A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Birmingham in April 2013

Our Vision

*‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’*

This is the investigation report into the death of a man who was found hanging in his cell at HMP Birmingham in April 2013. He was 27 years old. I offer my condolences to his family and friends.

A review of the man's clinical care and treatment at Birmingham was undertaken. The prison cooperated fully with the investigation.

The man was serving a short sentence and had been at Birmingham for just a week before his death. He had been held in the segregation unit since his second day at the prison after exhibiting strange and threatening behaviour and after his cell mate had made an allegation of sexual assault, which was later retracted. At first, staff suspected that he had a mental health problem, but it became apparent that he was under the influence of an illicit drug which he said he had smuggled into the prison and hidden internally.

As the effects of the drug wore off the man seemed to settle. He moved to a standard prison wing but immediately he reached his new cell he appeared to suffer an anxiety attack and asked to return to the segregation unit. He was reviewed by a mental health nurse who did not consider he was at risk of suicide and self-harm and arranged for a psychiatrist to see him the next morning. Sadly, he hanged himself that night and could not be resuscitated when he was found.

While it might not have changed the outcome, I am concerned that no immediate action was taken to search the man's cell or test him and take any appropriate follow-up action once it was known he had an illicit substance in his possession. None of the staff who assessed him considered he was at risk of suicide. While I think it would have been difficult for staff at Birmingham to have anticipated his actions, it is not clear that all of his risk factors were taken into account when assessing his risk and whether he needed further support.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

CONTENTS

Summary

The investigation process

HMP Birmingham

Key events

Issues

Recommendation

SUMMARY

1. The man arrived at HMP Birmingham on 23 April 2013. He was moved to the segregation unit the next day after the prisoner he had shared a cell on his first night alleged that he had sexually assaulted him.

2. The man's behaviour was described as bizarre and threatening. Officers wondered if he was suffering from a mental illness. He was assessed several times by mental health nurses, but it remained unclear whether or not he was mentally unwell.

3. On the afternoon of 26 April, an officer saw the man snorting something in his cell through a rolled paper tube. He said it was M-cat[1] that he had brought into prison hidden in his rectum.

4. The man continued to behave unusually for the next few days but by 28 April, he began to settle and he told a nurse that he had finished his supply of M-cat. That afternoon officers discussed with him the possibility of returning to a standard prison wing but he seemed reluctant. A few days later he agreed to move but when he reached the wing, he told the officer escorting him that he could not cope with being surrounded by so many people. He asked to return to the segregation unit and was taken back.

5. That afternoon two mental health nurses assessed the man. They did not regard him as at risk of suicide and self-harm and arranged for the prison psychiatrist to review him the next morning.

6. When the man was checked at 11.00pm that night, he was hanging from a noose that he had attached to a wall fixing. Officers cut the noose and attempted resuscitation assisted by nurses who arrived quickly. Paramedics arrived soon after and took charge of the resuscitation attempts. Sadly all efforts proved unsuccessful and he was pronounced dead at 11.34pm.

7. We believe that staff should have adopted a more proactive response to establish precisely what drugs the man was taking, confiscate them if possible or persuade him to surrender them. They should also have considered more consistent observation checks or support under the suicide and self-harm measures. We are also concerned that when he was found, staff did not fully adhere to the emergency response procedures.

[1] M-cat, is mephedrone, a synthetic stimulant drug of the amphetamine and cathinone classes. The drug is also known by the slang term meow meow. Until April 2010 mephedrone was considered a party drug or 'legal high'. However, following concerns about its side effects, the drug was reclassified as an illegal class B drug.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Birmingham informing them of the investigation and inviting them to contact the investigator if they wished to be involved. No prisoners came forward in response.

9. The investigator visited HMP Birmingham on 3 May 2013 and met the Director, the Head of Safer Custody, a representative from the prison officers' trade union and the Chair of the Independent Monitoring Board. He visited the segregation unit (known as the care and separation unit at Birmingham) where the man died. He obtained copies of his prison and health records. He subsequently interviewed 19 members of staff and one prisoner at Birmingham.

10. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation and a copy of this report has been sent to him.

11. South Staffordshire and Shropshire Healthcare NHS Foundation Trust appointed a clinical reviewer to review the clinical care the man received at Birmingham.

12. One of the Ombudsman's family liaison officers contacted the man's mother and his partner. He and the investigator visited them separately and both raised a number of issues for the investigation to consider. Their questions included:

    - Was he searched for drugs when he arrived at the prison?
    - Why were the drugs not taken from him?
    - Why was he not moved to a healthcare bed?
    - What medication did he receive?
    - What frequency of checks were made while he was in the CSU?
    - How had he been able to unscrew a ducting bolt to use as a ligature point?
    - Why was broken glass and so much blood in the cell when they visited after his death?

13. We have addressed some of the issues within this report and others in correspondence with the family.

HMP BIRMINGHAM

14. HMP Birmingham is a large local prison, principally serving the West Midlands courts. It holds a maximum of 1450 remand and sentenced men. Since 1 October 2011, it has been managed by G4S Care and Justice Services. Healthcare services are commissioned by Birmingham and Solihull Primary Care Trust (PCT). The prison healthcare centre operates 24 hours a day.

