Investigation into the circumstances surrounding the death of a man at HMP Birmingham in August 2004

Prisons and Probation Ombudsman for England and Wales

February 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Birmingham. The man was found hanging in his cell at Birmingham on 8 August 2004. He was 27 years old.

Since 1 April 2004, the Prisons and Probation Ombudsman's Office has been responsible for investigating all deaths of prisoners in custody. During a transitional phase, which included the time of the man's death, I did not conduct all investigations directly but oversaw the work of experienced Prison Service investigators who worked under my supervision. I am most grateful to the Prison Service for agreeing to those arrangements.

The investigation into the man's death was carried out on my behalf by a team led by the deputy governor at HMYOI Swinfen Hall. Except for minor editing for reasons of clarity and style, I have not amended the deputy governor's report. I am most grateful to him for his work on my behalf.

A clinical review to examine the man's medical care and treatment at Birmingham was carried out by a clinical reviewer of the Heart of Birmingham Teaching Primary Care Trust.

I would like to thank the Governor of Birmingham and his staff for their co-operation with the investigation.

My colleagues and I would like to offer our most sincere condolences to the parents, family and friends of the man. I am in no doubt as to the extent of their loss and sadness. In offering my sincere sympathies, I hope that this report may help both to explain what happened to the man and offer ways of reducing the incidence of self-inflicted deaths in the future.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2006**

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Ombudsman's Summary

The man appeared at Coventry Crown Court on 20 July 2004. He was charged with theft and breach of licence conditions. He was remanded in custody and taken to HMP Birmingham. The following day, he received a total of eight months imprisonment. It was not his first time in prison. He would have been released on 18 November 2004.

During reception and induction at Birmingham, the man indicated to staff that he had never deliberately self-harmed. It is clear from the investigation, however, that he had in fact attempted to take his life in the past. In addition, the Prisoner Escort Record that accompanied the man from the court to Birmingham made it clear that the man was considered a suicide risk.

Throughout his period of custody, the man constantly worried about his relationship with his girlfriend. Letters written by the man to his friend, and those received from the man's girlfriend, outline the extent of the problems and give an insight into the man's thought process at this time.

On 28 July, whilst located on B wing, the man self-harmed by using a razor blade to make superficial cuts to his upper thighs. The man was placed on a F2052SH, a document used for prisoners at risk of self harm or who have already harmed themselves. The doctor who saw the man referred him to a psychiatrist, but this referral never reached its destination. The F2052SH remained open until 3 August 2004. In line with Birmingham's policy for identifying prisoners at risk of self harm, an orange card was placed outside his cell door. Following closure of the F2052SH, no support plan was put in place but the man became subject to the pink card procedure. This is a local measure for staff to identify prisoners who have recently had a F2052SH closed, but who should not be left in a cell by themselves.

On 31 July, the man's friend visited him. The man's girlfriend accompanied the man's friend but, due to a problem with the booking of the visit, she was not allowed to enter the establishment. The man's girlfriend had told him that she would visit on 8 August but the investigation team was unable to find evidence of a visit being booked for that date.

Prior to custody, the man was taking medication for back pain and indicated in various letters that he was struggling without it and worried that he was addicted.

On 7 August on C wing, the man complained to staff several times about a pain in his arm or shoulder. Despite attempts by staff on his wing, Healthcare staff did not see him. He became very vocal during afternoon association and was challenged by the wing Senior Officer. The man was then returned to his cell. On entering his cell, an altercation with an officer took place with the outcome that the man was physically restrained and taken to the segregation unit. The

man wrote that he threw a chair at the cell door after it was closed and an officer opened the door and restrained him. The officer claimed the man swung the chair at him while the cell door was open, and that was why restraint was necessary. Officers involved in the restraint incident were not aware that the man was on a pink card.

While in the segregation unit, a partially completed safety algorithm was used to indicate whether it was safe to keep the man there. The form incorrectly indicated that the man had not self harmed while at Birmingham.

The man was relocated to B wing that same afternoon. He was seen by a doctor and given paracetamol for the pain in his arm or shoulder. Throughout the evening period, the man pressed his cell bell asking to see Healthcare and also asking for stronger medication. He produced a razor blade and threatened to kill himself. Although staff retrieved the razor blade, it would appear that this threat was not taken seriously and was not communicated to senior staff or recorded in observation books.

At approximately 10:00 am on Sunday morning, 8 August, the man was let out of his cell for morning exercise. His cellmate vividly recalled the man leaving the cell and gesturing that he was going to post a letter. The man's cellmate then shut the cell door firmly as both he and the man left to go on exercise. Yet despite the man being subject to pink card procedures, which meant he should not be left by himself in his cell, he somehow regained access to his cell alone.

At approximately 10:50 am, the man's cellmate returned to the cell after exercise. On entering, he discovered the man hanging from the cell bars at the far end of the cell having used a green bed sheet as a ligature. In response to the man's cellmate's frantic calls for help, staff responded and cut the man down. Nurses attended immediately and commenced Cardio Pulmonary Resuscitation. No vital signs were detected and paramedics pronounced death at 11:20 am.

Following the discovery of the man, a letter to the man's friend that he had posted shortly before his death was retrieved from the wing post-box. In the letter, he alleged that a Senior Officer on C Wing had assaulted him. He talked about his impending adjudication after the altercation with an officer who had entered his cell, his lack of employment in the prison and his relationship with his girlfriend. He wrote, "It's a toss up between stringing myself up or going on hunger strike. I don't know if I'm brave enough to kill myself, but we'll see."

A post mortem examination of the man noted that he had multiple old scars on both forearms which were consistent with being self inflicted. It concluded that his death had been caused by hanging.

Clinical Review

A clinical review of the health care the man received whilst in custody was requested from Heart of Birmingham Teaching Primary Care Trust (HoBPCT) on 20 August. The request outlined the man's known medical history, the fact that he had harmed himself in prison, and asked for the quality of Birmingham's health care records in relation to the man to be assessed as regards accuracy.

The Clinical Review was completed on 22 September 2004. It says that, although there should have been a psychological assessment of the man after he harmed himself by cutting his groin with a plastic knife, his medical record did not have a record of attempts to arrange an assessment or have the man seen by a more senior doctor. The clinical reviewer concluded:

"From the data available to me I conclude that in this instance the man was managed and monitored in accordance with established, and generally accepted procedures and that the man died despite such care."

I am unaware of the outcome of the HMP Birmingham risk management committee meeting which discussed the man's case on 21 September 2004.

Ombudsman's Conclusions

There is evidence to support the fact that the man had difficult experiences in childhood and that he had previously attempted suicide and self-harm. The Health Care Assessment in his F2052SH described the manas having been abused as a child, depressed, with a history of deliberate self harm. The original PER form completed by the escorting contractor clearly indicated a suicidal marker. It is of concern that this information was not transferred to the PER form, completed by the establishment, prior to attendance at court the following day. Additionally there is limited evidence to indicate that the PERs were available to staff whilst completing initial assessments for the man. During these early assessments, the man indicated that he had never been subject to F2052SH and that he had never deliberately self-harmed. These responses could have been discussed further if all the information had been available to the staff during interviews.

I recommend that the Governor ensures that the PER form should always be passed to the Health Care member of staff carrying out assessments. Staff should also be reminded about the importance of accurately transmitting important information recorded on PERs.

It is of concern that there was limited information written about the man during his time in custody, particularly, the lack of information recorded in his wing file.

I recommend that the Governor reviews the process for keeping wing records to ensure that staff make regular and considered entries on an individual prisoner's demeanour, interaction with staff and others, and any other noteworthy events.

It is of concern that the referral to a psychiatrist completed by the prison doctor did not reach its intended destination and was only discovered following the man's death.

I recommend that the Governor and the Head of Health Care review the system for delivery of important documentation from Health Care to other departments.

Following the self-harm attempt on 28 July, the man was promptly dealt with by wing and medical staff. The F2052SH documentation was appropriately opened. The man was located in a shared cell and the supervision and support record indicate that he was monitored and supported by staff.

There is evidence to suggest that those subject to F2052SH procedures are restricted from gaining employment within the establishment. Following the self-harm incident, the man stated that being unemployed was a contributory factor. The issue of employment is repeatedly mentioned in the F2052SH

documentation. However, during the investigation no application could be found to support this request.

