Investigation into the circumstances surrounding the death of a man at HMP Birmingham in November 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Birmingham in November 2008. At the time of his death he was a remand prisoner, having broken the conditions of his bail on 6 October. He was 29 years of age. It was his first time in prison.

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

Since the Ombudsman started investigating deaths in custody in April 2004, there have been 19 deaths in custody at HMP Birmingham, seven of which have been apparent suicides, including that of the man. I note that several issues which are dealt with in this report have been raised previously in other investigations.

The investigation into the man's death was undertaken by an investigator. In addition, a clinical review was conducted by a clinical reviewer on behalf of the local Primary Care Trust (PCT). I am most grateful to him and his review is annexed to this report. I have also had sight of an internal clinical review carried out by the Acting GP Clinical Lead at HMP Birmingham prison. I would also take this opportunity to thank all of the staff at Birmingham for their cooperation with the investigation.

It is evident from the investigation that the man was a quiet young man who, for the most part, kept himself to himself. None of us can say what was on his mind during the last few weeks of his life, or be sure of the reasons why he took the actions that he did. However, he had a history of mental health and drug problems and, although he was referred for assessments by both the mental health and drug detoxification teams, he was not seen during his five weeks in custody. Medication was prescribed, but not all of it was given to him, and it may be that withdrawal from drugs and his mental health difficulties became too much for him to bear.

Although the mental health and drug detoxification assessments were not fully completed, I do not believe that discipline staff at Birmingham could have foreseen the man's actions, given the limited information available to them. However, in addition to a number of healthcare recommendations I also make a number of recommendations relating to record keeping, the operation of the personal officer scheme and calling an ambulance in an emergency.

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

Jane Webb
Deputy Prisons and Probation Ombudsman **October 2009**

CONTENTS

Summary

The Investigation Process

HMP Birmingham

Key Findings

Clinical Issues

Other Issues

Conclusion

Recommendations

SUMMARY

The man was arrested whilst on bail and sent to HMP Birmingham in October 2008. During the reception process he was assessed by a nurse. He told the nurse that, although he was not currently taking any medication, he had previously been admitted to a psychiatric hospital and had harmed himself on several occasions. Although he expressed no concerns about his health, he told the nurse that he had been using heroin every day.

After consideration of the man's status the RGN (Registered General Nurse) referred him to the drug detoxification team that evening and made a non urgent referral to the primary mental health team.

He spent the night in the first night centre but, because of his late arrival, was not seen by the drug detoxification nurse. Although unable to assess him the nurse prescribed a number of drugs, in addition to the sleeping tablet prescribed by the prison doctor, to alleviate any possible symptoms of drug withdrawal. The man never received the drugs prescribed by the nurse, but the following evening did receive the sleeping tablets prescribed by the prison doctor.

Despite his name being added to the following day's detoxification clinic list, he was never seen by a member of the team and neither did he receive the rest of his prescribed medication. Having spent a week on the induction unit, he was moved to one of the main residential units then several further cell moves took place before his death.

Due to a backlog in primary mental health care assessments, the man's referral was not progressed until 21 October. Although one of the mental health team's nurses was asked to look into his background and contact the hospital where he had been receiving treatment, he was not fully assessed.

In November, just before lunch, a member of staff found the man hanging and the alarm was raised. Healthcare staff attended and resuscitation was attempted. However, this was not successful and he was pronounced dead by one of the prison doctors at 12.12pm.

My report makes a number of recommendations, the most significant of which relate to the man not being fully assessed by either the drug detoxification team or mental health team. I also draw attention to poor record keeping, highlight the apparent failure of the personal officer scheme and regret the apparent delay in calling an ambulance.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by an Assistant Ombudsman. He met the Governor of HMP Birmingham and a duty Governor, explaining the nature and scope of the investigation. Notices were issued to staff and prisoners at Birmingham informing them of the investigation and inviting them to contact the investigator who was appointed to conduct the investigation. The investigator also met the Governor of HMP Birmingham and gave feedback during the investigation.

2. The investigator spoke and liaised with the Independent Monitoring Board (IMB) and members of the Prison Officers Association (POA). (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.)

3. The investigator was shown the cell and wing where the man spent the last weeks of his life. The investigator reviewed his prison and health records and other documentation, including telephone records, made available to him upon request, and interviewed a number of staff at the prison. Although a notice was published for prisoners to invite them to contact my investigator with any information they felt was relevant to the investigation, none came forward. At the time of the investigation one of the prisoners who occupied a cell next to the man had been released and the other had been moved to another establishment. The investigator made enquiries with prison staff as to the identity of any prisoners on the wing with whom the man may have mixed. Officers on the wing reported that he kept himself to himself and did not mix with other prisoners and were unable to identify any prisoners who may have had contact with him.

4. An independent clinical review was undertaken on behalf of the local PCT by the clinical reviewer. The investigator also obtained an internal clinical review, into the man's death by the Acting GP Clinical Lead at Birmingham prison.

5. The investigator spoke with a Detective Inspector (DI) of West Midlands Police, who is acting on behalf of the Coroner. The investigator has also been in contact with the Coroner's office and a copy of this report will be sent to the Coroner to assist him with his enquiries.

