Investigation into the circumstances surrounding the death of a man at HMP Birmingham in January 2006

Report by the Prisons and Probation Ombudsman for England and Wales

March 2007

This is a report into the circumstances of the death of a man at Birmingham prison on 20 January 2006. The man was found in his cell on P Wing early on Friday morning with cuts to his stomach and left arm. Rigor mortis had already set in and he was pronounced dead shortly after having been discovered. He was 55 years old.

I would like to extend my sympathy to the man's family and his friends.

The investigation was carried out on my behalf by two of my colleagues. A clinical review of the man's healthcare at Birmingham was co-ordinated by the Clinical Risk Manager for the Heart of Birmingham Teaching Primary Care Trust. As part of the clinical review process, an independent medical report was completed by a clinical expert. The clinical review is attached as an annex to this report.

I would like to thank the Governor of Birmingham and his staff for their co-operation and assistance with this investigation. Particular thanks go to the Head of Safer Custody and his colleague who have provided my investigators with support throughout the investigation process.

The man was the sixth death in 18 months to have occurred at HMP Birmingham and the third of those deaths that appears to have been self-inflicted. While I am critical of the delay in entering the man's cell when he was discovered, I do not believe his death could have been foreseen or actions taken to prevent it.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2007**

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Summary

The man, a prisoner at HMP Birmingham, was three years into an 11 year sentence for a range of offences, including kidnap. A case management hearing was scheduled to take place in Cardiff Crown Court on 20 January 2006 relating to an additional pending charge of a serious sexual nature. (I do not believe the man was expecting to appear in court.) On the morning of that day, he was discovered in his cell with cuts to his left arm and to his abdomen. He was pronounced dead where he was discovered.

The man was 55 years old. He had spent much of his life in prison and had previously served an 8 year sentence at Birmingham.

He had a complex medical history and had been taken to hospital on a number of occasions. He had twice suffered cardiac arrests during the three years he had spent at Birmingham on his current sentence. A degenerative back condition meant that walking was difficult for him and consequently the man spent a great deal of time in his cell.

He was described by staff and prisoners as a 'quiet prisoner'. The man does not appear to have formed close friendships with other prisoners.

The only time that the man had been subject to suicide and self-harm procedures was during a period of food refusal between November and December 2005. It is local policy at Birmingham prison to place all prisoners who are refusing food on an open ACCT (Assessment, Care in Custody and Teamwork) form. The man told staff that he refused food because the kitchen did not supply him with a sufficiently low fat diet. When he began eating again, the suicide and self-harm arrangements were lifted. I have examined the management of suicide prevention procedures for prisoners who are refusing food and make one related recommendation.

The man's physical condition improved and he was transferred to a normal residential unit, P wing, on 16 December 2005.

At 6:10am on 20 January 2006, an officer was carrying out his roll count at the end of the night shift. When he reached the man's cell, he saw him on his bed surrounded by a great deal of blood. The officer did not enter the cell but immediately raised the alarm and staff came to assist him. It was between five and ten minutes later that an officer arrived and opened the cell.

I have made a recommendation to the Governor to review the radio call system and the policy for entering a cell in the event of an emergency. I hope that this will minimise any delay in responding to emergency situations in the future.

Efforts were made to resuscitate the man despite rigor mortis having apparently set in. The efforts continued by a single member of healthcare staff until fifteen minutes later when paramedics arrived and pronounced the

man dead. I have endorsed recommendations made by the clinical reviewer in relation to resuscitation attempts on prisoners under these circumstances.

As well as indicating my support for the eight recommendations made in the clinical review, I have made a further four recommendations of my own.

The investigation process

1. My investigators visited Birmingham prison on 26 January 2006 to formally open the investigation on my behalf. They met with the Head of Safer Custody.

2. During this visit, my colleague collected copies of the man's comprehensive prison files and was briefed about the circumstances surrounding his death. She also met with a representative from the Prison Officers' Association to explain how the investigation would be carried out. A notice to staff and a notice to prisoners were issued. These invited anyone who might have information relating to the man's death to make themselves known. No staff or prisoners approached the investigation team in response to these notices.

3. Local police and the Coroner's Office were informed of my investigation.

4. The investigation team returned to Birmingham prison on 9, 15 and 16 February in order to talk to staff and prisoners who had known the man or who attended P wing on the morning that he was discovered. Summary notes were made of these discussions and are referred to in the writing of this report.

5. During the course of the investigation, my colleague has spoken to the man's solicitor and to Gwent Police in relation to an outstanding criminal matter.

6. One of my family liaison officers wrote to the man's parents overseas to explain the process of my investigation and to give them an opportunity to raise any concerns. My officer also spoke to two of the man's step daughters, who were at times listed as his next of kin, to give them an opportunity to contribute to my investigation.

HMP Birmingham

11. HMP Birmingham can now accommodate up to 1,450 prisoners. It is a Victorian-style local prison with up to four levels of cells on each wing. Each level has a narrow landing outside a row of cells, overlooking a central wing association area on the ground floor.

12. The prison was last inspected by HM Chief Inspector of Prisons, in May 2004. Her unannounced inspection found that Birmingham had improved in all four key areas that the Inspectorate assesses: safety, respect, purposeful activity and resettlement. In her introduction, the Chief Inspector recognised Birmingham as 'a prison where positive attitudes, and a focus on rehabilitation, were firmly embedded, and which was continuing to make progress'.

13. There were some areas for development, particularly the relationships between staff working in different parts of the prisons. For example, work between healthcare and wing staff needed to become more joined up. In general, the inspection team seemed satisfied that progress had been made in recent years and that Birmingham was likely to go from strength to strength.

14. Recently, extra funding has enabled Birmingham prison to work with the Heart of Birmingham Primary Care Trust to improve the healthcare available to prisoners.

15. The man's death was the sixth death at HMP Birmingham in an 18-month period and the third apparently self-inflicted death in that time. I have undertaken separate investigations into all of these deaths.

Events before 20 January 2006

16. The man was remanded to Birmingham prison on 28 March 2003, facing a charge of Kidnap and several drug-related charges. His occupation was noted as 'Disabled' on his Personal Summary Sheet. His medical records identify that he was suffering from a chest infection, disintegrated disc and high cholesterol.

17. During his First Reception Risk Assessment dated 29 March 2003, it was recorded that the man had no history of self-harm or suicide attempts.

18. There is an entry made in the man's medical records on 24 September. The man was 'stressed by court case next week describes waking at night with pains in chest'. Following this entry, he was readmitted to the healthcare centre.

19. In October 2003, he appeared at Crown Court in connection with the offence of kidnapping.

17. The prison's General Practitioner (GP) medically assessed the man as being unfit to attend court on 7 October. He was short of breath, clammy and pale and was rushed to hospital by emergency ambulance. He had suffered an acute asthma attack. He returned to Birmingham prison from hospital on 9 October.