I recommend that the Governor carries out a review of employment arrangements to ensure that prisoners subject to F2052SH procedures are not automatically restricted from gaining employment.

The effectiveness of the F2052SH case reviews held on 30 July and 3 August is a cause for concern. The support plan for 30 July did not indicate specific responsibilities for staff or departments. No proper support plan was put in place following closure of the F2052SH on 3 August.

I recommend that the Governor implements a planned programme to train all relevant staff in suicide awareness and how to complete an F2052SH and developing an appropriate support plan following case reviews.

On 7 August, the man had complained of pain in his arm/shoulder and during the morning period he continually requested to be seen by medical staff. There is evidence to indicate that staff on B wing attempted on several occasions to contact the healthcare department to report the man's complaint. However, the man was not seen by healthcare with regard to this matter until 5:00pm. The fact that the man was not dealt with within a reasonable timescale, and he might have been in some pain, may have been contributory factors to explain his behaviour during the association period that afternoon.

There are conflicting accounts of what happened before the man was restrained. The officer involved says he was standing at the cell door when the man swung a chair at him. The man's account is that he threw the chair at the cell door after it was shut. The investigation has not succeeded in resolving these conflicting accounts.

I am concerned that the segregation safety algorithm was only partially completed and contained incorrect information. There is no evidence in the assessment to indicate that the man had been subject to a F2052SH and that he had self-harmed during his time in Birmingham.

I recommend that the Governor ensures that staff know how to complete a segregation safety algorithm and an audit process is implemented to monitor compliance.

Following the man's relocation to B wing on 7 August in the afternoon, he was seen by a doctor who prescribed paracetamol for the pain in his arm/shoulder. Throughout the evening, the man repeatedly attempted to obtain stronger medication from nursing staff. During the evening, the man threatened to swallow razor blades, and staff therefore searched his cell and removed all blades. But it would appear that this indication that the man was at risk of self

harm was not taken seriously, and it was not drawn to the attention of the Duty Senior Manager so there was no review of the man's pink card status, and no consideration was given as to whether the F 2052SH should be reopened. There is clear evidence that the man's risk of suicide and self-harm had elevated during the evening of 7 August.

I recommend that the Governor ensures that staff are aware of the importance of making sure that significant information relating to the risk of self harm is properly recorded and communicated.

I do not know how, during the exercise period on the morning of 8 August, the man came to be locked alone in his cell despite being subject to pink card procedures. His cell mate is certain that he firmly shut the cell door when leaving for exercise, and that there was no possibility of the man still being in the cell. No member of staff could recall letting the man back into his cell. I am concerned, however, that the fact that there is no headcount of prisoners remaining on the wing during exercise means that there is no effective management of those deemed to be vulnerable. In addition, it seems that there are times when prisoners are returned or removed from the wing without notifying landing officers.

I recommend that the Governor conducts a review into procedures for accounting for prisoners following the movement of prisoners to exercise and other activities. Particular attention should be paid to the issue of prisoners who may be vulnerable remaining on wings after movement.

I commend the prison for its pink card system which provides additional protection for vulnerable prisoners. However, the investigation also found evidence that staff were not always familiar with the system, and not always aware of its importance. The fact that the prison was well behind with suicide prevention training may be a contributory factor.

I recommend that the Governor reviews the pink card system to make sure it operates effectively.

The various shortcomings outlined above meant that the prison missed the following opportunities to increase the level of supervision for the man:

1 Following the Control and Restraint incident on C wing
2 Following the partial completion of the segregation algorithm
3 Following the man's behaviour on the evening of 7 August
4 On the morning of 8 August (due to lack of recording in the observation book).

I recommend that the Control and Restraint incident on C wing on 7 August is reviewed by the Governor as a means of potential learning for the future.

Staff responded promptly following the discovery of the man in his cell. Two prison officers and the man's cellmate worked together to cut the man down from the window bars. Almost immediately, trained nurses were on scene and commenced CPR. No vital signs were detected and paramedics pronounced death at 11:20 hours. The contingency plans were activated and worked effectively. However, it is of concern that the prison's procedures for dealing with incidents were interpreted to include pictures of the deceased. Additionally, there was no restricted access attached to these photographs.

I recommend that the Governor arranges for the prison's Police Liaison Officer to assist in the review and agreement of appropriate scenes of crime procedures. The local contingency plans should then be updated.

Recommendations

Healthcare:

I recommend that the Governor ensures that the PER form should always be passed to the Health Care member of staff carrying out assessments. Staff should also be reminded about the importance of accurately transmitting important information recorded on PERs.

I recommend that the Governor and the Head of Health Care review the system for delivery of important documentation from Health Care to other departments.

Operational:

I recommend that the Governor reviews the process for keeping wing records to ensure that staff make regular and considered entries on an individual prisoner's demeanour, interaction with staff and others, and any other noteworthy events.

I recommend that the Governor carries out a review of employment arrangements, to ensure that prisoners subject to F2052SH procedures are not automatically restricted from gaining employment.

I recommend that the Governor implements a planned programme to train all relevant staff in suicide awareness, how to complete an F2052SH case review and develop an appropriate support plan following case reviews.

I recommend that the Governor ensures that staff know how to complete a segregation safety algorithm and an audit process is implemented to monitor compliance.

I recommend that the Governor ensures that staff are aware of the importance of making sure that significant information relating to the risk of self harm is properly recorded and communicated.

I recommend that the Governor conducts a review into procedures for accounting for prisoners following the movement of prisoners to exercise and other activities. Particular attention should be paid to the issue of prisoners who may be vulnerable remaining on wings after movement.

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SENIOR INVESTIGATING OFFICER'S REPORT

Glossary of terms

IMB	Independent Monitoring Board
CPR	Pertaining to Chest (Heart and Lung) resuscitation
COCD	Code of Conduct and Discipline
CONTINGENCY PLANS	Plans to manage serious incidents
DSM	Duty Senior Manager (Orderly Officer)
DETAIL	Staff on duty for specified period
ECR	Emergency Control Room
F 2050	Prisoners Main Core Record
F 2050a	Prisoners Wing Record also called History Sheet
F2052SH	At Risk of Self-Harm Record
F213	Injury Report Form
F2169	First Reception Health Screening Form
GOV	Governor (Senior Managers) Graded A-F
HMP	Her Majesty’s Prison
HMCIP	Her Majesty’s Chief Inspector of Prisons
IMR	Inmate Medical Record
INDUCTION	Information giving and acclimatisation period following first time in custody
NOU	National Operations Unit
LIDS	Local Inmate Database System (computer)
NTS	Notice to staff

NTP	Notice to prisoners
OPERATING INSTRUCTIONS	Local instructions for specific tasks/duties
OFF	Officer
OSCAR 2/3	Assist Orderly Officer
OBS BOOK	Wing or Establishment Observation Book
PEGGING	Electronic record of supervision at Night
PIN PHONES	Wing Phones for prisoners, PIN number access
PER	Prisoner Escort Record
PO	Principal Officer
POA	Prison Officers' Association
Remand	Prisoner held in custody before conviction
SO	Senior Officer
Standard Audit	Prison Service Internal Audit System

Investigation Process

This is a report of an investigation commissioned by Stephen Shaw, the Prisons and Probation Ombudsman, into the death in custody of the man at HMP Birmingham on 8 August 2004.

The investigation team reviewed the man's prison records including his medical record (IMR).

Stephen Shaw, Prisons and Probation Ombudsman issued the terms of reference for the investigation on 12 August 2004; the investigation commenced on the same day. The Senior Investigating officer (SIO) met with one of my investigators at HMP Birmingham to discuss the investigation and to review available documentation. My investigator also met with the police officer in charge of the investigation, the Governor and a representative of the local Prison Officers' Association (POA).

The deputy governor met with the man's parents on 25 August 2004. The investigation procedure was fully explained to them and they were given the opportunity to contribute to the process. Additionally, they were given contact details in order for further assistance, advice and support.

Between 18 August 2004 and 25 September 2004, 39 Prison Service employees, 9 prisoners and the man's a friend were interviewed.

During the early part of the investigation the man's girlfriend was admitted to hospital and was unable to be interviewed.

The investigation team would like to thank the Governor and a Senior Officer both HMP Birmingham for their co-ordination of interviews, provision of documentation and support throughout the investigation.