6. A family liaison officer contacted the man's parents and, together with the investigator, visited them at their home shortly after his death. The visit gave his parents the opportunity to discuss my investigation and to raise any concerns or questions they wished to be addressed as part of this process. His parents raised a number of concerns:

    - Whether the prison was aware of the medication that he had been prescribed whilst in the community and what medication he was receiving whilst in prison.

    - If the prison was aware that he had attempted to take his life on two previous occasions.

- Whether or not there was a referral system in place at the prison whereby prisoners with known mental health problems are automatically referred for a more thorough mental health evaluation, in spite of their presentation at the time.

- If the prison was aware that he was a drug user and whether he was placed on any drug detoxification programme.

- Whether the prison made any attempt to contact his GP or St George's Hospital.

- His parents also explained that, despite their best efforts, it had not been possible to visit their son during the five weeks that he spent at Birmingham, explaining the ongoing difficulties they experienced in trying to arrange a visit to see him.

- Why he had been moved so many times during his time at Birmingham and whether or not there was anyone that he could have talked to if he was feeling vulnerable and low.

I have done my best to address these issues and I hope that this report helps his parents better understand the events before and after his death. Having read the draft report his parents agreed with the findings and my recommendations.

HMP BIRMINGHAM

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

Healthcare

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

Listeners and Insiders

9. Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress. They are available 24 hours every day and will meet prisoners to listen to their concerns. Insiders are also prisoners, who usually work on first night and induction centres, who offer guidance and information to new prisoners. Unlike Listeners, Insiders have no formal training.

PIN Numbers

10. The PIN number is a number given to prisoners which allows them to make telephone calls to friends and relatives. For the first 24 hours after the PIN number is first issued a prisoner can call any number they wish. After this period of time has passed, prisoners are only able to phone numbers authorised by the prison.

Visits

11. Prisoners are also advised that the last four digits of the PIN phone number should be used by their relatives to use in order to book visits. In order to arrange a visit the prisoner fills out the form, given to them during induction, to record the details of those people they wish to receive visits from. If a visitor rings the visitor line, or e-mails requesting a visit they are unable to do so unless they provide details of the pin number. If friends or families contact the prison to book a visit without the PIN number the prison notifies the prisoner that friends or family had attempted to book a visit but had been unable to do so because they did not know the prisoner's PIN number. The prisoner is reminded that he must forward this number in order that a visit can be booked.

Independent Monitoring Board Reports

12. In their annual report for 2007 the Independent Monitoring Board (IMB) raised the issue of there being little primary mental health provision at Birmingham. In their report for 2008 the IMB reports that, "There is still no primary mental health care provision …" The Birmingham and Solihull District Coroner has raised this matter

at inquests into two earlier prison deaths.

13. The IMB also reported a great deal of uncertainly within healthcare at the prison as the current contract has been subject to a competitive bidding process. They felt that this was having a destabilising effect on staff at all levels. The IMB argued that most of the difficulties had come about because of faults in original contracts coupled with uncertainty about what should have been agreed. However, they report that strenuous efforts had been made by staff to put things right.

HM Inspectorate of Prisons Report 2007

14. The last full inspection of Birmingham, by Her Majesty's Chief Inspector of Prisons, was in 2007. She said that at the time of her inspection there had been a significant improvement and that a strong and committed management team had succeeded in changing the culture within the prison. However, she concluded that her report was overall disappointing, citing that Birmingham was suffering from the pressures of an overcrowded prison system and that these pressures had made it more difficult to deliver safe, decent and purposeful outcomes for prisoners. She said that it was a credit to staff and managers that Birmingham was a much better prison than when it was last inspected in 2000 and that the scale of achieving that task should not be underestimated.

15. Her report also highlights a number of concerns raised by my own report into the man's death. These included that the personal officer scheme was not fully understood by staff and was not applied consistently. Officers did not maintain an accurate diary of their contact with prisoners and did not always identify significant events affecting them. Their entries were generally of a poor quality.

KEY FINDINGS

16. In October 2008, the man was transferred from Stafford Police Station to Cannock Magistrates Court, having been arrested the previous day for robbery whilst on bail. At 5.00pm he was transferred from court to Birmingham prison, arriving at 5.40pm. Escort staff recorded on his Person Escort Record Form (PER Form – a document used by escort staff to record a prisoner's known risks and other information) that he had previously used drugs and had a "self confessed alcohol problem". It was indicated that a medical assessment, police risk assessment form and court file were also attached to the PER form. (Birmingham prison has been unable to provide copies of either the medical assessment or police risk assessment form. It is not clear what happened to these documents, or indeed if they ever arrived at the prison.)

17. In reception a Senior Officer (SO) recorded on the man's wing history sheets, "Remanded into custody. First time in prison, rules and regimes explained, states fine no problems." The SO said that he could not recall seeing a medical assessment and police risk assessment form. However, he added that if a medical assessment form had been transferred with him it would have been immediately passed to the nurse in reception. The SO said that any police risk assessment form would also have been noted by reception staff and consideration made as to whether an Assessment Care in Custody and Teamwork (ACCT) booklet should be opened. (The ACCT document is used to assess, observe and support prisoners who are at risk. It highlights the problems and possible trigger points of a prisoner at risk of self harm and delivers a multidisciplinary plan to give support and help through a period of crisis.)