18. Two days later, the man was again rushed to the local Accident and Emergency Department where he suffered two cardiac arrests. There is a note in his medical record that his step-daughter was asked to consider turning off the 'machine' during this period in hospital. However, he recovered his health enough to return to Birmingham prison on 14 November. Even so, he was deemed unfit to attend court on 17 November 2003.

19. A medico-legal psychiatric report was written on 11 May 2004 by a Consultant Psychiatrist, to determine whether the man was fit to stand trial. According to the report, the man was diagnosed as suffering from post-traumatic stress disorder in January 2004. There is no other mention of this diagnosis in his files. In his report, the psychiatrist referred to the man's past history of Post-Traumatic Stress Disorder as a result of his experience in the Rhodesian army when a number of his friends were killed and he was one of only a couple of survivors. The report also states:

> 'He worries about becoming disabled or being in a wheelchair and he said he would rather be dead'.

The psychiatrist concluded that the man was fit to stand trial.

20. The man was convicted at Crown Court of kidnap, wounding and drug related charges. He was sentenced to 11 years imprisonment on 5 July 2004. An observation was made on the wing file, following the man's sentence:

> 'Seems ok. Was expecting a big sentence. Seen by Nurse in reception.'

21. The man underwent surgery on an abdominal hernia on 2 September 2004. Complications arose from this operation as the wound did not heal. He was referred back to the Accident and Emergency Department of the local hospital on 30 September. Initially, it seemed that the wound started to improve, but in November it worsened again. The matter was drawn to the attention of the Registered Nurse and the dressing on the man's abdomen was changed daily.

22. On 3 January 2005, the man's abdominal wound had started to bleed again and urgent medical assistance was requested. Following advice from a doctor of the Badger Service, a pressure bandage was applied overnight and he was transferred for a hospital appointment the following day. ('Badger' stands for Birmingham and District GP and Emergency Rooms.)

23. On 22 April 2005, Birmingham prison received a Production Certificate from Gwent Police. The Production Certificate was made in relation to the man's involvement in an alleged offence serious sexual offence.

24. The West Midlands Police, on behalf of their colleagues in Gwent, requested the man's presence at a police station in Birmingham on 26 and 27 May 2005 for questioning.

25. My investigator spoke to the man's solicitor and to Gwent Police. The solicitor briefly outlined the details of the charge against the man. It related to an offence that was allegedly committed about twenty years before in Wales. A DNA sample taken from the victim at the time of the offence had been rerun through police systems. The sample matched the man's DNA. The solicitor told my investigator that, if the charge was brought to trial, the man intended to plead not guilty to the offence and request that the DNA sample be rerun a further time.

26. The man was found in his cell on 22 May 2005, having suffered respiratory and renal failure. He was rushed to casualty at a local hospital where he spent three weeks in the Intensive Therapy Unit. He was discharged from the hospital on 14 June 2005.

27. Gwent Police contacted the man's solicitor before the interview was due to take place to confirm arrangements. They were informed by the solicitor that the man had been transferred to a local hospital and would not be produced for interview in connection with the alleged offence.

28. The man was rushed to hospital again on 18 July 2005. He was suffering from respiratory difficulties and recorded a temperature of 40.1°. An entry was made on his continuous medical record on 19 July 2005 that the hospital had informed the prison of a possible overdose of medication. Three days later, a further entry indicated this was a probable drug interaction rather than an overdose. The man was no longer prescribed Zoplicone following this medical emergency.

29. On 24 July 2005, Gwent Police gave advance disclosure of the pending allegation. They suggested that, given the man's medical condition, the 'least stressful' way of progressing the criminal investigation would be for him to

voluntarily submit a mouth swab for the purpose of DNA testing. This course of action was agreed by the man's solicitor.

30. At his own request, the man was seen by a Clinical Psychologist on 3 August. He wanted to discuss his medication. The man denied having suicidal thoughts during this appointment. He considered himself 'too involved to even think about it'.

31. Gwent Police attended Birmingham prison to sample the man's DNA as agreed by his solicitor. The legal visit took place in the normal Day Visit area of the prison on 24 August and a mouth swab was taken by a Detective Constable.

32. This sample was sent off for testing and Gwent Police informed the investigation team that the man's DNA matched the archive sample being held in connection with the alleged sexual offence.

33. Gwent Police liaised with the man's solicitor rather than with the man directly. They told my investigator that they felt that this approach was more sensitive in view of the man's deteriorating medical condition. Between the solicitor and the healthcare staff, it was agreed that police could interview the man on the healthcare wing at Birmingham prison.

34. The man continued to be affected by the severity of his medical condition. On 6 September 2005, during one of his many stays in the healthcare wing, he was moved to writing a 'will'. He passed the document to a Health Care Officer (HCO) who attached it to his wing file:

> 'Having flatlined six times it is not unrealistic to presume that I may do so again. I have decided should this happen and I fail to resuscitate, I would like my PlayStation 1, Rom-Case and enclosed games to go to the HCO so she may decide upon its use in the Health-Centre.'

35. Having worked on the healthcare centre at Birmingham prison for 16 years, the HCO knew the man well. He had spent a great deal of time on healthcare during his current sentence and a previous sentence served at Birmingham. She often dispensed medication to the man.

36. As part of her role, she organises activities for prisoners on healthcare, including the use of equipment such as PlayStations. She knew that the man was ill and suffered from several serious medical conditions. At the time that the man gave her his will, the HCO did not think that he was particularly ill or suicidal. She interpreted the will as a kind gesture to replace a previous PlayStation on healthcare that had been broken. The man had elected to give the will to the HCO because he had known her from collecting his medicine from her daily over the years. The man also knew that she co-ordinated activities on the healthcare wing.

37. On 10 September 2005, the following entry was made in the man's multi-disciplinary notes:

> 'It has been reported that though he is coming out to collect his meal, he is not eating it … Currently the man appears to be unhappy in mood'.

38. Until this entry, staff repeatedly noted that the man enjoyed a 'good dietary intake'. This is the first mention of him refusing his meals.

39. On 17 September, the HCO made the following observation in the man's multi-disciplinary clinical notes:

> 'Spoke to him at length because it came to my attention that he was giving away his belongings to other inmates. While speaking to him he informed me that he was only giving his food away. He claims that he hasn't eaten in 18 days but he had not lost any weight to support this (his words). He said he felt very unwell and further stated that he was dying slowly.'

40. On 22 September, a note on his continuous medical record was made as follows:

> 'Thinks he may as well die from not eating as he will die if he continues eating the way he was previously.'

41. The man was overweight and suffered a number of serious medical conditions. Medical advice had been given to him to reduce his weight as much as possible, including through a low fat diet. The prison has a low fat dietary option, which was made available to the man. A GP saw him on 28 September, regarding his food refusal. The man reassured the GP that he was 'not on hunger strike, just does not feel like eating'. On 6 October, a GP wrote to kitchen staff, on the man's behalf, about his diet.