Notices to staff and prisoners regarding the investigation were displayed throughout the establishment. In the early part of the investigation, the team spent a considerable period on both B and C wings talking to staff and prisoners. It would appear that the man was not that well known amongst the prisoner population. The two prisoners who shared a cell with the manon C wing had nothing of significance to add to the investigation. As a consequence, the decision was taken only to record on tape the information offered by the man's cellmate.

Events leading up to the man's death

Reception and Induction at HMP Birmingham

The man attended Coventry Crown Court on 20 July 2004 having been charged with theft and breach of licence conditions. He was convicted but sentencing had been postponed until the following day. He was remanded in custody and was received at HMP Birmingham at 7.42 pm.

The Prisoner Escort Record (PER) form from the Police is clearly marked as SU - suicidal risk - and WP - weapons risk.

A Cell Sharing Risk Assessment was carried out where the man was rated as a medium risk. The man informed staff that he had not previously been subject to a F2052SH. It is recorded that the PER document was available during this assessment. The document indicates that the man was the source of the information provided. However there is no evidence to indicate whether or not the SU-suicidal risk marker was discussed or considered.

On 20 July 2004, the First Reception Health Screen was carried out by the duty doctor. The man complained to the duty doctor of painful ribs and back. He also stated that he had never deliberately self-harmed and did not feel like hurting himself and was not feeling suicidal. There was no evidence to indicate whether or not the PER form was available during this assessment.

The assessment by the doctor during this interview describes the man as being stout and strong. His height was recorded as being 5'11". General health and mental condition were recorded as good. Under previous medical history it was recorded that the man had a chronic back problem and was addicted to dihydrocodine (an opiate-based analgesic).

A questionnaire was also filled out at this time on the first night centre. The man indicated that he had been in custody on 10+ occasions and that it was less than one year since he had last been released. During this interview he confirmed that he had never committed acts of self-harm. During this interview, the man was polite and co-operative. The interviewing officer raised no additional concerns. There is no evidence to indicate whether or not the PER form was available during this assessment.

The man was located to cell D1-011 at 8:40pm. D wing is the first night centre for prisoners entering HMP Birmingham.

The man was handed over to the escorting agency at 8:15 am on 21 July 2004. He arrived at Coventry Crown Court at 9:15 am. The man was sentenced in total to eight months, four months for the theft charge and an additional four months to run consecutively, for breaching licence conditions. The man was received back

at HMP Birmingham at 5:43pm and located at 7:00pm into D2-010. The PER used by the prison makes no reference to the suicide or weapons marker on the police PER the previous day.

On 22 July 2004 the cell sharing risk assessment – induction board review was completed. This documentation states (section 5) that the PER was not available for this interview. This review recorded that there were no problems or changes in circumstances.

At some stage on 22 July 2004, the man is moved to K wing. K wing holds prisoners who are engaged in some form of employment. Records indicate that he was located in two cells K1-022 and K1-019. He remained on K wing until 27 July 2004.

The CARAT team interviewed the man on 22 July 2004. Information held on this form indicates that the man was a non-drug user and that he had no suicidal thoughts. He also informed the team that he took regular medication (Dihydrocodeine – 8-16 daily) prescribed by his general practitioner. The man stated that he did require a service from the CARAT team. Additional notes state that the man felt there might be some issues surrounding the amount of prescribed medication he took. It was noted that the man was not on an open F2052SH. In a memo to a governor (dated 10/08/04), the CARAT team leader explained that when a CARAT worker went to see the man to carry out an initial assessment, he changed his mind as his only substance misuse was surrounding prescribed medication. The form was then changed to indicate he did not require the service.

At 8:09 am on 22 July 2004, the man made a telephone call to his friend. This call lasted approximately eighteen minutes. During this call the man expressed a whole range of emotions. Initially his speech sounded slurred and he became tearful. He complained about lack of contact with his partner and requested that the man's friend contact her on his behalf. Additionally he requested that his friend send him some money. He stated that he was happy with the length of his sentence and was clearly expecting longer. He further stated that he "has served longer in the dinner queue". He alluded to the fact that he had been living in the shadow of being arrested by the police for a considerable period. According to him, this load had now been lifted off his mind. He asked his friend to visit him. He stated that there had been lots of changes at Birmingham since the last time he was there. He also said that "they were giving him half his meds – so I am not feeling too bad". The man's friend asked him "on a scale of one to ten, how are you feeling"? He replied, "I am not going to top myself or anything like that."

He seemed sure that with a short sentence he would not receive the privileges associated with those prisoners serving a longer term. He further stated to his friend that with the short sentence he had hope for the future and could now move on with his life. The man told his friend that he had been treating his

girlfriend really badly and hoped that he had not hurt her too much. He further stated that he hoped she knew how much he loved her. He ended the call by requesting his friend to send him money.

Whilst the man was located in cell K1-022, he received a letter from his solicitors. The letter dated 21 July 2004, explained the details of his court appearance and the structure of his sentence. It also mentioned the appeal process. The man also received a letter from a probation officer. This letter dated 22 July 2004, contained information regarding advice and support from the probation service. An uncompleted housing benefit form was enclosed with the letter.

During the investigation we were unable to gain any form of evidence (written or oral) from 23 July to 27 July 2004.

The man's time on C wing

The man was moved to C wing, cell C4-007 on 27 July 2004. C wing has a capacity to hold 160 prisoners and is designated a category C training wing. A prison officer recalled the man coming onto C wing. He stated that the man was desperate for a job and indicated that K wing staff thought that C wing could facilitate this in a timelier manner. The man was informed that there were approximately 80 other unemployed prisoners and that he would have to complete an application form. The officer could not recall a labour application form being completed by the man. Additionally, he stated that being on the F2052SH seemed to slow the job application process down and that the labour allocation staff did not appear to deal with those prisoners subject to this process.

The man wrote a letter dated 26 July 2004 to his friend. In this letter he talked about his love for his girlfriend and how appreciative he was of the support from his friend. The man stated that he is struggling without his painkillers and starting to withdraw ('rattle'). He states that he was addicted to them and really worried after having a lucky escape with heroin (he thanked his friend for playing a role in helping him not to become an addict). Furthermore, the man stated that he was lucky to receive a short sentence, requested the man’s friend to bring his girlfriend to the visit and talks about an argument with his girlfriend prior to the court appearance.

On 28 July 2004 on C wing, the man was seen by a member from the IMB. The man spoke to her about his medication. The IMB member states that she contacted the healthcare department to arrange a doctor’s appointment. The meeting with the IMB member took place on an ad-hoc basis therefore no application was available.

At 2:00pm on 28 July, the man self-harmed with a razor blade by making superficial cuts to his upper thighs. He was seen by health-care. At 2:35 pm, the man was placed on an open F2052SH. At 3:00pm, the duty doctor recorded on

the health care assessment that the man was depressed, tearful, angry and that he had suicidal thoughts. Issues surrounding abuse as a child and medication were also recorded. A shared cell was recommended on normal location with level 3 supervision. The prison doctor records that the man was depressed, family problem with depression, suicidal attempts in the past, known to psychiatric team, nil medication, self inflicted laceration groin. The doctor also records level 1 care.

On 28 July, the prison doctor completed a Healthcare follow-up pro-forma. He referred the man to Psychiatrist and to smoking cessation. This referral did not reach its intended destination. The referral form was discovered in a box on the healthcare secretary's desk, on 9 August 2004. It could not be established how long it had been there or indeed, how it got there.

The man was subject to the Orange card system to denote that he was at risk and subject to F2052SH procedures. Upon his return to C wing he was located in cell C2-028.

At 2:35pm, the C wing residential manager completed page 2 of the F2052SH. He noted that the man was to be located in a shared cell and that the man had expressed a wish to be allocated work. The C wing residential manager wrote that if appropriate the man would be placed on the jobs list, via labour allocation. During the investigation, no application could be found to support this request. During the interview with the C wing residential manager he stated that although there was no policy not to place prisoners subject to F2052SH into employment it is a case of finding them the right place. He further stated that he likes them to be settled and off the book.

In a letter written to the man's friend on 29 July 2004 from cell C2-028, the man explained that he tried to kill himself the day before. He complained that he had been in Birmingham for 10 days and still had not received a letter from his girlfriend. The man was worried about her welfare and that their relationship was over. At the end of the letter, he stated that he had received three letters from his girlfriend and was elated.

