.

Healthcare

20. Healthcare at Birmingham is provided by the local Primary Care Trust (PCT). The PCT provides primary healthcare and contracts the Birmingham and Solihull Mental Health Trust to provide mental health care services within the prison and the inpatient facility.

HM Inspectorate of Prisons Report 2009

21. The last full inspection of Birmingham by Her Majesty's Chief Inspector of Prisons was in 2009. At the time of her inspection, she found there had been a significant improvement and that a strong and committed management team had succeeded in changing the culture within the prison. However, she concluded that her findings were disappointing overall, citing that Birmingham was suffering from the pressures of an overcrowded prison system and that these pressures had made it more difficult to deliver safe, decent and purposeful outcomes for prisoners. She said that it was a credit to staff and managers that Birmingham was a much better prison than when it was last inspected in 2007 and that the scale of achieving that task should not be underestimated.

22. However, at the time of her inspection in 2009, the then Chief Inspector raised concerns regarding ACCT reviews. She reported that many reviews were not multidisciplinary, attended by a variety of people who have contact with a prisoner, and some were attended by just the senior officer chairing the review. She also reported that the quality of ACCT entries and care plans varied considerably with some not reflecting a caring approach with night entries being "predictably" entered on the hour and on occasions only being led by the case manager.

23. My report into the man's death also reports on a number of issues at Birmingham that my office has highlighted in previous reports to deaths in custody. In particular these relate to staffing levels within the mental health in-reach team and the implementation of a code system for the use by staff in emergencies.

KEY EVENTS

24. The man was remanded into custody at HMP Birmingham, by Magistrates' Court, on 26 August 2009. He had been charged by police with the murder of a local woman the previous day. He arrived at the prison late that afternoon. Although he had previously been charged with a number of minor offences it was his first time in prison custody. The Person Escort Record (PER form – a document used by police, escort, and prison staff to record a prisoner's known risks and other information) noted that he was suffering from alcohol withdrawal and had a number of mental health issues, having been seen nine times by police surgeons during the three days he was in police custody. It was recorded that he was "vulnerable due to [his] offence".

25. During the reception process, staff recorded the man's personal details on page one of his Core Record F2050, (the reception record completed for all new prisoners). He provided the details of his mother as his next of kin. A Cell Sharing Risk Assessment (CSRA) was also completed indicating that he presented as a low risk to others and was deemed suitable to share a cell with others. (A CSRA is used to assess the risk that a prisoner would present to other prisoners when sharing a cell.)

26. The man underwent a first night reception health screen by a Registered General Nurse (RGN), one of the reception nurses. (All prisoners are given a first night reception health screen when they come into prison. The aim of the screen is to identify any needs or health concerns that the prisoner might have. It includes identifying a prisoner's past medical history, including mental health.) She noted on EMIS, the patient electronic medical record, that he had received a number of physical injuries to the right side of his forehead, he had a history of alcoholism and had previously been admitted to a psychiatric hospital in 2003. She recorded that he expressed no thoughts of harming himself and that he said he had no physical or health concerns. The nurse referred him to both drug and mental health services at the prison. Given his history of alcoholism, he was taken to the healthcare unit and prescribed medication to assist with the symptoms of his alcohol withdrawal.

27. Having been interviewed by staff on the prisons induction unit, the man signed a number of prison compacts confirming his understanding of prison rules and what was expected of him. He was also provided with a smoking pack (A pack provided to new prisoners which contains smoking materials) and was provided access to a telephone.

28. The following day, 27 August, the man was examined by a doctor. The doctor noted that he was undergoing alcohol withdrawal and was suffering from mild related symptoms. The doctor also noted that he had no history of contact with mental health services, except for his alcohol dependence, and reported no major physical problems, although this was at odds with what he had told the nurse the previous day.

29. The man spent the first few days of his sentence in healthcare, where he was kept for observation. During this time he suffered from poor sleep and on 29 August, was prescribed Zopiclone to assist with his insomnia. Over the following days no concerns were expressed by him or observed by nursing staff and as a consequence he was transferred to normal location, on C wing, on 9 September. His wing history sheets note that he was fine and had no problems to report.

30. Over the next few months, the man settled at the prison. He attended court a number of times and applied to do an art or computer course in education. It was also noted on a number of occasions that he had "…no concerns or problems at the moment".

31. On 7 December, the man was scheduled to have been reviewed by a Registered Mental Nurse (RMN). However, he was not seen. The nurse noted in the medical record, "Not unlocked, re-book appointment".

32. As a consequence of his father's death and of threats to take his own life on 14 December, staff opened an Assessment, Care in Custody and Teamwork (ACCT) on him. The following day he told staff that he was just in a low mood and had no intention of harming himself, citing that he needed to be strong for his son. He asked for the ACCT to be closed. Following the first case review the decision was taken to close the ACCT. A Senior Officer (SO) and another officer conducted the review with him. The SO noted in the ACCT that:

    "Following the ACCT review, it is felt by myself and the officer, that there is no benefit from keeping this ACCT book open. He is in a positive frame of mind and states he must remain strong. Good eye contact. Appears positive and is aware of staff and Listener support."

    Although a post closure interview was scheduled for 22 December, this did not take place.

33. On 23 December, the man was assessed by a Community Psychiatric Nurse (CPN). He reported him as being well groomed with good eye contact. The nurse noted that he was continuing to come to terms with his father's death and was concerned about serving a long sentence in prison and had thoughts that he would die in prison. The nurse made a referral for further assessment given the nature of offence and charges that he faced.