Her Majesty's Inspectorate of Prisons

15. HM Inspectorate of Prisons carried out an announced inspection of Birmingham in January 2012. The Inspectorate found that:

    "Planned [forced moves of prisoners] were well organised with events filmed from the initial briefing to the post incident debrief. Briefings were attended by a health care professional and discussed in detail the use of personal protective equipment and mechanical restraints ... Incidents reviewed showed that mechanical restraints were properly authorised, used as a last resort and removed as soon as the prisoner was no longer violent and refractory.

    "During the week of the inspection, two prisoners were located in the segregation unit … It was very commendable that there was such little use of the segregation unit in such a large prison. However, in one other case a prisoner …. was inappropriately managed on a residential wing … The segregation unit was clean and well ordered and cells were well furnished … Interactions between staff and prisoners in the unit were good … Staff working in the unit had received training for the role but none had attended mental health awareness, personality disorder or motivational interviewing training."

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community, who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In their annual report for 2011-2012, the Board were satisfied that the suicide and self-harm procedures were carried out correctly. They noted that the safer custody team completed frequent checks of appropriate paperwork and reviews, and personally visited any prisoner causing particular concern. The Board also commented on problems caused by the closure time of the prison pharmacy.

Previous deaths

17. The man's death was the eighth of nine apparently self-inflicted deaths at Birmingham since February 2010. As with his, two of the previous deaths occurred shortly the prisoners' arrival at the prison: one within five days and the other within nine days. There were no other close similarities between the circumstances of those deaths and that of his.

KEY EVENTS

18. The man arrived at HMP Birmingham during the afternoon of 23 April, after being arrested for failure to surrender to custody following a conviction for theft. He had been sentenced to 62 days imprisonment and his expected release date was 23 May 2013. He had previously been at the prison on 1 January and was released on bail the next day. At that time, reception staff had placed him on suicide and self-harm monitoring as he had made a noose from clothing and threatened to hang himself while he had been in police custody.

19. In line with standard practice, prison staff strip searched the man when he arrived at the prison. These searches are for visible items and prisoners are not routinely asked to bend or squat. During reception screening, he had separate interviews with a nurse and a prison officer. At both interviews, he said he had never harmed himself and had no thoughts of suicide or self-harm. (The information that he had been on suicide and self-harm monitoring in early January was available on the electronic prison record but does not seem to have been noticed.) He said he did not use alcohol or drugs. From reception, he moved to a shared cell in the prison's first night centre.

20. At a cell check in the early hours of 24 April, a Prison Custody Officer (PCO) saw the man and his cell-mate in the same bunk. The officer recorded that when he switched on the cell light, he got out of bed and came to the door to say that everything was okay. The officer spoke to the other prisoner and he too said that everything was all right. He told them both that he would be making further checks through the night.

21. At another reception interview on the morning of 24 April, the man said that he was not getting on with his cell-mate but when staff tried to move him to a different cell he became argumentative. He was eventually moved to a cell on his own but an officer noted in his prison record that his behaviour that afternoon had become, "bizarre, aggressive and threatening". She added that she had made a Threshold Assessment Grid (TAG) referral to the mental health team. (TAG is a quick method of gauging a person's mental health. The assessments can be completed by officers as well as clinicians. When a TAG assessment is sent to the prison mental health team, the duty mental health nurse will review the prisoner within 24 hours.)

22. At 5.00pm, another officer noted that the man had been making threats to staff, had been behaving in a bizarre way and had also made repeated requests to move to the segregation unit, (the care and separation unit). He had said that he was "getting tooled- up" and would attack anyone who opened his door. At around the same time, the prisoner he had shared a cell with on his first night, complained that he had sexually assaulted him the previous evening. The man was told that he would have to go to the segregation unit while an investigation took place into the allegation, but he then refused to move.

23. When a prisoner is to be moved forcibly to a new location there are established procedures which aim to minimise the risk of injury to both staff and prisoner. The procedures include the use of three or four trained staff wearing protective

clothing and supervised by a senior member of staff. A nurse usually accompanies the discipline staff and, if necessary, the prisoner is handcuffed.

24. The team of staff offered the man another chance to move voluntarily. He refused, so they handcuffed him and moved him forcibly. They reached the segregation unit at about 6.10pm and he was held for a brief time in cell 6 as there was an incident in the unit at that time. He was then moved to cell 13; a cell separated slightly from the other segregation unit cells used for prisoners who are particularly noisy or disruptive. Staff removed his clothes to search for concealed items and he was issued with fresh clothing. (The search was for visible items only.)

25. When prisoners move to the segregation unit, their mental health is assessed to ensure they are well enough to be segregated. A nurse noted in his clinical records that, he was angry and irritable, but was fit for segregation. The nurse completed a TAG assessment in which he scored three (a low score indicating minor potential mental health problems) and referred him for assessment by the mental health team.

26. After the nurse's assessment, Birmingham's Drug Strategy Manager authorised the man's segregation, but made an error in the paperwork that suggested he was unfit for segregation. He later wrote a statement to confirm his error and that he had considered him to be fit for segregation.

