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

Report by the Prisons and Probation Ombudsman for England and Wales

August 2011

The man was 40 years old when he died at hospital in September 2010. He had been found hanging in his cell at HMP Birmingham shortly before 2.30pm the previous afternoon. Staff performed cardio pulmonary resuscitation and he was taken to hospital. Sadly he did not recover. The post mortem report indicates that he died as a result of hanging.

He had never been to prison before. Following significant problems with alcohol misuse and depression, he violently assaulted one of his children and was taken into custody at the start of July. He was subject to self-harm monitoring for a month because staff were concerned about his state of mind. However, his mood seemed to improve and at the start of August the monitoring ended. He was assessed by a forensic consultant psychiatrist who did not think that he was clinically depressed. Staff thought that he was coping with the prison environment, but sadly he hanged himself two days before he was due to appear at the Crown Court to enter a plea.

I would like to extend my condolences to his wife, children, father, step-mother and siblings. The events of the last year have undoubtedly been extremely traumatic for them. I hope that my report provides them with a better understanding of what happened to him in prison.

The investigation was completed by one of my investigators. He visited Birmingham and interviewed discipline and healthcare staff. My Senior Family Liaison Officer contacted the family to tell them more about the investigation and to find out what concerns and questions they had about his death. I am very grateful to the relatives for their involvement.

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

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

I consider that staff at Birmingham demonstrated good practice and wise caution in view of the man's offence and several associated risk factors. Not only had he committed a violent offence against his child, but he also misused alcohol and had mental health problems. Additionally, this was his first experience of prison and he had made previous attempts to take his own life in the community.

However, the investigation has highlighted concerns about the prescription of anti-depressant medication and the way in which self harm monitoring is completed. Although I think that sensible decisions were evidenced and that observations were gradually reduced in a structured fashion, I am disappointed to note that a succession of different case managers oversaw the reviews and sometimes carried out the reviews on their own.

The investigation also serves to remind staff about the potential significance of court dates for those prisoners who have committed particularly emotive offences. I hope that some lessons can be learned. I make nine recommendations.

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 **August 2011**

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SUMMARY

1. The man had experienced problems with alcohol misuse and depression in the community. He had previously attempted to take his own life. At the beginning of July 2010, he was arrested for attempting to murder one of his young children whilst intoxicated. He was held in a police station where he tried to strangle himself. He was taken to hospital to treat his alcohol withdrawal symptoms.

2. On Monday 5 July, he was taken to court and remanded into custody. He was escorted to HMP Birmingham. Staff were informed of his offence and his attempt to harm himself at the police station. He was given medication to help him to continue withdrawing safely from alcohol. He was also prescribed anti depressant medication. He was referred to an alcohol worker and to the mental health team. Because of his background, his offence and his presentation, staff decided to begin self harm monitoring and implemented the Assessment, Care in Custody and Teamwork (ACCT) procedures.

3. He remained subject to ACCT monitoring but the frequency of the observations was gradually reduced. On 22 July, he was assessed by a forensic consultant psychiatrist, who did not think that he was clinically depressed. Nonetheless, he decided to double his daily dose of antidepressant medication as a supportive measure during a difficult period. However, due to an error the change in medication never happened and he remained on the lower dose. Because he seemed to be coping with prison life and showed no further signs of distress or suicidal intent, staff ended the self-harm monitoring and closed the ACCT document with his agreement on 2 August.

4. Throughout July, August and September, he was also supported by an alcohol in-reach worker, although his progress was slow. He received regular visits from his sister and her family. However, he was prevented from contacting his wife and children on the instructions of the local Public Protection Unit because of the nature of his offence.

5. Since the beginning of August, he had not given any indication to staff that he was thinking about taking his own life. However, his sister had become worried about him after a visit and contacted the prison on 22 August. A member of staff spent time talking to him, who said that he was not unduly anxious. He continued to be checked by the forensic psychiatric team but was unable to go to an appointment with the psychiatrist on 23 September because there were no officers available to escort him to the healthcare centre.

6. On Saturday 25 September, he was found hanging in his cell at about 2.30pm when his cellmate returned from an exercise period. Staff responded quickly and tried to resuscitate him. He was taken to hospital but sadly did not recover. He died in the early hours of 26 September. He had been due to go to the Crown Court on Monday 27 September to plead to the charge that he faced.

THE INVESTIGATION PROCESS

7. The investigator was formally notified of the man's death on 27 September 2010. Notices were subsequently issued to both staff and prisoners at HMP Birmingham, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information.

8. During the investigation, he liaised with Birmingham's safer custody unit. He visited Birmingham on 30 September and was provided with all documents relating to the man's time in custody.

9. On the same day, somebody claiming to be a member of staff at the prison but wishing to remain anonymous telephoned the Prisons and Probation Ombudsman's office. The caller asked whether the Ombudsman planned to investigate the recent high number of deaths at Birmingham as a pattern. (I refer to previous deaths in paragraphs 33 and 34 of this report.) The caller suggested that the treatment of prisoners by staff might be influencing the recent number of self inflicted deaths at the prison. The investigator wrote to the Governor of Birmingham informing him of this development.

10. He returned to Birmingham on 29 November and 16 December to interview 11 discipline and healthcare staff.

11. He wrote to the local Coroner's office to inform them of the nature and scope of the investigation. HM Coroner will be provided with a copy of the report of the Ombudsman's investigation.

12. After he was notified of the death, the investigator contacted the local Primary Care Trust. He asked for a clinical review to be carried out with regard to the man's healthcare at Birmingham. The purpose of the review is to establish whether the care that he was offered in prison was comparable with that he would have received in the community. A clinical reviewer completed the review.

13. Birmingham Safeguarding Children Board conducted a serious case review in view of the man's alleged offence against one of his children. The review explored whether those agencies involved with his family had taken full account of the needs of his children. (He had reported problems with depression and alcohol misuse, and had already tried to take his own life in the community.) The investigator liaised with the Chair of the case review panel during the investigation. The Board's findings have been forwarded to Ofsted for their consideration. The serious case review had not yet been published when I issued my final report in August 2011.

The man's family

14. My Senior Family Liaison Officer contacted the man's wife and sister in October 2010. She arranged to visit both of them to provide more information about the investigation and to hear their concerns. The Family Liaison Officer and investigator visited her at her home on 23 November. She expressed concern about what happened to her husband in the police station. I hope that the 'Key Findings' section of the report gives her a better understanding.

15. During the meeting, she told the investigator that her husband found weekends in prison very difficult, because there was less opportunity for purposeful activity and he had too much time to think.

16. She was upset that the news about her husband's death was already being broadcast on the television lunchtime news when she returned home from the hospital on the morning of Sunday 26 September. Her husband's organs were being removed for donation and she had yet to break the news of his death to her two children. She told the investigator that her children were in the room with the television on when the news was broadcast, but that she managed to prevent them from listening. She said that she was not told by any of the prison staff that the news would be released to the media so rapidly and therefore she was not expecting it.

17. She also told the investigator that the prison's family liaison officer led her to understand that the prison would cover the full cost of his funeral. She arranged the funeral and then discovered that the prison would only contribute about £3,200. She expressed concern that relatives should be given accurate information before they make funeral arrangements.

18. She was also upset that the prison's family liaison officer repeatedly called her by an incorrect name during an early telephone conversation. Despite being corrected, the member of staff continued to call her the wrong name. She also said that her husband's name had been misspelt on the receipt for his property. She felt that both incidents reflected poorly on prison staff.

19. The Family Liaison Officer and the investigator visited the man's father and siblings on 16 December. The man's sister told the investigator that her brother had said during a visit that one of the prison officers had belittled him, telling him that he was going to be bailed when in fact he was not. He had also reported being made fun of by an officer in the queue for dinner. It has not been possible for my investigator to identify these specific incidents, which were not recorded by staff, and so I draw the Governor's attention to the reported behaviour.

20. The siblings told the investigator that they were unhappy with the way that a senior manager spoke to them when they arrived at the hospital on 25 September. They thought that he seemed overly keen to emphasise how well the prison staff had reacted to the emergency. Given that the man never recovered, the family also found it somewhat tactless when the same

manager apparently told them that his appearance had improved since staff found him in the cell.

21. The man's sister said that she and her family felt poorly treated by staff in the visitors' centre during the months when their brother was held in Birmingham. They had not previously had to visit a prison and were consequently unaware of the way in which the visiting process works. She commented that prison staff did not help her family to understand the procedure. She also recalled that her son had difficulty getting into the prison to meet him when staff refused to accept a form of identification which had been deemed valid on a previous occasion. I draw the Governor's attention to her comments.

22. The family received a copy of the draft report as part of the consultation process. The man's wife and sister provided the Family Liaison Officer with their responses to the Ombudsman's findings. Their responses are included on page 47 and I have also made some additions to the text within the report.

HMP BIRMINGHAM

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

Market testing

24. When the man died, Birmingham was awaiting the outcome of a bidding process to determine whether it will be run by a private contractor. In March 2011, it was decided that G4S would take over the management of the prison.

Mental health treatment

25. Birmingham and Solihull Mental Health Foundation Trust provide mental health care at Birmingham. There are three tiers to the services they provide:

- The primary care mental health team treats the majority of mental health problems in Birmingham, such as depression.
- The mental health in-reach team treats prisoners with severe and enduring mental illnesses (such as schizophrenia).
- The forensic psychiatric team assesses and treats prisoners who have committed particularly serious or worrying offences.

26. Between July and September, whilst the man was held in Birmingham, the Primary Care Mental Health Team and the In-Reach team (which treats prisoners with more serious, severe and enduring mental illnesses) were not fully staffed. I addressed the ongoing lack of nursing staff in these teams when I investigated the death of another prisoner in Birmingham in June 2010. The staffing problem has been ongoing for some time.

