Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Birmingham, in February 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is a report into the circumstances of the death of a man at HMP Birmingham. He was found hanging in his cell on P wing in February 2010. I would like to offer my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by my colleague. A review of the man's medical care in custody was carried out by a clinical reviewer on behalf of the Heart of Birmingham Teaching Primary Care Trust.

I would like to thank the Governor and staff at Birmingham for their full and ready co-operation during the course of this investigation. I am particularly grateful to Birmingham's Safer Custody Manager, who provided a very high standard of liaison with my investigator and helped to arrange interviews.

The man was arrested in November 2009, and later charged with serious offences. He was subsequently bailed by the police and later appeared in court on 16 January 2010, when he was remanded to HMP Birmingham.

No self harm, suicidal or mental health concerns were identified during the reception process, but the man's inability to speak English was highlighted. In his first two weeks at Birmingham, there was no record of any problems. However, staff became increasingly concerned about his behaviour and frame of mind culminating in his admission to the healthcare unit two days prior to his death. However, he told staff that he would kill himself if he had to stay there and, later the same day, he was taken back to his wing. I think that the care which he received when he returned was appropriate and he appeared to settle down. There was no indication that he intended to take his own life on the wing.

There are a number of areas that warrant improvement. I make eight recommendations relating to the second day reception interview, communication with non English speaking prisoners, reviewing the suicide support procedures, mental health assessments, facilitating family contact and use of an emergency code.

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

Thea Walton
Acting Deputy Ombudsman **January 2012**

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SUMMARY

1. The man was a Punjabi speaking Indian national whose English was very limited. In November 2009, he was arrested by the police for a serious offence against his wife. He was subsequently charged and bailed by the police. He appeared in court on 16 January 2010, when he was remanded to HMP Birmingham after he failed to comply with his bail conditions.

2. During the man's first day at Birmingham, he was assessed by a number of staff. His inability to speak English was highlighted. No self harm concerns were identified and there was no evidence of any prior medical or mental health problems. As part of the reception process a cell sharing risk assessment was completed. Due to the nature of the man's offence and his vulnerability, he was taken to the vulnerable prisoners unit on 16 January.

3. At the beginning of February, the man's case records noted that there had been no problems on P wing. Both staff and other Asian prisoners found that the prison regime repeatedly had to be explained to him. In addition, his cellmate was changed a number of times as most of the men who shared the cell with him asked to be moved due to his bizarre behaviour.

4. On 20 February, the man's kettle and television were removed from his cell after he bent or chewed the electrical cables. This was not the first occasion that this had happened. The following day, he refused to leave the shared cell of two other prisoners. Staff managed to usher him out of the cell but, due to his behaviour, he was physically restrained. When he was taken back to his own cell, he was extremely distressed and would not let staff leave. He was examined by a nurse who felt that his behaviour was bizarre and referred him to a mental health nurse. He subsequently saw the man and concluded that he was very unwell and so he was admitted to healthcare.

5. When the man arrived in the healthcare unit, he again became very distressed. He refused to go in or stay in the cell and physically prevented staff from leaving. He was restrained twice and attempts were made to calm him down and explain why he had been moved to healthcare. The duty governor had been contacted and went to healthcare. A further attempt was then made to leave him in the cell, but he again refused to stay and continued to stop staff from leaving. He said that he would kill himself if he was left on healthcare and mimed putting a noose around his neck.

6. Healthcare staff felt that the man should remain on the ward, but the duty governor decided to move him back to P wing. When he returned to P wing, procedures for suicide prevention and self harm management were started.

7. On a day in February, the man was assessed by a different mental health nurse without the benefit of an interpreter. He concluded that he did not require immediate mental health intervention and he did not appear to have any thoughts or plans of self harm.

8. Later that night at around 9.30pm, the man was found hanging in his cell. Staff responded quickly and attempts were made to try and resuscitate him. However, he was pronounced dead by paramedics at 10.12pm.

9. The man's family were visited by Birmingham's duty governor and Governor in the early hours of the following morning and notified about his death.

10. There are a number of areas that warrant improvement. I make eight recommendations relating to the second day reception interview, communication with non English speaking prisoners, reviewing the suicide support procedures, mental health assessments, facilitating family contact and use of an emergency code.

THE INVESTIGATION PROCESS

11. The investigation was opened on 25 February 2010 by one of my investigators on behalf of her colleague. She was provided with all documentation related to the man during her visit. Notices were subsequently issued on 2 March, announcing the investigation to staff and prisoners. They asked anyone who had information pertinent to my investigation to contact the investigator, but no responses were received.

12. The investigator wrote to the coroner on 2 March, to inform him of the investigation and requested a copy of the post mortem report.

13. The Heart of Birmingham Teaching Primary Care Trust (PCT) was asked to conduct a review of the medical care provided to the man while in custody. The review and subsequent report were completed by a clinical reviewer and received on 18 February 2011. I would like to thank him for his assistance.

14. One of my Family Liaison Officers (FLO) spoke to the man's cousin on 9 March 2010, as his parents do not speak English. He visited them and six other members of the man's family on 22 March, accompanied by the investigator and a Punjabi interpreter.

15. During the visit the Family Liaison Officer and the investigator explained the investigation process. His family were keen to know why they were not notified by HMP Birmingham about the man's remand in custody and whether he understood his right to telephone his family. They also raised concerns about prison visits, the number of prisoners who shared a cell with their relative and the response to his mental problems. Following the family meeting, the Family Liaison Officer confirmed the issues in writing and this letter was translated into Punjabi. My report will also be translated for his family. They said that they were notified about their relative's death in person by Birmingham's duty governor who spoke Punjabi and they were able to visit his cell. The family's concerns are dealt with in the body of my report. I hope that it helps them to understand what happened in the time leading to the man's death.

16. The man's family received a copy of the draft version of this report as part of the consultation period. The family asked a number of questions about the report and these were highlighted by an MP who wrote to us on their behalf on 22 September 2011. We replied in full to this letter on 27 September but did not make any changes to the report. A copy of this final report has been translated into Punjabi and sent to the family.

17. The investigator visited Birmingham on four occasions between 11 and 19 May, and interviewed 18 members of staff and two prisoners. She was also given access to the man's prison file, including the medical record.

HMP BIRMINGHAM

18. HMP Birmingham is an adult male prison built in 1849. It serves the Crown Courts of Birmingham, Wolverhampton and Stafford as well as a number of surrounding magistrates' courts. In 2002, additional accommodation was built which provided a further 450 prison places. The prison now has an operational capacity of 1,450.

19. On 23 February 2010, information from Birmingham's safer custody unit showed that the prison had 255 foreign national prisoners out of a total prison population of 1359.

20. In 2009, the then Government announced that a number of prisons, including Birmingham, would be market tested. The outcome of the competition for the management of these prisons was announced by the Lord Chancellor and Secretary of State for Justice on 31 March 2011. At the time of writing this report, a private security firm called G4S have been successful in their bid to run Birmingham. The company will take over the management of the prison in October 2011.

21. Primary healthcare services at Birmingham are commissioned by the Heart of Birmingham Teaching Primary Care Trust (PCT). The PCT contracts the Birmingham and Solihull Foundation Mental Health Trust to provide mental health services. The prison has a 30 in-patient bed facility which is split into two wards, one tends to accommodate individuals with physical ailments and the second is used for prisoners with acute psychiatric problems.

22. Birmingham was last inspected by the then HM Chief Inspector of Prisons in December 2009. She found that whilst Birmingham had made some progress, "there was still a considerable amount to do to ensure a safe, decent and effective prison". She said that health services were "generally well managed" and mental services had improved. However, many Assessment, Care in Custody and Teamwork (ACCT) reviews were not multidisciplinary and the quality of ACCT care plans "varied considerably". (Assessment, Care in Custody and Teamwork (ACCT) is the prison's process to identify and care for prisoners at risk of self harm or suicide.) In addition, whilst some telephone interpreting services were used for prisoners who did not speak fluent English, there was no record of how often they are used in ACCT reviews. She also noted that the community cohesion and equality (CCE) policy dated 2009, covered various diversity strands such as race and disability, but not foreign national prisoners.

23. The Independent Monitoring Board (IMB) is a body of people appointed to each prison by the Secretary of State for Justice to be independent watchdogs of the public interest. They are not members of the Prison Service, nor are they part of the prison's management team. They are required to produce an annual report for the Secretary of State, highlighting good practice and flagging up areas of concern.

24. The IMB report for 2009-2010, said that the work of Birmingham's healthcare department was managed under a new contract. During the transition to the new contract, the IMB highlighted that healthcare suffered severe staff shortages and problems in recruitment. However, they found that progress had been made to address these problems. The IMB concluded that the prison's mental healthcare team offered a "well integrated" primary service.

25. At the end of the IMB's reporting period they noted that Birmingham had 221 foreign national prisoners from 45 different countries. One of the countries that was most commonly represented was India with a total of 18 prisoners. They said that new measures were introduced to identify non English speaking prisoners on their cell cards.

Previous deaths at HMP Birmingham

26. Between February and September 2010, six prisoners died at Birmingham after they apparently took their own lives. Very occasionally, a prison will experience such a cluster of deaths. I have observed a similar cluster of self inflicted deaths at different prisons since 2004 when my office became responsible for their investigations. The number and frequency at Birmingham in 2010 was unusual and concerning. I have therefore considered whether there are any similarities between the deaths. The man who is the subject of this report was the only foreign national prisoner to die in such circumstances, but the absence of an emergency code and the location of the defibrillator were concerns in this man's case and some of the other deaths.

KEY EVENTS

27. The man was born on 16 September 1984, and was an Indian foreign national. He spoke Punjabi and very limited English, but he could not write or read it. He had lived in England for seven to eight years and was married with one child, but he had no contact with his wife. He was considered to be vulnerable and his family believed that he started to suffer from depression around 2008, when he returned from India with his wife. However, he had no prior contact with mental health services.

28. On 25 November 2009, the man was arrested for offences against his wife. He was subsequently charged and bailed by the police. He then appeared in court on 16 January 2010, and was remanded in custody to HMP Birmingham because he failed to comply with his bail conditions. He had not been in prison before as he received a community sentence for his previous conviction.

29. During the man's first day at Birmingham he was interviewed in the first night reception centre (this is where prisoners receive information about life in prison and they are assessed by staff). A day one interview form is used by prison staff to document their findings and this was completed by an officer. It highlighted that the man spoke no English. The form shows that he had not expected to be remanded in custody and his family did not know that this had happened. The details of his next of kin were marked as "not known" and he was described as "very worried" about being in prison. No concerns were identified about self harm and the officer indicated that the man had not previously suffered from depression. He was described as polite and cooperative. The man signed the forms to show that he understood some of the prison's procedures such as the use of the telephones and television. His case notes show that he did not use his two minute telephone call. (This is available to prisoners when they first arrive in prison so that they can let their family or other significant people know that they are in prison.)

30. A nurse also assessed the man and completed a reception health screen (a routine health screen for all new arrivals into prison). He was described as a "quiet spoken man" who did not speak English. The nurse said that he could not read, write or sign the consent form. She wrote that another prisoner who worked in reception as a cleaner translated for him. No medical or self harm concerns were identified, but it was noted that the man had no prior experience of prison. He did not disclose any physical or mental health problems. He indicated that he preferred to share a cell with another prisoner who spoke Punjabi.