The three letters from the man's girlfriend were found in the man's possessions following his death. The envelopes are dated 22 July 2004, 26 July 2004 and 27 July 2004. All of the letters were posted first class with what appears to be a 28 July 2004 postmark. Additionally, the envelopes contain blue writing (Prison censor) outlining the man's cell location C2-28. The letter dated 22 July 2004 detailed lots of emotion surrounding the relationship and confirmed the man's girlfriend's love and support for the man. The letter dated 26 July was very emotional, alluding to past difficulties within the relationship. The letter ended with the man's girlfriend stating that she still loved him. The letter dated 27 July 2004 apologised for the venting of hurt and anger in first two letters. The man's

girlfriend indicated that she was looking forward to visiting with the man's friend on 31 July 2004.

On 29 July, the man was interviewed by the second prison doctor who recorded that the man was worried that his girlfriend was going to leave him. The man further stated that he was convinced that she would not now leave him, that he only had 16 weeks to serve and that he had no intent of committing suicide. The man also spoke to the doctor about getting married. The doctor concluded that the man seemed not to be suicidal. He recommended level 2 care. The man returned back to C wing and was observed to be "very chatty", seemed happy to be on level 2 and had no concerns with his present cell mate.

On 30 July, at 10:15 am, a 72-hour review took place. The C wing residential manager co-ordinated this review and recorded that the man stated that he is very much better. He also wrote that the man requested that the F2052SH be closed, as he wanted a job. It was agreed that the document would remain open but that the level of supervision should be reduced to level 3. The man was informed that a further review would take place on 3 August with a view to closure. The support plan identifies support from staff, contact with healthcare and encouragement to maintain contact with family. The plan did not indicate specific responsibilities for staff or departments. Prior to this review the man asked how long he would be on level 2.

At 9:30 pm on 30 July, the man was challenged by staff following a smell of burning coming from his cell. It was discovered that the man was lying on the floor, whilst holding burning paper underneath the bed in an attempt to cook toast on the metal frame of his bed. It is also recorded that the man became aggressive and confrontational.

On 31 July, the following comments are recorded in the F2052SH: " 14:20 awaiting visit in holding room. 14:30 sitting crying on visit."

There is no follow up action recorded in this document. The man's friend stated that she visited the man on this date. She attended the establishment with the man's girlfriend but due to a problem with the visit booking, the man's girlfriend was denied access. This was the reason why the man was upset and crying on the visit. The man's friend stated that he did eventually cheer up and that she arranged to visit again on 10 August 2004. The man's friend had attempted, on more than one occasion, without success, to book a visit for 8 August 2004 but could not get one.

On 1 August, a prison officer recorded in the F2052SH that the man was sitting writing a letter, still seemed down but was resigned to the situation. The officer stated upon interview that he wrote this statement following a visit to the man's cell. He indicated that the man stated that he "was a bit down". On the same

day the officer from C wing spoke to the man and recorded that the man states that he had no thoughts of self-harm or suicidal tendencies at present.

On 3 August 2004 at 3:30pm, the F2052SH was closed. A senior officer chaired the review and recorded that the man was very positive, stating that he had no thoughts of self-harm and was no longer depressed. He was speaking in a focused way, wanted a job and to attend remedial Gym. He further stated he was happy at the moment with his girlfriend.

The support plan was non-existent with no accountability, it states: "close 2052SH at 15:30 hours". In addition to the senior officer and the man, the review was attended by a staff nurse and the officer. Following the closure of the document, the man was placed on the pink card system to denote to staff that he had just come off an open self-harm F2052SH within the preceding 14 days. There is no record held in the establishment with regard to an application or referral to attend remedial gym.

During his interview the prison officer stated that the man was very positive during the F2052 SH review. He said that the man indicated that "he had got his head around it now, his head was alright". The man also asked about work. The prison officer suggested that he could probably get him on facilities. During the investigation, no application could be found to support an application for employment for the man in this work area.

The man made four telephone calls to his girlfriend on 3 August 2004.

15:40 hours phone call lasted 11 seconds (4th call on Tape)
The man asked if the man's girlfriend was there. Caller responded by saying she was not in.

15:39 hours phone call lasted 40 seconds (5th call on tape)
The man spoke very abruptly with a named individual. His girlfriend is not at home.

18:23 hours phone call lasted 49 seconds (6th call on tape)
The man asked for his girlfriend. His girlfriend was still not at home. The man apologised to a female for being short with the named individual on the last call. The man requested that his girlfriend stay in for call tomorrow.

20:10 hours phone call lasted 6 minutes and 27 seconds (7th call on tape)
The man's girlfriend was now at home and came to the telephone. There was a conversation between both regarding letters. The man apologised for nasty ones. The man then asked when his girlfriend was coming to visit. She stated she would visit on Sunday. The man asked if she had booked it. The man's girlfriend replied that the man's friend was going to book it on Monday (2 August 2004) and that she should be seeing her tomorrow. The man then got angry

about her children not looking after her. The man's girlfriend stated that she had received the man's letters. The man then mentioned about the razor blades and apologised. He further said he was "convinced that she didn't love him". He told his girlfriend that he was happy that he had received three letters from her. There was some discussion about the "bad letters". The man stated that was all right and that he is hoping to get a job. He stated that he would not ring for a fortnight. He told his girlfriend that his friend was sending him some money. There was then conversation about the visit on Sunday. The man then stated to his girlfriend that he was so glad that he was off "those pills". He ended the call by reaffirming his love for her. Throughout this short telephone call the conversation between both individuals appeared to be strained.

In a letter to his friend (written after Tuesday 3 August 2004) the man stated that he had spoken to his girlfriend on Tuesday evening (3 August 2004). He stated that she was coming to see him on Sunday and that he was looking forward to this event. The man states that he has been nominated for a job on facilities and should start the week after the man's friend's next visit on 14/15 August 2004. During the investigation we could not establish any form of evidence to substantiate the nomination for employment. Additionally, the man indicated that there were still issues surrounding communication with his girlfriend. He questioned whether or not his girlfriend would make it to the visit on Sunday. The man further stated that he had sent his girlfriend at least ten letters and only received three in return. He points out that two of these letters were nasty. The man also questions whether or not they have a future together. The man informed his friend that he has been training in his cell and that his "black eyes" have almost gone. He stated that he was feeling much better and thanked his friend for the card and support.

In a short undated letter to his friend, the man stated that it is now Saturday and he should shortly find out if a visit has been booked for tomorrow. There appears to be issues regarding communication with the man's girlfriend. During the investigation, there was no evidence to support the booking of the visit by the man's girlfriend.

During the investigation we were unable to gain any form of evidence (written or oral) for 4 August 2004 up to and including 6 August 2004.

Altercation on C wing

On Saturday 7 August 2004, the man who died complained to wing staff that he needed to see the healthcare dept. An officer who was on duty on C wing recalls that the man was always complaining about medication and specifically remembers the man complaining about a pain in his shoulder. A second officer (who also works on C wing) stated that the man had complained to him on several occasions during the morning period that he needed to speak to the nurse. He stated that he rang the healthcare department at various times in

order for them to see the man. He further stated that he informed the man of this contact. The second officer could not recall a nurse attending to see the man.

At approximately 3:00 pm whilst on association on C wing, the man again raised the issue of being seen by healthcare. The second senior officer stated that the man became very aggressive and loud he took the man into his office, accompanied by the officer and told him to calm down. He explained to the man that they had been on to the hospital about his medication, it was all being sorted, and that there was nothing further that they could do. The second senior officer told him to go back to his cell and calm down.

The man was walking back to his cell escorted by the officer. According to the prison officer when the man entered his cell he became very aggressive again. A prison officer explained that just prior to the incident he was stood at the cell door. He stated that the man picked up a chair and went to swing it at him. He further stated that he was unable to shut the door and restrained the man for health and safety purposes. A prison officer then initiated control and restraint by grabbing the man's head. In his final letter, the man indicated that upon returning to his cell, the cell door was locked and that he threw the chair against the door. He then stated that the officer opened the door and restrained him. The second officer on the scene heard a heated argument between the man and the prison officer. He saw the prison officer return the man to his cell. The next thing he heard was a bang and saw the prison officer going into the cell. He blew his whistle and attended to assist the prison officer. He indicated that the man wasn't particularly struggling and remembered that the man was complaining of a shoulder injury. When questioned as to whether or not the prison officer had opened the door to restrain the man, the second officer on the scene answered, "I never really saw what happened next."