27. When a PCO arrived on duty at around 8.30pm on 24 April, day staff told her about the man's disruptive behaviour and she heard him banging his door. She spent a lot of time speaking to him that night. He complained that other prisoners were shouting abuse at him through the window and thought that he was receiving e-mails, also through the window. She said that there were times during the night when he appeared to be talking to an imaginary person in his cell. She made an entry in the wing history book the next morning about his behaviour and suggested that his mental health should be assessed.

28. In response to the nurse's TAG referral the previous day, another nurse visited the man on the morning of 25 April. The nurse noted that he was "irate and loud", but denied hearing voices or having any thoughts of suicide or self-harm. He concluded that there was no evidence of psychosis and nothing to indicate that he needed to be on the mental health team's caseload.

29. A PCO told the investigator that he was on duty on 25 April and the man had remembered him from his previous short stay at Birmingham. The officer thought that he was well that day.

30. The officer on duty on the night of 25/26 April said that the man did not go to bed and she had spent most of the night talking with him. Most of his conversation was senseless and he would become angry and start shouting, although as quickly as he angered he would calm down again. He also asked to speak to a Listener[2], which she arranged. After 20 to 30 minutes, the Listener told her that he and the man had finished and he returned to his wing.

[2] Listeners are prisoners trained by the Samaritans to provide confidential support to other prisoners in distress.

She saw nothing in his demeanour that night to cause her to fear he might harm himself and said she believed he wanted to see a Listener because he could not sleep and wanted to talk to someone rather than because he was at risk of suicide and self-harm.

31. The Listener who spoke to the man that night, as with the Samaritans, was bound by a duty of confidentiality and could not disclose information revealed by a contact. All he was able to say was that the man had been very irate.

32. At the end of her shift the next morning, the officer noted in the wing history book that:

> "… [The man] has paced his cell all night talking to himself about anything and everything. Towards the early hours of this morning he started to become very angry and stared to bang his door. Again, staff could not reason with [him] …"

33. The nurse saw the man again on the morning of 26 April, after another TAG referral. This time, the TAG score was 12 (a score suggesting clear mental health concerns). He would not engage with the nurse, although he said he did not have any thoughts of self-harm or suicide. The nurse understood that this TAG referral had been made by an officer when the man was still on D wing, so it preceded the one by another nurse on 24 April. The nurse again concluded that there was no reason to take him onto the mental health team's caseload.

34. All prisoners in the segregation unit are checked daily by the duty doctor. Later that morning, the segregation unit officers told a doctor about the man's strange behaviour and that he was being monitored by the mental health team. The doctor had not met him before. He went to see him in his cell but he did not seem to want to talk. He did not persist as he did not wish to distress him. He was unaware of and did not suspect any drug use at that point.

35. A PCO first met the man on 26 April. He said that each time he went to his cell, he would ask what was happening with the police and if someone wanted to harm him. Justification for continued segregation must be reviewed and approved periodically by a multi-disciplinary team and the first review must take place within 72 hours of initial segregation. That afternoon, when an officer went to collect him for his review, he saw him snort something through a rolled paper tube. He asked him what it was and he told him that it was M-cat, which he had brought into the prison and kept in his rectum. The officer did not take him to the review but instead reported his drug use to the panel, who noted:

> "… Has been in the prison [four] days. Mental health team say no evidence of mental health issues. Bizarre behaviour whilst on the CSU. Observed taking drugs whilst in the CSU …"

36. The panel considered that as the man might become violent as a result of taking M-cat, he should not attend the review. They decided to keep him in the segregation unit for a further period until he had stopped taking drugs and for his behaviour to improve. The next review was set for 30 April and he was

given behavioural targets which included to “address detox issues”. The Head of Safer Custody requested a mandatory drug test on the grounds of reasonable suspicion that he was using drugs.

37. The prisoner the man had shared a cell with on his first night withdrew his allegation of sexual assault that day. An officer attempted to explain this to him, but he was verbally abusive and said he was not interested. The officer did not think he understood what he was trying to tell him.

38. The officer on duty on the night of 26 April said she found it difficult to remember how the man had been that night compared to some of his other nights. However, she recalled having a conversation with him one night when she told him that he needed to get some sleep but he said that he could not get into bed as there were “things in the bed”. She told him that there was nothing in the bed but he chose to sleep either on the floor or the work surface.

39. A PCO said he first met the man on the morning of 27 April. He said he was behaving strangely, it was difficult to have a sensible conversation with him and he was reluctant to leave his cell. Other officers told him he had been like this for several days. The officer understood that the mental health team were satisfied there he had no mental illness and that his strange behaviour was due to drug abuse. The officer said that despite previous involvement by the mental health team, he and his colleague were concerned that he did not seem to be getting better so they asked the duty manager and the drug intervention team to check on him. (His colleague made an entry in the man’s prison record about this although the entry appears under the officer’s name as he had not logged off after previously using the computer.)