34. The man was seen by a psychiatrist, on 7 January. He noted that the man had a long history of alcoholism and depression but had not received any previous psychiatric treatment; again this was at odds with what he had previously told the nurse. The man told him that he was anxious about his appearance in court the following day. He explained to the psychiatrist that he had experienced thoughts of self harm when he was first in custody but had no thoughts at that time. The psychiatrist noted that there was no evidence of any depression but that he was struggling

with his situation and that he was experiencing back pain which affected his sleep. The psychiatrist recorded that he discussed antidepressant treatment with him, but they agreed that it would not be beneficial.

35. On 18 January, a Registered Mental Health Nurse was stopped by the man on the wing. He told her that he felt he still needed support from the mental health team, and asked to see them. She made a referral for him to be seen. On 22 January, he was seen by Nurse A. The nurse noted that he presented as low in mood, with poor eye contact, but improved during the session. He told the nurse that he found it difficult to attend the session as he had felt so low but had benefited from the meeting.

36. Nurse A saw him again on 5 February. He told the nurse that he was finding prison life difficult and stressful and felt that, given his charge, he would never be released from prison. He told the nurse he had no thoughts of harming himself. However, the nurse noted that during the period of his trial he would require additional support. He said that he recognised the need to keep busy and said that he had good relationships with wing staff. He particularly mentioned the support from the SO, the wing's senior officer.

37. On 8 February, the man was seen by Prison Doctor A. The doctor noted that he was suffering from a number of physical ailments including back pain, tennis elbow, a condition where the outer part of the elbow becomes sore and tender, and an inguinal hernia, for which he had received treatment in the past. On 19 February, he was seen by Nurse B. The nurse reported that he was well groomed and willing to engage but was suffering from physical pain due to his hernia and found it difficult to sleep as a consequence. He told the nurse that he was constantly thinking about his upcoming trial and did not relish the thought of spending the rest of his life in prison. He assured the nurse that he was not thinking about harming himself.

38. Complaining of back pain the man was seen by Prison Doctor B on 26 February. During their meeting, he told the doctor that he was experiencing low mood and difficulty in sleeping, but did not want to be prescribed sleeping tablets. The doctor prescribed Mirtazapine to assist with his depression and sleeping difficulties. The doctor also made a referral for him to be seen at hospital for treatment of his hernia.

39. During a mental health review on 19 March with Nurse A, the man explained how he felt that his past behaviour had been a contributory factor to his father's death. He told the nurse that he was expecting his trial to take place in September. He told the nurse that he was currently coping and that wing staff were supportive. He said that he enjoyed working on the wing as a cleaner and that he kept busy most of the time. He said that he had no thoughts or plans of suicide or self harm, but continued to complain of back and shoulder pain and discomfort from his hernia. He was referred to a physiotherapist, and a referral for further

treatment of his hernia had already been made.

40. On 16 April, the man attended Crown Court and remanded back to the custody of Birmingham. On 28 April he was seen by Nurse C, who reported that he was settled and willing to engage with good eye contact. He told the nurse that he continued to keep busy as a wing cleaner, which he found beneficial, but continued to express difficulty in coming to terms with his charge and the possibility that he would receive a lengthy sentence. The nurse noted that he reported no thoughts of harming himself and that he felt that his contact with the mental health team was beneficial. She said that he was concerned about his physical health hoping that this would be "cleared up" before his trial.

41. On 4 May, the man was seen by Prison Doctor B. He reported that the man's hernia was causing him more pain. His outstanding appointment with the hospital was followed up and on 11 May he was seen at the hospital by a consultant. His name was placed on the waiting list for surgery and a pre-admission appointment was made for 3 June.

42. He was seen by Nurse C on 21 May for a mental health review. She reported that he appeared settled and was willing to engage. He reported concerns about his physical health and apprehension regarding his upcoming trial. He told the nurse that he was worried about being placed in a cell with others when thinking about the possibility of serving a long sentence. As a consequence she spoke to the SO on C wing who advised her that there were no plans for him to share a cell. She noted that, despite these concerns, he appeared settled and functioned well on the wing; a further appointment was arranged for 25 June.

43. On 14 June, the man was seen by a nurse. She noted that he was concerned about his trial, appearing low in spirit, and had asked to speak further with a member of the mental health team. He also told the nurse that he had a hernia which required treatment.

44. On 15 June, a prison doctor noted a call from the hospital to say that the man had tested positive for MRSA. The hospital advised that before surgery for his hernia could take place, he would have to be treated for MRSA.

45. The following day he attended hospital for his operation on his hernia, however, he was told that the operation would not take place because he had MRSA. He subsequently received successful treatment for the MRSA. The hospital had contacted Prison Doctor B the previous day to say that the appointment had been cancelled but the security department had not been informed.

46. On 19 June, Nurse C was approached by the man on the wing. She described him as appearing low in mood and spent time with him. He reported difficulty discussing his concerns as he had been told he could not discuss his trial. He said he felt he was not up to his cleaning job due

to the anxieties surrounding his trial. He denied any thoughts of harming himself saying that, “life is too precious” and described wing staff as very understanding.

47. During a subsequent meeting with Nurse C on 25 June, the man, although willing to engage, appeared “flat in mood”. She reported that his concerns remained focussed around his trial and physical health, hoping that his operation for his hernia would take place before his trial. He said that he would like to consider medication for his anxiety and disclosed that he was concerned about other prisoners finding out about his charge. Despite these frustrations she noted that he denied any thoughts of harming himself and a review appointment was made for 26 July. In interview, she said that he told her he benefited from attending his appointments.