18. An Officer completed a Cell Sharing Risk Assessment. (The CSRA is a form used to assess the risk that a prisoner would present to others when sharing a cell.) The Officer recorded that it was the man's first time in prison. He noted that, although he had no concerns at the time, he had described himself as someone who became angry and frustrated quickly and "tended to get himself wound up". The Officer concluded that he did not pose a risk to other prisoners, but that the situation would need to be reviewed regularly.

19. At approximately 7.15pm a Registered General Nurse (RGN) working in reception interviewed the man as part of the first night reception health screen. (All prisoners are given a first night reception health screen when entering prison. The aim of the screen is to identify any needs or health concerns that the prisoner might have. This includes identifying a prisoner's past history, including mental health and drug concerns.)

20. The RGN recorded on the prison's electronic medical information system (EMIS), that the man had told her he was not receiving any prescribed medication at the time. He said that he had previously been admitted to St George's Psychiatric Hospital, Stafford and been prescribed anti-psychotics and anti-depressants for drug induced schizophrenia. He said that he had a history of deliberately harming himself, having previously attempted to hang himself and take an overdose, but currently had no such thoughts. He told the RGN that he had used

drugs in the past month, taking heroin on a daily basis. He expressed no concerns about his physical health.

21. The RGN told my investigator that all the medical information she gathered during the health screen was obtained from the man alone. He gave her no indication that he was at risk of self harm at the time. Had he told her that he was in receipt of medication, she said she would have referred him to the prison doctor. Following the assessment by the RGN, who used the mental health triage criteria, he was referred on a non urgent basis to the primary care mental health team and the drug detoxification team. His details were entered on the relevant clinic lists.

22. At 7.59pm one of the doctors working on the induction unit that evening, prescribed the man with Zopiclone, a sleeping tablet prescribed to assist the relief of drug withdrawal symptons. (However, his prescription chart indicates that his first dose of Zopiclone was not administered until the evening of the following day.)

23. The man was transferred from reception to D wing, the prison's first night centre, where new prisoners spend their first night in prison. My investigator has been unable to establish exactly when he arrived at the first night centre. An Officer, who provided him with a smoker's pack and PIN telephone number, gave my investigator an approximate time based on his experience. He said that as the GUIDED booklet, (a document used to record the induction process) was not completed until the following day; it was most likely that the man would have arrived late on the unit, sometime after 8.30pm.

24. A second RGN from the drug detoxification team, went to assess the man at around 9.00pm, but was unable to do so as he had been locked into his cell. At 9.12pm she noted on EMIS, "Five were not seen due [to] time factor". Although she was unable to assess him she prescribed, in addition to the Zopiclone prescribed by the prison doctor, a number of other drugs used to help alleviate symptoms of drug withdrawal such as stomach cramps, nausea and headaches. They included Prochlorperazine Maleate, Ibuprofen, and Hyoscine Butylbromide. She told my investigator that because she was unable to see him, she could not give the medication she and the prison doctor had prescribed to relieve his symptoms, although the prescription was noted on EMIS as having been administered. The investigator could find no evidence to suggest that he was ever given the medication prescribed by her.

25. The second RGN provided a verbal hand over to the night detoxification nurse, a Registered Mental Health Nurse (RMN), and member of the drug detoxification team who was based on the detoxification wing in another area of the prison. The second RGN noted in the handover diary that the man was not seen as officers had locked him up.

26. At 10.43pm the RMN recorded on EMIS that the man was "Not seen because of time and the officers had to lock him up before he was assessed." She told my investigator that she made this entry on EMIS following the second RGN's handover earlier that evening. The RMN explained that in early October 2008,

she would not have had access to the induction wing to carry out drug detoxification assessments or administer prescriptions once prisoners were locked in their cells. (I understand that this has now changed and members of the drug detoxification team are now able to access prisoners at any time of the day and night.)

27. As the man had not been seen, his name was entered in the handover diary to be assessed the following day, 8 October, by a member of the drug detoxification team. However, he was again not seen due to a lack of time, the clinic doctor having to see 20 patients within a two and a half hour clinic. As a consequence he was added into the diary to be seen the following day, 9 October. However, upon his transfer to N Wing he had no further contact with the drug detoxification team.

28. The man's induction continued on the morning of 8 October. The induction officer interviewed him as part of the induction process and completed the unit's GUIDED booklet. The man told the officer that his family did not know where he was. Although he revealed that he had never previously been in custody, he claimed that he was not worried about it. The man said that he used alcohol daily and had recently been using heroin and amphetamines. When asked if he would benefit from a drug detoxification programme, he said that he would. He told the officer that he had self harmed more than five years previously but did not currently feel like harming himself. He confirmed that he had suffered from, and had been treated for, depression and other mental health problems. The officer noted that there were no concerns regarding his location in the prison and that he was polite and cooperative during the interview.