27. I gather from the manager of the mental health teams that, as of October 2010, they are now staffed as far as the budget allows thanks to a redeployment of nurses within the Primary Care Trust. The nurses from the primary care team no longer have to cover the work of the in-reach team. Two community psychiatric nurses (CPNs) work for the in-reach team and four nurses staff the primary care mental health team. The manager is also a CPN, meaning that there are seven mental health nurses available to treat prisoners.

28. Psychiatric assessment is also available. A forensic consultant psychiatrist visits once a week to assess those prisoners who have particularly severe complaints and who may have committed very serious offences of a violent or sexual nature. A social worker should work for the In-Reach team. However, the social worker has been absent on long term sick leave and has not been replaced in the meantime.

29. The man was assessed by the primary care mental health team before being referred to the forensic psychiatric team because of his state of mind and the nature of his offence (violence against one of his children).

Her Majesty's Inspectorate of Prisons

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

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

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

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

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

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

Independent Monitoring Board

33. The most recent annual report published by the Independent Monitoring Board (IMB) at Birmingham covers the year from July 2009 to June 2010. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB highlighted the problems experienced with recruitment of healthcare staff.

Previous deaths at Birmingham

34. Between February and September 2010, six prisoners died at Birmingham after they apparently took their own lives. Very occasionally, a prison will experience such a cluster of deaths. I have observed a similar cluster of self-inflicted deaths at HMP Chelmsford in late 2007 and early 2008. The number and frequency at Birmingham in 2010 was unusual and concerning. I have therefore considered whether there are any similarities between the deaths and whether prisoners face particular risks.

35. The man required mental health assessment and treatment. This is a subject I have addressed during previous investigations at Birmingham. When I investigated the death of a prisoner in November 2008, I recommended that staffing levels in the mental health teams at Birmingham should be reviewed to ensure that mental health treatment could be properly delivered. I was

critical of the ongoing lack of staff in the mental health teams during my recent investigation into the self-inflicted death of a prisoner in June 2010. Staffing in the mental health team remained a problem whilst he was in custody between July and September 2010. I understand that long standing vacancies in the mental health teams were eventually filled in October 2010.

Performance

36. The most recent ratings published by the Ministry of Justice in the final quarter of 2010 show that Birmingham scored 2 overall, indicating that its performance required development. The prison achieved the same score in the previous quarter. The minimum score is 1 (serious concerns) and the maximum is 4 (exceptional performance). The rating takes into account 34 different aspects of the way the prison is currently operating.

Assessment, Care in Custody and Teamwork (ACCT)

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

Listeners and Insiders

38. Listeners are prisoners who have been specially trained by the Samaritans to sit with and listen to other prisoners who are in distress. Their support is confidential and is not disclosed to staff or others. Insiders are experienced prisoners who volunteer to provide basic information and reassurance to new arrivals. They are on duty in court and in the prison.

KEY EVENTS

39. The man was arrested for attempting to murder one of his children at his home address just after 5.00am on Friday 2 July 2010. His wife had telephoned the police, stating that her husband had tried to harm one of their children and then himself. He was taken to the police station. He was charged with his offence on 3 July and was held in police custody until he could appear in court after the weekend. He was admitted to the Accident & Emergency Department that evening to be treated for alcohol withdrawal and returned to the police station in the early hours of 4 July.

40. He was judged to present a 'significant risk' to himself whilst in police custody. He was given a paper suit to wear to reduce the risk of self harm but he still tried to tie this around his neck to strangle himself. He did not injure himself but underwent a medical assessment. The police doctor recorded that he was alcohol dependent, had a thyroid condition and suffered from high blood pressure. The doctor wrote that he was experiencing 'mild [alcohol] withdrawal' symptoms. He was prescribed diazepam (a benzodiazepine commonly known as Valium often used to treat alcohol withdrawal) at 7.00pm and 10.00pm on 4 July, and at 7.00am on 5 July.

41. He was escorted from the police station to the Magistrates' Court on Monday 5 July. He spoke to a court Insider, who explained to him what was going to happen and completed a form recording that he felt suicidal. Court escort staff acted cautiously and made sure that he shared a cell with another prisoner. The cell was fitted with a camera so that he could be observed at all times. He was remanded into custody after his court appearance.

42. Later that day, he was taken from the court to HMP Birmingham, arriving shortly after 4.30pm. One of the officers who accompanied him in the escort vehicle completed a suicide and self harm warning form. He recorded that he had tried to strangle himself the previous day in the police station. The officer noted:

> 'Both the charge [of attempted murder] and very recent attempts at suicide indicate that he would be a cause for concern.'

43. Upon arrival at Birmingham, he was assessed by staff in the reception area. Senior Officer (SO) A completed a Cell Sharing Risk Assessment (CSRA). (Prison staff use the CSRA to determine whether a newly arrived prisoner is suitable to share a cell. This may not be appropriate depending on their previous behaviour and offences.) The officer recorded that it was his first time in prison and that he had attempted to strangle himself in police custody on 4 July. He assessed him as presenting a medium risk of harm to other prisoners.

44. Nurse A recorded on the CSRA that he was at high risk of harming himself, having made one attempt to strangle himself in the police station and another three or four months earlier. She noted that he was very upset and stressed

due to his offence. She wrote that he 'will need to share with a Listener initially'.

45. She then interviewed him to complete a first night reception health screening. She recorded that he was a heavy drinker, consuming about 80 units of alcohol per week or between six to eight cans of high strength lager each day. He said that he had been an alcoholic 'for many years'.

46. During their consultation, the nurse recorded that he had been given diazepam at the police station and had also been admitted to hospital over the weekend because of withdrawal symptoms. She referred him to Prison Doctor A because he needed alcohol detoxification medication. The nurse recorded that he suffered from high blood pressure and hypothyroidism (an overactive thyroid gland). She obtained the details of his community doctor.

47. She again recorded that he was suicidal and was thinking about deliberately harming himself. As a result of recent events and alcohol withdrawal, he said that he was feeling nervous and jumpy. She noted that he seemed 'very distressed and depressed'. He said that he did not think that he would harm himself, but he indicated that he tended to get very upset during the night. She referred him for a first night mental health screening.

48. Afterwards, she discussed him with Community Psychiatric Nurse (CPN) A. They agreed that it would be appropriate to begin self harm monitoring. She began the Assessment, Care in Custody and Teamwork (ACCT) support procedures at 6.45pm that evening.

49. On the 'Concern and keep safe form' at the start of the ACCT document, she referred to the nature of his offence and his attempt over the weekend to make a ligature whilst he was in police custody. She wrote that he was very distressed and had talked about killing himself, and noted that he had tried to hang himself using the cord of a telephone charger in a park a few months earlier. He told her that he was experiencing flashbacks to his offence and felt unstable.

50. An officer and a SO completed the 'Immediate action plan' in the ACCT document at 7.30pm. The man was located with another prisoner in a shared cell on D wing and was given access to an Insider and the Listeners. He told the two officers that he was a 'borderline alcoholic'. The officers recorded that he would be given the necessary medication and would be referred to the mental health team.

51. Initially, ACCT monitoring required staff to check him five times every hour. Staff were asked to make a written entry in the ACCT document every two hours, and to record a meaningful conversation with him in the morning, afternoon and evening.

52. At about 7.30pm that same evening, Officer A completed a 'First Night in Custody' interview with him. She noted that his mood was low.

53. He then attended a mental health first night reception screening with CPN A working in the reception area that evening. He told the CPN that he had tried to hang himself in the past. He said that he had tried to strangle himself the night before in the police station using his own hands. They discussed his offence, his heavy drinking, the ACCT monitoring and his anti-depressant medication.

54. The CPN told the investigator that he remembered him showing signs of alcohol withdrawal. He remembered that he was open about his alcohol misuse and his offence. He said that he had not been engaging with mental health services in the community. He mentioned that he had been referred to Aquarius (a charity in the Midlands which helps alcohol misusers) but had not really engaged with them.

55. The man's wife wrote to my investigator after she received the draft version of this report. She explained that he was prescribed antidepressants by his GP and was referred to the practice counsellor. However, she did not feel that her husband's mental health problems were adequately addressed in the community.

56. The CPN referred him to the Primary Care Mental Health Team and arranged for him to be assessed again the next day. He also referred him to the prison's forensic psychiatric service for a full assessment. The CPN told the investigator that the nature of the man's offence (violence against his own child) and his presentation prompted him to make this referral. (A forensic psychiatrist comes to Birmingham once a week to assess prisoners who have committed particularly serious offences in order to determine if they have a mental disorder.)

57. After the assessment, the CPN referred him to the first night doctor to receive an initial seven day supply of citalopram (an anti-depressant). As a nurse, he could not prescribe medication himself, but he advised the prison doctor that he thought the man should be given the drug.

58. Prison Doctor A assessed him that same evening. He prescribed three types of alcohol detoxification medication: thiamine (also known as vitamin B1), vitamin B compound strong tablets and diazepam. These drugs were not prescribed again. The initial doses carried him through a 28 day period of alcohol withdrawal.

59. The doctor was reluctant to prescribe an anti-depressant until the man's medical notes could be obtained from his community surgery. He noted that he claimed to have been taking citalopram 'sporadically' in the community in the last couple of weeks. The doctor wanted to be certain what mental health medication he had been taking. He signed a consent form allowing the healthcare team to contact his surgery.

60. At 8.10pm, Officer B recorded that he was still in a low mood and had gone to speak to a Listener. At 9.00pm, Officer C had a long conversation with him, who was 'emotional', and tried to reassure him.

61. Because of his offence against one of his children, a member of staff at Stechford Public Protection Unit (PPU) telephoned staff in Birmingham's security department and sent them two faxes on 5 July. The PPU needed to tell prison staff that he was not allowed to contact his wife and two children. (The second fax added his father's name to the list because the children were staying with him at the time.) The faxes were received in the late afternoon but were not dealt with until early the following day. He was therefore permitted to make a two minute telephone call to his father that evening.