48. On 26 June, an officer wrote in the man’s prisoner record that he appeared:

> “… to be over his problems and is now putting more effort into wing based duties. States he cannot lift heavy weights as he suffers with a hernia and is awaiting a date for an operation. Makes himself available for any task that may be asked of him.”

Two days later a nurse recorded in his medical record that he was worried about his hernia operation that had been cancelled. The nurse wrote that he was confused and needed clarification as to when his operation was going to be.

49. Another pre-admission appointment was made on 29 June, for the man to attend hospital on 8 July. However, in a Security Information report dated 8 July, a governor reported that he was given a risk assessment with regard to his appointment at hospital that day. The governor said that he contacted a doctor regarding the appointment. He said that he was advised by the doctor that the man had a hernia and at some stage would require an operation. However, he felt the operation was not acutely serious. The doctor advised the governor that it was the man himself who was insisting that he needed the operation and that was why the appointment had been made.

50. The governor noted that in view of the seriousness of his trial, the doctor was quite content for the appointment to be postponed for a later date. The governor recommended that three officers should accompany the man for any future hospital appointments. In interview with my investigator, the SO said that he believed the appointment was cancelled because it was deemed not to be life threatening and that there were a number of other prisoners who needed to attend hospital appointments on that day, all of which would have required escorting by staff.

51. On 9 July, the psychiatrist discussed the man with his mental health nurse, Nurse C. In particular, they talked about his recent worsening of anxiety, in response to the “ongoing stressors”, including his upcoming

trial. The psychiatrist noted that further assessment would be based on further input from the primary mental health team and that there was no immediate risk of suicide or self harm noted. The doctor recorded that he was keen to engage with medication. The doctor prescribed Diazepam, a sedative used for the relief of anxiety, for four weeks.

52. The man was transferred to the care of Nurse D on 26 July. The nurse said that he had often seen him in passing on the wing he told my investigator,

> "… he seemed fairly settled you know: he was interacting well, he was a wing cleaner, he got on with the wing staff, you know. So generally his presentation was of a normal every day prisoner until he got into clinic."

53. The nurse said that there was a marked difference in presentation when the man was in clinic compared to when he was on the wing. During his first assessment with him on 26 July, the nurse reported that he was having nightmares about the death of his friend, his father and aunt. The nurse noted that he blamed himself for the death of his father and stated that he could hear the voices of people, "coming to get him", adding that he could not watch the television or read because of these dreams. He told the nurse that he could not talk to anybody about this incident or how he was feeling. He said that his medication did not work.

54. The nurse noted that the man felt hopeless, confused, and worthless, feeling irritable with people, and just wanting to be left alone. The nurse recorded that he spent all the time looking at the floor, had poor eye contact, and was hard to understand. He said the man did not appear to be distracted or derailed in thought or behaviour and even though he spent the session looking at the floor, he engaged well. He said that he was struggling with his cleaning job and that he could not be bothered about it or anyone else.

55. The man told the nurse that he needed sleeping tablets to get rid of the nightmares and said this was the only thing which would help him sleep. The nurse explained to him that sleeping tablets would not get rid of his nightmares or his anxieties. The nurse explained to him that he was grieving over the loss of his job and the death of his friends, father and aunt. The nurse suggested that he needed bereavement counselling as opposed to sleeping tablets. He told the investigation team that the man continued to ask for sleeping tablets throughout the review. The nurse said that he was anxious but, said he had no thoughts of harming himself or of any suicidal ideation. The nurse planned for him to receive bereavement counselling and made a referral to the doctor for a medication review.

56. On 3 August, an officer, wrote that the man was a mature prisoner who got on with his work with the minimum of fuss. The officer wrote that although there were no issues, he distanced himself from staff and was

encouraged to approach staff if he had any problems. On 7 August, the man's personal officer (an officer who is allocated to a particular prisoner to assist with problems or other issues), noted that he was a quiet man who worked well but had a tendency to worry about minor issues. The officer noted that although he had no concerns, he just needed reassurance that he was not in trouble for minor things. During interview with my investigators, the officer said,

> "… he was a quiet man, he was quite conscientious particularly in his job as a cleaner, he was always concerned that he was doing things the right way but he kept himself to himself not to the extent that he was withdrawn, but more that just when he finished his cleaning he'd go and sit and watch television, have a cup of tea or something like that. He was a bit older than most of the other prisoners on the landing so I felt that he perhaps wasn't in their peer group so much, didn't make friends with them very easily."

The officer said that he was not aware that he had any difficulty with other prisoners on the wing. As his personal officer, the man never approached him with any concerns about any other prisoners or to talk about his forthcoming trial. He told my investigation team that he could not recall if the mental health team had any contact with him. The officer said that at no time did he give him concern or show any indication of harming himself.

57. In an e-mail of 22 August, the wing SO wrote to SO B that a prisoner had said other prisoners on the wing were "gossiping" about the man's offence. It was reported that another prisoner was selling his medication to him to help him sleep. My investigator found no evidence to substantiate this claim.