31. The investigator spoke to a Listener (a prisoner trained by the Samaritans to listen and offer support to their peers). He explained that he first met the man in reception. The Listener said that a senior officer asked him to check that the man was alright as he could not speak English. He recalled that he had to repeat questions several times before the man understood him. In addition, he said that he presented as very nervous and anxious. He did not know why

he was in prison and told him that he wanted to go home.

32. As part of the reception process a cell sharing risk assessment was completed. This form helps assess the risk that they may present to their peers in a shared cell. The assessment indicated that a prisoner was also used to translate the reception process to the man. The form shows that he was considered to present a low risk in a shared cell and repeated that he wanted to share with a Punjabi speaking prisoner. However, due to the nature of his offence, it was recommended that he should be placed on rule 45 for his own protection and the duty governor was notified. (Rule 45 is when a prisoner is segregated from the main prison population for their own protection. This could be due to an individual's vulnerability or because of the nature of their offence.)

33. A Governor authorised the man's segregation under rule 45. He specified that this was due to the nature of his offence. He also noted that the man could not speak any English and it was his first time in custody. He concluded that the man was "very naïve", "very vulnerable" and would be "under threat" if he lived with the main prison population. The man was subsequently moved to P wing, the vulnerable prisoners unit, on 16 January.

34. The reception process also involves a further interview on the second day. This offers staff the opportunity to reassess any changes after a prisoner's first night, but this section of the man's form was left blank.

35. On 18 January, the man saw a Resettlement Officer. He recorded on the man's case notes that he intended to live with his "partner" following his release. The Resettlement Officer explained to the investigator that he interviews all newly arrived prisoners to identify whether they have any housing problems as a result of their imprisonment. He said that he "vaguely" remembered the man because he spoke no English and he used a Punjabi speaking officer to translate. The Resettlement Officer said that he asked him about his accommodation before coming into prison and his plans on release. The man told him that he lived with his family, but was unable to return to the address. The Resettlement Officer described the man as "calm" and said that it appeared he had no housing issues that needed to be addressed.

36. Over the course of the next two weeks, there were no further entries on any of the man's records or in the staff observation book (this is used to share information about prisoners) until 1 February. On this date, the Punjabi speaking officer wrote on the case record that there had been no problems with the man since he had been on the wing. He indicated that due to the language barrier, he wrote to the man's parents to let them know that he was in prison.

37. The officer told my investigator that he spoke Punjabi and he had a lot of contact with the man. He said that the man found it difficult to understand why he was in prison and also why he had to abide by prison rules. However, he did not consider that he was at risk of self harm or suicide. When he first arrived on P wing, the officer said that he helped him to try and contact his

family. He took him to the reception department to get his diary from his stored property. This contained a list of telephone numbers, but the man was unable to identify which one related to his family. The officer recalled that initially, the man did not know his address, but he obtained it from the foreign national co-ordinator. The officer explained that he is not allowed to make telephone calls for prisoners, but he wrote the letter, which is permitted.

38. The man's family told the investigator that they did not know where he was and they were worried about him being on his own. They were also concerned because he had mental health problems and they wanted to communicate this to the relevant establishment. However, they said that they then received two letters from the man around 5 or 6 February, and gave copies to my investigator. The first letter was not dated, but the envelope was post marked 4 February. It was written in English, but the person who wrote the letter was not identified. Nevertheless, it was addressed to "Dad" and said that the man was in HMP Birmingham. His father was asked to write as soon as possible and provide the family's home telephone number as the man had forgotten it. The second letter was again addressed to his father, it also was not dated, but the envelope was post marked 5 February, and it indicated that it was written by another prisoner. It repeated that the man had no contact telephone numbers, including his solicitor's details, and he wanted this information. The letter noted that the man's "miss" (wife) had put him in prison. The man asked his father to book a prison visit and to "take him [the man] out of here". He also provided his personal identification number (PIN). (This is a visits PIN code which is required in order to book a visit at Birmingham.)

39. The day after the letter arrived, although it was unclear if this was 6 or 7 February, the man's family told the investigator that his father went to the prison. They said that the letter was shown to a Punjabi speaking officer, but his father was redirected to another member of staff who did not speak Punjabi. When the man's father asked for an interpreter the individual concerned shrugged his shoulders. His father then asked another Punjabi speaking visitor to translate and he was told that he had to visit with his wife. Information from the prison shows that they have no record of any members of the man's family visiting the prison on either 6 or 7 February. However, his family went on to say that his father was advised to return at 2.30pm on 9 February, and given an appointment slip.

40. The man's family said that they returned as instructed on 9 February, but they were told that they did not have the correct forms of identification and therefore the visit was declined. The man's father told the investigator that he was not informed about this requirement when he previously went to the prison. The man's visits record shows that both his mother and father were on his list of approved visitors. In addition, social visits were booked on 9 and 10 February between 9.15am and 11.45am, but were both cancelled. Birmingham confirmed that both the man's mother and father were due to visit on these date. The visit on 9 February was cancelled due to lack of identification, but there was no recorded reason why it happened again on 10 February.

41. On 19 February at 11.00am, the man's family said that his mother, father and brother returned again to the prison and took various forms of identification with them. However, they were then informed that the visit could not take place as it was a Saturday. His family told the investigator that they had a leaflet from the prison which set out Saturday visiting times. They explained that they felt frustrated and asked for a Punjabi speaker, but no one was available. The man's mother said she was upset that the visit was refused. The family added that they were advised to speak to the man's solicitor in order to arrange a visit. Birmingham has no record of the family's visit.

42. My investigator spoke to some staff who worked on P wing. One officer told the investigator that he had some contact with the man because he spoke Urdu and could "get by" in Punjabi. He said that the man asked him about the general regime on the wing. He described him as always "even tempered", compliant and "nice and steady". He believed that the man got a lot of support from other Asian prisoners on P wing. He noted that he had shared a cell with a Muslim prisoner, but he was subsequently released. Another officer explained to the investigator that she had no regular contact with him as she was not based on his landing. She only remembered that he was unable to speak English which was comparatively rare. She said that the problem was usually solved through using staff or other prisoners as interpreters or by miming.

43. A Senior Officer (SO) was also interviewed by my investigator. He explained that he was in charge of P wing along with his colleague. Initially, he said that the man came across as "very, very quiet". Occasionally he would be approached by the man who tried to talk to him. However, the senior officer told the investigator that he had "absolutely no idea what he was trying to get across", but sometimes other Asian prisoners explained on his behalf. The senior officer noted that the man's peers said that he did not listen when they tried to explain the wing regime, visits or making telephone calls. He told my investigator that he did not know if this was because he did not listen or because he could not understand. He said that arrangements were in place to ensure that Punjabi speaking members of staff were regularly on duty so that they could communicate with the man. In addition, he said that Asian staff attempted to help the man to communicate with his family. They encouraged him to use the telephone and tried to help him with his visits and telephone lists (the lists contain details of people that prisoners would like to telephone and receive visits from whilst they are in prison), but he did not specifically ask to speak to his family.

44. The senior officer noted that other Punjabi speaking prisoners shared a cell with the man, but they came out "very quickly at their own request". He added that he could or would not settle with anyone. The investigator asked the senior officer whether the prisoners gave any particular reasons. He explained that the staff repeatedly got feedback that something was "not right", although the prisoners concerned did not provide anything specific. Despite this, the senior officer said that a lot of it related to "bizarre behaviour". For example, he would be "up and down" and walked around his

cell throughout all times during the night. He added that one prisoner apparently claimed that he was “sexually approached” by the man. He said that this raised problems regarding the “danger” that he presented to others. The senior officer recalled that the man exhibited “more and more a bizarre behaviour pattern” which the staff did not understand. Furthermore, he “attached” himself to other prisoners who could speak his language.

45. The investigator also spoke to the second senior officer who was also in charge of P wing who said that the man struggled to speak English. She thought that he might be able to say a few words, but he was not confident when he spoke. She confirmed that both the Punjabi and Urdu speaking officers had contact with him. She added that one of these officers arranged to see him because he had incorrectly filled in his request to use certain telephone numbers. However, she was unable to recall who had done this.

46. During interview with my investigator, the second senior officer on P wing indicated that the man associated with approximately six other prisoners and one of them spoke Punjabi, although she was unable to remember this individual’s name. However, she said that he approached her on behalf of the man to request general information and asked about a new kettle as the one in his cell was not working. She noted that the man looked “very, very frightened” and “uncomfortable”. Furthermore, the regime repeatedly had to be explained to him and why he needed to do certain things. Both Punjabi speaking prisoners and members of staff were used to clarify matters, but the senior officer said that she witnessed a level of “non retention” of information.

47. The second senior officer on P wing explained that she also saw the man when dinner was being served. At times he talked to his friends, looked quite happy and went to the exercise yard. However, on other occasions, she said he was like a “startled rabbit” and ignored everything and everybody as he walked around the wing. Staff reported that he frequently used his cell bell to ask to go home. Other prisoners who spoke Punjabi also said that he was “not right in the head”. The second senior officer told my investigator that the man shared a cell with at least three prisoners who subsequently asked to be moved. She recalled an incident where he had pulled his trousers down, although it was not recorded.

48. The next entry on the man’s record was on 20 February 2010, some three weeks after the Punjabi speaking officer’s documented contact. An officer wrote on the case notes that he went to the man’s cell after he pressed the bell to call staff. When he arrived, the man indicated he had no electricity and he wanted some hot water for a drink. The officer documented that this was not the first occasion that the electrical supply in the man’s cell had gone off because he had bent or bitten through the wire. The officer examined the kettle and found that the man had wrapped blue tape from his breakfast pack around the cord. Due to health and safety concerns he removed it and the television from his cell. The officer said that he asked another Punjabi speaking prisoner to explain to the man why this had been done. (The investigator attempted to speak to the officer on a number of occasions, but he was unavailable when she visited Birmingham.)

49. The officer was subsequently contacted in writing and asked to provide more information about this incident. He was unable to remember who mentioned that the man had previously bent or bitten through the wire. In addition, he did not know if this had been recorded. However, he said that he was sure that he informed a senior officer about removing the television and kettle as this was not normal practice. He also indicated that the man spoke very little English, but he used two other prisoners to translate whenever it was possible.

50. The first senior officer in charge of P wing was also asked about the incident on 20 February. He explained that when staff made their cell checks, they found that the man's kettle lead was splayed and broken. The senior officer said that this exposed the electrical wire and staff believed that the man had used his teeth to do it. He added that he also did this to the television cable. The senior officer confirmed that the items were removed for health and safety reasons and not as a punishment, but the staff did not understand why he had damaged the cables.

51. The following day on 21 February, the staff observation book indicates that control and restraint was used after the man would not go back to his own cell. (Control and restraint involves the use of a number of approved physical techniques to control the movement of a prisoner who is violent or refuses to follow instructions. It should be used as a last option after all other means of trying to resolve the situation, such as persuasion, have been tried and failed. When control and restraint is used prison staff are required to complete a use of force statement to record what happened.)

52. The officer who answered the man's cell bell on 20 February said in his statement that, at approximately 4.35pm on 21 February, he was working on the fourth landing on P wing. The man collected his evening meal and, instead of going back to his own cell, he went to another one. He sat down in the cell and refused to move. A further officer wrote in her statement that another prisoner translated, but the man still would not leave.