42. The HCO suggested to the investigation team that the man was not happy with the standard of low fat food being provided by the kitchen. It is clear from his food log that the man often collected his meal from the hotplate. His records show that he then threw it in the bin or gave it away to other prisoners because it was too greasy or not nutritious enough. This was the beginning of a food refusal episode which lasted until late November 2005.

43. A relative wrote a worried letter to the man dated 11 October 2005, that opens:

> 'I was saddened to hear that you think you won't make it, as you shouldn't think like that…'

44. A Probation Assessment entitled 'OASys' was printed for the man's file on the same day. The purpose of the assessment is to identify the level of risk that the prisoner poses, to themselves, to other prisoners and staff, and to the general public. It was generated upon the request of Gwent Police who were dealing with the outstanding charge. The document records that the man posed a possible risk to himself in custody:

> '…but only if a significant deterioration in his medical health occurs, as he stated during interview, that he would rather end his days in prison, than become a burden on his family when released.'

45. It appears that during the interview for this assessment the man stated that he would be happy to die in prison because the nature of his medical condition was making him increasingly dependent on others. He said that he was purposefully distancing himself from his family, so as not to become a burden on them.

46. In the afternoon of 13 October, a Detective Sergeant and a Detective Constable from Gwent Police interviewed the man in connection with the alleged outstanding matters. Immediately after the interview, the police contacted the Crown Prosecution Service who confirmed that he should be charged with a serious sexual offence and a related offence of kidnap. The police duly charged the man with these offences and technically bailed him until 27 October 2005 when he was due to appear at a Magistrates' Court.

47. The interview with Gwent Police took place on the healthcare unit as previously agreed. The following entry was made in his medical record that day:

> 'Visited by personnel from West Midlands police dept. No other issues raised…'

In the evening, the Charge Nurse on duty remarked in his medical record that the man 'remained settled'.

48. On 21 October 2005, the man's solicitor wrote to him following a legal visit by one of his colleagues to confirm that he was to plead not guilty to the pending charge.

49. He did not travel to the Magistrates' Court on 27 October 2005, but appeared via video link for a rescheduled hearing on 2 November. At this hearing, he was committed to the Crown Court for trial.

50. The man continued to refuse food. On 4 November, the prison medical officer spoke, at length, with the man about the effects of food refusal and made the following entry in his medical file:

> 'Not feeling well. Not eaten any meals for ten weeks … explained physical consequence and advised to drink one and a half of fluids each day. Said will not eat until provided with proper low fat meals … arranged for kitchen staff to come up and go through menu with him'

51. The man was a category B prisoner. His categorisation was reviewed on an annual basis and on 7 November 2005 it was decided that he should remain a category B 'due to medical cover and health needs'.

52. On 9 November, a doctor carried out a mental health assessment on the man. He concluded that there were "no psychiatric issues identified". The nursing notes from the same day refer to this consultation, as follows:

"Seen by the doctor this afternoon… the doctor feels that there does not appear to be any mental health issues… the doctor aware that a Governor and colleague dealing with the issues concerning kitchens and low fat meals."

53. The Assessment, Care in Custody and Teamwork (ACCT) process is used for prisoners who have been identified as at risk of self-harm or suicide. It requires that staff meet with the prisoner to identify key needs and decide on actions that could reduce the risk of self-harm or suicide. During these meetings, staff must assess the level of risk and agree how frequently prisoners must be observed. When a staff member performs an observation, he or she should try to engage the prisoner in conversation and record the interaction in the prisoner's individual ACCT file.

54. The man was on the healthcare wing throughout the food refusal episode that, according to his records, lasted for approximately three months. The prison medical officer carried out lengthy assessments of his condition throughout. On 18 November, the prison medical officer contacted a colleague at a local hospital to discuss transferring the man, if his condition deteriorated any further.

55. The HCO told the investigation team that after approximately one month of refusing his food, a Senior Officer requested that she raise the first stage of an ACCT form, which is a 'Concern and Keep Safe' form. She duly completed this form on 18 November 2005. The HCO recorded that the factor for particular concern was 'Very low mood'. The HCO told my investigators that it is local policy at Birmingham to open an ACCT for a food refusal protest. It was her impression the man resented the ACCT process as it invaded his fiercely guarded privacy.

56. After the 'Concern and Keep Safe form' was raised, an ACCT Assessment interview was carried out by another HCO on the same day. During this interview, this HCO recorded:

> 'denies ever having self harmed previously and believes his actions are justified as the diet provided by the kitchen is not sufficiently low fat.'

When responding to a question in relation to the man's desire to die, this HCO stated that, on the contrary:

> 'He does not wish to be dead – he is anxious that his physical condition is maintained.'

57. The ACCT CAREMAP was drawn up on the same day. The CAREMAP was intended to co-ordinate actions that might reduce the man's risk of self-harm through food refusal protest. Links were made with the kitchen who agreed that they should provide a low fat diet.

58. The food refusal log kept by staff was terminated on 24 November 2005 as the man was recorded as eating beans on toast. Despite the food refusal episode ending on that day, the ACCT document remained open. There was an entry made on his ongoing ACCT record:

> ‘Threatens to stop eating again if nothing is done [about the food from the kitchen].’

59. Three days later the wing record states that the man felt he had put on weight because he had started to eat again. On 6 December 2005, his wing record notes, ‘still feels that kitchen staff are goading him and testing his patience.’

60. The ACCT document was eventually closed on 10 December 2005 when it was recorded that the man had put on 16kg since 17 November 2005. As part of the ACCT closure process, he was asked how he would feel if the ACCT process were to stop and he replied:

“does not make any difference whether opened or closed”.

61. Following the closure of an ACCT, a post-closure interview is required to review a prisoner’s level of risk of self-harm. The man’s post-closure interview was scheduled to take place on 17 December 2005. There is no note of this interview on his ACCT file.

62. As part of the ACCT process, a case review should be held if a prisoner subject to ACCT is discharged from healthcare to ordinary location. The man was discharged from healthcare and transferred to P wing on 16 December, six days after his ACCT document was closed but before the post-closure interview was scheduled to take place. There is a blank ‘Review prior to discharge from healthcare’ form in the man’s ACCT file.

63. The first entry on the man’s wing record is made by his newly detailed Personal Officer, on 20 December 2005, when he writes that he will monitor the man’s ‘behaviour’.

64. At HMP Birmingham, a wing officer is allocated a row of cells on a particular part of the wing and becomes the personal officer for each of the prisoners in those cells. A personal officer should identify themselves to a prisoner when he first arrives on the wing and explain that the prisoner should come to them with any problems or concerns. A personal officer should monitor the welfare of the prisoners he has been allocated, including by talking to them occasionally. Due to the shift pattern at Birmingham, each prisoner has two personal officers.