62. As a result of the advice received from the PPU, staff in the prison's intelligence unit completed Security Incident Reports and wrote to their internal public protection and probation departments on 6 July. A memo (headed 'Immediate action') told prison staff that he was not to have any contact with his wife and children (but there was no mention of his father). The memo indicated that his telephone calls were to be listened to by prison staff and his mail was to be checked. It is not clear from the documentation precisely when he was told about the restrictions.

63. He spoke to a Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) worker at 7.40am the next day, Tuesday 6 July. (There is a CARATS team in each prison working with prisoners who misuse either drugs or a combination of drugs and alcohol.)

64. At about 10.30am, Officer D completed an ACCT assessment interview with him. She recorded that he was 'distressed' and 'depressed' by his offence and by being in prison for the first time. She noted his recent attempt to strangle himself in the police cell and previous attempt to end his own life by hanging. He also said that he used to cut himself at the ages of 11 and 12 to gain attention.

65. He told Officer D that he felt 'down and confused'. He asked about making contact with his family. He told the officer that he was having occasional suicidal thoughts. He estimated, on a scale of one to ten (ten being the most depressed), that his thoughts would probably equate to a score of five. He mentioned that he had support from his siblings and father.

66. Officer D explained rule 45 (which allows somebody who may be vulnerable within the general prison population due to the nature of their offence to ask to be held in a separate unit). However, he decided to stay amongst the rest of the prisoners for the time being. The officer noted that he would be speaking to the mental health team and the chaplain and should remain in a shared cell.

67. Straight after the assessment interview, SO B and Officer D sat down with him and carried out the first ACCT case review. They completed the 'Action following assessment' form. The officers noted that he seemed slightly more settled than the previous night. He expressed further concern about his family and his first experience of prison.

68. The officers decided that he should remain in a shared cell for support. The level of observations was reduced to twice each hour. Staff were asked to make an entry in the ACCT document every two hours and to record a meaningful conversation with him in the morning, afternoon and evening.

69. Prison Doctor B assessed him later in the morning. He said that he had misused alcohol for about 20 years and last drank about five days previously. He told the doctor that he did not misuse class A drugs and had never suffered from 'the DTs' (delirium tremens, severe withdrawal symptoms). The doctor noted that he had begun alcohol withdrawal treatment and agreed that he should remain subject to ACCT monitoring for the time being.

70. The doctor checked his ongoing prescriptions with his community doctor. Afterwards, he prescribed sertraline (an anti-depressant), atenolol (a beta blocker used to treat heart disease and high blood pressure) and levothyroxine sodium tablets (a hormone replacement for people with thyroid problems). The doctor prescribed 28 daily doses of each drug.

71. The same day, he told staff that he had alternative accommodation which was away from the family home and so he planned to make a bail application.

72. He moved to a cell on N wing in the early afternoon. During his wing induction, he was told about the Insiders, the personal officer scheme (each prisoner is allocated a personal officer who is the person he should initially turn to for help and advice) and the Incentives and Earned Privileges (IEP) Scheme. (The IEP scheme is intended to encourage and reward good behaviour. Additional entitlements can be gained in return for good behaviour. However, those entitlements can be lost if their behaviour deteriorates. Prisoners are granted either the basic, standard or enhanced regime.)

73. In the afternoon, he went to a full mental health assessment with CPN A. He said that he felt low because he could not see his children. He was unsure whether he was allowed to contact his wife and children and whether he would be able to cope with prison life. He reported that his alcohol misuse had increased before he was arrested, and had been drinking up to ten cans of high strength lager each day. He said that he had been drinking when he committed his offence. He alluded once again to previous attempts to take his own life, both very recently in police custody and during the previous year.

74. Whilst he did not think that the man currently seemed unduly distressed, the CPN recorded that he remained in a 'very low mood' and remained subject to ACCT monitoring. The CPN planned to speak to a doctor about his medication. He confirmed that he would be assessed by the forensic psychiatric service and booked a clinic appointment for him.

75. The same day, staff reviewed his CSRA. His risk of harm to other prisoners was once again assessed as 'medium'.

76. He attended a CARATs assessment at 10.45am on Wednesday 7 July with a CARATs worker who recorded that he misused alcohol but not drugs. He said that he was struggling to cope because of the nature of his offence. He told the CARATs worker that he had twice tried to hang himself. He said that he had been consuming seven to eight cans of high strength lager each day for the last two years. He mentioned financial problems and said that he had been very depressed for 12 months.

77. The CARATs worker referred him to the Alcohol Prison In-Reach Team. He said that he felt very low and was still thinking about 'ending it all'. The CARATs worker wrote in the ACCT document and raised concerns with wing staff.

78. The healthcare team received a copy of his medical records from his community surgery by fax the same day.

79. At about 2.30pm that afternoon, CPN B reviewed his mental health at the request of Officer E (who had become worried after speaking to him earlier in the day). The CPN spoke to him about his offence, committed under the influence of alcohol. He expressed remorse and said that he took full responsibility for his behaviour. He seemed 'dazed' by the speed of events and the prison regime. He expressed 'fleeting thoughts' about wanting to die but said that he would not act on them.

80. The CPN recorded in the ACCT document that CPN A would review him at the Primary Care Mental Health Team clinic. He wrote that he should remain subject to ACCT monitoring for the time being. He also noted that he could review him as and when required at the N wing mental health clinic.

81. Just after 3.00pm, Officer E arranged for him to make a telephone call to his father so that he could 'find out about his family'. The call was made using a generic 'welfare' telephone PIN number, rather than the unique one assigned to him, meaning that the security department would not have been aware of the call. The officer remembered during interview that he wanted to ask his father for money.

82. The officer told my investigator that he had not been instructed that he was not supposed to contact his father when he allowed him to make the call. The officer said in interview that he was not shown any of the faxes sent to the prison by the Public Protection Unit or the memo issued by the prison's intelligence unit. He assumed (because of his offence) that it would be inappropriate for him to contact his wife and children, but did not realise that the children were temporarily living with their grandfather.

83. He attended a gym induction at 8.30am on 8 July. The same day, the prison's security department advised the PPU that measures had been taken to prevent him from contacting his wife, children and father. On 9 July, he moved to a cell on A wing. His solicitor visited him in the afternoon.

84. SO C and Officer F met him to review his ACCT monitoring at 1.40pm on 10 July. They recorded that he had been warned not to disclose his offence to other prisoners because this might result in negative consequences. He said that he was not having any current thoughts of deliberate self harm, but still felt low. The officers agreed that his level of ACCT observations would be reduced to once an hour and that staff would record a meaningful conversation with him in the morning, afternoon and evening.

85. The same afternoon, a governor allowed him to make a free five minute telephone call to his sister from a staff telephone, because they had not spoken since he came into custody and she was worried about him.

86. He made an appearance at Crown Court on 12 July, returning to the prison later that day.

87. An alcohol in-reach worker assessed him on 13 July. She recorded his history of self harm, his violent offence and the fact that he was not supposed to contact his wife and children. She scored his alcohol misuse at 13 out of a possible 16. He said that he consumed between six and ten alcoholic drinks most days in the community.

88. He told her that he tended to drink Strongbow cider. He recognised that his drinking was a problem and affected his mood and his relationships with family members. He mentioned that he was making use of the Listeners in prison. He requested support to tackle his alcohol misuse. She planned to start one-to-one counselling before his next court appearance at the end of September.

89. SO D and Officer G spoke to him to review his ACCT monitoring at about 4.00pm on 14 July. He estimated, on a scale of one to ten (ten being the most depressed), that his mood would probably equate to a score of eight. However, he said that he was not currently thinking about harming himself. The level of observations remained hourly, with a significant conversation at least three times a day.

90. Officer H (one of his personal officers) recorded on 18 July that he was not mixing with the other prisoners much but was polite to wing staff.

91. Newly promoted SO E (formerly Officer G sat down with him to review his ACCT document at 10.30am on 21 July. (He was not accompanied by either another officer or a mental health nurse.) He said that he was not considering harming himself, but still struggled to cope with the prison regime. He told the SO that he was enjoying attending a British Institute of Cleaning Science (BICS) course. The SO noted that staff should encourage him to take part in more activities. The level of observations stayed the same.

92. A forensic consultant psychiatrist assessed him on 22 July as a result of CPN A's referral to the forensic psychiatric team. He said that he was coping with prison life and was no longer thinking about harming himself. He said that he had ruined his family's life and he expressed his belief that he would not be

allowed to see his children again. Nonetheless, the doctor managed to encourage him to think about the future.

93. He described episodes of self harm and ongoing depression in the months before he committed his offence. He said that he had not previously harmed himself as an adult. He recalled how he had become an alcoholic, his work had suffered and his relationship with his wife had deteriorated. He told the psychiatrist about the alcohol withdrawal symptoms he had experienced in police custody when he was arrested.

94. Although he did not consider that he was clinically depressed, the psychiatrist decided to double his daily dose of sertraline from 50mg to 100 mg. He considered the original dose to be ineffective for an adult, and decided to increase the dose as a supportive measure whilst he settled into prison life.

95. The psychiatrist told the investigator that he scheduled the increase in sertraline to start once his initial 28 day prescription expired (because he did not consider the change in dose to be especially urgent). (However, the electronic clinical record shows that the increase to 100mg did not happen as planned. The prescription for the drug remained at 50mg once a day until he died. This is something I explore in the 'Issues' section of the report.)

96. Having assessed him, the psychiatrist planned ongoing reviews of his antidepressant medication, the first to take place three or four weeks later. He reported severe headaches, and the doctor noted that an appointment to check this problem had already been booked with a general practitioner.

97. His sister telephoned the prison on the same day, 22 July. She explained that she had posted her brother some photographs of his children, but had since been told by social services that he was not allowed to have these because of his offence. The member of staff who answered the telephone checked and discovered that the photographs were being held by the prison's correspondence department. They made the following entry:

> 'I gave [the correspondence department] her permission to destroy [the photographs].'