29. During interview for this investigation the induction officer said that the man would have been provided with a number of booklets and leaflets explaining the prison's procedures, including how to make applications for visits and telephone calls and would have been greeted by one of the Insiders and told about the Listeners and the Samaritans telephone. During his time on the induction unit he was also seen by other members of prison staff including the Chaplaincy and Legal Aid Services team.

30. At 8.44am, using his PIN phone number the man attempted to make a call to his parents, but hung up. He called his parents again at 9.24am and spoke with his father. He told his father that he was in prison and would write to tell them when they could visit. He asked his parents to bring tobacco and money with them.

31. A third RGN saw the man at 10.10am and assessed him as part of the prison's Wellman health screen. She noted on EMIS that he had no relevant past or significant medical history and recorded a number of responses to general medical questions. She told my investigator that she based this on the information provided to her by him.

32. Later that day the man was moved to N Wing, the induction wing, for him to participate in the second stage of his induction.

33. On 9 October, the man attempted to telephone his parents but because he had not registered the number with the prison, the call was not connected.

34. The man wrote to his parents in a letter post marked 13 October. He asked them to send him tobacco and shampoo and to pass on his whereabouts to a friend. He also told his parents that he would understand if they did not want to visit him in prison.

35. The man was relocated from N Wing to A Wing on 14 October. An officer wrote in his Wing Sheets, "Arrived onto A wing A2-14, does not seem to be any problems." On 20 October, she wrote, "Has been a quiet week, he is a quiet individual who tends to 'get on' with things, no problems to report." She told my investigator that she was the personal officer assigned the cell in which he was placed. She could not recall introducing herself to him, saying that she did not "… make a case of going round and saying I'm your personal officer …" She said that she could not recall him approaching her about the use of the PIN phone or seeking information about arrangements for visits.

36. In a letter to his parents, post marked 20 October, the man wrote, "It's started to sink in now just how long it is gonna be that I'm going to be here." He asked his parents to arrange a visit when he was next in court. He would try and ring them in the next couple of weeks, adding that he had to fill in a form in order that they could be approved for visits, which he believed would "take a while".

37. Due to a backlog in primary mental health referral assessments, a second RMN, the only member of the Primary Mental Health Team (PMHT) at the time, evaluated the referrals to identify prisoners who should be seen as a priority. She identified the man as a priority and at a mental health team caseload meeting on 21 October; he was accepted by the Mental Health In Reach Team (MHIRT) for further assessment. An entry on EMIS records, "Discussed in Community Psychiatric Nurse Caseload Meeting. Referral received. Diagnosis of schizophrenia SW [a Clinical Psychiatric Nurse] to see."

38. The man was added to the case load of a Clinical Psychiatric Nurse (CPN). However, she said that on 24 October a colleague, a fellow CPN, accepted him onto her case load, on 24 October, as she was more available. The CPN said that she subsequently had no further involvement with him.

39. The second CPN was not accepting new cases as she was leaving the prison, but said that she offered to assist by carrying out background work and check ups on the referrals made to the first CPN at the meeting. The second CPN said that the first CPN gratefully accepted the offer of help.

40. A member of the MHIRT said that the second CPN had not gone to the meeting that morning in order that she could complete her caseload prior to leaving the prison. Although not party to any conversation between the two CPNs, the member of the MHIRT thought it correct to assume that the second CPN would not have been taking over the man's case.

41. On 24 October, the second CPN noted on EMIS that the man was known to St George's Hospital and was under the care of a hospital doctor, who last saw him on 12 September. She noted:

> "Known to St George's Hospital, Stafford. Under care of a hospital consultant, last seen 12 September 2008. Summary of OPA [out patient appointment] at that time indicates history of low mood. Previously prescribed Naltraxone however not current prior to remand. Prescribed no other medication. St George's Hospital would prefer a Consultant to Consultant transfer of information. Gave contact details for a prison consultant psychiatrist they will contact. Secretary advises me that there are no acute or risk issues that we need to be aware of until further information is conveyed."

    The second CPN said that the secretary did not pass a clinical opinion, but read from the last out patient letter.

42. The second CPN said that she then informed the prison consultant psychiatrist that the hospital consultant was to be in touch regarding the man's history, in line with South Stafford's standard working arrangements. She also said that she passed the information that she had been able to gather on him back to the first CPN, adding that had any concerns been raised from her telephone contact with St George's she would have alerted her colleagues. The consultant psychiatrist at the prison said that the second CPN did not make any handover either verbally or in writing regarding the man.

43. It was the man's birthday on 27 October, and he received a card from his parents. In a letter to his parents post marked 28 October, he thanked them for his birthday card, telling them that he had:

> "… ordered a new pin no for my phone so I will ring u in next couple of weeks ok. When I ring I'll give you the code you need to visit, I wont be able to fill in the application form for you to visit until I get a new phone no."

    He said that he had written the old number on his hand so he would remember it, but that he had washed it off by accident. (However, he continued to use the PIN phone system after this date, indicating that he still had access to the PIN number.)