Another officer also responded to the alarm bell and assisted in the restraint. He remembers the man complaining about his shoulder and recalls the man saying that "he was not violent, he just wanted his medication sorting out".

A senior officer who normally works on A wing also responded to the alarm whistle. He took over the supervision of the incident. He described the man as being irate more than angry. He also stated that the man kept saying, "I didn't do anything". The senior officer applied handcuffs (handed to him by Oscar 2, the Principal Officer with responsibility for responding to incidents in the Victorian part of the prison where the man's wing was located) and explained to the man what was going to happen next. The senior officer was not aware that the man was on the pink card system. The man was relocated to the segregation unit.

When the Principal Officer arrived at the scene, the senior officer was already supervising the restraint. The Principal Officer took the decision to allow him to continue in this role and did not receive or seek a briefing from the wing manager, the second senior officer. Therefore he was unaware that the man

was on the pink card system. Upon interview, the Principal Officer was questioned as to whether or not it would be useful to have this information. He stated “if you are aware of all the facts then obviously you can develop a bigger picture of what has happened, what has occurred and where are we going to from here. At that stage not aware of him, probably a fault of mine not checking the cell card, but it was not made aware to me that he was on the pink card”.

A second senior officer stated that he felt it was the responsibility of the officer completing the actual move to (the segregation unit) inform the incident manager with regards to important information.

All those involved in the restraint of the man completed the use of force form. The Principal Officer completed the paperwork as the supervising officer. Under the heading Nature of incident (description of circumstances prior to the use of force), he states “ once in his cell, the man picked up his chair and started to smash it against the cell wall”. However, when the prison officer was questioned about this wording, he stated that he had not indicated to the Principal Officer that the chair had been smashed against the wall. This is another example of the incident not being properly investigated.

The duty senior manager (DSM) on 7 August 2004 was the person who had overall responsibility for unified operations within the establishment. He stated that the Principal Officer had informed him of the incident involving the man on C wing. He made the following entry in the DSM’s diary: “Whistle alarm, (the man) relocated under restraint after threatening a member of staff with a chair”. Upon interview, the DSM, stated that he was not made aware that the man was on the pink card system. He further stated that he would have expected this type of information to be passed onto the incident manager.

Following this incident, there was no consideration given to reviewing the Pink card status. The man was placed on a Governor’s report for using threatening and abusive words or behaviour.

A prison officer on duty in the segregation unit was one of the staff that received the man into the unit, following the restraint. During her interview she stated that the man’s main concern was that he had messed up his chance of employment. The segregation officer also stated that she was aware that the man was on the Pink Card system. The actual pink card was handed over by C wing staff approximately 5-10 minutes after the re-location.

At 3:10 pm, the Segregation Safety Algorithm, a flow chart which indicates whether it is reasonable to keep a prisoner in the Segregation Unit, was partly completed in the unit by a nurse. Part A question 2 asks the following: 'Has the person self-harmed in this period of custody / are they on an open F2052SH or is the person currently taking any anti-psychotic medication?' The “NO” box is ticked. This is clearly incorrect. The segregation officer stated that the decision

to move the man to B wing was taken by a Principal Officer whom she was unable to identify. Oscar 2, a Principal Officer, indicated that he was not aware who gave permission for the man to move to B wing.

Relocation to B wing

At 3:45 pm, the segregation officer relocated the man to B wing. She took the man onto B3 (Healthcare department located here) and informed the healthcare staff that the man was now located on this wing. The segregation officer recalled speaking to a nurse who showed her some notes that contained a list to see the doctor. The man's name was on this list. The segregation officer stated that she physically showed the man this list and remarked to him "you have got yourself worked up over nothing really, because you are down to see the doctor anyway". The segregation officer further stated that she handed the man over to a wing officer, informing this individual that he was on the pink card system. During the investigation we were unable to establish the identity of the receiving officer. However, the senior officer in charge of B wing stated that shortly after his arrival he spoke briefly with the man and introduced himself. He was not aware that The man was on the pink card system until after his death. He further stated that The man was "a little upset by what happened" in C wing with the man also indicating "he was taken down the block for nothing". The senior officer in charge of B wing informed the man that had an opportunity for a fresh start on B wing.

The man was located in cell B3-019, a double cell, where there already was another occupant. The officer working on B wing recalled locating the man in his cell and collecting the man's property from C wing. He also remembered answering a cell bell and the man complaining of pains in his fingers. He further stated that he took the man to B3 (Healthcare centre) and left him with the nurse and doctor. The time was approximately 5:00 pm. The nurse and an on call doctor saw the man. The doctor recorded in the IMR (Inmate Medical Record) "a twisted left shoulder/sprain this AM with full ROM [range of movement] active with decreased abduction. Sprained shoulder, add paracetamol". The man requested stronger medication but was prescribed paracetamol.

At the time of the incident, the man's cellmate had been in Birmingham for approximately two months. The man's cell mate recalls the man coming into the cell and introducing himself. He stated that it was nearing the end of association and shortly afterwards, The man left to attend healthcare (described above). The man's cell mate stated that he was aware that the man was on the pink card system and that the card was located outside the cell.

Upon his return from healthcare, the man's cell mate recalled the man stating that he had been given some paracetamol and that his arm was hurting. Whilst listening to music, general conversation then took place between both individuals. After a while the man's cell mate began to write a letter, the man asked if he could borrow a letter and a pen. He specifically remembers lending

the man a green pen to write his letter (The letter retrieved from the post box following his death was written in green ink). At approximately 6:22 pm, the man's cell mate recalled that the man was lying on his bed writing his letter when he started moaning about his arm. The man pressed the cell call button and asked to see the doctor. The man's cell mate indicates that staff responded to the call and stated to the man that there was not a lot else they could do and that he had already seen the doctor. It appears that the man accepted this response and carried on writing his letter.

The cell bell was pressed at 7:25 pm and reset within thirty seconds. It was pressed again at 7:26 pm, became a priority call at 7:28 pm and was eventually reset at 7:53 pm, twenty seven minutes after the original call.

An officer was on duty on B wing as the evening duty patrol. He recalled answering the cell bell at approximately 7:30 pm. He stated that he went to healthcare to enquire about the man and established that the doctor had already seen him. He further stated that he obtained two paracetamol from the nurse and took these up to the man's cell. After handing these over, the man complained that he wanted something stronger. The officer on duty patrol stated that the man did press his cell bell again stating that he was still in pain with his arm. He told the man that he would get the nurse to go and see him. At this time the nurse was busy and the officer on duty patrol was also dealing with another prisoner on the 4's landing who had self-harmed. This prisoner was seen by Healthcare and subsequently placed on a F2052SH, he was also relocated to the 2's landing. The officer stated that it was approaching 8:00 pm by the time he completed these tasks. He indicated that he was working on his own for the majority of the evening. Apart from Control, whom he rang to obtain a number for the F2052SH, the officer did not inform anyone else. The duty senior manager was certainly not made aware of any issues on B wing during the evening duty period.

The man's cellmate confirmed that there appeared to be an incident on the 4's landing. He remembered the man shouting to the nursing staff, "Nurse can I see you please, nurse can I see you?" One of them replied, "yeah, we'll be down in a minute". He further stated that they did not appear and turned off the red light (cell call indicator). The man pressed it again and two officers came to the cell. The mans cell mate states that the officers said, "the nurse does not want to see you; the doctor is the only one that can prescribe medicine". The man's cell mate then went on to say the staff made a remark, indicating that the man had assaulted an officer. According to the man's cell mate this "really stressed the man out". In an earlier conversation the man stated that he never assaulted an officer. He said that he threw a chair but did not know an officer was behind the door.

The man kept pressing the cell call button and after ten minutes a nurse came to the cell. The visit by the nurse took place at 8:30 pm and was recorded in the

IMR (Inmate Medical Record). It reads as follows: Asked by officer on B wing to see inmate(the man). Spoke to inmate through hatch, explained had prescribed paracetamol at 20:00 hrs and cannot have any more until 12 midnight. C/o pain left arm, seen by doctor today. To be reviewed by night nurse if needed during the night.