53. The first senior officer in charge of P wing explained to the investigator that the man went to a cell occupied by two other Asian prisoners as they spoke Punjabi. He was asked to leave as it was tea time when prisoners have to be in their own cells, but he refused to do so. The senior officer said that there were already two people in the cell and there was not the option to have a third person. The prisoners tried to explain to the man that he had to return to his own cell, but he would not listen and said no.

54. The two officers wrote in their statements that they managed to usher the man out of the cell on to the landing. He grabbed hold of the railings and started to climb them. Both officers recorded that he was pulled away from the railings for his own safety and began to struggle. The officers wrote that he became "agitated" and "aggressive" and therefore control and restraint was used. An alarm was raised and they "secured" him until other staff arrived.

55. Two further officers documented in their statements that they responded to the alarm at 4.40pm and 4.45pm respectively. On arrival, they found the man being restrained. Both officers recalled that the man refused to comply with instructions from their colleagues and he could not speak English. The officer who responded to the alarm at 4.45pm said that this made it extremely difficult to communicate with him. The officer who responded to the man's cell bell on 20 February recorded that he believed that the man's problems stemmed from his "total lack of understanding of English". He added that he felt that he also had learning difficulties or mental health problems.

56. The first senior officer in charge of P wing wrote that he was alerted to a problem on the fourth floor landing on P wing at around 5.00pm. When he attended, the man was held face down on the floor under restraint. He was crying and shouting in Punjabi which staff could not understand. Attempts were made to tell him what to do so that staff could lift him off the floor back into a standing position. However, when this was done, the senior officer recorded that the man began to "fight against staff". The officer who had responded to the alarm at 4.40pm wrote that control and restraint was therefore used again.

57. During interview, the first senior officer told my investigator that communication with the man was an issue on two fronts. His first concern was that he was under restraint and did not have "a real clue" why this had occurred. Second, he said he needed to communicate with the man to try and calm him down. However, at the time there were no Asian staff on P wing. Therefore, the first senior officer said that he asked someone to go to a neighbouring wing to ask for a Punjabi speaking member of staff to come to P wing to interpret. He recalled that an officer arrived and was able to communicate with the man. The senior officer described how the man repeatedly said he did not want to be on his own, but he could not explain why. He added that the man was "wound up", "upset" and crying. The Punjabi speaking officer explained to him that he was being returned to his own cell. Whilst reluctant to go back, the man did so without any further use of control and restraint. Once he got to his cell, he became quite agitated and tearful.

58. At 5.10pm, a senior officer documented in her statement that she was called to P wing to assist with the man. She described him as "extremely distressed" and added that he would not allow officers to leave or close his cell door. The senior officer said that the Punjabi speaking officer spoke to the man, but he continued to refuse to move away from the door or stay seated in his chair. When staff attempted to leave his cell, the man grabbed and held on to their lower legs. The senior officer wrote that he would not listen to the Punjabi speaking officer and was unable to explain why he was so stressed. She also noted that staff explored whether he could share a cell, but this was not considered feasible as it had previously resulted in conflict. In addition, other prisoners had declined to be accommodated with the man.

59. During interview with my investigator, the first senior officer in charge of P wing added that the man was "in pieces" and "literally in floods and floods of

tears". He said that he and the Punjabi speaking officer stayed with the man. The senior officer explained that he talked with the man about the problem and how they were doing to deal with it. He said that the man told staff that he did not know why he was in prison, he wanted to go home and he had not done anything wrong. The senior officer recalled that he seemed to be unable to grasp why he was there. In addition, he said that the Punjabi speaking officer told him that the man would not listen when he tried to communicate with him. The senior officer said that he had to leave to attend to other duties, but the man was not alone and the Punjabi speaking officer and another colleague stayed with him.

60. The duty governor for the prison on 21 February told my investigator that he was contacted by the orderly officer who said that the man's behaviour had been erratic and he had not responded to requests to return to his cell. The duty governor asked a healthcare nurse to go to P wing to assess whether the man had problems that required healthcare advice.

61. Initially, a Registered General Nurse (RGN) saw the man. He wrote on the clinical record that he was called to P wing because of the man's "odd behaviour" and refusal to leave another cell. He knew that he had been restrained and moved. When he arrived at the wing, the RGN found the officers talking to the man who was crying. He examined him and noted no physical injuries, but he complained of mild pain in his right wrist. He described the man's behaviour as "funny" and "bizarre". The RGN was told that he had chewed the television and kettle electrical cables. He was also advised that the man did not want to be alone, but the Punjabi speaking prisoners did not want to share a cell with him because of his behaviour.

62. The RGN explained to my investigator that he carried a prison radio and was responsible for responding to any emergencies in the prison. He added that, if officers plan to apply control and restraint, a nurse must be present to observe. He said that he received a call via his radio to attend P wing. He confirmed the details in the clinical record, clarifying that he was being contacted as part of the control and restraint procedure and not because the man was hurt or unwell. Although the man was not calm, he allowed the RGN to examine him after a Punjabi speaking officer explained why this was necessary. Officers told him that the man had been seen chewing the cables of his television and kettle the previous day. He appeared to be in a "heightened level of distress". In view of his presentation, the RGN arranged for the man to be assessed by a member of the prison's mental health team. The RGN asked a Registered Mental Health Nurse (RMN) to assess the man and then left to continue with his other duties.

63. The clinical record shows that the RMN went to see the man on P wing. He was told by a senior officer that his condition had deteriorated over the previous few days. Again it was noted that he had chewed a television cable, but whilst it was plugged in and switched on. However, the first senior officer in charge of P wing told my investigator that the man did not bite through the cable whilst it was connected to the electrical supply and he only broke the wires. The RMN wrote on the clinical record that the man appeared "very

agitated", tearful and "irrational". In addition, he said that he refused to listen or comply with any requests from a Punjabi speaking member of staff.

64. The RMN explained to my investigator that he worked on one of the prison's in-patient wards and also responded to mental health emergencies within the establishment. He confirmed that he was called to assess the man on 21 February, after he refused to return to his cell. Prior to attending P wing, the RMN said that he checked the man's medical record to see if he had any previous contact with the mental health services or whether he was taking any medication. When he arrived on the wing, the RMN said that he spoke first to the senior officer in charge of P wing. He said that the senior officer told him about the incident regarding the television cable and that several prisoners had said that he had been behaving strangely. The RMN told my investigator that he appeared "very unwell". He described the man's speech as incoherent and said he was "distracted", crying and his thoughts were erratic. He therefore decided that the man should be admitted to healthcare.

65. The staff observation book records that the duty governor agreed with this course of action. During his interview with my investigator, the duty governor said that the orderly officer contacted him and said that the man was being taken to healthcare.

66. The RMN went on to tell my investigator that he contacted healthcare and arranged for a constant supervision cell to be made available. In line with Prison Service policy, the duty governor should be consulted about the use of constant supervision, but there was no record to show that this occurred. (Constant supervision is when a prisoner is supervised by a designated member of staff on a one to one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly.)

67. The senior officer who was called to P wing to assist with the man at 5.10pm on 21 February said in her statement that the move was explained to the man. She added that he calmed down, packed his belongings and was escorted to healthcare by herself, the RMN and three officers. She described the man as "compliant at the time".

68. An officer's use of force statement shows that he escorted the man from P wing to healthcare around 6.15pm. The clinical record indicated that he was admitted to ward one on healthcare. The senior officer who was called over to P wing to assist with the man wrote in her statement that the man was shown to his cell by a healthcare officer. In addition, one of the Punjabi speaking officers explained to the man that he was on healthcare to be observed by medical staff. However, the man refused to go in the cell, pushed staff and tried to grab his belongings. The first senior officer in charge of P wing said that two officers attempted to walk him into the cell, but he started to struggle and control and restraint techniques were used again.

69. During the RMN's interview with my investigator he confirmed that he was present when the man initially arrived on the ward. He said that as the man approached the constant supervision cell he became upset again and

grabbed hold of one of the escorting officer's legs. The RMN repeated that control and restraint was used to put him in the cell on healthcare. He added that he saw the man head butt the cell walls, try to get out of the cell and repeatedly "rush" staff who tried to stop him. At this point the RMN said that he left to carry on with his other duties.

70. The senior officer who was called over to P wing to assist with the man says in her statement that the man eventually calmed down and he was examined by a nurse. She said that the Punjabi speaking officer tried to explain to the man that he needed to comply with instructions and listen to staff. In addition, he was told that he would be safe on healthcare and he needed to stay there. The senior officer said that he repeatedly interrupted and spoke over the Punjabi speaking officer. She contacted the duty governor and told him that healthcare staff had recommended constant supervision.

71. The duty governor said in interview with my investigator that he was contacted by the orderly officer. He was told that the man had reacted badly to being moved to healthcare and staff had used control and restraint. The duty governor explained that he received a further call to say that he was "resisting all attempts" to relocate him so he too went to healthcare. He recalled that he spoke to the orderly officer and healthcare staff.

72. The statement of the senior officer who was called over to P wing to assist with the man shows that the duty governor asked staff to make another attempt to leave the man in the cell, but when this was done he ran towards a wall and banged his head on it. Staff then intervened and he grabbed at them so that they could not leave the cell. When he refused to comply with staff instructions, the senior officer who had been called over to P wing said that control and restraint was used again. (This was the fourth time that control and restraint techniques were used.) Staff tried again to leave the cell, but the man used his hand to prevent the cell door from being closed. His hand was released, but he pulled the door and then grabbed at staff again. In order to stop him, they re-entered his cell and he "slipped" on his back. He started to bang his head on the floor and staff once more intervened to protect him from injury. The Punjabi speaking officer managed to calm him down. The senior officer wrote that the man told the officer that he would kill himself if he was left in healthcare. He assured the officer that he would be "ok on his own" on P wing.

73. The duty governor repeated in his interview with my investigator that staff tried to place the man in a healthcare cell and secure the door. However, he "resisted all attempts". He said that the Punjabi speaking officer tried to talk to him, but he did not respond. The duty governor then spoke to the man and found that they both came from the same region in Punjab. The man calmed down when he realised that they could communicate fluently with each other. The governor tried to explain to him that he wanted him to stay on healthcare so that a doctor could see him the following day and check that he was "ok". However, the man did not want to stay. He said that he was not sick and wanted to return to the wing. He told the duty governor that he had refused to go back to his cell on the wing because he had no television and he was

angry that it had been removed. The duty governor said that he asked the officer about it. He told him that the television cable was unsafe and looked as though it had been chewed. It had been taken away for health and safety reasons.

74. During the duty governor’s conversation with the man, he asked him if he had any physical or mental health problems. The man told him that he had none. He checked if the man had received any “medical help” prior to his remand. Again, he said that he had not had any such intervention. He told the duty governor that he was “not mental” and that he was fine. He said that the man was calm, but as soon as staff tried to leave him he became distressed and said that he did not want to stay on healthcare.

75. The clinical record shows that the RGN examined the man again following the use of control and restraint in healthcare. He described him as “agitated”. The man said he would take his own life if he was left in healthcare and used a bed sheet to show how he would hang himself. The RGN wrote that the man had banged his head against a bed and his fingers were caught against the door. However, there were no obvious signs of injury. He recorded that the man had minor grazes on his left hand and right wrist, but he said that he was “ok”.