44. The man was moved to B wing on 29 October. On 31 October, he assaulted his cell mate sustaining injuries to himself. He was treated on the wing by a fourth RGN. She noted on EMIS that he had several lacerations that she had cleaned and applied dressing to, noting that two cuts to his lip might require stitches. She recorded that he was happy to wait for the evening GP for further assessment of his injuries.

45. At an adjudication held on 3 November, the man pleaded guilty to a charge of assault, explaining that he did not intend to hurt anyone but had just 'lashed out'. He was found guilty of the charge and given five days stoppage of earnings at 50 percent and seven days loss of association and gym as well as the use of his private cash. On 5 November, he was located in a single cell on C wing, cell 2-

27, following a cell sharing risk review, which was completed as a consequence of the assault on another prisoner.

46. On 11 November, the man submitted a Prisoner's Application for Change of Visitor Details request listing the names of his parents. In a letter to his parents, postmarked the same day, he told them the PIN number required for them to book a visit and again requested that they bring tobacco with them.

Events in November

47. An Officer told police that at about 9.15am he unlocked the man's cell door for the association period. (Association is the time when prisoners are unlocked from their cells and can associate with each other, make telephone calls, and take showers etc.) He said he did not notice what the man was doing, only that he did not reply.

48. At around 9.45am the man approached the SO and asked her where he could obtain a pin phone credit form. The SO said that she showed him the box on the wing in which the PIN application forms were kept but could not recall whether or not he actually took the forms away with him. A second Officer told my investigator that he recalled that the man did not leave his cell that morning for association.

49. At 10.44am the man rang his cell bell. The second Officer told the police that he had asked to use the telephone. The second Officer said that because he knew he had not gone out for association, he let him leave his cell to make a call. The man made a second attempt to phone his parents at 10.50 am; however the number was disallowed again. Soon afterwards, the second Officer said that he appeared at the office asking for a PIN application form. The second Office said that he gave him a form, telling my investigator that he did not ask for assistance in completing it.

50. An uncompleted PIN phone query form was found in the man's cell after his death. Although the form is undated it is of the type held on the wing and I believe it was probably completed by him that morning. The application form listed the telephone number of his parents, however the form was incomplete.

51. At approximately 11.40am a third Officer unlocked the cell for the lunch period. On opening the door he saw the man hanging from the window bars of the cell. He immediately raised the alarm by shouting for assistance to nearby colleagues. The first Officer, who was supervising prisoners nearby, responded immediately. A fourth Officer also went to the cell, having heard the Officers' shouts for assistance. The officers went into the man's cell. The first and third Officers supported the man's weight whilst the fourth Officer attempted to cut the ligature from the window bar, but due to the thickness of the ligature he was unable to do so.

52. The SO also responded to the shouts for assistance from the Officers. Upon arriving at the cell, the SO radioed for assistance, asking that Hotel 2, the emergency response nurse, go to C wing immediately. The SO then went into

the cell.

53. A fifth Officer was returning to his office via C wing, when he saw the SO emerge from cell C2-27 and run towards the office. The officer saw the man hanging and went inside immediately to assist the officers already there. A sixth Officer, who was in the vicinity, also went into the cell to provide assistance

54. A PO said that he too saw the SO leaving the cell while attempting to use her radio as she hurried along. The PO used his radio at 11.42am to ask members of the healthcare team to attend immediately.

55. The SO returned to the cell with an additional ligature knife. He saw that the fourth Officer was having difficulty cutting the ligature from above, and so attempted to cut it at the end around the man's neck. The ligature was eventually cut free from around his neck several minutes later by a seventh Officer. (The Wing Observation Log records that it took approximately five minutes for the ligature to be cut.) During interview for the investigation, the staff said that the man did not respond throughout.

56. A nurse was Hotel 2, the emergency response nurse. She was with another nurse in the nurses' treatment room on B3 Landing, when she received the emergency call to go immediately to C2 landing. (The nurses' station is located off the centre of the prison and was within a couple of minutes walk of the man's cell.) Although unaware of the nature of the emergency, Hotel 2 took the emergency response bag and, with the other nurse, made her way to C2 landing.

57. Hotel 2 said that the man was lying motionless on the cell floor, with ligature marks prominent around his neck. She told the investigator that she sent the other nurse to fetch additional emergency equipment including the defibrillator and oxygen and also to confirm that an ambulance had been called. Hotel 2 said that she could gain no response from him and found no signs of life.

58. Hotel 2 immediately commenced cardio pulmonary resuscitation (CPR) with the assistance of the fourth and sixth Officers. On her return to the nurses' station to collect further emergency equipment, the nurse informed another nurse of the situation. Both nurses then went back to the man's cell. They took the blue emergency bag containing the Automated Electrical Defibrillator (AED), oxygen, ambubag with face mask and other emergency equipment.

59. When the second nurse arrived at the cell, she found Hotel 2 and two of the officers carrying out CPR. The second nurse attached the defibrillator to the man but the machine indicated that no shock (to restart the heart) should be administered and that CPR should be continued. The nurses and officers therefore administered CPR until the paramedics arrived at 11.52am. The prison doctor arrived at 12.00pm. The man had not responded to the resuscitation attempts by nursing staff and paramedics, and the doctor pronounced him dead at 12.12pm. (In his clinical review the clinical reviewer concluded that the efforts to resuscitate the man were prompt and well executed. He cited the healthcare response as an example of good practice.)