98. On 25 July, his sister visited him. The same day, he complained of either a headache or migraine to Nurse A, who dispensed paracetamol and ibuprofen (a pain killer). She checked that he had a doctor's appointment booked in a week's time.

99. He asked Prison Doctor A for a repeat prescription on 28 July. The doctor wrote in the clinical record that he was not sure what he wanted and that he needed to be more specific.

100. SO F and Officer I met him to review his ACCT monitoring at 6.55pm on 28 July. They agreed that the hourly checks should stop and level of observations should be reduced to a conversation with him in the morning,

afternoon and evening. If progress continued to be positive, they thought that the ACCT document might then be closed at the next review.

101. Two members of his extended family visited him on 1 August. He received further visits from family members on 8, 13 and 15 August.

102. On 2 August, SO G sat down with him to review his ACCT document. (The SO normally works on the segregation unit, but was working a shift on A wing.) She spoke to wing staff about him but was not accompanied by either another colleague or a mental health nurse. He said that he felt a lot better than when he first arrived in prison, but that he still felt 'down'. He told the SO that he was not thinking about suicide or self harm.

103. The SO explained that staff were available to talk to him and that other support networks could also be accessed. After the review, they both agreed that the self harm monitoring should end and so the ACCT document was closed. He indicated on the same day that he would like to be given a job on the wing.

104. The same day, Prison Doctor C assessed him. He said that he had been having recurring headaches two or three times each day that lasted for an hour at a time. He also suffered from them at night. He was not vomiting and his eyesight did not seem worse. The doctor prescribed diclofenac (a form of pain relief) to be taken three times a day for a week. The doctor thought that his condition should be reviewed in a week if the headaches persisted. He wanted to check his eyesight but the necessary equipment was not working.

105. As the psychiatrist intended, Prison Doctor D used the electronic clinical record system to increase his daily dose of sertraline from 50 mg to 100 mg at 11.40am that morning, 2 August. However, less than an hour later, at 12.24pm (presumably at the end of his consultation with him) he used the same system to reduce the dose back to 50mg per day. Therefore he never received an increased dose of sertraline. The clinical record does not explain the reasoning for the alteration.

106. Between 3 and 8 August, three officers made six daily entries on the 'ACCT Plan Post Closure Phase Summary Sheet'. (This document is designed to record how the prisoner is coping after the end of ACCT monitoring.) The officers recorded that he was going to work and said that he had no problems or concerns. It was noted that he felt better, was spending time with other prisoners during the association period, got on well with his cellmate but 'kept himself to himself'.

107. At 11.20am on 10 August, one of the chaplains and an officer (in charge of A wing at the time) completed a post-closure ACCT review with him. (This meeting is supposed to take place a week after ACCT monitoring has ended.) They noted that he talked about the progress he had achieved and was now able to cope with his current regime. They recorded that there were 'no self harm issues' and that the ACCT document was 'now closed'.

108. The In-reach worker spoke to him about his alcohol misuse again on 12 August. He told her that, although he was still low in mood, he felt more stable and had begun a six week course in the workshop which kept him busy. She gave him an alcohol in-cell workbook to begin and planned to carry out a one-to-one session with him a few weeks later.

109. On 15 August, he used the prison landline telephone for the final time.

110. Another of his personal officers made an entry in his P-NOMIS record on 18 August. (P-NOMIS is the electronic record keeping system where relevant details about a prisoner are stored.) The officer noted that he was very polite, complied with the wing regime at all times and kept his cell tidy. The officer also wrote that he got on well with his cellmate and gave staff no cause for concern.

111. On Sunday 22 August, his sister visited him. Late in the afternoon, she telephoned the prison switchboard (calls are routed to the gate lodge at the weekend) to express concern about his wellbeing. The duty governor asked SO H (the orderly officer, also known as Oscar 1) to interview him to check how he felt. The prisoners are locked up for the night at about 5.00pm on a Sunday and so he unlocked him from his cell and took him to the wing office to speak to him.

112. He said that he had just been having a bad day and was not contemplating harming himself. He said that, because he had no job in the prison and it was a weekend, he had had a lot of time to think about his next court appearance. (Prisoners are locked up at about 5.00pm not only on Sundays, but also on Fridays and Saturdays.) He told the officer that he was grateful for his sister's care and concern. They agreed that he did not want or need to recommence ACCT monitoring. After locking him back in his cell, the SO telephoned his sister to put her mind at rest.

113. His solicitor visited him on 23 and 26 August. Family members visited him on 29 August and 5 and 12 September.

114. On 31 August, his repeat prescriptions of atenolol (50mg per day), sertraline (still set at 50mg per day) and levothyroxine sodium began. He was told to take one tablet of each drug once a day for 28 days. He collected them from the hatch under supervision once a day.

115. CPN A discharged him from the primary care mental health team on 1 September because the forensic psychiatric team was overseeing his mental health treatment. (He did not meet him in order to do this.)

116. The next day, 2 September, a CPN assigned to the forensic team reviewed his anti-depressant medication on the psychiatrist's behalf. He said that he was feeling slightly better and was about to start a job. She recorded an improvement in his mood since the psychiatrist had decided to increase his dose of sertraline (although the dose had never actually been doubled as the doctor planned). He said that he had trouble sleeping and she made another

appointment for his mental health to be reviewed by the psychiatrist on 23 September.

117. The In-reach worker spoke to him about his alcohol misuse again on 8 September. He had partially completed his in-cell workbook, so she decided to schedule a one-to-one session with him on Friday 10 September. However, when she returned to carry out the assessment on 10 September, he had not brought his workbook with him. He asked for time to finish completing the workbook and they agreed that she would return the following week to carry out the planned one-to-one session.

118. On 12 September, Officer H wrote in his P-NOMIS record that he continued to be polite to staff and other prisoners and to comply with the wing regime.

119. His solicitor, as well as members of his family, visited him on 14 September. The same day, the In-reach worker visited him again. He had still not completed his workbook and so they discussed his motivation to address his alcohol misuse. He explained that he was not currently concerned about his alcohol use, which was a lower priority at the time, and was 'not committed to addressing his previous alcohol issues'.

120. She recorded that he was no longer subject to ACCT monitoring and was trying to keep busy at work. They agreed that she would speak to him again after his court hearing at the end of the month to determine what work could be done with him in prison in the longer term to address his alcohol problem.

121. On 17 September, he received a further visit from members of his family. He moved to cell 18 on the second landing of A wing on 22 September. He had a new cellmate. The cellmate told my investigator that the man did not make much conversation at all over the next few days and did not confide that he was thinking about harming himself.

122. He was supposed to attend an appointment with the forensic consultant psychiatrist on 23 September. However, the prison regime was halted whilst discipline staff attended a union meeting about the forthcoming bids by different private contractors to take over the management of Birmingham. As a result, staff were not available to escort him to the healthcare centre where the psychiatrist was waiting and the review of his mental health did not take place.

25 and 26 September

123. Shortly after 1.45pm on 25 September, the cell was unlocked and his cellmate went out to exercise in the yard. He declined the chance to exercise and chose to remain behind. He was locked in the cell on his own whilst other prisoners on the wing went to exercise. Before his cellmate left, he checked with him that he would be out in the yard for about an hour. Until that time, they had been watching snooker on television.

124. The cellmate later told the police that he had seemed just the same as usual. Officer H told my investigator that exercise normally takes place at about 1.30pm or 1.40pm on a Saturday and usually lasts for about an hour.

125. At about 2.25pm, the cellmate was brought back to the wing. He waited by the door of their cell (number 18 on the second landing of A wing) for about a minute for staff to unlock it. Officer H, who escorted the men back from the exercise yard, unlocked the cell door and then moved swiftly along the wing as usual to unlock another cell (the neighbouring one, number 17). (Prisoners are supposed to let themselves back into their cell, then shut the door behind them.) The officer had not collected the cellmate for exercise and was unaware that his cellmate was locked inside the cell. The observation flap was closed and the officer did not look inside.

126. The cellmate opened the door, went into the cell and initially thought that the man was facing away from him, looking out of the window. He was partially obscured by a curtain. He then saw the ligature and realised that something was wrong. The man was hanging from the bars on the window at the back of the cell. He had his back to the door and had used a bed sheet to form a ligature. The cellmate left the cell in shock and went up to Officer H (who had just let another prisoner into cell 17), calling to him and tapping him on the shoulder. He gestured to indicate that the man had hanged himself. The officer went to the doorway of cell 18.

127. The officer immediately blew his whistle and went into the cell. Officer J (who was locking prisoners up on the other side of the landing) joined him in the cell. He supported the man's weight by his waist, whilst Officer H cut through the bed sheet using his anti-ligature knife. The man vomited as the ligature was cut from his neck. The two officers placed him on his cellmate's bed in the recovery position with his back to the wall. Officer K entered the cell to help. Senior Officer (SO) I requested a '999' ambulance and the emergency response nurse using his radio. Officer H told my investigator that the emergency response healthcare staff responded 'straightaway'. The control room contacted the ambulance service at 2.26pm.

128. Nurse B (the emergency response nurse), shortly followed by Nurse C, arrived in the cell from the nursing station on B3 landing at about 2.27pm. They were informed that the SO had asked for an ambulance and that it was already en route. At the nurses' request, both officers moved him on to the floor to allow them to begin cardiopulmonary resuscitation (CPR). Officer K supported his head. His feet were facing the window and his head was nearest the door. Nurse C could not find a pulse or any indication that he was breathing.

129. The nurses started CPR straight away, before the emergency response bag was brought into the cell by the discipline staff. They then inserted a plastic airway into his throat and placed a mask and inflatable bag over his mouth. This was attached to an oxygen cylinder which was brought over from B wing. Nurse C attached a defibrillator to him. (A defibrillator is a small portable machine that searches for an irregular heart rhythm. If one is found, the

defibrillator can deliver an electric shock to reset the rhythm.) However, the machine advised that he should not be shocked. At the request of one of the prison managers, two more nurses arrived at about 2.33pm to assist their colleagues. They helped to give continuous CPR in rotation.