65. The investigation team spoke to one of the man’s personal officers during the investigation. He described the man as a quiet prisoner who often did not associate with other prisoners, but would occasionally walk up and down the wing with his walking stick to exercise. The officer would often pop his head around the man’s cell door to check that he was all right, because he would spend a lot of time by himself in his cell. He said that he saw no sign that the man was suicidal, although he did recall the pink coloured cell card outside his cell. There was a pink card outside the man’s cell because he had recently been subject to ACCT procedures.

66. A letter from the man's solicitor, dated 30 December 2005, sought to arrange an appointment in the new year with the man for him to see the papers in connection with the pending charge against him.

67. The personal officer wrote an entry in the man's wing history record on 4 January, suggesting that he was 'trying to manipulate the diet process'. At interview, the officer recalled that the man was the only prisoner on a low fat diet on P wing. On occasion, he would go to the hotplate to collect his dinner and it would often look bland. If the man did not like it he would collect an ordinary meal, stating that his meal was covered with grease.

68. Four days later, on 8 January, an entry in the man's wing history sheet confirmed that there was at least one occasion when the man's diet did not turn up.

69. The man received a legal visit on 17 January 2006 to discuss the forthcoming case management hearing.

70. The personal officer was on duty from 7.15am to 4:30pm on Thursday 19 January. He said that the man did not mention the charges that he was facing, or his forthcoming court date, at any time. The officer recalled nothing that occurred during his shift on 19 January that suggested the man might take his own life.

71. An officer was working the late shift on P wing on 19 January. He began work at 12:30pm and described his duties as the 'day to day maintenance' of the prisoners, including locking and unlocking the cells when necessary. He recalled that he was asked by two nurses, RGN and one other nurse whom he did not recognise, to open the door for cell P1-07 (the man's cell) at about 7:15pm. (The accompanying nurse was a nurse who had started working at Birmingham prison in January 2006 and was shadowing the RGN). She confirmed that she did not enter the cell and cannot recall the conversation between the RGN and the man.

72. The RGN told my investigation team that she had not seen the man since he had left the healthcare centre. On 19 January, she was asked by her line manager to assess whether the man was 'fit to travel'. The RGN said that she did not realise he was listed to appear in court the next day.

73. When she entered the man's cell she told him that she had come to see how his medication was. He told the RGN that the painkiller for his back pain had been changed because the previous one had interfered with the medication he was taking for his heart problems. The man told the RGN that he thought that the new painkiller was not effective. The RGN said that she would put him on the list to see the doctor the next day.

74. During interview, the RGN told my investigation team that the man would understand from this conversation that he would not be attending court in the morning. She said that the doctor does not start his shift until 9am, by which time the man would have missed his escort to court. The man had been at Birmingham for sufficient time to be familiar with the shift patterns of the doctor.

75. As she was leaving the cell, the man told the RGN that he understood he was supposed to be going to court the following day. She replied that she did not know anything about a court appearance and had come simply to check his medication. The man went on to tell the RGN that he would not be going to court because his solicitor had sent a letter to the healthcare centre to say that he was not fit to travel.

76. The RGN went on to explain to my investigation team that it is *local practice* at Birmingham that healthcare staff do not inform a prisoner that they are going to court in the morning, even if the prisoner directly asks the member of healthcare staff. My investigator was subsequently informed by Head of Safer Custody, that there is no such *written policy* at Birmingham prison.

77. The RGN described the man as smiling and in a very good mood when she saw him. She saw no signs that he was going to harm himself that evening. The officer on duty, said that he did not know the man well, although he described him as a quiet prisoner. He recalled that the man lay on his bed watching the snooker and appeared 'in normal spirits' during the nurse's visit.

78. At this point, it should be noted that the clinical review (attached to this report as an appendix) records the RGN's account of events slightly differently from that told to my investigation team. The RGN told the clinical reviewer that the man would see the doctor before going to Crown Court. In other words, that the man would have been able to see the doctor before his transfer time on 20 January, and could have been assessed as 'fit to travel' by the doctor and therefore escorted to the court.

79. However, I do not consider that the man thought that he was going to appear at Crown Court on 20 January 2006. Gwent Police described the hearing on 20 January as a 'case management hearing' where the man's solicitor was going to ask for the criminal trial to take place in the Birmingham area due to the man's medical condition.

80. Nevertheless, at 4:46pm on 19 January 2006, a fax was sent to Birmingham prison, listing the man as due to appear in Crown Court at 11:30am on Friday 20 January. The man's solicitor, also told my investigator that he was hoping to gain permission from the judge for the trial to be heard in a local Crown Court, given the man's medical problems. The solicitor did not expect the man to attend court that day because of his physical condition. The hearing was planned to go ahead without him attending.

81. An officer started his night shift on P wing at 7.45pm. This was the officer's first set of nights. In line with normal procedure, he counted the prisoners on the wing at the start of his shift. He recalled looking through the observation panel into cell P1-07 and seeing the man lying on his bed, either playing on his PlayStation or watching television.

82. The officer received the court list from another officer at 10pm that night. During interview, the night duty officer told my investigators that he had been instructed not to tell prisoners about forthcoming court appearances. The

officer had joined the Prison Service eight months prior to the man's death and therefore had only recently completed his training for new officers. During this training, he was told not to tell prisoners about court appearances until the morning that they were due to appear in court. He understood that this was due to security to ensure the prisoner could not alert anyone outside of the prison to the fact that he was appearing in court.

83. The officer noticed that the man and a prisoner, located in the cell adjacent to the man, were both listed to appear in court on 20 January. He did not tell either prisoner that they were listed for court.

84. The officer recalled that only one prisoner on the wing was subject to ACCT observations during the night shift. As well as carrying out the required hourly observations on this prisoner, the officer also spent time talking to a prisoner on the second landing who had his light switched on. The officer said that it was a quiet shift on the wing that night.

20 January 2006

85. Towards the end of a night shift, at around 6am, wing officers must make another roll count of prisoners on their wing. The night duty officer told my investigators that he used this exercise as an opportunity to wake up his 'courts', those prisoners who are due to appear in court later that day and need to be woken to prepare for the journey.

86. At around 6am on Friday 20 January, the officer began his roll count as usual. He knew that the man who died and the prisoner located in the cell next to him, were listed to appear in court that day. With that in mind, he deliberately worked his way around the landings from the top landing to the bottom and then anti-clockwise around the first landing where the prisoner and the man who died were located. This meant that he came across the prisoner and their cells towards the end of his roll count.

87. The officer reached the prisoner's cell (P1-08) and woke him for court. His normal procedure would be to knock on the door, open the observation panel and activate the cell light from a panel on the outside of the cell. He would inform the prisoner at this time that they were appearing at court.