60. The control room incident log records that an emergency call was made to the West Midlands Ambulance Service at 11.47pm. Although Hotel 2 asked for an ambulance to be called, my investigator has been unable to establish who made the request for an ambulance to attend.

61. The staff who discovered the man and responded to the emergency were invited to a hot-debrief that afternoon. (A hot-debrief is a meeting held as soon as possible after a major incident.) A review of prisoners at risk of harming themselves was completed. I also understand that those officers involved in the incident were approached by the care and welfare team. Several officers said during interview that they were impressed by the level of care offered to members of staff.

62. The man's parents were told of his death by Family Liaison Officer, Governor and Chaplain that morning. His parents commented on the sensitivity and kindness shown to them by staff following his death.

ISSUES

Clinical issues

63. On his arrival at Birmingham on the evening of 7 October, the man was assessed by a RGN, a member of the prison healthcare team. As a consequence of his history of substance misuse, she referred him to a second RGN from the drug detoxification team. However, due to his late arrival on the induction unit, he was not seen that night by her. He was locked in his cell by the officers in preparation for the prison entering the Night State, when all prisoners are locked up and staffing levels are reduced.

64. An Operational Order on the Late Processing of Prisoners 137/2008, issued by the Governor on 12 September 2008, advises staff the Duty Governor and Night Orderly Officer will ensure that staff are available to supervise the processing of prisoners who arrive late. The order goes on to say that:

    > "Prisoners identified as having immediate health needs will be given necessary medical attention. Any prisoner identified as having immediate mental health problems or detoxification problems will be seen by the appropriate staff on the first night centre."

    The arrangements for the man did not meet the requirements of the Order, and he did not receive the medical attention which he needed.

    The Governor should remind staff on the Induction Unit to unlock prisoners who have been identified as having immediate health needs in order that appropriate treatment by healthcare staff can be provided.

65. The man was not seen by a member of the drug detoxification team either on 7 October, or over the following two days, due to a lack of nursing resources. Upon his transfer to N Wing he appeared to be omitted from the drug detoxification team's list of assessments.

66. In his clinical review the clinical reviewer says that, although the man was known to have a history of drug abuse and was prescribed treatment, a drug assessment was not carried out. His only treatment appears to be medication prescribed to relieve the symptoms of opiate withdrawal. The clinical reviewer concludes that, when admission reviews have been missed because time is short, there should be a "fail safe" system to ensure that they are carried out the following day. I agree with his conclusions.

    The Healthcare Manager and Drug Detoxification Team Manager should ensure that when admission reviews have been missed as a result of lack of time, there should be a "fail safe" system to ensure that they are carried out the following day.

67. However, I would hope that it would seldom or never be necessary for the "fail safe" system to be deployed on the day after a prisoner's arrival, because the Governor's Operational Order should ensure that the necessary assessments

take place on the very first day or night of a prisoner's custody.

68. Although the man was not seen by the second RGN from the drug detoxification team, she noted on EMIS that a number of drugs, in addition to the sleeping pills prescribed by the prison doctor, were prescribed to relieve any initial symptoms of drug withdrawal. However she told my investigator that, because she was unable to see him, she was unable to give him his medication. Although his prescription charts show that he did receive his sleeping tablets on the subsequent evenings, the investigator could find no evidence to suggest that he ever received those drugs prescribed by the second RGN. Failure to administer prescribed drugs is of great importance to any patient, but especially to a prisoner, in custody for the first time, who may be experiencing drug withdrawal symptoms.

The Healthcare Manager and Drug Detoxification Team Manager should ensure that systems are in place to guarantee that medication prescribed to prisoners is administered appropriately and on time.

69. In her internal clinical review the Acting Clinical GP Lead at HMP Birmingham states that the man told nursing staff that he had a history of mental health problems. He claimed that he had not seen a psychiatrist for some time, even though he had actually done so only a month before his arrival at Birmingham. She also reported that he informed staff of his previous history of self harm but said that he had no current thoughts of harming and his behaviour did not raise any concerns with staff. She said that on the basis of these observations, rather than refer him for an urgent assessment that night by the CPN, he was actually referred to the Primary Mental Health Team (PMHT).

70. Unfortunately, due to a backlog of work and shortage of staff, the man was not assessed by the PMHT. His case was highlighted at a review of the prisoners referred to the PMHT, but who had not been assessed. He was discussed at a meeting on 21 October and referred for further assessment by a member of the MHIRT. Background information was sought from St George's Hospital and arrangements were put in place for further contact between the hospital consultant, the hospital contact and the consultant psychiatrist, but no contact was made. The man had no further contact with mental health services at the prison.