130. The duty governor arrived on the wing at about 2.30pm. He asked for a doctor to come to the cell, but none were in the prison at the time. The first paramedic arrived on a motorcycle at 2.33pm. The prison manager arranged for staff to be posted at each locked gate to usher the paramedic through to A wing as quickly as possible. Discipline staff ensured that any prisoners still out on the landing were locked back in their cells.

131. The first paramedic arrived on A wing at about 2.36pm, asked for a briefing from the nurses and took charge of the emergency. At 2.39pm, the paramedic asked the officers and nurses to help move the man out on to the wing landing, where there was more room to continue resuscitation.

132. At 2.40pm, an ambulance and additional paramedics arrived at the prison. Resuscitation continued and he was given adrenaline at about 2.45pm. A pulse in his finger was detected at 2.53pm. Further adrenaline was administered at 2.56pm. A doctor arrived on the wing at 2.57pm. Shortly after 3.00pm, he was moved on to a stretcher and taken to the ambulance.

133. An officer kept a log of the emergency. Two other officers travelled in the ambulance with him when it left the prison at 3.13pm. The paramedics advised the duty governor that he was in a critical condition. Another manager followed in a separate vehicle to join the two officers at the hospital. The man was not handcuffed and a risk assessment did not take place due to the speed of the emergency.

134. The ambulance arrived at the hospital at 3.18pm. He was brought into the resuscitation area at 3.19pm. Shortly afterwards, the accident and emergency team asked prison staff to confirm what medication he was prescribed. The hospital staff continued to treat him.

135. Whilst he was taken to hospital, a member of the Independent Monitoring Board, or IMB, and SO I went to speak to his cellmate to make sure that he was coping.

136. After a discussion with the Governor, the duty governor briefly re-entered the man's cell (which had now been locked and sealed) at about 3.15pm in order to check for any note which he might have written. He could not find one and left. The cell was resealed.

137. He checked the details of the man's next of kin and telephoned his sister's home address. She was unavailable but her 21 year old son answered the telephone and the duty governor told him what had happened. He was initially unable to contact the man's wife on the telephone (there was no record of a telephone number) but he managed to get in touch with her at 4.40pm.

138. The prison manager and the duty governor held a hot debrief for all the staff involved in the emergency in the prison boardroom at about 3.45pm. (A hot debrief meeting allows staff to discuss any immediate lessons that can be learned from the emergency. It also permits managers to check how staff are feeling.) A member of the care team attended the debrief and went to A wing to speak to any staff who might have been affected by the emergency.

139. The man's sister, brother-in-law and nephew arrived at the hospital at 3.57pm. They went in to see him and then spoke to another manager. They left a short while later before returning with other family members.

140. At 4.00pm, a SO went to speak to the cellmate and check on his welfare. He had been moved to a different, shared cell. The prison manager also spoke to him. The orderly officer helping to run the prison with the duty governor arranged for members of the care team to speak to staff. Staff also ensured that prisoners on A wing with open ACCT documents were reviewed. They found a legal letter addressed to the man on A wing but did not open it.

141. At the hospital, he had not regained consciousness since being found. At about 5.40pm, he was taken for a computerised tomography (CT) scan to check for brain activity. He was attached to a ventilator and located in the Critical Care Unit, but his condition showed no sign of improvement. At about 7.30pm hospital staff confirmed that he had sustained brain damage. They asked his family to come to the hospital to make a decision about what to do next. At 7.45pm, the duty governor updated the man's wife about his poor condition and she went to the hospital. (She had not been in contact with him because of his offence.)

142. At about 8.00pm, his relatives returned to the hospital. They met the consultant to discuss his condition and then left the hospital again. Further family members visited at 9.45pm, 10.00pm and 10.50pm.

143. His condition deteriorated rapidly after midnight. A consultant carried out a brain stem test at 1.10am on 26 September but there was no sign of brain activity. Shortly after 2.00am, a second brain stem test was conducted. The result confirmed brain death and at 3.00am the consultant declared that he had died. Members of his family were with him at his bedside. The duty governor arrived at the hospital at about 3.35am to speak to members of the family. They asked that the designated family liaison officer wait until Monday 27 September to contact them, and that she should treat his wife and sister as the next of kin.

144. In accordance with his wishes, his organs were donated after permission was obtained from the Coroner's office. He remained on the life support machine whilst his organs were removed for transplant. The duty governor contacted the Ministry of Justice's press office shortly before 9.00am on 26 September, as per the National Offender Management Service's policy. The news of his death was announced on television at lunchtime that day. All the prisoners

subject to ACCT monitoring at Birmingham were either reviewed or spoken to again by wing managers on 26 September.

145. He had been due to receive a visit from family members on 26 September. He was also due to make his next appearance at Crown Court on Monday 27 September in order to plead to the charge he faced.

146. The post mortem report indicated that he died as a result of hanging. The toxicology report showed no evidence of either alcohol or unexpected drugs in his body. His funeral was held on 8 October. The family liaison officer returned his property to his wife on 22 November.

ISSUES

Events prior to the man's arrest

147. Birmingham Safeguarding Children Board (BSCB) is completing a serious case review as a result of the man's alleged offence against his child. Their report will explore whether the agencies involved with the family took full account of the needs of the children. He had tried to take his own life twice the previous autumn. Since that time, he had been prescribed anti-depressants and offered alcohol counselling, which by his own account he did not engage with. His family told my investigator that they had been very worried about him in the community before he committed his offence. They said that they had taken him to hospital for assessment and thought that he needed to be held there for his own good. The serious case review had not yet been published when I issued my draft report.

Assessment, Care in Custody and Teamwork (ACCT) monitoring and support

148. In my most recent annual report, I wrote about prisoners such as the man, who have been charged with the (in this case attempted) murder of a relative. I discussed the increased likelihood of a suicide attempt:

> 'Although suicide following homicide is a relatively rare occurrence, a study published in the *Journal of Forensic Psychiatry and Psychology* in April 2009 recorded 203 such incidents over the nine years between 1996 and 2005. The same study suggested that the risk increased the closer the relationship between perpetrator and victim. The Prison Service Order (PSO) 2700 on suicide prevention and self-harm management also rightly suggests that prisoners accused of killing a partner or family member pose a greater risk of subsequently taking their own lives. This has been reflected in a number of the Ombudsman's investigations where the alleged homicide of a family member or partner has been followed, sometimes very swiftly indeed, by the self-inflicted death of the person accused of the offence.'

149. I have found that staff at Birmingham demonstrated a commendable amount of good practice when he arrived at the prison. Because of the nature of his offence (an attempt to murder one of his children), his presentation (alcohol misuse and depression) and his very recent attempt to harm himself in the police station, he was a clear candidate for self harm monitoring. Staff had access to all of the relevant information and also listened to what he was telling them. They put the ACCT self harm procedures in place to safeguard him on the night he arrived in prison. The ACCT document remained open throughout his first month in custody. Although I will highlight a couple of problems with the way the ACCT process was managed, I consider that the level of observations was sensibly and gradually reduced and that monitoring ended in a logical fashion with his consent.

150. As well as beginning ACCT monitoring, staff took a number of other appropriate measures to help him. He had already been provided with

alcohol withdrawal medication in the police station and had indeed been taken to hospital by the police on the weekend of 3 and 4 July. The healthcare staff maintained his alcohol withdrawal medication for the subsequent 28 days. Staff also made an appropriate referral to an alcohol in-reach worker, something I discuss later in the report.

151. He was also appropriately referred to a consultant forensic psychiatrist and was monitored by the mental health in-reach team. Again, I address his mental health treatment later in this report.

152. The clinical reviewer praises the way in which staff identified the risk of suicide when he arrived in custody and referred him quickly to appropriate support services.

ACCT Care Map

153. I am not satisfied that the ACCT care map (checked and signed by SO B on the morning of 6 July) was sufficiently clear and detailed to be of help to his colleagues. The document should detail the ways in which the prisoner's low mood can be addressed and the likelihood of self harm can hopefully be reduced. The care map is supposed to outline sensible, achievable, practical measures that will be implemented to help the prisoner. Annex 8G of PSO 2700 states that the care map should aim to address the problems identified in the ACCT assessment interview. Specific reference should be made to practical measures such as mental health intervention.

154. Although the SO obviously had good intentions and set out two goals – for the man to settle into the prison regime and become more involved in prison activities – he did not detail how the goals would be achieved. I am concerned that a member of staff who had not met him before but who was tasked with his ACCT monitoring would not have gleaned much in the way of helpful information from the care map.

155. Given that he misused alcohol and suffered from depression, engagement with both an alcohol worker and the mental health team might have been clear and constructive actions to have added to the care map. (There is no mention of depression or alcohol misuse on the care map.) Any member of staff would have then been able to look only at the care map and clearly identify his two biggest problems.

156. PSO 2700 also states that the care map should be appropriately updated after subsequent case reviews. None of the SO's colleagues who subsequently reviewed his ACCT monitoring added to the care map.

157. During interview, the SO agreed that the care map he completed did not set out any specific, practical measures designed to improve the man's frame of mind. He expressed his dissatisfaction with the current ACCT document. He thought that a list of goals and actions which a member of staff could easily circle might be a means of allowing somebody like him to quickly identify a prisoner's needs. However, the SO accepted that staff need to work with the

ACCT document in its current form. The Governor may wish to consider guiding staff in the completion of the care map and offering a number of constructive ways in which help can be planned. I make the following recommendation:

The Governor should remind staff of the need to use the ACCT care map in a focussed and constructive manner. Staff should try to avoid general phrases and should aim to outline clear, measurable, achievable and realistic goals and actions.