58. On 23 August, the man was seen again by Nurse D. The mental health nurse noted that he appeared slightly low in mood, communicated well, kept good eye contact, but continued to worry about his father, his victim's death and his friends. The nurse also reported his anxieties because he was no longer prescribed diazepam. He would not consider other ways to manage his anxiety. He again asked to be prescribed either sleeping tablets or diazepam but it was again explained that this was not an appropriate way to manage his sleep and anxieties. He told the nurse that he had previously received leaflets on how to manage anxiety and sleep. He said they did not work, but when quizzed he admitted to not reading them. The nurse made a referral for his medication to be reviewed by one of the prison doctors.

59. In an e-mail to SO C the same day, SO B reported a long conversation with the man, during which he said that he did not feel at risk on C wing and was happy to remain there. SO B said:

> "He gives the impression of being confused. He did see the healthcare team today. He has been on remand for nearly a year and his trial is

> due to start in November. He is very unclear as to what the future hold. He feels that staff on C wing offer him a great deal of support. I mentioned to him being monitored on an at risk book, to which he replied he did not feel at risk. I have stated he can approach my self or any staff at anytime."

SO B told my investigator that during his long chat with the man at no time did he show any signs or thoughts of harming himself.

60. The SO spoke with him again on 27 August. He told the officer that he did not feel under threat and wanted to remain on the wing. He said he had settled over the last year and liked the support from staff. The SO said that he spoke about his pending trial and told the officer that he took ownership of events, but was hopeful that his murder charge would be reduced. He said he advised him to speak with his legal team to ensure he got a fair hearing at his trial.

61. In an entry by a prison doctor the same day it was reported that wing staff suspected that the man may have been trading his medication. The doctor indicated that a review of his medication would be completed to see whether or not it was required. SO A told my investigator that he and other staff on the wing had a good rapport with him. He remembered rumours that he was involved in trading medication. He said that there was not much evidence of his involvement, but he was obliged to make a security information report. No further action was taken and he felt the man was happy about that.

62. SO B told my investigator that the man was always very polite and was an industrious cleaner, who he never had to challenge about his work. He described him as a little bit of a "loner" and someone who appeared not to have many friends. He said that he would often talk about his trial. Speaking with him the following day, 28 August, the SO said that he appeared in a good frame of mind, continuing with his duties as a cleaner. He said they spoke about the weekend's football matches and as the man was from Stoke-on-Trent, he was keen to talk about Stoke City's Britannia Stadium. The SO said that the man,

> "…at no time presented me with any signs of concern. He expressed no self harm intentions. I felt he was coping well with his time in custody. He even thanked me and Senior Officer A for regularly taking time to talk to him."

63. The SO told my investigators that at no time did he have any concerns about the man or that he was at risk of harming himself. He said that he always took time to chat with the officers, and had done so as soon as he arrived on the wing. He said that he, "… was never any different from the day we sort of really became aware of him to the last time I saw him. He was never a different person".

29 August

64. An Operational Support Grade (OSG) was coming to the end of her shift at 6.00am on 29 August. In interview, she said that she carried out a roll check at the end of every night shift. That morning, she recorded that all of the prisoners on C wing were in their cells and accounted for. She said that all week the man had been awake when she had completed her morning rounds. However, that morning he appeared to be asleep. She said she assumed he was having a lie-in, as it was the weekend, and he did not need to wake early.

65. Officer A came on duty that morning and completed his regular roll check of the wing. At about 7.34am, he checked the man's cell. On opening the cell door's observation flap he saw him lying on his bed. He was on his back with blood all over him and the floor. The officer used his radio to call for Oscar 1, the senior officer responsible for the running of the prison at the time and Hotel 2, the emergency response nurse, to attend immediately and blew his whistle. The officer went into the cell to assess the situation and saw that he was still alive. He described his breathing as shallow, and saw that he had made a deep cut to the left hand side of his throat. The officer noticed there was no blood coming out of the wound. He radioed for an ambulance to be called.

66. Officer B responded to the alarm, along with the OSG, and followed Officer A into the cell. Officer B tried to get a response from the man, but there was none. However, he noticed that he was taking short breaths every three to five seconds and that the bleeding from his wound had stopped.

67. SO D also heard the alarm and went straight to the man's cell accompanied by SO E. He said he could see from the amount of blood that it was a serious act of self harm. The man had used a razor blade to cut his neck. SO D said he asked SO E to call an ambulance and provide details to the communications room. The call for the ambulance was made at approximately 7.35am. (All prisoners have access to a variety of goods and items, which can be purchased from the prison canteen (shop). If someone is subject to ACCT then consideration may be given to removing access to certain items, such as razors. However, staff have to bear in mind that the removal of everyday items can increase the stress and anxiety of those at risk of harming themselves and consequently placing them more at risk form harm.)

68. Nurse E said that he was the early start nurse holding the emergency response radio, call sign hotel 2, when he heard the request for him to go to C wing. He said that, on his arrival, he found the man lying on his bed unconscious in a pool of blood, with a lot of blood on the floor. The nurse said that he immediately asked for an ambulance to be called, and was told that one already had been. On examination, the nurse observed that he was very pale, had "low respirations" (breathing), shallow pulse, and could not move any part of his body or talk. He said he immediately put

him in the recovery position, on his left side. He started oxygen therapy through a mask, and his breathing appeared to improve.

69. The first response paramedic arrived at 7.43am followed by an ambulance and two further paramedics at 7.48am. The nurse said that the paramedics administered intravenous fluids to re-hydrate the man. The paramedics continued to work on him until he was taken to hospital, leaving the prison at 8.10am.