76. My investigator spoke to the RGN about his second contact with the man. He said that he received another call via his radio, about an hour after he first saw him, and was asked to go to healthcare. When he got there he found that control and restraint had been used once more and he was required to examine the man for any signs of injury. The RGN said that the duty governor was present but it was almost impossible to assess the man. The RGN explained that the man talked loudly and was tearful. He confirmed that staff tried to keep him in the cell, but he would not sit still and repeatedly attempted to leave. The RGN added that the man also mimed putting a noose around his neck wherever staff tried to exit the cell. Furthermore, he grabbed hold of the duty governor’s leg and begged him to take him back to P wing.

77. The RMN explained to my investigator that he was also called back to see the man in healthcare. When he returned, the duty governor was present and speaking to the man.

78. In interview with my investigator, the duty governor said that he spoke to healthcare staff. He said that he was told that the man was not receiving any treatment or medication. In addition, there was no medical information about any illness or “other history”. He said that he also discussed the available options.

79. The RMN wrote on the clinical record that the duty governor was advised by nursing staff and a healthcare officer about the use of constant supervision. During interview, the RMN said that he told the duty governor that he believed that he was “acutely unwell” and needed to be supervised constantly by staff. The RMN added that he felt that the man should also be provided with a Listener. Therefore, he contacted D wing and arranged for the Listener used

during the reception process to see the man. When he left the ward, the RMN said that he was under the impression that the man would remain in the constant supervision cell.

80. During the RGN's interview for this investigation, he said that both he and the RMN advised staff that they thought that the man should remain on healthcare with constant supervision. This was because he felt that the man was irrational. The RGN believed that the man did not understand why staff wanted him to stay in healthcare. He wondered if the man thought that his move to healthcare was a punishment. The RGN considered that the decision whether to leave him on healthcare or return him to P wing was complicated. He said that there was a question about whether the man's move to healthcare would have added to his distress. Nevertheless, the RGN said that both he and the RMN were "overruled" by the duty governor who decided that the man would return to P wing.

81. The duty governor explained to my investigator that as the man was not having any medical treatment at the time, the "general feeling" was that he should be observed regularly, rather than constantly, by staff. The duty governor decided that the best thing to do was to take the man back to his cell on P wing and see if he remained stable. He recalled that the man visibly calmed down when he was told that he would be taken back to P wing. The staff observation book documented that the duty governor decided to return the man back to P wing "instead of putting" him on constant supervision in healthcare. The senior officer's statement also reflected the duty governor's decision.

82. Prior to the man's move back to P wing, the senior officer supervised an officer placing handcuffs on him. He explained that this was because the man would not fully listen to instructions. He was then "supported" by two officers and moved back to his cell on P wing. In interview with my investigator, the duty governor confirmed that the man was escorted back to P wing and that he was present throughout, but no restraints were used. He recalled that the man chatted quite calmly and happily with him about his brother and father and he apologised for his earlier behaviour.

83. Once the man arrived back at his cell, the senior officer recorded that the cuffs were removed. She described him as "a lot calmer". The RGN told my investigator that he also accompanied the man back to P wing. He was examined for any injuries and the man declined to take any painkillers. The RGN also said that the man was much calmer and appeared to be pleased to be back on the wing.

84. During the duty governor's interview, he told my investigator that one of the officers obtained a new television and cable. Staff also gave him a sandwich and he made himself a cup of tea. He got his legal papers out of his cupboard and asked for them to be explained. The duty governor said that he did this and described the man's cupboard as very well ordered. The man told him that he was angry with his wife and he did not think that it was right that he was in prison. Furthermore, he was adamant that he was not

"mental". Initially, the duty governor said he felt that the man might have taken an illicit substance and this might have caused his strange behaviour. The duty governor recalled that he was aware that other prisoners had asked not to share a cell with him and one said that he felt "uncomfortable" about the man's behaviour.

85. The first senior officer in charge of P wing commented in interview that he was "very surprised" when the man returned to P wing with other staff and the duty governor, as the man had said that he did not want to be on his own on the wing. The senior officer saw the man and confirmed that he was provided with a television as well as some books, as he had asked for reading material, but he was not given a kettle. He explained that the man had access to a boiler on the landing in order to make a hot drink. He described him as "totally calm" and a more collected individual compared to an hour earlier. He told my investigator that "it was chalk and cheese … a total switch from one to the other". He said that staff were advised about the incident on healthcare, the rationale for the man's move back to P wing and also that he had "jumped at the chance" to return.

86. A cell sharing risk review was completed by the first senior officer in charge of P wing on the same day 21 February, and endorsed by the duty governor. It said that the man was agitated and his behaviour had been erratic throughout the day which was considered to be "unusual". The review indicated that he had no previous mental health issues, but it was suspected that he might have used unauthorised drugs, although there was no indication about what may have prompted this speculation.

87. The duty governor told my investigator that he met with the P wing manager, who he did not identify by name, and they started the ACCT monitoring. The governor added that he also arranged for the man to see a Punjabi speaking Listener that evening.

88. ACCT monitoring was started by an officer at 6.55pm and this was reflected on the clinical record by the RGN. The ACCT document shows that this was because the man had "mimicked" a ligature around his neck and deliberately banged his head. The first senior officer in charge of P wing told my investigator that an ACCT was opened because the man was distressed, on his own in the cell and they wanted to make sure that he was "alright", due to his earlier presentation.

89. In line with Prison Service policy, an immediate ACCT action plan was also put in place and agreed by the first senior officer in charge of P wing. This noted that the man was provided with a Listener. The ACCT ongoing record shows that this took place at 6.55pm. The staff observation book also recorded that he saw a Listener who said that he was a lot calmer and he did not want to go back to healthcare. The senior officer confirmed that the man saw a Listener from D wing and spent between 30 to 40 minutes with him. The Listener repeated what the man had told staff earlier, namely that he did not want to be in prison, he did not know why he was there and he should be

taken home. The senior officer said that the Listener tried to explain the situation to the man, but he would not listen.

90. The ACCT document also shows that the man was to be checked by staff five times an hour. (Observations are made by prison staff to check on the wellbeing of a prisoner.) It was also noted that he knew that he could use the telephone. The duty governor recalled that he left the man in the knowledge that he was being monitored under the ACCT procedures and was due to have a mental health assessment.

91. The duty governor told my investigator that he contacted P wing later that night and spoke to an officer. He was told that the man was sleeping and had calmed down. During the night, the ACCT ongoing record indicates that he watched television and then slept until 7.05am the following day.

92. During the morning of 22 February, the ACCT ongoing record shows that the man spent two hours in the prison's exercise yard. He also interacted with other prisoners and then collected his lunch time meal. In the afternoon, he watched television in his cell and went to association. (This is the period of time when prisoners are out of their cells and are able to associate with each other. They can make telephone calls, have haircuts, play table games, watch television and take part in other wing-based activities.)

93. As part of the ACCT monitoring, the man was interviewed at 2.45pm by a trained ACCT assessor, and a prisoner who saw the man in reception was used to translate. The record shows that the man said that he was distressed because of the language barrier. He felt frustrated because he was on his own, had no one to talk to and had neither a kettle nor a television. The man indicated that he was now fine and was not thinking about harming himself. He explained that he was in touch with his two year old son and had telephone contact with his brother, mother and father. The man said that he would try to arrange a visit, but in the interim he would write a letter. The ACCT assessment form shows that the translator thought that the man had "mental health issues" related "to his age". The ACCT assessor wrote that a referral to a CPN would be appropriate. He concluded that the man was happier and had been provided with a television and kettle. He was described as lonely and it was noted that he wanted to share a cell with a Punjabi speaking prisoner.

94. The ACCT assessor told the investigator that he had no previous contact with the man. He explained that the ACCT interview was difficult because it was carried out through an interpreter. He felt that this removed an opportunity to properly assess the man's body language and build up a rapport with him. In addition, the interpreter told him that he found it hard to properly gauge the man. The ACCT assessor indicated that he was not convinced that the man had been honest about how he felt, but there were no signs of mental illness at the time.

95. During interview, the prison Listener said that he thought that the man was depressed. He also felt that he may have had a “learning difficulty” or “a young mind” or a combination of both.

96. An ACCT review was also held on 22 February, at 4.00 pm. An interpreter was used again, but there was no indication whether this was a prisoner or a member of staff. The second senior officer in charge of P wing chaired the meeting and an ACCT assessor and the man were also present. An ACCT care and management plan (care map) was completed. This is the form used to identify the concerns and how they will be addressed by staff and/or the prisoner. It indicated that an interpreter and language line (an interpreting telephone service) would be used to overcome the man’s frustration in relation to communication. In addition, the senior officer referred him to the prison’s community psychiatric nurse (CPN) so that he could be reviewed. The care map form notes that staff should consider a number of areas. This includes action to link a prisoner to people who can provide support, but there was no indication that this was considered. The record of the review shows that the man’s ACCT observations were reduced from five to two an hour, but there was no indication as to why this happened.

97. As part of the ACCT review, the second senior officer in charge of P wing told my investigator that she spoke to the man on her own, but she “did not get very far”. However, she believed that she had all the necessary information following the ACCT assessor’s assessment. In addition, she said that they spoke to staff who raised no significant concerns, although it was recognised that he needed to see a CPN. She felt there were “absolutely some significant mental health issues”. She added that the man’s presentation on 22 February was “no different” from usual and he looked a little timid, but there was no evidence that he was in a crisis.

98. On the same day, the clinical record indicated that an RMN sent a threshold assessment grid (TAG) on behalf of her colleague to the prison’s mental health team. (A threshold assessment grid is a standardised assessment of the severity of a patient’s mental health problems.) There was a hand written note on the form that said “21/02/10 seen by [RMN]. Relocated to ward 2, but refused to stay. Self harming returned to P wing on instructions of [duty governor] (see EMIS)”. (EMIS is the electronic clinical record.)

99. During the rest of the afternoon, the ACCT ongoing record shows that the man again attended association, spent time in his cell and watched television. He collected his evening meal at 6.30pm and the record indicated he also “wandered” around the wing and removed the cell cards of other Asian prisoners, together with his own on three occasions. The staff observation book shows that another prisoner shared a cell with him during the night.

100. The next observation was done at 10.00pm by an Operational Support Grade (OSG). He said that the man was awake and watching television. During interview, he told my investigator that he tried to talk to him, but this was difficult because the man could not speak English. Two hours later, he wrote

that the man appeared to be asleep and this remained the case until the following morning.

Events on the day of the man's death

101. The ACCT ongoing record shows that the man was awake at 6.00am and watching television. Some 15 minutes later, the staff observation book recorded that the man's cellmate pressed the cell bell and asked to be moved. A more senior member of staff subsequently attended and the cellmate was transferred to another cell, but there were no further details.