ACCT case management: lack of continuity

158. As a result of shift patterns and the man moving wings, the senior officer acting as case manager at his ACCT review meetings differed on each occasion. PSO 2700 indicates that a senior officer is supposed to be designated as the case manager at the start of the ACCT process to oversee subsequent reviews:

> 'Wherever possible the Case Manager should arrange subsequent reviews at a time that he or she can be present, in order to provide some continuity of care for the prisoner.'

159. If the same member of staff attends successive ACCT reviews, he or she can hopefully observe any deteriorations or improvements in the prisoner's mood. They also possess prior knowledge of the prisoner. If both staff members reviewing the document have not taken part in previous ACCT discussions, it is necessary to explain the prisoner's circumstances and background, which is time consuming and potentially unsettling for the prisoner. I make the following recommendation:

The Safer Custody Department should consider how to facilitate the attendance of the same case manager at successive ACCT review meetings in order to minimise disruption and provide continuity and reassurance to the prisoner.

ACCT case management: carrying out reviews with a single member of staff

160. Although I consider that the man's ACCT monitoring was generally well managed, and that the level of observations was sensibly and gradually reduced, I am concerned that two senior officers carried out ACCT reviews without other professionals being there. PSO 2700 states:

> 'One of the attendees [at subsequent ACCT reviews] must be the named Case Manager (and failing that, the Manager responsible for the prisoner's location), one a residential officer who works in the area where the prisoner is located and the other an appropriate member of non-discipline staff. The case review must also be attended by the prisoner ...'

161. On 21 July, SO G reviewed his ACCT monitoring without other members of staff being present. The SO had been promoted the previous week. Whilst

still an officer, he had attended the previous review meeting on 14 July, which was managed by SO D.

162. When he spoke to my investigator, SO G said that he had just been promoted when he reviewed the man's ACCT document and had not yet attended the training which all SOs who perform the role of case manager are supposed to receive. He agreed that he should have taken a colleague into the meeting with him.

163. He said that he has since received the case manager training, in October 2010. He now recognises that it is best practice to take either a discipline officer or another professional, such as a mental health nurse, into a review meeting. He acknowledged that it is ideal to adopt a multi-disciplinary approach.

The Governor should ensure that senior officers are not obliged to act as ACCT case managers unless they have received the appropriate training.

164. SO G conducted the final ACCT review with the man on 2 August. She was not accompanied by either a fellow officer or another relevant party, such as his alcohol in-reach worker or a mental health nurse. However, she did speak to wing staff about his circumstances. When she spoke to my investigator, she agreed that she could have adopted a multi-disciplinary approach to the ACCT review in order to ensure that she did not take sole responsibility for ending the ACCT support and monitoring. She could not recall exactly why she carried out the review unaccompanied. I make the following recommendation:

The Governor should remind ACCT case managers to adopt a multi-disciplinary approach when conducting reviews. They should be accompanied by another member of discipline staff and, if possible, another professional who has been working with the prisoner, such as a mental health nurse.

165. Although she should not have closed the ACCT document without inviting other colleagues into the review meeting, the SO's decision does make sense in the context of previous review meetings. Staff suggested at the penultimate review that, on the next occasion, it might well be appropriate to end ACCT monitoring, given his progress. When she closed the ACCT document, the level of observations had been gradually reducing across successive ACCT reviews and had most recently been set at the minimum, namely three conversations with him each day. ACCT monitoring had been ongoing for nearly a month and his presentation had not given undue cause for concern throughout this period.

166. I consider that the decisions to begin and then maintain ACCT monitoring were very wise, given the circumstances of his offence. However, a month later, staff thought that he had started to adjust to prison life. He did not voice

any suicidal thoughts and I think that the level of observations had been gradually and sensibly reduced.

167. There were a significant number of risk factors in this case:

- The nature of his offence against his child.
- His history of alcohol misuse.
- His history of depression.
- The fact that he had not been to prison before.
- His previous attempts to take his own life.

Each factor was an indication that he might make a further attempt on his life. I acknowledge that ACCT monitoring is not supposed to continue indefinitely if staff are satisfied that the risk has reduced. However, it is important that staff do not rely solely on a prisoner's reassurances, but also consider risk factors such as those I have outlined.

168. Nonetheless, in this instance, trained professionals such as the psychiatrist assessed him and thought that he did not seem unduly distressed. Help for his mental health and alcohol misuse remained in place after the ACCT monitoring ended. On balance, I judge the decision to close the ACCT document to have been a reasonable one at the time.

169. After the ACCT monitoring came to an end, staff checked him every day for the next week, culminating in a post-closure review meeting on 10 August. This gradual disengagement from ACCT monitoring was handled sensibly and was in excess of the requirements of the Prison Service Order. He still gave no particular cause for concern and so it was not appropriate for the ACCT support to resume.

<u>Whether there was any risk of self harm in August and September</u>

170. After 2 August, he was not subject to ACCT monitoring again. He was not subject to any additional checks or observations when he died. The records show that he gave no indication to any member of staff that he was actively thinking about harming himself. He did not voice any suicidal thoughts. He was noted to be a polite prisoner who caused no trouble and complied with the regime.

171. His sister did become concerned about him after a visit in late August. She telephoned the prison to express her anxiety. The duty governor acted appropriately and asked the orderly officer to speak to him. SO H took the time to unlock him and interview him. He thanked the SO for his concern and was grateful to his sister for her obvious worry for him. However, he denied that he was feeling especially low or that he required self-harm monitoring. The SO telephoned the sister afterwards to update and reassure her.

172. Another month passed before he took his own life, and during this time no further concerns came to light. I also consider the absence of any ACCT monitoring at the time of his death to be reasonable.

Whether the man was allocated to the appropriate part of the prison

173. Because he was charged with attempting to murder his son, he faced possible difficulties with other prisoners. He was twice given the option of moving onto the vulnerable prisoners' unit (VPU, located on P wing). In prison parlance, this is known as asking for rule 45. Officer D (on 6 July) and SO C (on 10 July) both spoke to him during ACCT reviews about this option and explained its implications. On both occasions, he declined the option and said that he wanted to try to live amongst the general prison population. There is no further reference to him asking about the possibility of relocating to the VPU in his records. I am satisfied that, had he felt intimidated amongst the other prisoners, he knew that the VPU was available to him.

Alcohol in-reach referral

174. He was referred to the alcohol in-reach team. Engagement with the team is voluntary and prisoners can disengage at any point. The in-reach alcohol worker told my investigator that, although he was motivated to speak to her and continued to keep their appointments, he found it difficult to engage with the alcohol misuse literature and one-to-one counselling.

175. She discussed his situation with him and agreed that they would return to the issue of his alcohol misuse, and hopefully start some one-to-one work, after his forthcoming court appearance. His offence and plea hearing were preoccupying him. The need to address his alcohol misuse was a lower priority for him, so they agreed to delay any further work until he felt less distracted.

176. She maintained regular contact with him throughout his time in Birmingham. She clearly and helpfully recorded all of her interventions and I consider that she made every effort to offer him assistance with his alcohol misuse. I hope that the Governor and her manager will draw my comments to her attention.

Mental health treatment

177. CPN A was the first night mental health nurse who assessed him when he arrived in Birmingham. He initially referred him to the primary care mental health team. (This team treats the majority of mental health problems in Birmingham, such as depression.)

178. During interview, the CPN told the investigator that he did not refer him to the mental health in-reach team (who treat prisoners with severe and enduring mental illnesses such as schizophrenia) because he said that he had never taken anti-psychotic medication and did not have this sort of mental health disorder.

179. However, the CPN did refer him to the forensic psychiatric team because he met the necessary criteria. This team assesses and treats prisoners who have committed particularly serious or worrying offences. In this instance, his

presentation and the nature of his offence (violence against his own child) prompted him to make the referral. The CPN told the investigator that the man never attended the primary care mental health clinic because the forensic psychiatric team took over his care.

180. The visiting forensic consultant psychiatrist assessed him on 22 July as a result of the CPN's referral. He did not consider him to be clinically depressed. He thought that the current 50mg dose of sertraline (an antidepressant) was ineffective for an adult, and believed that the prescription should either be increased or cancelled altogether.

181. Following his assessment, the psychiatrist decided to double the daily dose of sertraline to 100mg to provide him with some supportive medication. He thought that he might be vulnerable and that the antidepressant medication should continue whilst he settled into the prison regime. However, he stressed to the investigator that, from his presentation on 22 July, he did not consider that he was clinically depressed.

182. Although the psychiatrist planned to double the dose of sertraline, the clinical record shows that the intended change in the prescription was never properly implemented. The last repeat prescription of sertraline on 31 August remained 50mg. This was the dose that the man was still receiving when he died.

183. He told the investigator that, because he did not consider the change in medication to be especially urgent, he decided to increase the dose of sertraline at the end of the current 28 day prescription for the 50mg. The electronic clinical record system shows that the planned increase in sertraline to 100mg was implemented at 11.40am by Prison Doctor D on 2 August (the day the original 28 day prescription ended). However, at 12.24pm the same day, another colleague, Prison Doctor C, decreased the dose back down to 50mg (presumably at the end of the consultation he had with the man).

184. Prison Doctor C did not make a note in the clinical record to explain why he had amended the sertraline prescription. It is possible that he had not seen the psychiatrist's entry in the record and presumed that Prison Doctor D increased the dose in error. Although my investigator has interviewed him, precise information about the changes made to the sertraline prescription was only provided afterwards.

185. In his clinical review, the clinical reviewer comments that, even if the dose of sertraline had been doubled as was intended, 'this is unlikely to have made a material difference to the outcome'. He thinks it more likely that the man's imminent return to court may have prompted an impulsive decision to take his own life. Nonetheless, I make the following recommendation:

The Head of Healthcare should review the administration of the man's sertraline prescription on the electronic clinical record system to learn lessons and ensure that such an error is not repeated.