71. In her internal clinical review the Acting Clinical GP Lead said:

> "The management of the man's case was poor in that communication failures occurred at several points.
>
> - He self-reported psychiatric history was not reliable, had nursing staff known that he was currently under close review by the psychiatrist he would have been referred to the CPN that night. The newly created PMHT at that time consisted of one nurse who was physically unable to undertake the workload. The dangers of this had been reported to senior management on several occasions as had the very high vacancy rate and

sickness absence rate of nursing staff.

- As he was locked up on the night of his admission and not seen by the detoxification nurse, an opportunity to discover more pertinent information was missed.

- When his case was discussed at the MHT meeting he should have been booked for an urgent review as he had already been in the prison for two weeks.

- The decision to wait for consultant-consultant discussion should have been questioned and the prison psychiatrist asked to contact St George's Hospital as soon as possible to explain that such strategies are inappropriate in a prison setting.

- The prison cannot put the onus on outside agencies to contact us to forward essential clinical information. Also if contact details are given, they must be phone numbers which are manned or have answer machines attached."

72. In his clinical review the clinical reviewer confirms the Acting Clinical GP Lead's findings. He concluded that there appeared to be no identifiable consultation by a prison doctor at any stage during the man's stay in prison, despite his history of major mental illness. He said that:

    "There appears to have been communication failures, particularly in referral procedures, which may reflect reduced staffing levels, consequent on poor recruitment and retention."

73. I am very concerned to read the Acting Clinical GP Lead's and the clinical reviewer's findings, and in particular that the newly created PMHT was grossly understaffed and that this had been reported to senior management on several occasions. It cannot be stressed how important the speedy identification of prisoners with mental health problems is in order that the correct care can be provided. It is clear that in this instance the man was failed by the system. Based on the findings and conclusions of the Acting Clinical GP Lead and the clinical reviewer I make the following recommendations.

    The local Primary Care Trust, Birmingham and Solihull Mental Health Trust and Heads of Healthcare and the Mental Health In Reach Team should urgently undertake a needs analysis and review of mental health provision, including staffing levels, and satisfy themselves that the appropriate mental health provision is being delivered at Birmingham prison.

    The Healthcare Manager should satisfy herself that communication between the primary health team and MHIRT is adequate, ensuring that procedures are in place in order that staff are aware of and have responsibility for the prisoners in their care.

74. In his clinical review the clinical reviewer said that, although the computerised medical notes held on prisoners at Birmingham add clarity, there is no

identification of the role of the practitioner making the recording. He concluded that, in order to facilitate case reviews, practitioners should add their role at the time of entry. Additionally he notes that all the entries on EMIS were listed as "consultations" when they might in fact be indicating another activity. In the light of his findings, I make the following recommendation.

The Healthcare Manager should remind all healthcare staff of the need, when entering entries on EMIS, to clearly identify their role and the nature of their consultation/activity.

Wing history sheets

75. My investigator was unable to establish any detail about the time that the man spent in custody from written prison records and, in particular, his wing history sheets. After 20 October, and until his death, only two entries were made, one relating to his assault of another prisoner and the other to the subsequent adjudication. I am saddened that prisoners such as the man may have a lower profile on the wings than other prisoners, and be less demanding of staff time and attention. They may go unnoticed and, as a consequence, less is recorded in their history sheets and less information is available for staff or for investigations such as this. Birmingham's own personal officer scheme expects entries to be made at least once weekly and significant entries highlighted in the wing observation book.

The Governor should remind all staff of the importance of completing wing sheets and observation books, noting their interactions with prisoners.

Personal officers

76. Although a particular Officer was the man's allocated personal officer when he transferred to N Wing, she told my investigator that she did not formally introduce herself. The officer said that she was the movements officer when he moved from the induction wing to A wing, and was responsible for assigning him a cell and completing a brief check as to how he felt. She also said that, because of the particular cell where he was located, she was his personal officer. However she told my investigator that she did not formally introduce herself during the time he was on the wing. She said that she had not received any training with regard to the personal officer scheme nor was she aware of any guidance for staff.

The Governor should ensure that the Personal Officer Scheme is operated properly and in accordance with the local protocol, reminding staff of their roles as personal officers.

The man's contact with his parents

77. During his time at Birmingham, the man and his parents wrote to one another on a number of occasions. In his letters he told his parents that he was organising his PIN phone contact and arranging for their names to be put on his visitors list. However, it is apparent that he was unable to complete these tasks as he did not

use the PIN phone system successfully. It was only in the final letter to his parents, postmarked 11 November, that he was able to provide them with the last four digits of the PIN phone number which are required to book a visit.

78. The Ombudsman's investigator made enquiries with regard to the information provided to prisoners about making contact with their families, including PIN phone arrangements and applications for visitors. He was satisfied that this information was not only explained to prisoners during the induction process but that they were also given information explaining the processes. Unfortunately the investigator has been unable to establish whether or not the man simply had difficulty in understanding how these processes were completed and was not forthcoming in seeking assistance or if indeed he lacked sufficient motivation to complete them.

Cell movements and access to Listeners

79. During his time at Birmingham the man moved cell five times. Having arrived in reception, 7 October which was his first night, was spent on the first night centre. He would have had access to both Listeners and Insiders, and be made aware of their presence during the induction process. He was then briefly moved into another cell on the centre the following day, 8 October, before being moved to N Wing, the induction wing.