102. The man's cellmate told my investigator that he shared a cell with the man for one night only. He explained that he spoke English and Somali, so he was unable to communicate with the man. In addition, he said the only word the man appeared to know was "yes". He said that the man obsessively rearranged his possessions and moved them around frequently. For example, he repeatedly folded his clothes and made his bed. The man's cellmate said that he felt uncomfortable because the man constantly moved about even during the night and so he asked to be moved. He added that the man looked "rough", his cell smelled and it appeared that he had not washed. The second senior officer in charge of P wing told my investigator that the prisoner approached her to say that he could not get on with him. She explained that he was unable to cope with the man's "unusual behaviour" and the language barrier.

103. No concerns were noted on the ACCT ongoing record by the officer at 7.00am. He wrote at 9.00am that the man was "doing well", he laughed and joked and made good eye contact. Two hours later, he said that the man participated in the wing exercise and again no concerns were identified. At lunch time, he collected his meal then watched television. The officer told my investigator that he was on duty until 12.00pm. He said that he saw the man who appeared perfectly normal during the morning.

104. Following the referrals made by the second senior officer on P wing and the RMN to the prison's mental health team the previous day, the man then saw an RMN from the prison's Primary Care Mental Health Team (PCMHT), at 12.35pm in his cell. (The PCMHT deals with prisoners who have moderate mental health problems.) The RMN reflected his observations in the clinical record. He noted that the man's English was "very limited" and he pointed out the door, sink and television. The man seemed anxious to explain to the RMN that he was not "mental". The RMN asked him if was happy and he replied "yes". He wrote that the man smiled, shook his hand and was friendly. Based on his presentation, the RMN concluded that the man did not appear to have any plans or thoughts about harming himself, but he noted that he would be reviewed in the P wing clinic. At the bottom of the TAG referral form was a hand written note. It said "seen by [initials of RMN] on 23/2/10 – MH caseload. P wing clinical 18/3/10".

105. The RMN from the prison's PCMHT explained to my investigator that one of his responsibilities is to assess prisoners who are referred to the mental

health team. He added that the purpose is to identify if there is an immediate need for mental health intervention. On the day of the man's death, he said that he had to see four prisoners between 10.30am and 12.00pm and he had to attend a meeting in the afternoon. However, he recalled that this did not mean that he spent less time with the man. He repeated the details that he recorded on the clinical record and said that he knew about his "bizarre" behaviour in healthcare two days earlier. He described him as slightly overly friendly and exaggeratedly happy.

106. Throughout the assessment the RMN said that the man repeated "no mad, me no mad". The RMN told my investigator that he found it difficult to communicate with him. The RMN did not add his assessment to the ACCT ongoing record because he did not know that it was open even though he had mentioned it on the clinical record. However, the RMN said that he did know that the man had threatened to kill himself if he was left on healthcare. The nurse told my investigator that he did not consider that immediate mental intervention was required and neither did he believe that he was at risk of self harm. However, he said that he was sufficiently concerned about the incident on 21 February to book an appointment at a mental health clinic.

107. In interview, the duty governor said that he contacted P wing again to ask about the man. He was told that he was calm and had been assessed by someone from healthcare.

108. At 2.30pm, an officer wrote on the ACCT ongoing record that the man was standing in his cell looking out of the window. She saw him again at 4.30pm, when he was on his bed. She tried to talk to him to check if he was "ok", but he did not reply.

109. The man had his evening meal at 6.30pm and the officer recorded that there were no concerns about him although, due to "language problems", she was unable to talk to him.

110. The same officer also carried out the next ACCT observation at 8.30pm and said that he had stood in his cell looking at the cell door during the previous two hours. The officer went back to the man's cell during the evening because there was a fire alarm on the wing. She recalled that he was standing in his cell, staring at the observation panel on the cell door. However, he did not seem distressed or concerned and she was not worried by his behaviour.

111. The prison goes into night state from 9.00pm to 7.30am the following day. This is the period when the main day and evening routine has been completed, all the prisoners are accounted for and are locked in their cells. A principal officer (PO), the night orderly officer, is in charge of the prison. The assist night orderly periodically walks around the establishment, checking that staff are carrying out their duties and that prisoners are safe. The response team is available to assist with any incidents. Officers or OSG staff patrol the wings. They are provided with a cell key in a sealed pouch to use to go into a cell in an emergency. However, because of the security implications of

opening a cell at night when a few staff are on duty, all night patrol staff are trained to use the radio to call for assistance. After assistance has been summoned, the member of staff should decide whether to go straight into the cell or wait for assistance. Their decision depends on the nature of the situation, the circumstances in the cell and the need to maintain safety and security whilst responding to the emergency.

112. The OSG told my investigator that he started his shift at 8.30pm on P wing. He explained that as part of the handover he was provided with the details of prisoners on an ACCT which included the man who is the subject of this report. The OSG said that he saw the man at 8.45pm which is reflected on the ACCT ongoing record. He was watching television, which the OSG confirmed in his interview with the police. The OSG then left the man's cell and continued with his other duties.

113. At about 9.30pm, the OSG said that he returned to the cell to check on the man again. On arrival at the cell, the OSG said that a sheet obscured the gap between the top and bottom bunk beds. He said that the man was facing the opposite wall, his knees were on the floor suspended half way down the bunks and he was partially covered by a sheet. The OSG immediately used his radio to call for emergency assistance. The control room incident log shows that this was done at 9.36pm. It also indicated that the OSG said that staff were "required immediately" on P wing and he identified the man's cell. The log noted that an RGN, the assist night orderly officer and the response team were all called at the same time. After the OSG asked for assistance, he kicked the cell door to try and get a response from the man. At this point an officer arrived.

114. The officer told my investigator that he was working on N wing, which is next door to P wing. He heard a call from control asking the emergency response nurse to go to P wing. As he was very close, he decided to respond to the call. He explained that he walked over to P wing where he found the OSG kicking the man's door. He noticed that the man had an orange card outside his cell which identified that he was being monitored by the ACCT processes. The OSG told the officer that he thought that the man was already dead. He opened the observation flap on the cell door and saw a towel over the end of the bunk beds near the door. The officer explained that he could see the man's hair and the lower half of his body. He added that his legs were splayed out behind him and were not supporting his body. He said that the man appeared to be suspended between the bunks.

115. The officer decided to go into the cell and used the key in the sealed pouch to open the door. Once inside, he confirmed that the man was hanging. He believed that he had wound together two bed sheets as if to make a rope. The OSG told the investigator that he too went into the cell and said that the man had rolled up his bed sheet. This had been passed around the top of the bunk bed mattress and frame and then knotted at the back near the wall. The other end of the sheet was used as a noose and another sheet had been used to obscure the view from the door.

116. The officer explained that he used his cut down tool (an implement designed to cut ligatures) to cut through the sheet. He recalled that it took two or three attempts as the sheet had been wound together and was quite thick. He then laid him on the floor. He told my investigator that his immediate thought was that the man had died as, although he was not cold to the touch, his eyes were open. He checked for a pulse, but he could not find one.

117. At this point, an officer from the response team arrived. During interview with my investigator, he said that he started his shift at 9.00pm as part of the prison's response team. He heard the emergency call over the radio for the response nurse to go to P wing. He felt that it was a serious matter and decided to respond. He was a short distance from P wing and estimated that it took him about two minutes to get there. When he arrived on the first landing, he shouted out "where are you?" The OSG called down to him that they were on the fourth landing and the officer went up to this floor. The OSG was outside the man's cell and said that he believed that the man was dead. The response officer then went into the cell and saw the officer from N wing with the man lying on the floor. He too noticed a ligature.

118. The officer from the response team checked the man for a pulse, but there was none. He examined the man's eyes and described these as "staring". He said that the man was warm to touch so he thought that the hanging had taken place recently. He twisted the man's ear, but there was no response. He and the officer from N wing then started CPR. (Cardio pulmonary resuscitation (CPR) is an emergency lifesaving procedure that is performed when a person's own breathing or heartbeat has stopped.) The officer from N wing passed him a face mask and he began rescue breaths whilst the officer from N wing did chest compressions. (Chest compression is a procedure that is part of CPR and consists of rhythmic applications of pressure over the lower half of the chest.) The officer from the response team said that the assist night orderly officer and the RGN arrived within a few minutes.

119. The RGN told my investigator that she was the emergency response nurse on that day, and was therefore located on B wing in the outpatient part of the healthcare centre. She had a radio, but did not have keys. The RGN explained that, in the event of an emergency, she waits for the night orderly officer to collect her. The RGN received an urgent call to go to P wing at about 9.30pm, but she was not provided with any details other than to attend the wing immediately. She picked up the emergency bag which contained a number of medical supplies including an oxygen mask, pain killers and bandages and then waited for the night orderly to collect her.

120. At around 9.35pm, the assist night orderly officer said in his prison statement that he heard (over his radio) the OSG ask for assistance on P wing and he collected the RGN. She told my investigator that, en route to the man's cell, she picked up an oxygen cylinder. She explained that P wing is situated some distance from B wing. On the way, a further radio call asked for the estimated time of arrival. The night orderly assist's prison statement shows that they got to P wing at approximately 9.40pm, four minutes after they

received the request from the control room. This time of arrival was also documented in the RGN's account on the clinical record.

121. Once they got to the man's cell, the RGN said that she found two members of staff performing CPR. She took over doing chest compressions. She asked the officer from N wing to telephone 999 to ask for an emergency ambulance. The assist night orderly officer said in his prison statement that he also contacted the control room to organise an ambulance. The control room log shows that they were asked at 9.40pm to call the ambulance, the same time that they arrived at the man's cell. The log recorded that an ambulance was called a minute later at 9.41pm.

122. The RGN also asked the officer from N wing to collect the blue emergency bag from the treatment room and she gave him her key to open the door. This bag contained more oxygen and a defibrillator (an electrical device that is used to restore a normal heart beat by applying a brief electric shock). However, he returned a number of times but said that he could not find the bag. The RGN refused to leave the man and so the defibrillator was not brought to his cell. Following her interview with my investigator, the RGN clarified that she did not consider that it was advisable to leave the man without a medically qualified member of staff. She documented on the clinical record that she continued to check him, but there were no signs of life. The officer from N wing confirmed that he was asked to get the blue emergency bag, but he told my investigator that he was unable to find it. He added that he was not familiar with P wing or the treatment room, but the OSG also looked for it and he could not find the blue bag either.

123. The officer from the response team continued to perform CPR until the paramedics arrived. The log shows that they got to the prison gate at 9.43pm, two minutes after the control room made the call, and they were escorted to P wing. Shortly afterwards, at 9.45pm and 9.46pm, respectively an ambulance and second paramedic arrived at the prison gate. They were all accompanied to P wing.

124. The assist night orderly officer said in his statement that the first paramedic reached the man's cell at 9.48pm, which was reflected in the RGN's account on the clinical record. This was seven minutes after the control room made the call for an ambulance. The RGN told my investigator that the paramedics arrived very quickly and they took over. The officer from the response team said that CPR continued until the paramedics got to the man's cell. On reflection, he felt that emergency first aid training would be useful for select staff, such as those who work at night.

125. The Night Orderly Officer completed a report to the Governor. He said that the paramedics pronounced the man dead at 10.12pm. His body was subsequently taken at 2.10am to the mortuary at outside hospital. The man's family said that they were notified about his death at 2.25am by the Governor and the duty governor who was on duty and could speak Punjabi.

126. Following the man's death, an immediate debrief was held with staff. Individuals interviewed by my investigator confirmed that they had been offered and received support. The man's funeral took place on 20 March.