70. During his transfer to hospital, staff did not use restraints. Escorting staff were advised to withdraw to a distance that allowed access for medical staff. On his way to hospital, the man stopped breathing and paramedics started Cardio Pulmonary Resuscitation (CPR). He arrived at hospital two minutes later and was operated on. He was put on a ventilator in the intensive care unit.

71. At approximately 8.30am, Officer A opened an ACCT document and security information report. A hot debrief took place later that morning and staff were offered the support of the care and welfare team at the prison. (A hot-debrief is a meeting held as soon as possible after a major incident to ensure the welfare of staff.) All those interviewed by my investigators said that they appreciated the support given to them in light of the incident and the man's subsequent death.

72. The man's mother was informed by telephone of the situation and of his condition at 10.35am by a governor. At around 1.00pm, the man's mother and her son-in-law arrived at the prison and were met by two governors.

73. In the early hours of 30 August, hospital staff told the man's mother by telephone that his condition had worsened. His family attended the hospital once again and were met again by two governors from the prison. Shortly after lunch, he was pronounced dead.

74. A post mortem was undertaken by a pathologist. He also had access to a number of police photographs of the cell in which the man was found. The pathologist reports that he appeared to have cut his throat with a razor, as he could see it in the police photographs. The doctor also noted that,

> "… attached to the window latch, there is a piece of green material that appears to have come from a bed sheet. A strip of similar material is seen lying on the floor within the blood."

75. The pathologist reports that the wound on the man's neck was consistent with having been caused by a razor blade. In addition, there were two marks that had the appearance of being caused be a ligature. He concludes,

> "… I consider that the deceased initially attempted to hang himself. The ligature however broke, causing him to fall to the floor. It is

> possible that some of the other external injuries and particularly the intense bruising of the right chest wall will have been caused while he fell."

However, the doctor did not consider that hanging had contributed directly to the cause of death. The doctor concludes that the man's cause of death was as a result of an "incised wound of neck".

76. Over the following days, staff spoke to prisoners on the wing and asked whether they had any information relating to the man's death. One of these prisoners said that he thought he was a "bit down" the day before not wanting to speak to people. One prisoner alleged that a number of other prisoners had been calling him names the night before his death. It is very hard to prove such allegations, particularly after somebody has died. However, my investigator has not seen any other evidence that he was being intimidated.

CLINICAL ISSUES

Mental Health contact – sharing of information

77. Whilst at Birmingham, the man was seen regularly by members of the mental health team. During these meetings, he regularly expressed his concern about his impending trial. Staff identified the need for increased support when the trial approached. However, there is no evidence this information was relayed to prison officers working on his wing.

78. As a consequence of an assessment on 5 February, Nurse A noted in the man's medical record that he would need additional support during his trial period. The nurse told my investigators that he would have relayed this kind of information to the wing senior officer. There is no record of such a conversation in his files. The nurse told the investigation team that he would not necessarily have recorded such a conversation.

79. On 21 May, during an assessment by Nurse C the man raised similar concerns. In interview, the nurse said she told SO A about the concerns that the man had about his forthcoming trial in a telephone conversation. She said she also discussed his fears of being forced to share a cell with another prisoner. However, the SO told my investigators that he was never informed of his concerns and anxieties. The SO said that the mental health team never approached him with concerns about him coping in prison and that no one ever raised the fact that the prospect of his court case was causing him particular distress. However, he said he would like to have thought that if there had been any worries the man would have told him personally because he spoke to him regularly.

80. Nurse D assessed the man on two occasions in the weeks leading to his death. He told my investigator that he could not specifically recall feeding any information back to the officers on the wing about him. He said that his meetings with prisoners were confidential, between a clinician and a patient. The nurse said,

    > "There was nothing there to discuss, with me to refer back to the wing and say 'this man is in a low mood, he's going to kill himself'… if we start breaking patient confidentiality … who's going to come into clinic? He was in low mood, not a mood to kill himself, he had no thoughts of self harming, no thoughts of killing himself."

81. During interview for this investigation, the mental health nurse said that he knew the man "in passing" from moving around the wings. Before he came under his supervision, the nurse described him as "interacting well … his presentation was of a normal everyday prisoner until he got into clinic". The nurse told the investigation team that there was a difference between the man's demeanour on the wing and how he presented himself in clinic. Even still, he did not formally pass on his concerns to wing staff. He was worried about breaching the man's trust and compromising their patient/clinician relationship.

82. As the wing cleaner, the man would often talk to the senior officers and SO A described their “door as always open”. The senior officer did not recall speaking to a member of the mental health team about the man’s risk factors. He said he was not aware of the difficulty that he was having coming to terms with the prospect of his trial. The SO did not think that he was at risk of self harm. He said that “we actually believed that if he had got a problem he would come to us because of how we were with him”. However, the man did not speak to the senior officers about what was on his mind. The regular conversations he had with the senior officers on his wing were an important source of support to him. Approaching a trial for murder is a time of heightened risk of any prisoner. However, the senior officers were not aware of his specific concerns and therefore were not in a position to use those conversations to deliver ongoing support on a daily basis.

83. I understand that Nurse D was concerned about breaching the man’s confidence. However, as a result of this, there was no communication between wing staff and the mental health team. Information sharing, in particular between medical staff and officers, is a recurring theme for my office. Staff often cite medical confidentiality as a reason for not having shared information that, had it been communicated properly, could have assisted in keeping prisoners safe.