88. After the officer had knocked on the prisoner's cell and woken him, he went to the man who died's cell to wake him for his journey to court. It was about 6:10am by that time. The officer recalled opening the observation panel on the cell. He noticed that the cell was in darkness so the officer activated a cell light from outside of the cell. He remembered speaking. The officer said that there was a moment when he did not register what he was seeing. Then he noticed that there was a significant amount of blood around the man. At that point, he realised that the man had seriously self-harmed. The cell door remained closed and locked.

89. The officer recalled seeing the man lying on his back in the cell with cuts to his left forearm and surrounded by blood. He used his radio to call for assistance. Although the officer cannot recall exactly what he said, the Control Room log recorded the following:

> 'From P^{12}. Requires O^2 and H^2 to attend P wing Imm.'

90. The officer was asked by the Communications team whether he would also require 'response'. The officer told my investigators that he was not sure whether response would be required. He checked that the radios were no longer on the 'talk-through' setting. ('Talk-through' is a system which enables all officers on the night shift to hear each other speaking over the radio without all radio calls going through the communications team.) The communications team told him that the system had been taken off talk-through, in line with normal procedure, at around 6am. The officer then explained to the Communications Officer that he had come across a prisoner on his roll count who had 'cut up' and appeared deceased. The

Communications Officer confirmed that response would be needed and proceeded to call response.

91. At this time, an Officer Support Grade (OSG), a new member of staff, was carrying out her roll count on an upper landing on N wing. N wing is adjacent to P wing. At night there are no locked doors or gates separating the two wings and staff can move freely between them. She heard the night duty officer on P wing kicking and shouting and ran down to see what was wrong. When she arrived at the man's cell, the officer informed her that 'one's cut up' and she immediately looked through the observation panel on the man's door. The OSG was distressed by what she saw through the observation panel.

92. Upon hearing the officer's radio call for assistance, a response officer, who was working a night shift on 19/20 January, made her way immediately to P wing and then directly to the man's cell. She looked through the observation panel and saw the man. She told my investigators that the man 'appeared dead' at that time. The response officer did not enter the cell. She saw that the OSG was distressed and escorted her to P wing office until all staff were called to debrief.

93. The duty staff manager reports that there were no problems throughout the night shift of 19/20 January until he heard the call for assistance from the officer at 6:10 am. He requested an early update and was informed by radio that the man had 'cut up', which he understood to mean that he had made cuts to arms. The duty staff manager instructed control room to call for a 'blue light ambulance' and the ambulance was called at 6:19am.

94. Arriving ten minutes early for his morning shift on P wing, a day officer got to the wing at 6:20am to discover the night duty officer outside the man's cell. The officer said: 'I believe the man is dead, I have called Oscar 2 and Hotel 2 to attend'. The day officer and the night duty officer waited for Oscar 2 (an assistant duty staff manager) and Hotel 2 (a nurse) to attend the cell. The man's cell remained closed and locked.

95. A prison officer carrying out a night shift on a wing will always carry a cell key in a sealed pouch for use in emergencies only. The night duty officer told my investigators that Prison Service policy instructs officers never to enter a cell alone for personal safety and for the safety of the prison. The officer said that he learned this policy during his officer training course. He told my investigators that it is a matter of judgement as to when there are sufficient staff for a cell to be entered safely.

96. A large control desk is located centrally in Birmingham prison. It is accessible from the healthcare centre during the night shift when much of the prison is locked up. When there is a medical emergency, the medical response make their way to the centre immediately. They are met there by the Orderly Officer who is the only member of staff with access to the whole of the prison during a night shift.

97. The nurse heard the night duty officer call for assistance at approximately 6:15am and responded immediately. He picked up the medical emergency bag which contains basic first aid items such as dressings. He made his way to the 'centre' to wait for the orderly officer for the night shift.

98. The orderly officer received instruction to attend P wing at 6:10. He made his way to the centre to meet the nurse. The nurse and the orderly officer made their way to the wing together. Upon arrival, they were briefed about the man's self-harm.

99. The nurse went to the office on P wing to collect the 'blue' emergency bag that contains oxygen and a defibrillator. He had requested that someone contact the healthcare centre to retrieve a 'machine'. A Health Care Assistant (HCA) received the request for a 'machine' via the Communications Office. She was unclear what the nurse had meant by a 'machine'. She was instructed by the Communications Officer that she was needed on P wing immediately and to make her way there without the 'machine'.

100. In fact, the nurse was worried that the defibrillator on P wing might not be working. He had forgotten the word for 'defibrillator' and described it as a 'machine'. He was concerned that vital time should not be lost if it was not working and thought that a back-up defibrillator should be brought just in case. In the event, the defibrillator located on P wing was in working order.

101. Another response officer for the night shift was at the gatehouse when the night duty officer originally called for assistance. As response officer, he was required to attend any emergency. He drew keys to be able to move around the prison and made his way directly to P wing. He arrived there and was informed by the orderly officer and the nurse that the man who diedwas due to appear in court but could not be woken.

102. The night response officer entered the cell followed by the nurse and the orderly officer. The night duty officer followed them into the cell, looked around and then left.

103. During interview, the night response officer said that there was a lot of blood in the cell. There were towels and blankets around the bed. The night response officer presumed that the man had put the towels and blankets around the bed to stop the blood from going under the door and alerting staff to his self-harm. He recalled that the man looked grey and was not breathing.

104. A number of staff members remembered seeing a red toothbrush on the floor with a razor blade embedded into the head of the toothbrush.

105. The nurse recalled that the cell light was on and the man was lying on the bed. The man was not showing any signs of life. The nurse immediately assessed the man's condition. He asked the night response officer to straighten the man's leg which was tucked under him. The night response officer recalled that this was difficult because the leg was stiff. The nurse then used the defibrillator that was located in the office on P wing.

106. An information download was made from the defibrillator and analysed as part of the clinical review process. This download showed that Cardio-Pulmonary Resuscitation (CPR) was carried out in accordance with instruction from the defibrillator and was performed adequately. The record shows that the nurse began to tire after three minutes. This is normal, but the nurse refused the help that was offered to him by colleagues and continued CPR by himself.

107. The printout from the defibrillator also showed that the man's heart rhythm was asystole. According to the clinical review:

> 'This heart rhythm is associated with a very poor outcome (less than 3% survival rate).'

108. A Principal Officer (PO) arrived for the morning shift. As soon as he signed onto the radio system, the duty staff manager requested that the Principal Officer attend an emergency on P wing.

109. When he arrived on P wing, there were three officers in the cell with the man and the nurse was performing CPR. He asked the officers to leave the cell and give the nurse space to perform CPR.

110 . The Principal Officer was an experienced scene commander. He felt it was important to preserve any evidence for the police. He stood by the door to ensure that people did not enter the cell unnecessarily. He told my investigators during interview that, had the nurse requested assistance with CPR, he would have allowed a member of staff to enter the cell to assist him.