127. The post mortem report concluded that the ligature mark on the man's neck was consistent with self-suspension (hanging). In addition, the pattern of injuries around this area was in keeping with the indication that his knees were on the ground. The report also found that the man had multiple areas of bruising to his upper limbs and "the pattern of which is suggestive of gripping type injuries". The report indicated that these would be consistent with the restraint that took place around two days prior to the man's death. It also noted that there were some injuries to his arms that suggested that restraint was at least at one point "relatively forceful". However, the forensic pathologist could not comment on the appropriateness of the restraint or whether excessive force was used. There was also an area of bruising to the man's lower back which was described as "more unusual". The report concluded that this could have been due to a "restraint type scenario" or as a result of "seizure activity" which is known to arise in those dying of hanging. Despite the gripping injuries, the forensic pathologist said that there were no injuries that suggested that he had been physically assaulted immediately prior to death and there were no further injuries, "such as black eyes, that must suggest that other forms of physical violence had been utilised during the restraint".

ISSUES

Clinical care

128. A clinical review of the man's medical care whilst he was in custody was carried out by a clinical reviewer on behalf of the Heart of Birmingham Teaching Primary Care Trust. In his review, he primarily raises concerns about the absence of an appropriate interpreter during key assessments. These will be reflected in the following sections.

The man's day two reception interview

129. As part of the reception process at HMP Birmingham, prisoners are interviewed during their second day at the prison. However, the man's reception form for the second interview was left blank. It is unclear why this occurred, but there was no evidence on any of his prison records to show that he was interviewed on 17 January 2010. This process is used to enable staff to assess whether there have been any significant changes after a prisoner's first night in custody. In particular, there is a focus on self harm and it provides an opportunity for staff to identify any fresh concerns. Whilst there was no evidence that there were any significant changes in the man following his first night, I am concerned that the absence of any record to show that he was interviewed indicates that this was not done. I therefore make the following recommendation:

The Governor should satisfy himself that prisoners are routinely interviewed and assessed on their second day in prison and this is recorded on the day two interview form.

Language barrier

130. When the man arrived at Birmingham, staff quickly identified that he could not speak English. The prison is fortunate to have Punjabi speaking members of staff and they were resourcefully used to communicate with him. This is evident during the resettlement officer's assessment on 18 January, and the Punjabi speaking officer's involvement in the control and restraint procedures. I was also pleased to see that arrangements are in place to ensure that Punjabi speaking members of staff are regularly on duty. It was especially useful that one of the governors speaks Punjabi. He was able to talk directly to the man and also with his family.

131. My investigator asked the two senior officers in charge of P wing whether the prison had any translation provisions in place. They both indicated that staff had access to 'Big Word' (a telephone translation service). It is notable that there was no record that this was ever used during the period that this man was at Birmingham. I am concerned that there was perhaps an over reliance on other prisoners to interpret during key assessments. The nurse used a prisoner who worked in reception as a cleaner when she completed the man's health screen. The clinical reviewer commented that "it was not appropriate" to use a cleaner "as an ordinary bystander" for this purpose. He went on to

say that it was unclear why the telephone translation service was not used. I note that prisoners were also used during other parts of the reception process and for the ACCT assessment interview.

132. Whilst it is fitting to use prisoners to explain the general regime, it is perhaps less advisable for them to interpret during key assessments, especially when it could involve the disclosure of private, confidential and sensitive information. I was therefore pleased to see that the minutes of the safer custody unit meeting held on 23 March, showed that each wing was going to be issued with a 'Big Word' pin number. This was "in an effort to promote the system and put it to better use". I trust that this is now fully operational. In such circumstances, I make no recommendation, but this suggests to me that 'Big Word' was probably under used in the prison.

133. Problems with communication were also highlighted during the man's ACCT observations. Both the OSG and officer indicated that they could not talk to him due to the language barrier, although they both made efforts to do so. An Urdu speaking officer was on duty on the day of the man's death, and he was in a position to speak in Punjabi. However, after his departure the ACCT ongoing record showed that the non-speaking Punjabi/Urdu officer mainly made the subsequent observations. Due to the language barrier, the OSG and officer were reliant on their observations alone. This left both members of staff and the man unable to communicate with each other at a time when there were concerns about his risk of harm. I therefore make the following recommendation:

The Governor should ensure that staff can effectively communicate with non English speaking prisoners who are at risk of harming themselves and being supported by ACCT monitoring.

134. There were two other occasions when communication with the man was an issue, but these will be addressed in the following sections.

The man's contact with his family

135. The man was in custody for 37 days and throughout this time he had no direct contact with his family. There is no Prison Service policy that stipulates that prisons must notify the family of a prisoner who has been remanded in custody. My investigator asked the second senior officer in charge of P wing about what the prison can do to help prisoners keep in touch with their families and facilitate it. She explained that staff "to a point" encourage such contact. In addition, prisoners are shown how to put their telephone numbers on the system. She said that there is always a duty governor who can be contacted if it is a "real crisis" to arrange a visit for a prisoner. When such a request is made, she indicated that this has been acted upon "quite well".

136. On the day the man arrived at Birmingham, he did not use his two minute reception telephone call. Efforts were subsequently made by the prison to help him contact his family. This is evident by the commendable assistance given by the Punjabi speaking officer in terms of obtaining the man's home

address and writing a letter to his father on 1 February. In addition, the first senior officer in charge of P wing said that staff encouraged the man to use the telephone and they tried to help him with his visits and telephone lists.

137. The information from the second senior officer in charge of P wing shows that the man was confused about the telephone list as he filled in the form incorrectly. This is perhaps unsurprising given that he spoke very limited English and he could not read it. However, he was subsequently given help to rectify the matter. The man's lack of contact with his family via telephone was probably compounded because he was unable to identify their telephone number from his diary, despite the assistance of the Punjabi speaking officer. In addition, the letters to his father show that he could not recall his home number and he asked twice for this information. This may perhaps explain why he did not use his two minute telephone call on 16 January. In the absence of a telephone number, I consider that it was difficult for the prison to take any further action. In these circumstances, I am satisfied that Birmingham made reasonable attempts to try and facilitate the man's telephone contact with his family.

138. The information from Birmingham shows that the man was also given assistance with completing his visitors list. It is evident that this was done because both the man's mother and father were approved as visitors and were therefore authorised to visit him. In addition, he had a visitors PIN code which he mentioned in his second letter to his father. This demonstrates that the relevant measures were in place so that he could receive visits from his parents. Whilst there was no record that his brother was approved, I am satisfied that the prison provided the man with assistance to ensure that he was in a position to receive visits from some of his family.

139. The man's family said that they first went to the prison the day after they received his letter, but it was unclear whether this related to the one that arrived around 5 or 6 February. There is no requirement for prisons to record unannounced visits by friends or family. However, Birmingham checked both 6 and 7 February and they had no record of the man's family going to the prison on either of these dates. This does not mean that it did not happen, but in the absence of such information it has not been possible to explore what took place.

140. The prison provides general information about how they communicate with visitors who do not speak English. They said that staff are instructed to use 'Big Word'. The foreign national manager confirmed with the prisoners' visitors centre (where all visitors report on arrival) that this is the case. However, the visitors centre also indicated that they use pictures and other visitors to interpret. According to the man's family the latter happened when they first attended the prison. It is possible that the visitor may not have translated correctly, although this is pure speculation.

141. The man's family's account of what took place when they went to the prison on 9 February is supported by the prison's records. They confirm that the man's mother and father were booked in to visit him on this date. Birmingham

also explained that a visit did not take place because the man's parents did not have the necessary identification. However, his family said that they were not told about this requirement. Again, in the absence of a record of the earlier visit, it has not been possible to determine what information his family may have been given about visits. Whilst the man's family do not raise concerns about the visit on 10 February, I am disappointed that there was no indication why it was cancelled.

142. There was again no record of the man's family going to the prison on 19 February or any evidence that a visit was booked on this day. However, my investigator confirmed that visits are permitted on Saturdays, although 19 February, was a Friday. Nevertheless, his family indicated that they asked for a Punjabi speaker, but no one was available.

143. There is no reason to doubt that the man's family attempted to visit him on a number of occasions. Based on their account of events, they were clearly frustrated by the language barrier. I am therefore concerned to learn that other visitors are used to translate, along with pictures, despite the instruction to use 'Big Word'. This runs the inherent risk that key information is not effectively communicated to non English speaking visitors. In this case, it is likely that this may have contributed to the man's family being unable to visit him at a time when they were very concerned about his welfare. I make no recommendation because I have been unable to fully establish what took place when his family visited the prison. However, the Governor may want to consider reminding staff in the visitors centre to use 'Big Word' in line with local instructions.

144. Birmingham has provided a copy of their draft 2010 foreign national prisoners policy. It defines a foreign national prisoner as a person who is not a British citizen. I am pleased that it has a specific section on telephone calls, letters and visits. This includes the provision for all foreign national prisoners to have one five minute telephone call at public expense per month. In addition, they will be eligible for this facility if they have not received a visit during the previous month. There was also reference to the prison visitors scheme for those prisoners who have not received regular visits. The draft policy refers to contact through letters, but this is restricted to the provision of airmail letters. However, the man was unable to read or write and his family are resident in England. He was only able to write to his father thanks to the assistance of both a Punjabi speaking officer and a fellow prisoner.

145. Since the man's death, Prison Service Instruction (PSI) 52/2010 has been published in October 2010, and it sets out the procedures for the induction of prisoners. It specifies in paragraph 3.26 that;

> "Any special needs of particular categories of prisoners, such as foreign national prisoners (e.g. lack of knowledge of English or local customs, family contact issues) … must be addressed."

146. I am pleased that this instruction has been issued to prison staff. However, I remain concerned that there is no formal facility in place at Birmingham to

assist non English speaking prisoners who are unable to read or write to correspond with their family. In keeping with PSI 52/2010, I make the following recommendation:

The Governor should ensure policy is in place to help foreign national prisoners, who are unable to read or write, to communicate with their family through letters.

The response to the man's request to share a cell with a Punjabi speaking prisoner

147. During the reception procedures on 16 January, the man said that he preferred to share a cell with a Punjabi speaking prisoner. He repeated this request during his interview with an ACCT assessor on 22 February, when it was also identified that he was lonely.

148. The second senior officer in charge of P wing indicated that the man shared a cell with at least three prisoners during his 37 days at the prison. The reasons for the first change stems from the release of one prisoner. An Urdu speaking officer described this individual as a Muslim, but there was no indication whether he spoke Punjabi. However, the main reason for the other changes related to prisoners' concerns about the man's "bizarre" behaviour which was viewed as "not right". On one occasion the first senior officer in charge of P wing said that the man made a "sexual approach" towards another prisoner, but there were no further details about this incident. The second senior officer on P wing indicated that the man had pulled down his trousers, but it is not clear whether these events were linked. The information from the prisoner provides some specific details about why he asked to be moved. This again was due to the man's behaviour and the language barrier.

149. The other concerns about the man's behaviour were coupled with the reluctance of his peers to share a cell with him. The second senior officer in charge of P wing explained that one of her primary concerns is to ensure that the prison provides a safe environment for all prisoners. She said that she has to look at whether it is safer to separate prisoners "even if one is a little bit down in mood".