40. A nurse went to see the man on the afternoon of 27 April, at the request of the duty manager. He noted that he was talking to himself, there were signs that he was hallucinating and he did not respond to his repeated questions. He considered that he had deteriorated since he had seen him two days before, which he thought was possibly due to his illicit drug use. The nurse noted that there were no in-patient beds available in the healthcare centre. He discussed him with a colleague who, in turn, spoke to the healthcare manager, and then arranged a follow-up review with a nurse for the next morning. He thought it was reasonable for him to remain in the segregation unit pending this review.

41. A nurse noted that the man was still talking incoherently that evening and advised officers to call the healthcare centre again if there was any deterioration in his condition.

42. On the morning of 28 April, an officer wrote in the wing history book:

> “… Quiet night on unit … [nurse] came down once to see him and found no issues. He has since slept throughout the night changing from lying on his work surface to lying on the floor. There was only one bizarre episode during the night where he decided to eat his cold food very quickly whilst dancing and pressing his taps continually. This lasted for around 20 minutes …”

43. The duty manager who saw the man that morning was satisfied that he was fit to remain in the segregation unit but asked for the detoxification nurse to assess him. A nurse saw him that morning and noted:

> "… [He] stated that his "head was shot" as he had taken a large amount of M-cat that he had brought in with him. He stated that he last took some two days ago and was [recently] taking small doses … in the community. He [attributed his recent behaviour] to his drug habit. He stated that he could not put anything together and could not even remember what he had done yesterday. He denied having any more M-cat … and vowed that he would never take anything of that nature again … drug induced symptoms [appear] to be reducing compared to the reports given yesterday. He is more coherent and insightful … Admission to healthcare is not required at this point."

44. The nurse referred the man to the detoxification team and requested a urine test to confirm drug use. He was later told that someone from the drug detoxification team had gone to see him but he was asleep. In hindsight, the nurse considered that he should have been monitored under the suicide and self-harm prevention procedures.

45. An entry in the wing history book that afternoon noted the nurse's visit and the probability that the man's state of mind was due to excessive use of an illicit substance. Plans were made for a swab to be taken to determine the substance taken and manage his detoxification. Staff considered that he was located appropriately. In the afternoon, it was noted that:

> "Staff were able to get him to [use] the shower and facilitate a phone call. Detox team have been and taken a mouth swab. Unable to persuade him to relocate onto [a standard wing] but we have managed to get a half decent conversation out of him. Still very confused and having trouble piecing together the last few days."

46. Sometime during 28 April, one of the segregation unit officers completed a security information report in which he noted that the man had been observed sniffing a white powder two days before which he claimed to be M-cat. There was no note of any action to be taken as a result.

47. At midday on 29 April, a doctor found the man very much better than when he had last seen him three days earlier. He spoke about using M-cat, which he had also been using in the community. He seemed embarrassed about his behaviour while under the influence of the drug and said he would never take it again.

48. A friend of the man told the investigator that he had telephoned her every day from 23 April to 29 April. He sounded confused during the earlier calls and he eventually told her that he had been taking M-cat which he promised not to use again. He had cried during some of the calls which he had not done before. (As all prison calls should be recorded the investigator asked the prison for a

recording of his telephone calls. He was told that the only record was of a call made on the evening of 23 April, when he first arrived, but it had not been possible to find it.)

49. A PCO who worked a day shift on 29 April told the investigator that he could not recall anything of significance from that day, other than the man was more settled than he had been previously. An officer who had been on duty that night said that he slept through that night.

50. A residential manager went to the segregation unit on the morning of 30 April to conduct some disciplinary hearings. While there, he checked the prisoners and said he had spent 15 minutes with the man chatting and joking in his cell. He said that he had no recollection of what had happened in the previous days and asked what he had done. He was embarrassed and apologetic about his behaviour and said that he would not take M-cat again.

51. A doctor saw the man late morning. He prescribed some cream for dry skin and noted that he was otherwise fine. The doctor knew that the plan was for him to transfer to a residential wing later that day.

52. A PCO met the man when he first went into the segregation unit and he was then off duty for several days. When he returned after the weekend, he found he was much better and fit to leave the segregation unit. The plan on 30 April was for him to move to B wing so an officer spoke to a PCO, the B wing movements officer, to arrange the move[3]. Both officers went to see him to tell him where he was going and that he would have a single cell. He said he was content to move.

53. At around 3.00pm, an officer took the man to B wing and up to his cell on the top landing. As they walked through the wing, some friends of his greeted him and he said hello to them. However, when they got to the cell, he said "I can't do this at the moment". The officer asked what the problem was and he said there were too many people around. The officer asked him if he wanted to go back to the segregation unit and he said that he did. He went to cell 3 in the segregation unit (he had previously been in cell 13).