111. The Principal Officer asked the night duty officer to commence a log. The officer fetched paper and a pen from the wing office and noted down times and people who attended the cell.

112. The nurse continued CPR until the paramedics arrived at 6:35am, approximately fifteen minutes later. The HCA arrived during that time and remembered seeing the nurse alone in the man's cell performing CPR with a bag and a mask, and also doing chest compressions. She went to put gloves on to enter the cell and assist the nurse in his resuscitation efforts. Before she could put on the gloves, the Principal Officer asked her not to enter as he was concerned that she might contaminate the cell.

113. The paramedics arrived at 6:35am. The nurse stayed in the cell to observe them. They did not attempt any further CPR and pronounced the man dead.

114. The Principal Officer told my investigators that he was concerned about other prisoners on P wing being able to see into the man's cell. He said that there was some difficulty in locating screens to obscure the man's cell, but eventually some were found in the segregation unit. Sheets were rigged up to the upper landings to prevent prisoners seeing into the man's cell from above.

He felt it was important to hide his cell before prisoners on P wing were unlocked.

115. The Principal Officer told my investigators that he was particularly concerned about the prisoner located in the cell next door. That prisoner was also due to appear in court and the Principal Officer was worried that it would have been difficult to escort him from his cell without him seeing into the next door cell.

116. My investigators spoke with the prisoner, next door to the man who died, during the course of the investigation. He did not hear anything out of the ordinary during the night of 19 January. He recalled hearing the response to the man being discovered in his cell. He overheard someone say that the man was definitely dead and he later heard the defibrillator being used.

117. The prisoner remembered that paramedics were still present when he was unlocked. He recalled seeing a screen around the man's cell that he was walked past. He confirmed that he did not see into the cell.

118. A doctor from Birmingham PCT was called to the prison to certify the man's death. He arrived and certified death at 7.35am.

119. Staff were debriefed at 9:15am in the prison's Care Suite. All staff were invited to attend, with the exception of the nurse and the HCA. Another nurse also told my investigation team that the prison did not offer her support following the man's death.

120. All other members of staff felt that they were well-supported and had adequate opportunity to speak to counsellors if they needed to.

121. The night duty officer commented that it was a shame that the Care Suite was so small. The OSG was very upset by the man's death and the size of the Care Suite gave her very little privacy.

Informing the man's family

122. The man had listed his next of kin as his parents who lived in South Africa. A Governor spoke to the man's father on the morning of 20 January, but was concerned that he had not effectively communicated what had occurred. A Governor, Head of Prisoner Services, contacted the man's mother at 1pm and explained that her son had died.

123. A Family Liaison Officer for my office, contacted the man's mother, by telephone to tell her about the investigation. The man's mother was grateful to be informed of the investigation and wanted to see a copy of this report. She wrote to my office on 9 March 2006, raising concern about her son's food refusal and his frustration about receiving the correct diet for his condition. She told my colleague in a later conversation that she felt that the investigation report and the clinical review unfairly suggested that her son's family overseas were not interested in the man while he was in prison, or in the investigation process following his death. The man's mother said that she maintained contact with her son until three weeks before he died and was pleased to be consulted in the investigation process. She was concerned that her son's food refusal may have had something to do with her son taking his own life. I trust that I have covered this issue in enough detail in my report. The man's mother later told my colleague that the report showed that the prison was trying hard to make improvements, following her son's death.

124. The man had also listed two women, identified as step-daughters, on his next of kin sheet. My Family Liaison Officer, contacted both women separately. Although both were grateful to be informed of the man's death, neither expressed any concern with his care in prison. Neither of them wanted to see a copy of this report.

Clinical Review

125. At the beginning of the investigation process, my investigators approached the Heart of Birmingham Teaching Primary Care Trust (HOBT PCT) to undertake a clinical review of the man's medical care in prison. They kindly agreed to undertake the review and look into the matters that my investigators had raised in the preliminary stages of the investigation.

126. A PCT Risk Manager, oversaw the clinical review process. The risk manager appointed a doctor, an Associate Dean at the West Midlands Postgraduate Medical and Dental Deanery, to undertake an independent medical report.

127. The risk manager also attended the Serious Untoward Incident review that took place on 31 March 2006, chaired by the Birmingham and Solihull Mental Health Trust.

128. The Mental Health Trust produced a Joint Clinical Review document, in conjunction with the Heart of Birmingham PCT.

129. The risk manager wrote an overall Clinical Review document, which was finalised in June 2006.

130. I draw on all of these sources of clinical information in the following analysis of the man's care. My thanks go to the Heart of Birmingham Teaching Primary Care Trust for the thorough review which has greatly contributed to the report.

131. The main areas, highlighted by the clinical review process, are as follows:

- record keeping,
- resuscitation procedures,
- primary care and psychiatric services involvement in prisoners refusing food.

Issues considered during the investigation

Could the man's food refusal episode have been an early indication that he was thinking of taking his own life? Was it appropriately managed?

132. The man was only subject to self-harm monitoring procedures once during his time at Birmingham, between November and December 2005. At this time, he had claimed to have refused food since September. In line with local policy, an ACCT document was opened by healthcare staff.

133. Prison Service Safer Custody Group guidance on food refusal, issued in consultation with the Department of Health, encourages prisons to consider developing a policy of opening an ACCT document for all prisoners refusing food. It is thought useful to promote communication about the reason for the prisoner's food refusal and to identify actions which may dissuade a prisoner from refusing food. The guidance recognises that food refusal is more usually a form of protest rather than self-harm.

134. The man made known to staff that he did not consider the ACCT process to be helpful. In fact, he considered it to be intrusive. During the assessment interview, when the ACCT document was being opened, the man told the HCO that he:

> '…does not wish to be dead – he is anxious that his physical condition is maintained.'

135. The man told staff on a number of occasions that he was refusing his food because the food was not low in fat. Following medical advice, he was worried about his physical health and obesity.

136. In accordance with Birmingham's food refusal policy, a GP was involved in the clinical care of the man during this period of food refusal. The GP did not attend the suicide prevention case reviews.

137. The risk manager at the Heart of Birmingham Teaching Primary Care Trust, oversaw the clinical review process following the man's death. He was concerned that the GP was not represented at the suicide prevention case reviews. However the case reviews that were held on the 6 December and 10 December were both led by trained mental health professionals, who gave medical insight to the review process.

138. From the records, the man's actions were apparently not motivated by a desire to end his life through food refusal. He clearly stated that his motivation was to preserve his health rather than to jeopardise it. However, it is not possible on the evidence to determine, beyond doubt, whether the man's food refusal was an early indication that he might take his own life.

139. As part of the clinical review process, a Serious Untoward Incident meeting was held by Birmingham and Solihull Mental Health Trust. During

the meeting, the GP at Birmingham prison, said that she was in the process of reviewing Birmingham's food refusal policy.