The man's cell mate recalls this visit and that the conversation took place through the observation flap. He also states that the man said to the officers "I need to see a doctor for my arm" and " Is this what it takes for me to kill myself before I can see a doctor?" The man was obviously unhappy at the response and remarked to the mans cell mate " You see what I mean mate, if anything happens to me, contact my solicitor". The man then continued writing his letter. The man's cell mate did not take the man's threat seriously. During interview, the officer on duty patrol and the nurse do not recall this specific threat. The officer on duty patrol stated that the man was making all sorts of threats, saying that he was being stitched up by C wing. He said that he visited him again and advised the man if the pain got any worse to press his cell bell and speak with the night staff. He indicated to the man that with a change of nurse he might have more success in getting some painkillers. The nurse also stated that the man was angry but that there were no indications from him that he would self-harm.

Removal of razor blade from the man's cell

At this point in the interview with the night duty patrol officer, I asked him if anything else had happened specifically with the man during the evening. The officer answered, "No, I went to his cell about three times, four times. I responded with the following; "something that just needs to be cleared up, his cell mate stated to us that during one of the visits, and I'm assuming it was during the evening duty, that during one of the visits he held up a razor blade to the flap and the man's cellmate stated that two officers were worried about it and came into the cell, can you recall that at all"? the officer responded "yes, ah yes that's correct" and "we went and took his razor blade out of the cell". Additionally, I asked him; "can you just describe what you can remember of that conversation in terms of him showing you the razor blade and why you undid the door". The officer replied; "I went in there, he says, get me a doctor, I'll swallow the blade. So I went and took, pre-empted, you're not going to swallow the blade, I'll take the blade off him, searched the whole pad and took all blades out". The officer was fully aware that the man was on the pink card system. I asked the officer "if it entered his mind at all to think why he (the man who is the subject of this report) been on the pink card and to seek guidance on whether or not you should probably open the book (F2052SH) up again"? The officer responded, "Actually at the time it did not" and " I thought it was just a threat to demand."

The night patrol officer did not update the observation book, make any comments in the man's wing file or inform the orderly officer. The officer could not recall the

last time he received suicide prevention training. The duty senior manager stated upon interview that he would have expected to have been informed about the man's behaviour.

The night officer was "floating" between both B and C wings during the evening duty period. He recalls attending the man's cell that evening with a nurse. He also stated that he was the second officer present when the razor blades were retrieved. He further stated that he knew the man was on the pink card. The night officer was also in attendance when dealing with the prisoner on the 4's he stated that this person had cut his wrists. When I asked the night officer if he heard the man say that he was going to kill himself, he replied; "Yeah. He did say he was going to harm himself, well whether it was harm himself or cut himself or kill himself, I can't remember now". When I asked the night officer whether or not he and the night patrol officer had considered informing the orderly officer or to placing the man back on a F2052SH, he stated that he presumed the nurse or the senior officer on the wing would do this. His reasoning for this thought process was that he was not the regular member of staff on B wing and was only "flitting" between both wings. I asked him from what he had witnessed, whether or not he had any responsibilities in this process. He replied; "Yeah, I presume, I thought that with me not being the B wing officer, the officer on B wing or the nurse or the senior officer would have been doing that. I presume they would have been told about it.

The night patrol officer states that he last saw the man at approximately 8:45 pm when the man put his bell on again to ask for medication (cell call records indicate the bell was pressed at 8:43 pm and reset at 8:44 pm). The night patrol officer went off duty at approximately 20:50 hours. Prior to this he handed over to the night patrol, OSG (operational support grade). He informed the OSG of the issues surrounding the man during the evening duty period. The OSG confirmed that he was given a full handover including the details of the incident on C wing earlier in the day. He stated that he was aware that the man was on the pink card. He further stated that along with the F2052SH he also pegged those on the pink card system. (The peg is registered on the computerised system when the cell call button is depressed outside the cell. This is recorded as a "visit".)

The OSG stated that the man pressed his cell bell shortly after he commenced his shift. this was answered within a minute. He said that the man told him that he was suffering with pain in his left arm and that he wanted to see a doctor. The OSG used his radio and asked Oscar 2 (assist orderly officer) and Hotel 2 (night nurse) to attend and speak with the man. The acting senior officer had the call sign Oscar 2 and a nurse responded as Hotel 2. Both recall attending B wing and speaking with the man. The nurse stated that the man wanted stronger medication for the pain. He explained to the man that he was only allowed to prescribe paracetamol. The acting senior officer stated that the man was given two paracetomol at approximately 10:00 pm. The OSG confirms this, he stated

that at around 10:00 pm, the man pressed his cell bell (cell call record registered at 10:04pm hours) and requested the medication.

The OSG explained that he had a lengthy conversation with the man. He advised him that the night staff had done all they could and it would probably be best if he could try and get some sleep. According to the OSG, the man thanked him for his help. The man's cellmate recalled that this conversation went on for approximately fifteen minutes. During this conversation the man asked the OSG if he could find out if it had been recorded that he had assaulted an officer on C wing. The OSG said that he went and checked the observation book on C wing. He then went back and told the man that there was nothing of note recorded on the wing. The OSG indicated that the man seemed relieved when he received this information.

The man's cellmate states that following the conversation with the OSG, the man was on his bed watching a film on the television. According to the man's cell mate, the man fell asleep before the end of the film. When the programme ended, the man's cell mate called over to the man, but he was still asleep. The man's cell mate turned the television off. The OSG stated that by eleven thirty, the man was asleep. The cell call button was not pressed again during the night period.

Sunday 8 August 2004

The senior officer in charge of B wing received a briefing from the night duty OSG and noted his comments in the observation book. He states that he was first on duty in the morning and carried out the physical headcount of the prisoners on B wing. He was not informed about the previous evening and the retrieval of razor blades from the man. He said that he would have expected this information to be entered into the observation book.

On Sunday morning, 8 August 2004, the man and his cell mate were located in their cell. The man's cell mate stated that the man woke up first and smoked a rolled up cigarette. They were both waiting for exercise, which usually takes place at 08:30 am. An officer stated during his interview that exercise was late due to a power failure. The man's cell mate stated that he discussed exercise with the man, both were fairly certain that it was not going to take place. The man's cell mate stated that the man did not seem like he was stressed, he was lying on his bed with his hands behind his head. The man's cell mate recalled that some prisoners were out on the landing. One prisoner looked through the observation flap and requested a "burn" [cigarette]. Approximately ten minutes later they were unlocked for exercise.

The man's cell mate states that he left the cell with his rubbish bin to empty it into a large dustbin that was located across the landing. He further states that the man shouted to him to close the door after replacing the bin. He also recalls the

man holding a letter in his hand and gesturing that he was going to post it. The man's cell mate stated that he went back to the cell to replace the bin and to collect his own letters for posting. The man's cell mate states that this whole process took no more than a "minute and a half". The man's cell mate made it very clear that there was no chance of the man being or hiding in the cell. He recalled very clearly closing and locking the door shut when he left the cell.

After closing the cell door, the man's cell mate went down the stairs onto the 2's landing to post his letters. He recalls prisoners on the landing waiting to be searched prior to exercise. He posted his letters, got searched by an officer and then went downstairs and outside for exercise. He said that he was on exercise between forty- five minutes and a hour. The man's cell mate further stated that he had looked for the man on the exercise yard but could not see him.

A third prison officer stated during interview that he was detailed to work on landing B3 on Sunday morning. He recalled that due to staffing difficulties, he was working on his own. He did not receive a briefing regarding the man but states that he did read the observation book and noted the comments made by the OSG. The third prison officer unlocked for exercise. He recalls both the man's cell mate and the man coming out of the cell and walking past him. He remembered that there was a pink card outside the cell. He unlocked all of the cell doors and shouted "last call fellows, the gate will be closing". The third prison officer stated that the prisoners on the three's had to walk down onto the two's landing where they would be rubbed down prior to leaving the wing. He then stated that he walked around the landing and checked all the doors to see if they were closed. He further stated that all the flaps and doors were closed. Approximately five to ten minutes later a church service was called. He recalls that only three prisoners from his landing attended this service. The third prison officer stated that he did not let the man or anyone else back into his cell following the call for exercise.