150. Both the reluctance of Punjabi prisoners to share with the man, together with the repeated requests by other prisoners to be moved, placed Birmingham in a difficult position. I appreciate that staff had to strike a balance between trying to accommodate both the needs of the man and other prisoners. Under these circumstances, I am satisfied that they made reasonable attempts to try and fulfil the man's request, although this was not always with a Punjabi speaking prisoner.

The response to concerns about the man's mental health

151. Following the man's reception health screen on his first day, no concerns about his mental health were identified. Just over two weeks later on 1 February, a Punjabi speaking officer documented that there had been no

problems with the man since he was placed on P wing. This appears to reflect the second senior officer's recollection that there was a "very quiet period". However, both senior officers in charge of P wing said that staff repeatedly got feedback from other prisoners that something was "not right". There were also concerns about the man's "bizarre" behaviour and that the prison regime frequently had to be explained to him. There is limited information about the former as the first senior officer said that other prisoners were not specific. However, he did say that this involved the man pacing his cell and a "sexual approach" towards another prisoner. There are insufficient details to determine whether action should have been taken at this point. Regardless of this, I consider that it would have been prudent for staff to try and establish some further information. The concerns from other prisoners about the man's behaviour were not an isolated incident and therefore warranted some investigation.

152. Coupled with these concerns, there was an incident on 20 February when an officer recorded that the man had bent or chewed through the television and kettle electrical cables. Whilst he wrote that this was not the first occasion that this had happened, my investigator was unable to find any record of any similar incident. In addition, the officer was unable to identify the source of this information. There were also different accounts of what happened. The RMN wrote on the clinical record that he was told that the man had chewed through the television electrical cable when it was plugged into the electrical socket and switched on, but the first senior officer said that this did not happen. He indicated that, during cell checks, staff discovered that the electrical cables were splayed and they believed that he had done this with his teeth. However, the RGN said that he was told that staff saw the man chewing the cables. Due to the conflicting versions from staff, it was not possible to determine what precisely took place. Despite this, I am satisfied that there were concerns that he had damaged the electrical cables. In addition, it is likely that he used his teeth to do it and this may have happened on more than one occasion.

153. Due to the health and safety concerns, I think that it was reasonable for the officer to remove the television and kettle from the man's cell. He indicated that he told a SO about it, although he did not record that this was done. However, the first senior officer was clearly aware that this incident had taken place. Given the nature of the man's behaviour, coupled with the earlier concerns, I am surprised that no further action was taken. Whilst the second senior officer believed that the man was referred to the prison's mental health team, there is no record to show that this occurred. The first senior officer indicated that staff did not understand why the man was damaging the cables, yet there was no evidence that attempts were made to try and determine the cause of his behaviour.

154. In addition to these events, the accounts from the majority of staff who saw the man on P wing on 21 February, show that he was extremely distressed, agitated, incoherent and tearful. While he was unable to explain his behaviour, staff were able to determine that he did not want to be on his own. The RGN saw him promptly and he was sufficiently concerned to ask an RMN

to assess him. Again, this was done promptly and he then concluded that the man was "very unwell" and should be admitted to healthcare. The clinical reviewer notes that the RMN's assessment was completed without an interpreter. However, I am content that a Punjabi speaking officer was present when the RMN saw the man. Furthermore, due to the man's distressed state, I believe that it would have been inappropriate to use 'Big Word' at this point.

155. Once the man was moved to the healthcare unit, he began to exhibit similar behaviour when attempts were made to leave him in the cell. The significant difference is that he said that he would hang himself if he had to remain there. The duty governor was kept informed of events that evening and subsequently went to healthcare where he was able to witness the man's behaviour for himself.

156. Prior to the duty governor making his decision to move the man back to P wing, he indicated that he spoke to him and staff. However, there were evidently two conflicting views about how the situation should be managed. Both the RGN and RMN said that they told the duty governor that the man should remain in healthcare with constant supervision. The RGN felt that they had been "overruled" by the duty governor, although he acknowledged that the decision was complicated.

157. In interview, the RMN believed that the man may have suffered a "psychotic episode". He attributed this to the stresses of the man being in prison, the nature of his offence, the language barrier and lack of contact with his family. The RMN felt that the man's behaviour on 21 February was consistent with this judgment. He said that he was strongly of the opinion that he needed a proper psychiatric assessment. The RMN added that what the man wanted in these circumstances was "irrelevant". He considered that the man should have been kept in the constant supervision cell for his own safety. The RMN said that the crux of the matter was that he was ill and needed to be on healthcare. He noted that, in his experience, many prisoners exhibit the same type of behaviour as this man when they arrive on healthcare, but eventually calm down after a while.

158. In view of the man's similar behaviour on both P wing and healthcare, I appreciate that the decision was very finely balanced. The duty governor was in the fortunate position of being able to communicate and establish a rapport with the man. He appropriately checked his mental health background. I have no doubts that his decision to move him back to P wing was driven by his concern about the man's wellbeing.

159. I have carefully considered the information that was available at the time that the decision was made to move the man back to P wing. Due to the growing mental health concerns, I consider that it would have been advisable for him to remain on healthcare. Whilst he gave his assurances that he would be fine on P wing, the available information at the time appeared to suggest otherwise. Although it is imperative that the views of prisoners are taken into account, I think that there was an over reliance on what the man said about

staying in healthcare. There may also have been too much emphasis placed on the absence of any information of prior mental health problems, together with the indication that he was not having any treatment. This is important to consider, but there had been growing concerns about his mental health from both prisoners and staff. The second senior officer in charge of P wing said that she felt that these were “significant”. The duty governor was certainly aware of the incident involving the electrical cables and that other prisoners felt “uncomfortable” with him. The events on 21 February represented a significant deterioration in his condition. At this juncture, neither staff nor the man could account for this or any of his earlier behaviour. In my view, the man’s explanation that the removal of his television caused his behaviour did not provide a sufficient reason for the events on that day. In addition, whilst it was suspected that his behaviour may have been due to the use of drugs, there was no evidence to support this suspicion.

160. There is no way of knowing if the man’s life may have been saved if he had stayed on the healthcare unit. However, I am surprised that the duty governor did not follow the advice of both the RMN and RGN. I would be even more critical if the duty governor had not been able to speak to the man in his own language. In my experience it is very unusual for the views of clinical staff to be overruled by non clinical staff. The nurses both gave the impression during interview that they had strongly indicated that he should remain on healthcare. Such a course of action would have provided an opportunity for a thorough mental health assessment to be completed. In addition, this may have determined whether a mental illness was causing the man’s concerning behaviour. The prison would then have been in a better position to decide what action should be taken.

161. Once the man was moved back to P wing, he was placed on ACCT monitoring. The level of care shown to him by staff, and particularly the duty governor, is worthy of mention. He spent time with the man and went through his legal paperwork. In addition, he was given something to eat and he met a Listener. However, I am surprised that he was provided with a television given that he had previously damaged the cable. The first senior officer noted that there was a complete change in the man’s behaviour when he returned to P wing. In addition, other staff felt that he appeared to be a lot calmer. There was no record of any further concerns on 22 February.

162. On the day of the man’s death, the RMN’s assessment from the prison’s PCMHT presented another opportunity to assess the man’s mental health. Again, he saw the man quickly following the referrals by the first RMN and the second senior officer the previous day. However, whilst the second RMN said that he knew that the man had threatened to kill himself, I am concerned that he was unaware of the open ACCT. This is surprising given the RGN wrote on the clinical record two days previously that he was on an ACCT. Furthermore, there was a handwritten note on the TAG referral form to say that reference should be made to EMIS. I therefore make the following recommendation:

The head of the mental health team should ensure that, prior to undertaking mental health assessments, nurses should find out whether the prisoner is being supported by the ACCT procedures.

163. I am concerned that the RMN from the prison's PCMHT assessed the man even though he could not effectively communicate with him. The clinical reviewer also highlights that this was done "without any help from language support". The RMN has subsequently acknowledged to both my investigator and the clinical reviewer that, with hindsight, an interpreter should have been used. However, the need for one was evident at the time of the assessment. This is reinforced by the second RMN's own observations on the clinical record that the man's English was "very limited". I do not consider that his ability to point out various objects was a sufficient demonstration that he understood the second RMN.

164. The RMN from the prison's PCMHT also acknowledged that he found it difficult to make a proper assessment because of the difficulty communicating with the man. Again this is reflected in his record and recollection of the man's responses. Despite his concern that he was unable to assess the man because of the evident language barrier, he still managed to conclude that he did not appear to have any plans or thoughts of self harm. In addition, without being able to talk to the man, the RMN decided that he did not require immediate mental health intervention. I view both the man's very limited responses and his "over friendly" manner as inadequate grounds for such judgements. I therefore make the following recommendation:

The head of the mental health team should ensure that an approved interpreter is used during all mental health assessments for non English speaking prisoners.

165. On the day of the man's death, the man's cellmate's recollection suggests that he had neglected his personal hygiene, although staff on the wing did not identify this as an issue. The second senior officer in charge of P wing said that one of the reasons for the cellmate's move related to the man's "unusual behaviour". However, his account of the man obsessively rearranging his possessions and pacing his cell suggests that there was a more significant problem.

Constant supervision

166. Prison Service Order (PSO) – 2700 sets out the Prison Service's policy on suicide prevention and self harm management. This says that constant supervision can only be authorised by a doctor or nurse in consultation with the duty governor or the duty governor in consultation with a nurse or doctor. When the RMN first saw the man on 21 February, on P wing he said that he contacted healthcare and arranged for a constant supervision cell to be made available. However, there was no indication that the duty governor was consulted about it. In this case, it is not significant because constant supervision was not put in place. However, it is worthy of mention as the

Governor may want to satisfy himself that healthcare staff are aware of these important procedures.

The use of control and restraint on the man

167. On 21 February, during the afternoon and early evening, control and restraint was used on the man on a number of occasions. The first, at tea time, followed the incident when he refused to leave the cell of two other prisoners. Based on the available information, staff tried to encourage him to follow instructions, but he did not do so. A Punjabi speaking member of staff was not initially available on P wing and the second senior officer quickly asked for one. A Punjabi speaking officer arrived and he was able to communicate with him in Punjabi. In line with Prison Service policy, the man was examined by an RGN for any injuries and none were found, although he complained of mild pain in his right wrist.

168. Control and restraint was used on a further two occasions in healthcare. There were also two instances when staff had to physically intervene to prevent the man from injuring himself. He was checked again by the RGN on healthcare and also when he returned to P wing. There was no record of any significant injuries or substantial complaints from him following the use of control and restraint.

169. I am mindful that the post mortem report shows that the man had multiple bruising to his upper limbs which is "suggestive of gripping type injuries". However, these were found to be consistent with the restraint that took place in the two days prior to his death. The forensic pathologist also found that, on at least one occasion, restraint was "relatively forceful", but could not comment on whether it was appropriate or excessive. "More unusual" bruising was found on his back and two possible explanations were offered for this injury. These related to the use of restraint and "seizure activity". Despite the gripping injuries, the forensic pathologist said that there was no indication that he had been physically assaulted immediately prior to his death. In addition, the report noted there were no further injuries which suggested that other physical forms of violence had been used during the restraint.