140. I am pleased to learn that Birmingham is taking a proactive approach by undertaking such a prompt review of the food refusal policy. The draft of the food refusal policy is a comprehensive and well researched document, encompassing early GP and psychiatric involvement in the care of the patient.

Birmingham's review of the food refusal policy should be swiftly concluded by the healthcare manager and any identified action points implemented.

141. I think that the ACCT process encouraged communication between healthcare staff and the man about his dietary problems. For example, healthcare staff contacted the kitchen and requested that they visit the man to discuss his problem with the low fat dietary options. This is a good illustration of the ACCT process working to improve communication and care planning. While I recognise that he resented the ACCT process, I think it was appropriate to manage his food refusal using the ACCT system.

Were the man's complex medical needs appropriately met by Birmingham prison?

142. For this question, I refer to the clinical review. The doctor was commissioned by Heart of Birmingham Teaching Primary Care Trust, to undertake an independent medical review of the man's care. It was the doctor's view that, the:

> '…management of the man's complex needs to have been clinically appropriate.'

The Heart of Birmingham Teaching Primary Care Trust's Risk Manager oversaw the clinical review process. The risk manager confirms the doctor's views.

143. The clinical review process unearthed concerns about record-keeping at HMP Birmingham. Six recommendations were made about records, as follows:

- **'Clinicians identifying themselves clearly when they make entries into the records;**
- **A signature form at the front of the records for each new clinician to record their name, signature and designation;**
- **Care plans should identify the significant clinical issues and how they are going to be treated;**
- **The notes should be regularly reviewed by clinical and in particular nursing staff and returned to date order.**

- **The nursing and medical records should be contemporaneous, and the practice of having separate nursing records should stop immediately. This practice makes a clinical review of the patient, or a subsequent review of his care extremely difficult, and has the potential for vital information to be missed.**

- **Maintenance of good clinical records is essential in all aspects of clinical care and the introduction of a computerised clinical record as soon as possible is imperative. This will eliminate so many of the problems identified including regular access, transfers to court or other prisons, and access to records from other primary and secondary care organisations.'**

144. The final recommendation made by the clinical review is also related to record-keeping:

> **'There should be clear guidelines and recording in the prisoner records of any recommendation regarding ability to attend court.'**

145. Accurate, contemporaneous record-keeping is vital to ensure the joined-up care of prisoners. The man's complex needs made it crucial to his care in particular. I endorse all of these recommendations.

Could staff have responded more efficiently following the radio call when the man was discovered at 6:10am?

146. As soon as he failed to get a response from the man, the night duty officer radioed the Communications Room to request immediate assistance. He did not open his sealed key pouch and enter the cell, but waited for the orderly officer to attend.

147. The OSG arrived shortly afterwards and looked through the observation panel on the cell. From her own account, she was very distressed by what she saw and may have gone into shock. When the first response officer got to the cell she also looked through the cell door, then assisted the OSG in her distress. Still the door remained shut and locked. The day officer then arrived, yet still the door was shut and locked. It was not until the second response officer, the nurse and the assistant staff manager arrived that the cell door was opened.

148. It took between five and ten minutes for the second response officer to get to P wing from the gatehouse. In a letter from the West Midlands Police to HM Coroner for Birmingham and Solihull, a Detective Constable writes that, 'the time of death cannot be confirmed by any person'. It is likely that rigor mortis had set in by the time that the man was discovered, given that night response officer reported stiffness in the man's leg when he attempted to straighten it. I do not think that the five or ten minute delay would have affected the outcome in this case.

149. The night duty officer, who was the first one to find the man, was confident in first aid and had worked as a patient carer before joining the Prison Service. He had also specialised in transporting the bodies of people who had died to undertakers. It was his impression that the man was dead when he first discovered him due to the colour of his skin and the amount of blood in the cell.

150. The officer believed that he acted in accordance with Prison Service policy. He told my investigators that he understood that an officer should never enter a cell on his own for the officer's own safety and the safety of the prison. The assistant duty staff manager, told my investigators that he felt strongly that staff should have another member of staff with them before they open a prisoner's cell at night.

151. However, the sealed pouches are given to night staff officers to use in the event of an emergency. And Birmingham prison has a clear policy about when an officer should enter the cell during a night shift. The 'Local Instructions for Nights – Incidents (Immediate Response)', effective from 1 September 2004, says:

> 'Life must take precedence over security.'

152. There is a local instruction to Night Staff, specifically about opening cells. Critically, this document sets out:

> 'Where there is, or appears to be, immediate danger to life, cells may be unlocked with one member of staff, if it is safe to do so.'

153. I conclude that staff should have entered the man's cell more rapidly, in accordance with Birmingham's local instruction. However, I do not criticise the night duty officer for his actions. He was undertaking his first shift of nights and was an inexperienced member of staff. He thought he was acting in accordance with proper procedure.

The Governor should take urgent steps to ensure that all staff on night duty are familiar with Birmingham prison's Local Instructions to night staff. In particular, staff must be made aware of the circumstances in which cells can, and should, be entered by one member of staff during a night shift.

154. When asked, no member of staff responding to the emergency on P wing knew what kind of emergency they were heading towards. In fact, the Principal Officer told my investigation team that he could have been attending anything, even a riot, given the little information he received. However, no member of staff to whom my investigators spoke thought that additional information would have improved their response to the man's death.

155. In his radio call, the night duty officer had used the word 'immediate'. My investigators were told that this word is generally understood by staff at

Birmingham to mean an emergency situation when used in a radio call, although this is not a formalised policy.

156. In some prisons, a formalised code system is used to identify the nature of an emergency in the call for assistance. For example, if someone has breathing difficulties, staff would call for Code Blue assistance and medical staff would bring appropriate equipment with them.

157. My investigation team was told that there was no code system for the purpose of security. Staff were concerned that prisoners would learn to understand the code system and then inappropriately become aware of emergencies occurring around the prison.

158. In the clinical review documentation, it is noted that healthcare staff should always have sufficient medical equipment with them to deal with any emergencies. The clinical review goes on to state that the response system is under review, but has been much improved over the last twelve months.

159. I accept that more precise information about the nature of emergency they were attending would not have altered staff's response in this case. However, I am concerned that there is no formalised code system for responding to emergencies. I understand that staff are worried about the security implications of a code system, but do not agree that such a system would pose any security issues. Moreover, I reiterate Birmingham's own Local Instructions to night staff:

> 'Life must take precedence over security.'

The Governor and healthcare manager should urgently consider the introduction of a formal emergency code system for emergency radio calls.

Were resuscitation attempts carried out appropriately?

160. The nurse attempted to resuscitate the man for approximately fifteen minutes. He was using the defibrillator, an oxygen mask and carrying out chest compressions by himself for the entirety of that time. His efforts are to be commended. However, the nurse did refuse offers of assistance with CPR. His refusal of these offers is unlikely to have altered the outcome in the man's case, but in future cases could prove crucial.