80. The man moved on 14 October from the induction wing to A Wing, before being moved to B wing on 29 October. His last cell move to C Wing took place on 5 November, as a consequence of being found guilty of assaulting another prisoner. Although I agree that he appears to have moved frequently, when seen within the context of life in a local prison, I believe his movements around the prison were not excessive. He would have had access to Listeners and the Samaritans' telephone whilst located on any of the wings.

Emergency codes

81. During interview Hotel 2 told the investigator that she was not aware of the nature of the emergency that she was attending when she received the call to attend C2 landing immediately. Although I appreciate that there are no mandatory requirements to use any specific emergency code system, many prisons use a call system such as red (for blood loss) and blue (for breathing difficulties). The codes inform staff of the nature of an emergency in language that is easily understood. Although I make no recommendation, I invite the Governor to consider the introduction of a code system for emergency calls.

Delay in calling ambulance

82. The man was discovered by the third Officer at about 11.40am, but it was some five minutes later at 11.47am before the control room made an emergency call for an ambulance to attend. Although Hotel 2 asked for an ambulance to be called as soon as she reached the cell, the investigator was unable to establish who made the emergency call. I appreciate that these timings may not be completely accurate but it would appear that it was at least five minutes before

the emergency call was made. Action was taken on the instruction of a nurse and not by officers who were first to arrive at his cell.

83. A Governor's Order, 36/2008 on Medical Emergencies issued on 26 March 2008, states that,

> "The Officer (or other person) supervising the incident scene may request that an ambulance is called, prior to the arrival of Hotel 2, Oscar 2 or Oscar 3, if they believe that the prisoner's condition is sufficiently serious to warrant doing so. This is particularly important where the prisoner appears to be unconscious and/or not breathing."

I therefore make the following recommendation.

The Governor should remind staff of the contents of his Governor's Order 36/2008, emphasising that any member of staff can authorise the calling of an ambulance in an emergency.

Incident reports

84. My investigator has also drawn to my attention the fact that a number of officers who responded to the alarm being raised did not complete post incident reports/statements. Although I make no formal recommendation, I would ask the Governor to remind staff of the importance of completing comprehensive and accurate statements after such events.

CONCLUSION

85. When the man entered prison he alerted staff to his history of mental illness and drug abuse. As a consequence he was referred immediately for assessment by the drug detoxification scheme. However, the gravity of his mental health problems appears to have been lost in his explanations to staff. Although it was recognised that he would require a mental health assessment, it was not considered that an urgent referral was necessary and he was never assessed. Of the five weeks that he spent at Birmingham, little is known about his time at the prison.

86. It is possible that the outcome might have been different if there had been an early intervention by mental health services at Birmingham and if mental health support for the man had been provided. Instead we have a sad story of a young man, in custody for the first time, who seems to have been overlooked by prison and healthcare staff.

RECOMMENDATIONS

1. The Governor should remind staff on the Induction Unit of the need to unlock prisoners who have been identified as having immediate health needs in order that appropriate treatment by healthcare staff can be provided.

   Accepted – Operational Order 105/2009 explains the duties for the effective handover to night staff to ensure prisoners are seen on their first night.

2. The Healthcare Manager and Drug Detoxification Team Manager should ensure that when admission reviews have been missed as a result of lack of time, there should be a "fail safe" system to ensure that these are carried out the following day.

   Accepted

3. The Healthcare Manager and Drug Detoxification Team Manager should ensure that systems are in place to guarantee that medication prescribed to prisoners is administered appropriately and on time.

   Accepted – Systems have been reviewed and are being audited to ensure compliance

4. The local Primary Care Trust, Birmingham and Solihull Mental Health Trust and Heads of Healthcare and the Mental Health In Reach Team should urgently undertake a needs analysis and review of mental health provision, including staffing levels, and satisfy themselves that the appropriate mental health provision is being delivered at Birmingham prison.

   Accepted

5. The Healthcare Manager should satisfy herself that communication between the primary health team and MHIRT is adequate, ensuring that procedures are in place in order that staff are aware of and have responsibility for the prisoners in their care.

   Accepted – Primary health care team created November 2008 and mental health register jointly managed by the second RMN.

6. The Healthcare Manager should remind all healthcare staff of the need, when entering entries on EMIS, to clearly identify their role and the nature of their consultation/activity.

   Accepted – All team leaders have responsibility to ensure this happens.

7. The Governor should remind all staff of the importance of completing wing sheets and observation books, noting their interactions with prisoners.

   Accepted – An operational order is written reminding staff of this requirement

(81/09)

8. The Governor should ensure that the Personal Officer Scheme is operating properly and in accordance with the local protocol, reminding staff of their roles as personal officers.

   Accepted – Operational order 197/2008 outlines the personal officer scheme

9. The Governor should remind staff of the contents of his Governor's Order 36/2008, emphasising that <u>any</u> member of staff can authorise the calling of an ambulance in an emergency.

   Accepted – Operational order 86/2009 outlines this requirement.