170. I appreciate that the man's family may be concerned about the use of control and restraint as well as the level of bruising that he sustained. Based on the use of force paperwork, I am satisfied that the Prison Service's procedures on the use of control and restraint were followed. I also found no evidence to suggest that the use of force was unreasonable or disproportionate.

The man's ACCT review on 22 February

171. Annex 8G of PSO 2700 sets out the procedures for the first ACCT review. Paragraph 14 says that where there are mental health issues, an appropriate member of healthcare staff must be invited to make a contribution to the first review, in writing or by telephone if they are unable to attend at such short notice. It adds that the appropriate member of the chaplaincy team must also be invited to attend. At the man's first ACCT review, the only two members of

staff who were present were the second senior officer in charge of P wing and the ACCT assessor. There is no evidence that healthcare were invited to attend or contacted to make a contribution to the meeting. I accept that the man appeared to react adversely to contact with healthcare staff but I consider they should have been invited to attend, especially given their involvement with him the previous day. Had he objected then a decision to exclude them could have been made on that basis. The absence of healthcare staff highlights HM Chief Inspector of Prison's finding in 2009, that many ACCT reviews at Birmingham were not multidisciplinary.

The Governor should ensure that an appropriate member of healthcare staff and a member of the Chaplaincy are routinely invited to ACCT reviews, especially when a prisoner has mental health concerns.

172. The record of the first ACCT review shows that an interpreter was used, but the individual was not identified. I consider that it would have been good practice to record this information. However, I am pleased to see that Birmingham's 2010 draft policy on foreign national prisoners addresses this issue. It specifies that 'Big Word' or an accredited interpreter must be used during ACCT reviews for foreign nationals who are not fluent in English. I trust that the policy will be finalised in the near future to ensure that this can be put in place.

173. I am surprised that the man's observations were reduced less than 24 hours after he was placed on ACCT monitoring. The rationale for this decision was not explained on the record for the first review. The second senior officer in charge of P wing told my investigator that she tries not to continue to make five observations an hour if the prisoner is not "presenting that much of a risk". She added that there is no rush to increase or reduce the level of observations. The second senior officer recalled that she tried to speak to the man on his own, but she "did not get very far". This is unsurprising given that his English was very limited. However, based on the ACCT assessor's assessment, the information from staff and the little communication with the man, the second senior officer told my investigator she felt "completely justified" that two observations was sufficient. She considered that this was high enough for staff to keep an eye on the man, but low enough to be "kind of discreet and not at his door all the time".

174. It was entirely appropriate for the man's observations to be reviewed. However, prior to making the decision it would have been prudent for the second senior officer to have obtained information from healthcare and awaited the outcome of the referral to the CPN. Particularly, as she considered that there were "some significant mental health issues".

175. The care map (a form to identify the concerns and how these will be managed) reflected the man's frustration with communication and it also addressed the mental health concerns. However, there was no evidence that the review considered what could be done to link him with people who could provide support, especially his family. This was despite the prompt on the form that this should be explored. I appreciate that during the ACCT

assessor's assessment, he indicated that he was in contact with his family. However, he also said that he was frustrated about being on his own, with no one to talk to and feeling lonely. His sense of isolation was evident by his inability to speak English, the frequent moves of other prisoners from his cell and their reluctance to share with him. Furthermore, it was known that he had repeatedly asked to go home and he did not understand why he was in prison. In such circumstances, this area warranted some consideration. I make the following recommendation:

The Governor should ensure that ACCT reviews consider what support can be given to non English speaking prisoners and this should be reflected in the record of the case review.

The OSG's response when he discovered the man

176. On 26 January 2010 the Chief Operating Officer in the National Offender Management Service (NOMS), issued instructions to all prison governors on the actions that staff should take on discovering a prisoner who has self harmed through hanging. His letter says that:

> "… before entering a cell every effort should be made to gain a verbal response from the prisoner. This together with what the member of staff can observe through the panel and any knowledge of the occupants, should inform a rapid dynamic risk assessment of the situation and a decision on whether to enter immediately or wait for assistance."

177. When the OSG went to observe the man around 9.30pm, he did not have a full view of him as he was facing the opposition direction. He promptly radioed for assistance. In line with the instructions, he tried to gain a response from him by kicking the door. The officer's account showed that he arrived at this point. He made a rapid assessment and decided to go in the man's cell. I am satisfied that the OSG took the appropriate action. In addition, due to the prompt arrival and actions of the officer there was no evidence that there was a delay in staff going into the man's cell.

Code system for emergencies and location of the defibrillator

178. A common theme to emerge from some of my recent investigations at Birmingham, and an earlier one at the prison, is the lack of a proper code system when officers needed to communicate with colleagues over the radio net in an emergency. The emergency response nurse told my investigator that she was not provided with any details about the nature of the emergency, but she felt that this would be helpful.

179. Following an investigation in 2008, I made no recommendation about the introduction of an emergency code. However, I invited the Governor to consider introducing one. In a more recent investigation of another death in 2010, which is currently in draft report, the Governor indicated that Birmingham were in the process of introducing emergency codes. Subsequent enquiries in August 2010, found that Birmingham had decided

not to implement a code system. This was on the basis that all the necessary equipment was contained in one emergency bag and therefore managers had agreed that a radio call of “emergency assistance” was sufficient. However, this emergency bag does not contain a defibrillator. There is no mandatory requirement for prisons to use a particular code, but I believe that it is beneficial as it alerts staff about the nature of the emergency, helps them to prepare mentally and enables clinical staff to take the necessary medical equipment if they are in a position to do so. I understand that work is underway to establish a national emergency code system. However, in the meantime, I repeat my previous recommendation:

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

180. The location of the defibrillator was evidently an issue in this man’s case. The emergency response nurse appropriately asked the officer to get the defibrillator, but he was unable to find it. They both attributed this to his lack of familiarity with P wing. The nurse told my investigator that she later checked the treatment room and found the blue emergency bag with the defibrillator.

181. The clinical reviewer does not comment on whether the lack of a defibrillator had an impact on the attempts to revive the man. However, according to the officer, the man showed no signs of life and the emergency response nurse confirmed that this was the case. In such circumstances, it appears that the man was already dead when he was found and the defibrillator is unlikely to have made a difference to the outcome.

182. Prompt access to a defibrillator is crucial to increase the chances of resuscitating a prisoner who has stopped breathing. The introduction of an emergency code would help to alert clinical staff that a defibrillator is required. This could then at least permit clinical staff to take it en route to the emergency. However, since the man’s death, the emergency response nurse told my investigator that the blue emergency bags, containing the defibrillators, have now been moved from the wing treatment rooms to the wing offices so that wing staff know where to find them. I am pleased that Birmingham has taken action to rectify the matter. In such circumstances, I make no recommendation, but the Governor will want to satisfy himself that all staff are aware of the location of the defibrillators.

CONCLUSION

183. The man was a Punjabi speaking Indian foreign national whose English was very limited. He appeared in court on 16 January 2010, and was remanded to HMP Birmingham after he had failed to comply with his bail conditions.

184. During the man's first day, the prison established that he could not speak English, read or write. Despite the availability of a telephone translation service, I am disappointed that it was not used during the 37 days that he was at the prison. Difficulties with communication were particularly evident during some of the ACCT observations and the assessment undertaken by a registered mental health nurse on the day of his death.

185. The lack of any family contact is notable. I am satisfied that the prison made reasonable efforts to try and facilitate it, although Birmingham has no formal structures in place to assist foreign national prisoners with literacy problems to correspond with their families. I am in no doubt that his family attempted to visit him, and they were very concerned about his welfare, but I have been unable to establish exactly what occurred when they attended the prison. However, I am concerned that again, despite the availability of a telephone translation service for non English speaking visitors, this does not appear to have been used.

186. No self harm or mental health concerns were identified in the course of the reception process. During the man's first two weeks at Birmingham, there was no record of any problems. The first documented concern occurred three days prior to his death. However, prior to this he displayed some worrying behaviour which may have suggested an underlying mental health problem, but there was no evidence that any action was taken. He was then admitted to the healthcare unit two days before he died. Due to the reoccurring concerns about his mental health and behaviour, I consider that it would have been advisable for him to remain on healthcare for a thorough psychiatric assessment to be undertaken. I cannot say with any certainty whether this may have prevented his death. However, I am content that the care and action that was taken after he returned to his wing was appropriate. There were no further concerns about his behaviour. He appeared to be much calmer and settled down. There was no indication that he intended to take his own life on the wing.

187. There are a number of areas that I consider could be improved. I make eight recommendations related to the second day reception interview, communication with non English speaking prisoners, ACCT reviews, mental health assessment, facilitating family contact and use of an emergency code.

RECOMMENDATIONS

1. The Governor should satisfy himself that prisoners are routinely interviewed and assessed on their second day in prison and this is recorded on the day two interview form.

   This recommendation was accepted at draft stage. The prison commented: "All prisoners are interviewed and assessed on their second day at HMP Birmingham and this is recorded in the Guided Document."

2. The Governor should put provisions in place to ensure that staff can effectively communicate with non English speaking prisoners who are on ACCT monitoring.

   This recommendation was accepted at draft stage. The prison commented: "Staff can access "The Big Word" telephone translating service if there is no member of staff available who is able to speak the language of the prisoner."

3. The Governor should ensure policy is in place to help foreign national prisoners who are unable to read or write to communicate with their family through letters.

   This recommendation was accepted at draft stage. The prison commented: "Foreign National Policy to be reviewed with a view to putting procedures in place for prisoners to communicate with family through letters in their own language when they are not able to read and write."

4. The Head of the Mental Health Team should ensure that prior to undertaking mental health assessments nurses should find out whether the prisoner is being supported by ACCT procedures.

   This recommendation was accepted at draft stage. The prison commented: "The Primary Mental Health/In-Reach team do prior to carrying out assessments ascertain if the prisoner is on an ACCT."

5. The Head of the Mental Health Team should ensure that an approved interpreter is used during all mental health assessments for non English speaking prisoners.

   This recommendation was accepted at draft stage. The prison commented: "Where it is required approved interpreters are used on the initial assessment and further reviews to ensure accurate assessment and recommendations."

6. The Governor should ensure that an appropriate member of healthcare staff and a member of the Chaplaincy are routinely invited to ACCT reviews, especially when a prisoner has mental health concerns.

   This recommendation was accepted at draft stage. The prison commented:

"Primary Care Mental Health/In-reach team will attend reviews of those prisoners on their caseload and attend if it is felt that mental health input is required.

It is not always possible to have a member of the Chaplaincy at a review due to the workloads of the department, although if there is a specific need they are informed and invited to the review."

7. The Governor should ensure that ACCT reviews consider what support can be given to non English speaking prisoners and this should be reflected in the record of the case review.

   This recommendation was accepted at draft stage. The prison commented: "When it identified that there are specific language problems then appropriate arrangements are made to support the prisoner – such as putting someone who speaks the same language into the cell with the prisoners. This is documented during the review process and the care map is updated to reflect the same."

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

   This recommendation was partially accepted at draft stage. The prison commented:
   "The emergency response staff carry bags that have the all the equipment to deal with all emergency situations – whether breathing difficulty or severe bleeding. De-fibrillators are located at 9 prominent sites throughout the prison. A Colour coded system would not make the response system any more expedient than it is as it stands."