84. In his clinical review the clinical reviewer reports that medical staff frequently reported their concerns about the man and how he would react to his trial and the need for support at that time. However, as with my investigator’s findings, the clinical reviewer reports that this information was not relayed to the prison staff. Therefore, no such support measures were undertaken. I agree with the clinical reviewer’s findings and make the following recommendation:

    The Head of Healthcare should ensure that there are clear and recognised pathways of communication between clinical staff and officers in cases where there are concerns regarding the mental health, or other issues, of patients.

Mental Health Intervention in the weeks leading to the man’s death

85. In his clinical review the clinical reviewer reports that on 26 July, Nurse D documented a clear deterioration in the man’s symptoms. The clinical reviewer says,

    > “There is documentation of “no self harm or suicidal ideation”, but there is also documentation of feelings of “hopelessness and worthlessness”. The need to assess suicidal ideation is clear, but the mere act of documenting that the question was stated is, in itself, inadequate. In this case, it seems that there was significant clinical deterioration and I would have expected this to lead to further action, whether this is increase frequency of review, additional clinical support or even just the

> sharing of the concerns with the wider prison staff. It seems though, that the only action taken was advice to seek bereavement counselling."

In interview Nurse D told my investigator that,

> "There was no need to open an ACCT book on this gentlemen because he wasn't coming across that he needed an ACCT book opened. He had not thoughts of self-harming; he had no intentions of self harming or committing suicide."

86. A month later on the 23 August, Nurse D conducted a second mental health review. At this review the nurse noticed an improvement in mood compared to the previous meeting, with more eye contact, but that the man remained "slightly low in mood". The clinical reviewer comments that,

> "On this occasion, there is no documentation of suicidal or self harm ideation, and this is an important omission. The consultation seems to have been predominantly around the patient's request for sleeping tablets and that the CPN felt was not indicated (and is able to justify why and give alternative management plans)."

87. The clinical reviewer reports that,

> "This last clinical contact could have been undertaken more thoroughly. The deterioration in clinical symptoms could have precipitated more frequent review / support rather than a routine follow up at four weeks, indeed earlier in his remand period, he was reviewed more frequently than this when his clinical symptoms were much more stable. Also, there should have been a formal assessment of suicidal / self harm ideation, though it is clear from the notes that the CPN felt that clinically the situation had improved since last reviewed. It also seems that the issue of request for sleeping tablets may have been the dominant component of the consultation and therefore taken the emphasis away from a thorough assessment of mental state, and this aspect is managed appropriately."

88. He says that,

> "Overall, there was appropriate assessment of the patient's mental health and at appropriate and regular intervals by the appropriate members of staff, though the frequency of these review tailed off in the weeks prior to his suicide. As mentioned, I feel that this is a significant issue. It seems that there were two contributory factors: firstly the severity of his deterioration in mood was not fully appreciated or acted upon, and this deterioration was not communicated adequately with other members of the clinical and non-clinical team; secondly staffing issues meant that more regular appointments were not possible."

89. He concludes that,

> "It is probable that further assessment by the ACCT team would have been beneficial prior to his suicide in August 2010, though it may be that there were insufficient indicators suggesting a need for this. There was, however, the apparent deterioration in mental health documented above, and I think that increased support, and possibly more formal assessment, would have been beneficial."

However, he adds that between March and June 2010, the man's mental health assessments were appropriate and the management plans appeared clear and justifiable. In consequence of his findings the clinical reviewer makes the following recommendation which I endorse:

The Head of Healthcare should ensure that staff are aware of the need to thoroughly explore the mental state of patients with respect to mood, including exploration of possible suicidal ideation, in every mental health review or relevant assessment. This information should be adequately documented, and the relevant actions taken.

Staffing

90. During the investigation, several members of staff described staff shortages within the mental health team. Nurse C told my investigators that there should be four members of the primary mental health team and a manager but at that time there were only two full time members. These two primary care nurses who worked with the two members of the inreach team (who support those with a severe and enduring mental health condition) to provide all provision of mental health care at the prison.

91. In his clinical review the clinical reviewer comments on the staffing levels at the prison. He reports that the man did not receive frequent medical reviews in the weeks prior to his death. He writes that it was possible that more frequent reviews would have flagged up a medical need for more intensive intervention. He acknowledges it is not clear whether the staff shortages directly led to a decreased frequency of clinical review or whether the decision was taken in line with the man's needs. However, I agree with the clinical reviewer that such shortages must have affected the delivery of mental health services at Birmingham. He concludes "it is imperative that sufficient clinical staff is available to ensure that an adequate service can be provided".

92. I note that in my recent report into the death of a prisoner at Birmingham in June 2010, I commented on the understaffing of the mental health team at the prison. Indeed, I made similar comments following a death in custody investigation in 2008. I am concerned that I am, once more, commenting upon the mental health team's staffing levels. I acknowledge the difficulties involved in the recruitment and retention of staff. However, it is imperative that prisoners have access to mental health care. I agree with the clinical reviewer's findings and following recommendation which

should be addressed:

The Head of Healthcare must ensure that the prison provides adequate mental health staff in order to facilitate medical reviews at a frequency dictated by clinical need.

Prescription of Diazepam

93. On 9 July, the psychiatrist discussed concerns regarding the man's "worsening of anxiety and mood" with Nurse C. As a consequence of this meeting, the doctor prescribed Diazepam. The clinical reviewer reports that it would appear that he did not assess him in person due to time implications. During interview for this investigation, the psychiatrist explained that he followed the Integrated Drug Treatment Services protocols (IDTS – a programme used for prisoners going through detoxification) for the prescription of diazepam. He explained that he was not required to conduct a face to face assessment as long as he was satisfied the prescription was appropriate on the basis of the clinical record. The man was assessed by the mental health nurse, and her recommendation was sufficient.