161. The man was positioned on the bed during the nurse's resuscitation efforts. Although this is not generally good practice, an assessment has been undertaken by the West Midlands Ambulance Service and I understand the mattresses are firm enough not to detract from the quality of the CPR.

162. The download from the defibrillator showed that the nurse tired within three or four minutes. I understand that the Principal Officer prevented the HCA from entering the cell in order to preserve it for police procedures. Again, I draw attention to Birmingham's own policy that:

'Life must take precedence over security'.

163. I refer to and endorse the recommendation of the clinical review:

'**Staff undertaking resuscitation should access assistance from colleagues who have received training and have been assessed as competent to do so**.'

164. The clinical review describes the commencement of CPR on a patient who is showing signs of having rigor mortis as a matter of 'concern'. I have commented on the inappropriate initiation and continuation of CPR in a number of other investigation reports. However, I agree with the clinical reviewer that if the member of staff has any doubt about the status of the patient they must commence CPR.

165. The clinical review suggests that Birmingham prison is in the process of formulating a verification of death in custody policy. I will be very interested to have sight of this policy, especially if it goes some way to resolving the dilemma healthcare staff currently face when confronted with patients who appear to have been dead for some time.

166. It is worth noting that the clinical review goes on to recommend that the PCT themselves 'should develop and implement guidance for staff on whether to commence resuscitation in the event of an incident such as this'.

167. I am very disappointed that all healthcare staff were not invited to the staff debrief. Healthcare staff play a vital role in the response to a death in custody and should be supported, alongside discipline staff.

The Governor must ensure that healthcare staff are routinely invited to the staff debrief following a death in custody.

Were there any indications of the man's intention to end his life?

168. There is no evidence that a post-closure ACCT review meeting was held for the man. He transferred from the healthcare centre to P wing seven days after the ACCT had been closed. Had the review meeting taken place, it might have been a useful opportunity for staff from healthcare and from P wing to discuss the man's ongoing needs. The post-closure review should have taken place. On a point of housekeeping, the Governor should ensure that a system is in place to audit post-closure reviews.

169. The man had a number of severe medical conditions. He had suffered cardiac arrests on two occasions during his three years at Birmingham. He could not walk easily, only occasionally coming out of his cell to walk the length of the wing for 'exercise'. He expressed his concern to probation staff about being a 'burden' on his family upon release due to his disablement. He said that he would be 'happy to die in prison'.

170. The man was serving a long sentence, the majority of which was still ahead of him. He was facing new charges of a particularly serious sexual nature.

171. Despite all of these risk factors and the failure to convene a post-closure ACCT review, I have not seen any evidence that clear signs that the man was going to take his life were missed.

172. It is apparent that staff, especially in the healthcare centre, had got to know the man well over the years that he spent in Birmingham prison. His personal officer had made attempts to engage him by entering his cell to check how he was feeling. Everyone was surprised that he had chosen to take his life when he did.

173. The man's solicitor, had known him for some time and described the man as a 'robust' chap. While he expressed no doubt that the pending allegation of a sexual offence from years previously had deeply affected the man, he was shocked that the man appears to have taken his own life.

174. A nurse knew the man from his time in the healthcare centre. During her visit, the night before he died, the nurse described the man as being in 'a very good mood'. She told the clinical review team that he made good eye contact with her. She had no concerns when she left his cell.

175. A day duty officer was outside the cell when the man was being seen by the nurse. He described him as being 'in normal spirits'.

176. During the night that he died, the man concealed his self-harm by placing towels and blankets around the bed.

177. In these circumstances, I do not believe that the man's death could have been predicted or actions taken to prevent it.

Summary of Recommendations

Clinical

I agree with the recommendations made in the comprehensive clinical review provided by the Heart of Birmingham Teaching Primary Care Trust:

- **Clinicians identifying themselves clearly when they make entries into the records.**
- **A signature form at the front of the records for each new clinician to record their name, signature and designation.**
- **Care plans should identify the significant clinical issues and how they are going to be treated.**
- **The notes should be regularly reviewed by clinical and in particular nursing staff and returned to date order.**
- **The nursing and medical records should be contemporaneous, and the practice of having separate nursing records should stop immediately. This practice makes a clinical review of the patient, or a subsequent review of his care extremely difficult, and has the potential for vital information to be missed.**
- **Maintenance of good clinical records is essential in all aspects of clinical care and the introduction of a computerised clinical record as soon as possible is imperative. This will eliminate so many of the problems identified including regular access, transfers to court or other prisons, and access to records from other primary and secondary care organisations.**
- **There should be clear guidelines and recording in the prisoner records of any recommendation regarding ability to attend court.**
- **Staff undertaking resuscitation should access assistance from colleagues who have received training and have been assessed as competent to do so.**

Local

Birmingham's review of the food refusal policy should be swiftly concluded by the healthcare manager and any identified action points implemented.

Heart of Birmingham Primary Care Trust finalised the food refusal policy in October 2006, for review in October 2007.

The Governor should take urgent steps to ensure that all staff on night duty are familiar with Birmingham's Local Instructions to night staff. In particular, staff must be made aware of the circumstances in which cells can, and should, be entered by one member of staff during a night shift.

The Inquest into the death of the man took place in July 2006. During the inquest process, HM Coroner for Birmingham and Solihull districts discussed this recommendation at some length. As a result of the discussion, the Coroner wrote to the Governor of Birmingham, suggesting that this recommendation be reworded, as follows:

"Cell doors must not be opened by a Staff Member at night when he or she is on his/her own unless in his/her judgement at that time he/she believes:-

1. That he/she can save a life by doing so and
2. That he/she is not endangering the lives of other prisoners or the security of the Prison."

The Governor is yet to respond to this recommendation or the suggested rewording.

The Governor and healthcare manager should urgently consider the introduction of a formal emergency code system for emergency radio calls.

The prison has informed my office that the implementation of a code system has been considered previously, as part of a broader extensive review of emergency procedures in autumn 2005. In the feedback following this report, it is stated:

"Following that review the procedure implemented was that the emergency response nurse would take all the equipment to all emergencies – the 'red' bag with dressings etc and the 'blue' bag that contains the defibrillator and resuscitation equipment. The blue bags have been placed in strategic positions around the prison. The issue of a code system has been discussed but was not implemented. This was not for security reasons. It was felt that the emergency nurse should be equipped for all eventualities – if the immediate code given out by an untrained prison officer was incorrect, or if a 'red' code for bleeding turned into a 'blue' code for cardiac arrest, it may lead to further delay in getting the appropriate equipment to the patient.

The Governor must ensure that healthcare staff are routinely invited to the staff debrief following a death in custody.

The Prison Service is yet to respond to this recommendation.