The third prison officer stated that no prisoners are individually marked off on a roll board when they attend exercise. The prisoners are counted off the wing and onto the exercise yard. This total is then radioed back to the wing. The third prison officer stated that following this movement there is no procedure for an actual roll reconciliation of his landing. The actual number of prisoners attending exercise are marked out on the board with the presumption that the rest are on the wing or attending other activities. The third prison officer stated that after helping out with the church service he was asked to cover a toilet break for an officer. He then went to the exercise yard to replace the officer from B wing. During this period there was no officer patrolling the three's landing. When he returned from supervising exercise, the officer working on B wing took up duties on the 3s landing. He does not recall seeing the man during this period.

The second prison officer was also working on B wing on Sunday morning. He was detailed to work on the two's landing. The senior officer in charge of B wing

had a telephone call from home and he had to leave the establishment. The second prison officer, being the most senior officer, took over responsibility for the wing.

The second prison officer also stated that the wing roll following movement to exercise was not reconciled. He stated "You work out how many of your landing has gone (to exercise) by how many's left". Additionally he said that "when the prisoners have gone out, you just check to see whether there are any doors left open or not and close the doors that are open". When I asked him about procedures to check those prisoners (left on the wing) subject to the pink card or F2052SH he stated that:

> "if there are any on orange cards (F2052SH) you know automatically to check those cells, because it could always be that one of them has been locked in on their own. And a number of times I've had to open the door and throw the lock because the chap on the exercise has just shut the door. Pink cards, you pretty much have to check the same. But because there is no booklet and their photograph you have to rely on experience of knowing who that person is".

The officer from B wing also stated that he does not do a physical head count (of the Landing/Wing) following movement to exercise. The senior officer in charge of B wing also confirmed that the wing roll is not reconciled following movement to exercise. He stated that the management of prisoners subject to a pink card was normally left to the landing officers. A prison officer who also works on B wing stated on interview, that following movement landing officers should conduct a head count but that he was not instructed to carry out this task.

The senior officer in charge of B wing stated that LBB's (a check of Lock, Bolts & Bars) are usually completed by landing officers during the exercise period. Two landing officers carry out this task. Records show that this task was not completed on this particular day. The senior officer further stated that the possible reason for this might have been due to his departure and the subsequent reduction in staffing levels on the wing. He also confirmed that the wing roll is not reconciled.

At some point, the man regained entry to his cell. The third prison officer indicated on interview that all the cell doors were checked and locked after exercise had gone out. It is unclear how the man got back into his cell. However, he was subject to the pink card and should not have been in the cell on his own. During interviews, several staff indicated that they had experienced difficulties in the past with specialist and non-uniformed staff not informing wing staff of prisoners they had taken off or brought back to the wing. Although not common practice, this has included letting prisoners back into their cells. Staff also indicated that there was more awareness of the F2052 SH (orange cell card) rather than the pink card system.

The discovery of the man

At approximately 10:50 am, exercise finished and prisoners were returned to their cells on B wing. At 11:00 am, the officer from B wing unlocked B3-019 allowing the man's cellmate back into his cell. Upon entering the cell, the man's cell mate discovered the man hanging from the cell bars at the end of the cell. The man's cell mate immediately raised the alarm by frantically banging on the back of the cell door and by pressing the cell call button. The officer and the second prison officer arrived at the cell. The B wing officer and the man's cell mate took the weight of the man's body whilst the second prison officer used the "big fish" knife [a specialised tool] to cut the ligature and release the man from the window bars. The man was placed in the recovery position on his bed. The second prison officer felt for a pulse. None was detected and he stated that the man was not breathing. Almost immediately, the nursing staff arrived (Healthcare centre located on B wing). CPR was commenced and Paramedics were requested to attend immediately. No vital signs detected by trained nurses.

The principal officer attended the scene. He was closely followed by Oscar 2. Oscar 2 recalled a nurse requesting a "blue light". He contacted the control room and requested the attendance of an ambulance. He then took on the role of "scene bronze commander". The principal officer attended the control room. The duty governor was already present in this location and had activated the establishment contingency plans. Two paramedics arrived at the establishment at 11:13 am. They arrived on scene at 11:15 am. The man was pronounced dead by the paramedics at 11:20 am

Events following the man's death

The security senior officer attended the scene in response to the alarm. After the man's death was pronounced, he took charge of the scene and acted as liaison with the Police. He instructed all staff to leave the cell. Following local contingency plans, he then proceeded to take photographs of the scene, these included photographs of the man's body. Following this he then sealed the cell with a padlock. He remained outside the cell until the Police arrived. The photographs were stored in the security incident file, which was located in the security office. The security senior officer stated that anyone who worked in security could potentially have access to this file.

Following the man's death, a letter written in green ink from the man to his friend was retrieved from the post box on B wing. In this letter, the man stated that the Senior Officer on C wing had "got all pissed at me, dragged me by the arm into the office, pinned me against the wall, threatening to knock me out if I tried to tell him how to run his wing". However, during the interview with the second senior officer, he categorically denied this accusation. He described that he gave the man a "good telling off and that I had to shout at him to get through to him, but certainly I didn't touch him, that is not my way". The man then went on to describe the incident with the prison officer. He wrote that he was told to bang himself up and indicated that he did this. He then states that he threw a chair against the back of the door, which was locked. He further stated that the officer looked through the "flap", opened the door, came rushing through, grabbed him round the neck so he went to the floor. Upon interview, the prison officer stated that the door was not closed and that the man grabbed a chair and made an attempt to swing it at him. He further stated that he was not able to close the door and restrained the man for his own Health and Safety.

The man described to his friend that he had been moved to another wing and was awaiting an adjudication on Monday morning. He was worried that he would not be considered for employment following the incident with the prison officer. He indicated that his friend would not be visiting the next day (Sunday 8 August 2004). The man apologised to his friend and stated that he had lost everything. He again repeated the claim that the senior officer had assaulted him.

The man then wrote:

> "It's obvious to me that my girlfriend has had second thoughts about us, so here I am for the next three months, getting stitched up for no good reason, in pain, both in my heart and physically. Just make sure that if anything happens to me that this letter goes to the right people to explain what happened yesterday."

The man followed this by stating:

> “It’s a toss up between stringing myself up or going on hunger strike. I don’t know if I’m brave enough to kill myself, but we'll see. This whole sentence is fucked up. I get assaulted and I end up getting knicked.”

The man ended the letter:

> “My girlfriend is right in a way I am scared of being on my own but not because I don’t want to be on my own, I want to be with her anyway got to post this now, hopefully see you soon.”

The man's history of self harm at Birmingham

The investigation established that the man had attempted suicide in the past. Although there were no specific details, a parole report completed by the Probation Service stated the following:

“The applicant has attempted suicide in the past and whilst resident in the West Midlands some years ago had contact with a Community Psychiatric Nurse due to depression. Probation records indicate that mental health services were of the view that due to his experiences in childhood, which included physical and emotional abuse, he had poor impulse control, which contributed to suicidal behaviour.”

The man’s friend stated to my investigators that the man had scars on his body as a result of self harm attempts.

<u>20 July 2004</u>

The PER form completed by the escorting contractor clearly indicated that the man was a suicidal or self harm risk.

The man was first received into HMP Birmingham on 20 July 2004. A cell sharing risk assessment was completed with the man informing staff that he had not previously been subject to F2052SH. It is recorded that the PER document was available during this assessment.

On 20 July 2004, the first reception health screen was carried out. The man stated that he has never deliberately self-harmed and does not feel like hurting himself and is not feeling suicidal.

On 20 July 2004, the man assisted in the completion of a questionnaire on the first night centre. He stated that he had been in custody on 10+ occasions and that it was less than one year since he had been released. During this interview he again confirmed that he had never committed acts of self-harm. There is no evidence to support the PER being available during this assessment. This document remains uncompleted. There is no evidence to indicate that the man took part in the 2nd day Induction programme. The respective pages are blank.

<u>21 July 2004</u>

On 21 July 2004, the man attended Coventry Crown Court for sentencing. The PER completed by the establishment makes no reference to the suicide or self-harm markers contained on the escorting contractors PER received the previous evening.

22 July 2004

On 22 July the cell sharing risk assessment – induction board review was completed. This documentation states that the PER was not available for this assessment.