94. In his clinical review, the clinical reviewer questions whether it was appropriate for the doctor to prescribe diazepam without seeing the man. In his report he says, "It is my opinion that the doctor should have made a formal assessment of the patient when these concerns were flagged up". He goes onto say:

    > "… while this is not ideal – it can at times be clinically justified to prescribe in the short term on the advise and assessment of the [mental health nurse], though this is not best practice."

    He says it would have been preferable for the psychiatrist to have made a face to face review of the man himself in such circumstances.

95. He makes the following recommendation for the consideration of the Head of Healthcare:

    The Head of Healthcare should remind doctors that prescribing of medication such as benzodiazepines should ideally be undertaken only after they make a clinical assessment in person and that such face-to-face review should also take place if other members of staff flag up concerns about the mental health of patients.

Cancelled hernia appointment

96. The clinical reviewer reports that although the man complained of a number of ongoing physical health issues they were managed appropriately from including a referral for surgical repair of his hernia. He reports that the man was "… particularly troubled by the hernia, and there are a number of mention of his concerns with respect to

this." He goes on to say:

> "the planned attendance for hernia repair was then cancelled on the day at the behest of the prison, seemingly for "security reasons". The doctor was consulted regarding this and confirmed that the procedure could be postponed."

97. In interview, the doctor said he could not recall speaking with the security department with regard to the cancellation of the hospital appointment, but confirmed that he had done so on a few previous occasions in relation to other prisoners. He said,

> "…from a medical point of view he [the man] didn't have a serious condition. Working in a prison you have to have kind of thought towards the whole process and not just insist on serving treatments if it's causing security concerns and breaches. I feel I have some kind of duty to play a part in that. Obviously I can't let it impede on my medical treatment of someone but in this case I think there were concerns about, I don't know whether it was staffing or some security issues, and it wasn't a serious condition that needed to be seen straightaway."

He said that due to the differing numbers of prisoners that were allowed to go out on a day to day basis:

> "We do get the question back quite commonly do they really need to go out and again every case is different and if clinically we're happy that they can be delayed, because sometimes we get the response we haven't got enough officers to go out, if were clinically happy with that we do agree but if there's any concerns we say we're worried the patient needs to be seen then obviously there no question about it but you do get pressure and obviously you don't want to be the person who's causing so many problems if a patient doesn't need to go our right then, so you do the that kind of pressure posed."

98. In his clinical report the clinical reviewer comments:

> "Clearly, an elective procedure such as hernia repair can be postponed without a huge impact on prognosis, but it is a shame that this occurred when the patient was concerned particularly about this issue. It also raises a concern that the prison may intervene in clinical matters and cancel procedures or hospital attendance for non-clinical reasons."

99. It is clear from the prison records that the man was worried about his operation and that this played on his mind. I appreciate that on occasions prisoners' appointments will have to be cancelled due to security reasons or staff shortages. It would appear however, that his appointment was cancelled due to unspecified security considerations. I am concerned that this can impact on the equality of care a prisoner may receive compared to someone in the community. I make the following recommendation:

The Governor and Head of Healthcare should review the measures applied when prioritising who attends hospital appointments and ensure that appointments are rebooked promptly when they are cancelled.

100. There was no entry in the clinical records about the cancellation, or reasons for it, and whether or when it was rearranged. The clinical reviewer says, "This is inadequate record–keeping at best, and – if the appointment was not rearranged, then would demonstrate poor clinical care." I agree with his findings and endorse his recommendation:

The Head of Healthcare should remind all staff of the importance of clear record-keeping.

OTHER ISSUES

ACCT

101. On 14 December 2009, several months after his arrival at Birmingham, staff opened an ACCT on the man as a consequence of his father's death and threats to take his own life. The ACCT was closed by staff the following day. Although I accept that the closure of the ACCT had no bearing on the actions that he ultimately made eight months later, I make the following observations with regard to the operation of the ACCT process at this time.

102. No Immediate Action Plan was completed and the assessment interview was poorly completed. Although no Action Following Assessment Case Review was completed, a Case Review did take place the following day, chaired by the case manager, SO B. It was only attended by one other officer and no one from a different discipline (such as a nurse or chaplain for example) attended. It was at this case review that the decision was taken for the ACCT to be closed. Additionally, the entries in the ongoing record are brief. I also note that although a post closure interview was scheduled for the 22 December, it was never undertaken.

    The Governor should ensure that mechanisms are effectively in place to ensure that post closure reviews are undertaken.

103. During interview with my investigator, SO B, the case manager, confirmed that he had not received any ACCT training, including training to the mandatory foundation level and I therefore make the following recommendation.

    The Governor should satisfy himself that all staff are trained to the appropriate level in ACCT and that all ACCT documents are of a reasonable standard.

Emergency codes

104. Officer A called for immediate assistance on his radio. A nurse was nearby and attended to the man promptly. However, during an interview with my investigator, the nurse said that he was unaware of the type of incident he was attending as Birmingham did not have a code system to tell staff what they are heading towards. He said that when staff request immediate assistance it could sometimes be misleading because staff "use 'immediately' to mean emergency but it is not quite an emergency".