186. The psychiatrist recorded in his notes that he planned to review the man's anti-depressant medication three or four weeks later. He told the investigator that he was particularly busy during August because he was working alone after the departure of two trainee psychiatrists who assist him throughout the academic year. He said that he had to prioritise which patients needed to be reviewed most urgently and, based on his assessment of the man's presentation on 22 July, he decided that a review of his medication could wait a little longer than originally intended.

187. Although the review did not happen as soon as planned, CPN C (a forensic mental health nurse) reviewed his antidepressant medication on 2 September. She noted that his mood had improved and attributed this change to the psychiatrist's decision to double his dose of sertraline (although no increase had actually been implemented).

188. She referred him to the psychiatrist for another review. This appointment was scheduled for 23 September, two days before he died. However, the review did not take place on that date because the prison regime was shut down whilst discipline staff attended a union meeting about the forthcoming possible privatisation of Birmingham. The psychiatrist was waiting in the healthcare centre but there were no staff available to escort him to his review. The psychiatrist only attends Birmingham once a week on a Thursday, so he was unable to schedule another appointment with him before he died.

189. I understand that staff needed to meet to discuss potentially huge changes to the prison, namely its proposed move into the private sector. It is regrettable that the prison regime was suspended to the detriment of the psychiatrist's patients. I appreciate the significance of the market testing process but do not think that the prison's daily routine should have been reduced in such a way as to detract from the care given to prisoners. The doctor had not assessed him since July and was due to see him two days before he went on to take his life. We cannot know whether the missed appointment would have reduced the risk that he would harm himself but nevertheless it was a missed opportunity for him to talk about his thoughts. I make the following recommendation:

The Governor should notify the Head of Healthcare if the prison regime has to be suspended. The Head of Healthcare should then advise their staff of potential disruption so that alternative arrangements can be made to treat patients.

The man's headaches

190. Prison Doctor C assessed the man on 2 August after he complained of headaches. He prescribed pain relief and told him that he would review his condition after a week if his headaches did not improve. Just as is the case in the community, he told my investigator that the responsibility rested with him to make a further application to see the doctor if his symptoms persisted. The doctor did not automatically schedule a review after a week and did not

assess him again. There is no further record of him complaining of headaches in August and September.

191. During the assessment, the doctor was unable to check his eyesight due to the necessary equipment not working properly. He wanted to check if his headaches might be associated with his vision. The doctor explained that he no longer relies on the opthalmoscope in the prison surgery and instead carries his own.

The Head of Healthcare should ensure that all equipment in the healthcare centre is fully functioning and available for daily use.

Whether the man's court appearance increased the risk that he would harm himself?

192. Section 4.10 of PSO 2700 states:

> 'Prisoners charged with homicide are a particularly high-risk group, and within this prisoners charged with homicide against a partner or family member are at an exceptionally high risk of suicide ….
>
> 'Care of such prisoners will require close monitoring of trigger points, for example during any trial or around key anniversaries.
>
> 'Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken.'

193. The man was charged with attempted murder of his own child. He was due to attend court on 27 September (two days after he took his own life) to plead to the charge he was facing. This was his first court appearance since July. In retrospect, staff have reflected with my investigator on how his imminent court appearance may have reawakened his feelings of guilt and made him feel more vulnerable than usual.

194. I investigated the earlier death of a prisoner who took his own life at another prison during a murder trial. The National Offender Management Service subsequently issued a Safer Custody Learning Bulletin to all staff in January 2010 about the risk associated with court appearances and the need for vigilance:

> 'A recent apparently self inflicted death has highlighted the risk of self harm and suicide associated with trials that are likely to expose the prisoner to particularly intense emotional pressure. Circumstances likely to increase risk include the following:
>
> • A murder, serious violent or sexual offence where the victim is a family member (particularly the prisoner's child or partner)

• A trial that will attract a high level of public interest where there is likely to be public shame on the prisoner prior, during or immediately following the trial

• The breakdown of other family relationships in relation to the above offences'

195. The bulletin asked staff to consider whether they had put adequate processes systems in place to address this sort of risk. As both PSO 2700 and the bulletin indicate, prisoners who have committed a violent offence against a family member remain especially vulnerable whilst still on remand. The experience of court can be very stressful even months after the original offence was committed. No special check was made on the man as his court date approached. As the clinical reviewer notes in his clinical review, support systems such as self harm monitoring were gradually removed as his mood seemed to improve across the summer.

196. He suggests that it would be worth looking at previous cases similar to the man's to consider the potential for the risk to increase as an important court date approaches. The reviewer highlights some of the possible contributory factors, such as him having no previous experience of custody, having previously attempted to take his own life before he came into prison and having relatively recently developed mental health problems.

197. The manager of the mental health teams told the investigator that his death just prior to his next court appearance has caused staff at Birmingham to reflect on the lessons that might be learned. She expressed the desire to focus on the issue of court dates and their impact on potentially suicidal prisoners.

198. I echo the clinical reviewer's view that lessons should be learned. It may be worth considering how those prisoners who are particularly vulnerable as a court date approaches can best be identified. Perhaps attention could be focussed on particular groups, such as the patients under the care of the forensic psychiatric team or those that have committed an offence of domestic violence. Were such prisoners to be placed on a register, they could be assessed by a mental health nurse prior to a court appearance. I make the following recommendation:

The Governor and the manager of the mental health teams should work together to implement the Safer Custody Quick Time Learning Bulletin published by NOMS in January 2010.

Emergency response

199. The clinical reviewer writes in his clinical review that the response when the man was found hanging in his cell was 'well coordinated'. He considers that the 'well organised efforts' of the staff involved probably allowed him to survive a little longer than he otherwise might have done. I agree with him. I

have been critical of previous resuscitation efforts at Birmingham, but I am pleased that in this instance, the emergency response seems to have been rapid and effective. A member of the Independent Monitoring Board, who was present on 25 September, also praised the efforts of staff when my investigator visited the prison to open the investigation.

Support for the man's cellmate

200. The cellmate told my investigator that he felt supported by prison staff after the man died. He said that staff had checked how he was feeling several times in the days afterwards, and he was given the chance to speak to the safer custody manager. He had not been subject to ACCT monitoring since July 2010, and said that he did not feel too badly affected by what had happened. He did not feel the need to resume ACCT monitoring.

Media notification

201. The man's family has complained about the speed with which his death was communicated to the media. He died in the early hours of Sunday morning. By lunchtime his death was featured on the television news bulletins. When his wife returned home, she saw the broadcast before she even had a chance to break the news to her children.

202. My investigator spoke to a senior press officer with the Ministry of Justice (MOJ). She explained that it is normal practice for the press office to initially notify only the Press Association (PA) about a prisoner's death. However, the press office will not contact the PA until prison staff confirm that the prisoner's immediate next of kin have been told about his death.

203. The MOJ press office releases only the prisoner's name, the fact that they have died and confirmation that the Ombudsman will be investigating the death. The information is not widely distributed beyond the PA. If other media outlets decide to pursue the story and contact the press office, they are provided with a brief press release providing the same details.

204. She acknowledged that information may reach the media before family members other than the next of kin can be told. She said that the press office cannot risk delaying the release of information indefinitely, partly because other prisoners become aware of the information and there is a risk that they will leak the information themselves.

205. I appreciate that the duty governor acted appropriately and as instructed by informing the MOJ press office about the death in custody. The immediate next of kin were present at hospital and knew that he had died. I understand that it can be difficult to find a suitable moment to tell relatives that news of the death in custody will be released to the media.

206. Although the release of information to the media cannot be halted, I would urge safer custody and family liaison staff to bear in mind the higher profile of certain prisoners as a result of their alleged offences. The supplementary

advice for family liaison staff attached to PSO 2710 (about events following a death in custody) touches on the way the family should be advised about the media when the news is broken to them:

> 'If the family is concerned about media intrusion, suggest that they make a single statement, perhaps providing a photograph, to only one newspaper. If necessary, seek advice from Press Office.'

207. I would ask the Head of the Safer Custody Department to draw the attention of family liaison staff to both the PSO and this section of my report.

208. As I have already commented in the 'Investigative process' section of the report, the man's family were not only upset by the way that the media publicised his death so quickly. His wife was frustrated by family liaison staff repeatedly using an incorrect surname during a telephone call. An incorrect spelling of his surname was used on the label on his property. The family also thought that the duty governor, whilst perhaps trying to sound encouraging, struck the wrong tone when they arrived at the hospital.

209. I think that it is a challenge for prison staff to deal with the family of a prisoner who has apparently taken his own life. However, it is their duty and one which should be carried out carefully and accurately. I do not make a formal recommendation. However, I would ask the Governor to remind family liaison staff that small details, such as the spelling of a person's name, have the power to communicate (inadvertently and unfairly) to a family a lack of personal commitment to their welfare. Equally, staff should think about how to communicate established facts about the prisoner's condition in a calm and understanding manner.

210. The prison contributed towards the cost of the funeral in accordance with established Prison Service policy. However, the man's wife explained to the investigator that she was initially told that the prison would cover the full cost of the funeral. She expressed concern that relatives should be given accurate information about the prison's financial contribution before they make funeral arrangements. I draw her comments to the attention of the Governor.

Contact with family members

211. The local Public Protection Unit (PPU) sent two faxes to Birmingham's Security Department on 5 July, the day the man entered prison. The first fax instructed that he should not contact his wife and children, whilst the second fax added his father to the list. A member of the PPU also telephoned one of the staff in the security department.

212. Because the fax was received late in the afternoon on 5 July and was not dealt with until the next day, I can understand why he was allowed to telephone his father on his first night in custody. The next day, 6 July, the prison's intelligence unit issued a memo reminding staff that he was not to contact his wife and children. The memo omitted his father (perhaps because

his name was only included on a very similar second fax from the PPU) and was sent to public protection and probation staff.