54. After the man returned to the segregation unit, officers contacted the Integrated Drug Treatment Service (IDTS)[4] team to ask for a nurse to visit. A nurse went to see him and noted:

> "… [He disclosed that he came in with an ounce of M-cat and had used it daily until his supply ran out]. I asked him to describe … what happened when the officers attempted to move him to [B wing]. [He] explained that he has an anxiety issue … when he was in the community this stopped him from going out and about …He describes … anger when his anxiety starts, he cannot tolerate unknown faces [and] confined spaces as this exacerbates his symptoms … He feels embarrassed about this as he was

[3] The movements officer is responsible for prisoners movements and allocation of cells.
[4] IDTS stands for Integrated Drug Treatment Service and is a service that delivers treatment and support for prisoners with substance misuse problems.

a strong character a year ago … Throughout the interaction he displayed no overt signs of thought disorder [he was] rational in thinking, anxious and mildly tearful … I do not feel that his current presentation is related to substance misuse as he has not used [M-cat for two] days. [His] … anxiety is an ongoing problem and has been for the last year … spoke with … clinical service lead manager and she has advised me [to arrange a nursing assessment today] … have spoken with the doctor and he has commenced … a small dose of propranolol [for anxiety] and he will review him in the morning …"

55. When interviewed, the nurse said that the man had told her he had used M-cat in the community to help with his anxiety problems. He had been slightly tearful at the start of the consultation but by the end he had smiled and laughed a little. She did not fear that he would harm himself that night and thought she had made appropriate follow-up arrangements.

56. The doctor was in the pharmacy towards the end of the working day when the nurse telephoned to update him about the man. She had arranged a review by a mental health nurse and asked him to prescribe medication for anxiety (propranolol). The doctor told the investigator that he was dubious that his problem was solely anxiety, but he agreed to write a prescription.

57. A nurse from the mental health team visited the man at around 6.00pm that evening. She recorded similar information to the other nurse and also noted that he became very tearful and said that he needed help. She said at interview that one of the segregation unit officers asked whether he would be admitted to the healthcare inpatient unit, but there were no beds available that afternoon. She arranged for the prison psychiatrist to review him the next morning. She did not have any fear that he was at risk of harming himself.

58. The officer who was on duty until 8.00pm that evening said that the man did not have any medication. The prison later confirmed that he did not receive any propranolol that evening.

59. Two officers checked the man several times before they went off duty. One officer said that when he collected prisoners' plates after the evening meal he made a comment along the lines of: "If I say anything about being in the army, just ignore me". Apart from that comment, nothing of note happened before his shift ended and he handed over to the night officer.

60. An officer arrived for work at around 8.15pm. At about 9.00pm, he was asked to cover B wing as well as the segregation unit. He spoke about this with the night orderly officer[5]. As the two units adjoin one another and none of the prisoners in the segregation unit were on a raised level of observations, they agreed that the officer would be able to cover both areas.

61. At around 9.45pm, the man rang his cell bell and asked the officer for a razor. The officer told him that razors were not allowed in cells in the segregation unit

[5] The night orderly officer is the officer in operational charge of a prison at night time.

but he could have one when he went for a shower in the morning. He suggested to him that he should try to get some sleep and he said he would and asked the officer to switch off the light. The officer said that there is not a lot to occupy prisoners in the segregation unit, so it is not unusual for prisoners to make requests like this at night to give them something to do. He therefore did not consider the request for a razor out of the ordinary.

62. The officer made his next check of prisoners just before 11.00pm. He opened the observation hatch on the man's door, switched on the light and saw him hanging from a noose, which made from bedding material, and attached to a ducting bolt[6]. Although the officer held a radio, he ran upstairs to the nearby centre office to get help which he thought would be quicker as, at night, there is often a lack of response to radio calls.

63. The night orderly officer was dealing with paperwork in the centre office and when he heard the sound of someone running he began walking in that direction. He then saw the officer part way up the stairs, who shouted that someone was hanging. They ran to the man's cell and, on the way, the night orderly officer radioed for medical assistance. He unlocked the cell door and, tried to support the body as the officer climbed on a wall shelf and cut the noose. At that point a nurse arrived (CCTV shows that this was less than a minute after the two officers had entered the cell). As she began to treat him, the night orderly officer radioed a Code Blue alarm (indicating a prisoner with significant breathing problems needing all assistance). He also asked for an emergency ambulance.

64. The nurse examined the man and found that he was not breathing, he had no pulse, his pupils were fixed and dilated and his fingers were cyanosed[7]. She asked for an emergency ambulance to be called and for the night orderly officer to collect an emergency bag. (She had brought a small 'grab bag' containing limited emergency equipment while emergency bags contain full emergency equipment such as oxygen and a defibrillator[8].) She started cardiopulmonary resuscitation (chest compressions and emergency breaths), assisted by officers and another nurse, who had been on duty in the drug treatment unit. The nurses attached a defibrillator, which instructed that no shock should be given and that resuscitation attempts should continue.

65. Paramedics arrived at around 11.10pm and used their own emergency equipment to try to resuscitate the man, with help from the two prison nurses. Efforts to resuscitate him continued until 11.34pm when they decided that he could not be saved and he was pronounced dead.

66. When he first arrived at the prison the man had told reception staff that he was of no fixed abode and he gave no next-of-kin details. The prison asked the police for assistance and they obtained the name and address of his mother.

---

[6] Cells at Birmingham have water pipes running across the tops of the walls. The pipes are covered by ducts that are bolted together. The bolts are intended to be tamper proof as a special tool is needed for them to be unscrewed. The bolts are 20 millimetres long and 5 millimetres in diameter.