On 22 July, the man was located on "K" wing. Also on this date the CARAT's team interviewed the man. It is recorded that he was a non-drug user and that he had no suicidal thoughts. The man made a telephone call to his friend at 8:09 am on 22 July. When asked how he was feeling, the man replied "I am not going to top myself or anything like that".

The man wrote a letter to his friend dated 26 July. He stated that he was really struggling without his painkillers and starting to "rattle". He indicated that he is addicted to them and was really worried after having a lucky escape with heroin.

28 July 2004

On 28 July, the man was seen by a member from the IMB. The man spoke to her about his medication. The IMB member states that she contacted the healthcare department to arrange a doctor's appointment.

At 2:00pm on 28 July, the man self-harmed with a razor blade by making superficial cuts to his upper thighs. At 2:35pm the man was placed on an open F2052SH. The duty doctor recorded on the healthcare assessment that the man was depressed, tearful, angry and that he had suicidal thoughts. Issues surrounding abuse as a child and medication were also recorded.

On 28 July, The prison doctor completed a healthcare follow-up pro-forma. He referred the man to Psychiatrist and to smoking cessation. This referral did not reach its intended destination. This form was discovered in a box on the healthcare secretary's desk on 9 August 2004.

29 July 2004

In a letter written to the man's friend on 29 July, the man explained that he tried to kill himself on 28 July 2004.

The second prison doctor interviewed the man on 29 July 2004. In this consultation, the second prison recorded that the man was worried that his girlfriend was going to leave him but that he is now convinced that she won't leave him now, he has only sixteen weeks to serve and that he had no intent of committing suicide. The doctor concluded that the man seems not to be suicidal.

At 10:15 am on 29 July, the seventy-two hour review of the F2052SH took place. The C wing residential officer co-ordinated this review. It was recorded that the

man was very much better and that he requested that the F2052SH be closed because he wanted a job. It was agreed to that the document would remain open but that the level of supervision would be reduced to level 3. The man was informed that a further review would take place on the 3 August with a view to closure. The support plan does not indicate specific responsibilities for staff or department

31 July 2004

On 31 July the F2052SH document records that at 2:30 pm, the man was crying on his visit. The man's friend stated that she visited him on this date. She attended the establishment with the man's girlfriend but due to a problem with the visits booking, the man's girlfriend was denied access. This was the reason why the man was upset.

The man's friend stated that she informed the man that she would arrange to visit him again on 10 August. The man's friend states that she attempted on more than one occasion to book the visit for 8 August. She complained about excessive delays in gaining a telephone response from the visits centre.

1 August 2004

On 1 August, the officer on C wing recorded that the man stated that he had no thoughts of self-harm or suicidal tendencies at present.

3 August 2004

At 3:30pm on 3 August, the F2052SH was closed. A senior officer chaired the review and recorded that the man was very positive, stating that he had no thoughts of self harm and no longer depressed. The man stated that he was happy at the moment with his girlfriend and once again requested employment. The prison officer suggested that he could probably get the man on facilities working around the establishment. No record of an application could be found during the investigation.

The support plan completed at this review is non-existent with no accountability, it states: Close F2052SH at 15:30 hour. Following the closure, the man became subject to the "Pink Card" procedures. A pink cell card was completed and placed outside of his cell. This denotes to staff that the man had recently come of an open F2052SH (within the preceding fourteen days).

A principal officer was detailed Oscar 2 duties and attended C wing to supervise the altercation between the man and the prison officer. Oscar 2 did not seek or receive a briefing from the wing manager, the second senior officer. Oscar 2 stated that he was not aware that the man was on the Pink card system. A second senior officer felt that it was the responsibility of the officer completing the

re-location, to inform the incident manager with regards to the pink card information.

The duty senior manager for 7 August 2004 was informed by Oscar 2 about the incident with the man on C wing. The duty senior manager was not informed that the man was subject to the pink card system. He further stated that he would have expected this type of information to be passed onto the incident manager.

Following this incident there was no consideration given to reviewing the pink card status. The man was placed on a Governor's report for using threatening and abusive words or behaviour.

At 3:10 pm the Segregation Safety Algorithm was partly completed in the Segregation Unit by a nurse. Part A question 2 asks the following: has the person self-harmed in this period of custody / are they on an open F2052SH or is the person currently taking any anti-psychotic medication? The "NO" box is ticked.

The segregation officer then handed the man over to the staff on B wing. She states that she informed them that he was on the pink card system. The senior officer in charge of B wing was the wing manager for this particular period. He recalled introducing himself to the man. He remembered the man being "a little upset by what happened" in C wing and that the man felt "he was taken down the Block for nothing". The senior officer in charge of B wing was not aware that the man was subject to the pink card procedures.

The man's cellmate stated that he was aware that the man was on the pink card system and that the card was outside the cell.

A nurse recorded in the IMR that she visited the man at 8:30pm. The man's cellmate recalled this visit. He stated that the man said to the staff present, "I need to see a doctor for my arm" and "Is this what it takes it takes for me to kill myself before I can see a doctor?" Additionally, the man said to his cell mate, "if anything happens to me, contact my solicitor". The man's cell mate did not take this threat seriously. During interviews, the night patrol officer and the nurse do not recall the man making this specific threat. However, the officer who was the assisting officer floating between B and C wings does recall this threat and stated on interview " Yeah, he did say he was going to harm himself, well whether it was harm himself or cut himself or kill himself, I can't remember now". The nurse also stated that the man was angry but that there were no indications from him that he would self-harm.

Two officers removed two razor blades from the man's cell after he said he would swallow a blade. Both officers knew the man was on the pink card but did not update the observation book, inform the Duty Senior Manager of their actions or the man's behaviour.

The second prison officer stated that the wing roll following movement to exercise was not reconciled. He stated “You work out how many of your landing has gone (to exercise) by how many’s left”. Additionally he said that “when the prisoners have gone out, you just check to see whether there are any doors left open or not and close the doors that are open”.

When he was asked about procedures to check those prisoners (left on the wing) subject to the pink card or F2052SH he stated that “ if there are any on orange cards (F2052SH) you know automatically to check those cells, because it could always be that one of them has been locked in on their own. And a number of times I’ve had to open the door and throw the lock because the chap on the exercise has just shut the door. Pink cards, you pretty much have to check the same. But because there is no booklet and their photograph you have to rely on experience of knowing who that person is”.

The senior officer in charge of B wing also confirmed that the wing roll is not reconciled following movement to exercise. He stated that the management of prisoners subject to a pink card was normally left to the landing officers.

During interviews several staff indicated that they have experienced difficulties with specialist and non-unified staff when they have not been informed of prisoner movement on or off the wing. Although not common practice this has included letting prisoners back into their cells. Staff also indicated that there is more of an awareness of the F2052SH (orange cell card) than the pink card system.

At approximately 10:50am exercise was completed and prisoners were returning to their cells on B wing. At 11:00am an officer unlocked B3-019 allowing the man’s cellmate back into his cell. Upon entering the cell, the man’s cell mate discovered the man hanging from the cell bars at the end of the cell.

Two paramedics arrive at the establishment at 11:13am. They arrive on scene at 11:15am. The man is pronounced dead by the paramedics at 11:20am. There is no evidence to support the attendance of a doctor to certify death.

The man’s Record of Events, a file where events or incidents should be recorded by staff, was opened on D wing on 20 July 2004. A second entry was made when he moved to K wing on 22 July 2004. A third entry was made on 30 July 2004 following the man’s F2052SH review. A fourth entry was made on 7 August 2004 at 15:00 hours when the man was re-located in the Segregation unit. The final entry was also made on this date. It states: “2052SH closed 3/8/4. From Seg.” None of the information outlines specific details about the man and his period in custody. This information is recorded on only twelve lines, on the inside cover of the file.

Between January 2004 and June 2004 a total of 356 F2052SH books were opened up in the establishment. This figure equates to an average of 59 books opened per month over this six-month period.

Statistics provided for the investigation team show that 79 staff had received suicide prevention training during the training year (2004). The “caring for prisoners at risk of self-harm/suicide” guide states that all staff having contact with prisoners must be trained in the foundation modules. The suicide prevention team estimate that 400+ staff fall into this category. Training records show that since March 2003, 219 staff have received suicide awareness training. However, the training records for 2004 do not reconcile with those produced by the suicide prevention team.