213. Officer E allowed him to telephone his father on 7 July. The officer told my investigator that he correctly assumed that contact with his wife and children would be inadvisable. However, he said that he did not see the PPU's fax, nor did he see the intelligence unit's memo (which, in any case, only mentioned his wife and children). He was therefore unaware that he should not contact his father.

214. My investigator asked the officer how the information might be disseminated to wing staff actually working with the man (because the memo was only sent to probation and public protection staff). He said that, to the best of his knowledge, there is no particular system whereby the security department alerts N wing staff to these sorts of developments. I do not think it sufficient for public protection information such as this to be sent to specialist staff and exclude wing staff who may often arrange telephone calls. I therefore make the following recommendation:

The Governor should ask the security department to review its procedures when they are instructed by the police to prevent contact between a prisoner and his victim. Information concerning persons who must not be contacted should be disseminated to all those who might facilitate a telephone call, including wing staff.

215. I would like to record the good practice of both the Governor and later SO H in helping the man's sister to allay her own concerns about her brother. The Governor arranged a telephone call between brother and sister on 10 July, whilst the SO went to speak to the man on 22 August to check on his welfare after his sister telephoned the prison with concerns. Afterwards, he telephoned back to reassure her.

Personal officer scheme

216. The personal officer scheme is an issue I revisit frequently during my investigations. Birmingham's scheme is cell based. Pairs of officers are allocated a certain number of cells on a wing and are responsible for checking the welfare of the prisoners living in those cells. One or other of the 'personal officers' is supposed to speak to the prisoner and record an entry about him on a weekly basis. In total, across two and a half months, staff made four entries about the man.

217. One of his personal officers told my investigator that he did not think, given staffing levels at Birmingham, that it was realistic or achievable to expect him to make a new entry each week on the P-NOMIS records about all of the prisoners he was responsible for. Whilst I do not make a recommendation, I draw the Governor's attention to the way in which the personal officer scheme operates and suggest that he may wish to review it with his management team to ensure that staff feel that the expectations can be met.

CONCLUSION

218. The investigation raises several issues for consideration. The way in which prescriptions are administered and dispensed needs to be explored to make sure that a similar error does not reoccur. I am reassured by the clinical reviewer's opinion that the level of antidepressant medication would probably not have had a significant effect on the man's actions. As well, I do not think that his doctor's review should have been missed on 23 September.

219. Very sensibly, he was made the subject of self harm monitoring as soon as he arrived at Birmingham. He said he was feeling very low. Staff also took account of his offence, his history of alcohol misuse and depression and his attempt to harm himself in the police station. Self harm monitoring remained in place for about a month, during which time the level of observations was gradually reduced.

220. As I have already discussed, prisoners who have tried to murder a family member are more likely than most to try to take their own lives once they are taken into custody. He also had a history of depression, misused alcohol, had never been to prison before and had previously tried to take his own life in the community. I consider that staff in reception took the right steps, referring him to an alcohol worker and a forensic psychiatrist and putting ACCT monitoring in place. However, when his mood seemed to improve, staff gradually reduced and then ended their observations.

221. During the next two months, he did little to concern staff or draw attention to himself. He was neither worryingly quiet, nor distressed and chaotic. He complied with the regime and staff thought that he was starting to accept prison life. His sister became worried about him and asked staff to check him. They did so and satisfied themselves that he was coping. A month passed and he sadly took his life just before his next court appearance.

222. There were several factors which had increased the likelihood that he might harm himself. He had received good levels of assessment, treatment and support from a range of multi disciplinary staff in his first month in prison. However, he seemed to settle into the regime and did not speak of being worried about going to court. The impact of a court date can be crucial in cases such as these. We cannot know whether he had this in mind when he took his own life, but it seems likely that his forthcoming appearance at least reminded him of his alleged offence.

223. Unfortunately no one wondered whether having to plead to a serious charge of attempting to murder his child would put him at risk. Had the court appearance been recognised as a possible trigger, I have no doubt that the ACCT support would have been reinstated. The Governor and the Head of Healthcare will need to think carefully about ways in which the court appearance of a vulnerable prisoner who has committed a traumatic and emotive offence can be monitored.

The family's response to the draft report

224. The man's wife wrote to my senior family liaison officer after she received the draft version of the report. She sent an extremely thoughtful and reflective letter in which she described her husband and the difficulties he had faced. She was very keen that her thoughts, and those of her children, should be reflected in the final report. I have made a number of additions to the text to include her comments, principally on pages 14 and 15. I am very grateful to her for her contribution.

225. The man's sister also provided the following response to the draft report:

> 'I was appalled by the fact that he was unable to attend his follow up appointment with the psychiatrist on 23rd September and I strongly agree with the recommendation that alternative arrangements should be made for the patients to be able to meet with healthcare professionals, it may not have made a difference but even so I feel it would have been a chance for him to express himself and I believe he would have been given some guidance or reassurance as to how to cope with his court appearance a few days later.
>
> 'With regards to his prescription for Sertraline being increased to 100mg due to his vulnerability at the time, it is my understanding that such medication can take up to 4 -6 weeks to have an affect on the patient, the psychiatrist requested the dose change to take affect from 2nd August, this did not happen, he died in September giving time for the medication to take affect, I believe it may have helped him, although I do understand that the psychiatrist did not believe he was suffering from depression as such and that he appeared to be coping with prison life when he saw him and much has been made about his 'problem' with alcohol, I am no expert but I believe alcohol was a result of his depression rather than his depression being a result of his alcohol consumption. He was determined to commit suicide and indeed while in prison he did not have access to alcohol, still the feeling of wanting to die did not leave him. The points I am making are: If the psychiatrist had requested a dose increase then that should have happened, and I find it frustrating that there is no real explanation as to why this didn't happen other than it seems to me an inability to interpret the computerised system correctly.
>
> 'Also the last telephone call he made on 15th August, this was to me asking why my son had not visited him as arranged, this was the day that my son was denied access due to his ID being deemed unsuitable, I think this should be noted as it reiterates the point I was making about the insensitivity of the visitors centre, one of the points I raised with you at our meeting in December, my son asked if they could get a message to him letting him know that he had tried to visit, he was told that they would and obviously this did not happen. I realise that a formal recommendation has not been made but I cannot stress strongly enough the importance of visits both for the prisoner and the visitor, I

received two telephone calls that day, one from him and one from my son, both of them upset, and what can I do to make it better, nothing, that makes three people upset.

‘I am not surprised about the comments made about him being polite to the officers as that was him!

‘On a more positive note I want to say thank you to the officer for allowing him a free call to me after I telephoned the prison as I was very distressed and wanted to find out if he was ok, I remember the call vividly and the relief I felt just hear his voice.’

RECOMMENDATIONS

1. The Governor should remind staff of the need to use the ACCT care map in a focussed and constructive manner. Staff should try to avoid general phrases and should aim to outline clear, measurable, achievable and realistic goals and actions.

   The prison accepted the recommendation and provided the following response:

   'Further guidance will be provided to all staff of the requirement of a quality ACCT Care Map and how it should be appropriately reviewed and updated. This will be reemphasised as part of our internal staff training on safer custody.'

2. The Safer Custody Department should consider how to facilitate the attendance of the same case manager at successive ACCT review meetings in order to minimise disruption and provide continuity and reassurance to the prisoner.

   The prison partially accepted the recommendation and provided the following response:

   'Due to the size of HMP Birmingham, it is likely that internal wing changes and individual staff shift patterns would make this recommendation extremely difficult for HMP Birmingham to achieve. Instead our priority will be to focus on detailed case reviews which will provide managers a good insight into previous reviews which can then be built upon.'

3. The Governor should ensure that senior officers are not obliged to act as ACCT case managers unless they have received the appropriate training.

   The prison accepted the recommendation and provided the following response:

   'No Senior Officer is obliged to act as a Case manager if they feel they are not suitably skilled. Advice, guidance and support is always available from the Safer Custody team and Senior Managers. Internal training has focused on training for Senior Officers and managers will ensure development needs are identified and acted upon.'

4. The Governor should remind ACCT case managers to adopt a multi-disciplinary approach when conducting reviews. They should be accompanied by another member of discipline staff and, if possible, another professional who has been working with the prisoner, such as a mental health nurse.

The prison accepted the recommendation and provided the following response:

'Further guidance will be provided to all ACCT case managers on the need to undertake prior planned and effective multi disciplinary case reviews.'

5. The Head of Healthcare should review the administration of the man's sertraline prescription on the electronic clinical record system to learn lessons and ensure that such an error is not repeated.

   The prison accepted the recommendation and provided the following response:

   'A review will be conducted by the lead GP and the pharmacy department.'

6. The Governor should notify the Head of Healthcare if the prison regime has to be suspended. The Head of Healthcare should then advise their staff of potential disruption so that alternative arrangements can be made to treat patients.

   The prison accepted the recommendation and provided the following response:

   'This system is already in place but will be reinforced by the Governor.'

7. The Head of Healthcare should ensure that all equipment in the healthcare centre is fully functioning and available for daily use.

   The prison accepted the recommendation and provided the following response:

   'A review of all equipment in the healthcare centre will be conducted by the Head of Healthcare with her management team and any items in need of replacement will be sourced and replaced.'

8. The Governor and the manager of the mental health teams should work together to implement the Safer Custody Quick Time Learning Bulletin published by NOMS in January 2010.

   The prison accepted the recommendation and provided the following response:

   'The Governor and the mental health team manager will liaise and determine the best way that the Quick Time Learning Bulletin can be implemented at HMP Birmingham.'

9. The Governor should ask the security department to review its procedures when they are instructed by the police to prevent contact between a prisoner and his victim. Information concerning persons who must not be contacted should be disseminated to all those who might facilitate a telephone call, including wing staff.

   The prison accepted the recommendation and provided the following response:

   'The Head of Security will conduct a review of how relevant information is disseminated effectively throughout the establishment to all relevant staff including those on Residential units.'