[7] Cyanosis is when the bodily extremities turn blue through lack of oxygen.

[8] An automatic external defibrillator measures electrical activity in the heart and issues audible instructions about management of the patient including whether or not an electrical shock should be given to re-establish an effective heart rhythm.

The Director, along with the duty manager, visited the man's mother at around 4.00am to inform her about what had happened. One of his two brothers was also at the house.

67. A debrief was held with staff involved in the response to the man's death. They spoke about their individual involvement and were told of the support available through the prison's care team.

68. Officers told the other prisoners in the segregation unit individually about the man's death and advised them about the support available through the Listeners scheme or the Samaritans. Checks were made on all prisoners subject to suicide and self-harm monitoring in case they had been adversely affected by the news of his death.

69. A family liaison officer was appointed and she telephoned the man's mother on the afternoon of 1 May to introduce herself. His mother had a lot of questions so arrangements were made for her to visit the prison the next day with her sister. At the meeting on 2 May, staff gave her some information about the circumstances of her son's death and offered financial assistance with the funeral expenses.

70. The man's partner was subsequently identified and the prison also contacted her.

ISSUES

Clinical care

71. The clinical reviewer reviewed the man's clinical care in custody. She concluded that, overall, Birmingham's healthcare staff demonstrated good team working and he received care that was broadly equivalent to that which he could have expected in the community. However, she identified some areas for improvement and we repeat those most relevant to his death.

Location in the segregation unit

72. When the man arrived at Birmingham on 23 April he had a standard first reception health screen, which identified no physical or mental health concerns. He was asked about his use of alcohol and drugs and denied using either. He spent his first night in a shared cell in the first night centre.

73. By the afternoon of 24 April, the man began to behave in what was described as a bizarre manner. He made threats to staff suggesting that he would attack anyone who opened his door. During that day, his cell mate complained that he had sexually assaulted him the previous evening, so he was moved to the segregation unit. Although he had said he wanted to go there, he then refused to move voluntarily and officers used 'control and restraint' techniques to take him there.

74. The man continued to behave strangely. Officers were unclear whether he was suffering from a mental illness and referred him to the mental health in-reach team for assessment. As well as reviews by mental health nurses, the duty doctor saw him daily. Prison staff were still unsure about the cause of his behaviour when he was observed on 26 April snorting a substance just before a segregation review. He told staff that the substance was M-cat (or mephedrone), which he had brought with him into prison. The review panel was concerned that be might become aggressive as a result of using the drug, so he was not allowed to attend the review.

75. In view of both the allegation of assault and the man's behaviour, we are satisfied that it was a reasonable decision to separate him from the main prisoner population and move him to the segregation unit. The staff used approved procedures for doing so. The investigator has viewed video evidence of the move and was satisfied that it was carried our appropriately. For safety, it was also prudent to exclude him from the segregation review at that time.

76. The clinical reviewer considered whether the man should have been transferred from the segregation unit to the healthcare inpatient unit. On at least two occasions it was noted that no inpatient beds were available, suggesting that otherwise this would have been considered. She discussed with Birmingham's healthcare manager the process for admitting prisoners to an inpatient bed at the prison. The healthcare manager said that the duty healthcare manager is contactable 24 hours per day to discuss potential admissions and the duty doctor can also be consulted. She added that there are 30 inpatient beds,

which is usually sufficient, but she is discussing with prison managers scope for a further cell to be made available for assessments. The clinical reviewer concluded that he received a level of observation and care while in the segregation unit which was in line with that he would have received as an inpatient in the healthcare centre. We agree that he received an appropriate level of healthcare input while he was held in the segregation unit and there was no evident overriding clinical need suggesting he needed to be admitted as an inpatient.

Response to the man's apparent use of mephedrone

77. The man apparently brought into prison with him a quantity of M-cat (mephedrone) concealed in his rectum, which he used several times until it was finished. The investigator spoke to the Head of Safer Custody about what can be done when a prisoner has concealed illicit items in his rectum. The law does not allow prison staff to carry out intimate searches or remove items concealed in this way (although prisoners can be asked to squat if there is reasonable suspicion they might be concealing an item). He said the general approach was to hold the prisoner in the segregation unit until the evidence suggested they were no longer in possession of the item. He said that since the man's death the prison has produced some advice for staff and prisoners on the dangers of M-cat.

78. Although the Head of Safer Custody believed that no substantive action could have been taken, there is provision for searching and testing prisoners in these circumstances. National guidelines provide for searching both cells and prisoners and require prisons to have strategies in place for doing so. Prison Service Instruction 67/2011, Searching of the Person, authorises prison officers, operational managers and prisoner custody officers to carry out full (strip) searches. They do not have the legal powers to carry out intimate searches (defined as intrusion into a bodily orifice) but a full search can include a check of a person's mouth and, if there are grounds to suspect that the prisoner has something hidden in his anal or genital area, staff are expected to conduct a closer visual inspection.