105. This office previously suggested the introduction of a code system in a report into the death of a man at Birmingham in November 2008 and in three out of four of the last apparent self inflicted deaths to have occurred at the prison. It is a useful way to convey quickly information as to the nature of an incident, who should attend and what they should bring, it can

also alert the communications room staff to call an ambulance.

106. I understand that he National Offender Management Service will soon introduce service wide guidance on the use of emergency codes in prisons. However, in the meantime I again repeat the following recommendation.

The Governor should implement a code system to notify responding staff about the nature of an emergency.

107. In his clinical review the clinical reviewer reports that staff's response on 29 August was "expedient and appropriate…" He goes on to report that:

> "There is a documented delay of 10 to 15 minutes before the paramedics arrived, and the only clinical issue around this is whether or not cannula (drip) insertion and intravenous fluid could have been put up during this time."

He concludes that even it this had been facilitated, "It is unlikely that it would have made any difference to the outcome anyway as it seem that the patient was already significantly clinically compromised by extreme blood loss".

Allegations of bullying

108. After the man's death, a prisoner on his wing told staff that he was being bullied the night before his death. My investigator found no evidence to substantiate these claims. However I cannot rule out the possibility. It is clearly documented that he spent much of his time on his own and appeared to have little interaction with other prisoners. He did have good relations with officers on the wing, of which he was appreciative. Although there is no evidence to suggest that he was bullied, it is possible that had he been bullied, he would have raised his concerns with staff given his obvious appreciation of their support on other issues.

109. Recent research undertaken by the office has revealed that bullying features in some 20% of self inflicted deaths in prison. This statistic only serves to highlight the importance that prisons place in identifying and dealing with bullying. Whilst there is no evidence that staff at Birmingham were aware of the alleged bullying whilst the man was alive, it only serves to remind the prison of the need to be vigilant.

CONCLUSION

110. In the year that the man was at Birmingham, he had regular contact with members of the mental health team. However, it was during these sessions that he regularly expressed his anxieties about his forthcoming trial. His presentation during his mental health reviews differed to the approachable hard working wing cleaner known to officers.

111. It is a common cause that those remanded for murder are at an increased risk of self harm, particularly when they are approaching trial. Indeed my office has on an all too regular basis reported about such circumstances. As a consequence a quick time learning bulletin has been produced by the Offender Safety Right's and Responsibilities group within NOMS highlighting the need for extra vigilance amongst staff for prisoners facing trial for specific offences and on the anniversary of such offences.

112. I do not believe that staff at Birmingham, in the weeks leading up to the man's death, were fully aware of the anxieties and pressures that he was evidently going through at that time. Having taken the decision to take his own life, firstly by his apparent attempt to tie a ligature from his cells windows bars and then by making cuts to his neck, it is probable that he had been determined to take his life. However, had there been better communication between the mental health team and the officers looking after him may have assisted in his care.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there are clear and recognised pathways of communication between clinical staff and officers in cases where there are concerns regarding the mental health, or other issues, of patients.

   Accepted – A daily report is provided to the Governor via the Duty Manager by way of written report, for the Governor to circulate to the wider prison as required.

2. The Head of Healthcare should ensure that staff are aware of the need to thoroughly explore the mental state of patients with respect to mood, including exploration of possible suicidal ideation, in every mental health review or relevant assessment. This information should be adequately documented, and the relevant actions taken.

   Accepted – All mental health staff are qualified mental health practitioners and are aware of their roles and responsibilities in relation to reviewing potential clients and documentation of their interactions in accordance with NMC code of conduct.

3. The Head of Healthcare must ensure that the prison provides adequate mental health staff in order to facilitate medical reviews at a frequency dictated by clinical need.

   Accepted – The mental health in-reach team are adequately and fully staffed based on the establishment noted within the contract.

4. The Head of Healthcare should remind doctors that prescribing of medication such as benzodiazepines should ideally be undertaken only after they make a clinical assessment in person and that such face-to-face review should also take place if other members of staff flag up concerns about the mental health of patients.

   Accepted – Issues were discussed at the meds management committee meeting – all prescribers were informed about the need to carry out face to face consultations wherever possible. In the event that a face to face consultation cannot be carried out due to prison regime, the same should be documented in the clinical notes. A clinical audit will be carried out form time to time to identify constraints.

5. The Governor and Head of Healthcare should review the measures applied when prioritising who attends hospital appointments and ensure that appointments are rebooked promptly when they are cancelled.

   Accepted – A robust system is now in place for booking prisoner appointments and rebooking cancelled appointments as necessary.

6. The Head of Healthcare should remind all staff of the importance of clear record-keeping.

   Accepted – All staff have been reminded of the importance of clear record keeping.

7. The Governor should ensure that mechanisms are effectively in place to ensure that post closure reviews are undertaken.

   Accepted – System in place where Post Closure Reviews are highlighted on the Residential 'Daily ACCT List'. Residential Managers are to utilise the list as reminder of any Post Closure Reviews due in their area.

8. The Governor should satisfy himself that all staff are trained to the appropriate level in ACCT and that all ACCT documents are of a reasonable standard.

   Accepted – All staff must be trained to a least Foundation level in ACCT. Training manager to schedule a slot on Staff Induction and a regular slot for refresher ACCT Case manager and refresher ACCT Foundation on Staff Development Days.

9. The Governor should implement a code system to notify responding staff about the nature of an emergency.

   Accepted – We are currently reviewing the use of Medical Emergency Response Codes and how we can best take this forward at HMP Birmingham.