79. The man had been strip searched when brought to the segregation unit and given replacement clothing. That would suggest that the M-cat was concealed intimately at that point. However, it is possible that once in the segregation unit the M-cat was stored elsewhere. It might have been in his mouth, cell or clothing. A full cell search and search of him and his clothing would have helped to establish this. We are surprised that this was not done immediately it was observed that he was on his own admission snorting M-cat on the afternoon of 26 April. There was no active intervention or any evidence of any discussion with him about the risks he was taking. It is possible that at that time the rest of his supply was in his cell or concealed elsewhere on his body.

80. Staff do not appear to have given much, if any, consideration to the potential risk of overdose or the possible effects of withdrawal when he ran out of the drug. The guidelines stipulate that these measures should not simply be for punitive purposes, but also to provide appropriate support for the prisoner.

Despite this, it took some days before a urine sample was taken for testing to inform further action.

81. On 26 April, after the man was seen ingesting drugs, an operational manager completed a request for a mandatory drug test and also asked for the detoxification nurse to assess him. The assessment was completed several days later. As he was actually taking illicit drugs at the time we are concerned that this did not prompt immediate action.

The Director should ensure that when there is clear evidence a prisoner is in possession of illicit drugs, staff carry out a cell search and a search of the prisoner as quickly as possible. Mandatory drug tests should also be conducted.

Assessment of the risk of suicide and self-harm

82. Assessment, Care-in-Custody and Teamwork (ACCT) the Prison Service suicide and self-harm prevention procedures aim to monitor and support prisoners at risk to themselves. Instructions state that any member of staff who observes behaviour which might indicate a risk of suicide or self-harm must open an ACCT plan. The prisoner is then assessed and supervised at regular intervals according to the perceived level of risk.

83. Initially, staff wondered whether the man's behaviour was due to mental health problems. ACCT monitoring is not necessarily implemented for those who are mentally ill unless there are also concerns that they are at risk to themselves. It became apparent that his unusual behaviour was likely to have been drug-induced and his behaviour settled once he had used up his supply.

84. The man then suffered some form of anxiety attack when staff took him to B wing on the afternoon of 30 April. He explained that he could not cope with the number of people on the wing. Two mental health nurses saw him later that afternoon. Both made arrangements for follow-up care, which was to include a review by the prison psychiatrist the next day. Neither nurse thought that he was at risk of suicide or self-harm.

85. Prison Service Order 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody) lists a number of risk factors and triggers for suicide and self-harm. These include, early days in custody, irrational behaviour, segregation and substance misuse or detoxification.

86. Healthcare staff assessed the man's mental state several times and asked him about self-harm or suicide. When questioned, he said he had no thoughts of harming himself. We have considered whether staff should have started, or at least considered self-harm prevention procedures. It seems that in assessing his risk of self-harm, staff relied heavily on his statements that he had no such thoughts and also focussed on the risk of deliberate self-harm. In previous cases, we have been critical of prison staff placing too much reliance on what the prisoner tells them and ignoring the weight of other risk-related information. He took illegal drugs over several days and displayed very erratic behaviour

resulting in several requests for him to be examined by mental health staff. He was also being investigated for an alleged sexual assault. He had been briefly on an ACCT plan the last time he had been in Birmingham in January. These factors should have been considered carefully in the context of suicide and self-harm but it is not apparent what weight, if any was given to them.

87. Beginning to monitor the man at an early stage would have offered him important support and might also have acted as a deterrent to further use of M-cat. We are concerned that initially staff took insufficient account of all the risk factors, particularly those associated with his drug use. We note that he was seen a number of times by mental health nurses who did not indicate any concerns. We accept that it would have been very difficult to predict or prevent his actions but more weight should have been given to the known risk factors which should have been considered by staff conducting the initial assessments of the suicide and self-harm procedures. The act of taking M-cat in the quantity he did with the resulting effect on his behaviour could also have been regarded as an act of self-harm triggering a need for ACCT monitoring. We make the following recommendation:

    The Director and Head of Healthcare should ensure that all the known risk factors of a prisoner are fully considered when determining their risk of self-harm or suicide.

88. CSU processes mean that prisoners in that unit are generally checked more frequently than would be the case for prisoners on a standard prison wing. National Prison Service instructions no longer stipulate this frequency of checking. Instead, the level of checks is dependent on the perceived need for each individual prisoner. It is unclear what level of check was set for the man or whether the frequency of checks influenced the consideration as to whether or not to open and ACCT. He was subject to hourly checks on the evening and night of 30 April but there was less frequent recording before that. While there is clear indication of more frequent interaction with him than is evidenced by the systems used to record monitoring checks, it is not possible to ascertain the precise frequency. Because of his known drug use we would have expected frequent recorded observations for safety reasons, even if he was not regarded as a risk of suicide and self-harm.

    The Director should ensure that staff clearly record the frequency of agreed checks for each segregated prisoner and staff check prisoners at the required intervals.

Administration of medication

89. When a nurse visited the man on the afternoon of 30 April, she considered that he should have some medication for anxiety and a doctor prescribed propranolol. She recorded her notes at 4.37pm. The Head of Healthcare told the clinical reviewer that the prison pharmacy closes at 4.30pm and medicines such as propranolol are not available after that time.

90. The consultant psychiatrist and Birmingham's mental health lead told the clinical reviewer that he did not believe that a dose of propranolol given on the evening of 30 April would have made any difference to the outcome for the man. However, the doctor and nurse both seemed to believe that he would receive his first dose that night which the nurse felt would help relieve his anxiety. However, the pharmacy was closed at that time and there was no system to dispense the drug out of hours. We therefore agree with the clinical reviewer's view that the prison would benefit from a review of prescribing practices to ensure that necessary medication is available at all times.

The Healthcare Manager should ensure that an appropriate range of medicines is available for prescription outside standard hours.

Accommodation fabric checks

91. Accommodation fabric checks are periodic checks of the physical security of prison cells. Their purpose includes ensuring that prisoners have not modified the cell to create ligature points. Officers should physically check the door lock, window frame and window bars and ensure that the screws on hinges, locks and bolts are secure.

92. The segregation unit at Birmingham was built in late 2003 and fitted with safer furniture (designed to minimise ligature points and other potential means of self-harm). It seems that at the same time, the cell water pipes were covered using metal ducting fixed by specialist bolts, which could only be unscrewed using a special tool. The man looped bedding over a bolt which was partly out of its fixing.

93. The Head of Safer Custody at Birmingham said that the segregation unit cells were checked daily. As well as checking the locks and bars, he understood that staff practice was to make a visual check of the ducting bolts, but not to check that they were tight.

94. Cell 3 had last been occupied on 18 April and there is no information available about how the bolt came to be loosened and partially unscrewed. The man's cell contained no tools or other equipment that would have allowed him to unscrew the bolt had it been properly tightened before he went into the cell and there is no evidence that an unscrewed bolt had been identified during the fabric check.

95. The cells in the segregation unit were not designated safer-cells, so it was not unreasonable that bolts had been checked visually and all appeared in place and in proper order. The man was not held in the cell because he was regarded as at risk of suicide and self-harm so there was no reason for particularly detailed checks. The Head of Safer Custody told the investigator that since the man's death, the prison had further secured the bolts with a glue or resin and we consider that an appropriate response.

Emergency response

96. The officer found the man hanging in his cell just before 11.00pm on 30 April. He was carrying a radio and a cell key in a sealed pouch but rather than radioing for assistance and going into the cell he ran towards the nearby centre office to get help from the night orderly officer. Fortunately, the night orderly officer was in the office and, on hearing someone running, began walking towards the sounds to be met by the officer. They both ran to the cell and went in. CCTV shows that 29 seconds elapsed between the officer running to get help and the two of them entering the cell.

97. The officer thought that he had obtained a swifter response by acting as he did compared to radioing for assistance. However, it was only a matter of good fortune that the night orderly officer was in the centre office at the time in his role as night orderly officer, he could have been anywhere in the prison.

98. Instruction to prisons in PSI 3/2013 about emergency medical response requires staff to use a code in medical emergencies to indicate the nature of the incident, to help ensures that the correct emergency equipment is taken and to alert the control room to call an ambulance immediately. An emergency Code Blue was not issued until the officer called one after the nurse arrived about a minute or so later resulting in a short, but unnecessary, delay. A quick response is vital in increasing chances of successful resuscitation.

99. Both the officer and night orderly officer believed that staff should not enter a segregation cell alone whatever the circumstances. This is not correct. Birmingham's night operating instructions state:

    "Under normal circumstances, authority to unlock a cell at night will be given by the Night Orderly Officer.

    "Under normal circumstances, no cell will be opened unless there are three members of staff present …

    "Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer.

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

100. The correct action was for the officer to have radioed for immediate assistance, then broken his key pouch and entered the cell provided he was satisfied that it was safe to do so, which would have been a reasonable assessment in the circumstances. We acknowledge that the man was hanging in a high and awkward position and it is questionable whether he would have been able to take any action until joined by the night orderly officer. Nevertheless, it is a concern that staff at the prison were unaware of the need to intervene where there is immediate danger to life.

101. The nurse who responded to the emergency took a ‘grab bag’ containing limited items of emergency equipment such as a barrier mask and an airway tube (to help deliver oxygen particularly where the patient’s neck is damaged). When she reached the man she realised that she would need an emergency bag (a much larger and heavier bag containing items such as an oxygen cylinder and defibrillator. She asked the night orderly officer to collect one (there are ten emergency bags in various locations at the prison). She said that in her experience officers tended not to bring emergency bags to an incident until asked to do so by the first response nurse.

The Director should ensure that Birmingham’s emergency response procedures are consistent with Prison Service Instruction 03/2013 and that all staff are aware of their responsibilities during a medical emergency through an emergency response protocol which:

- **Provides clear guidance to staff on efficiently communicating by radio the nature of a medical emergency;**
- **Ensures there are no delays in calling, directing or discharging ambulances;**
- **Ensures that staff called to the scene bring the relevant equipment; and**
- **Ensures that staff are aware that, subject to a personal risk assessment, they should enter a cell in a life-threatening situation.**

RECOMMENDATIONS

1. The Director should ensure that when there is clear evidence a prisoner is in possession of illicit drugs, staff carry out a cell search and a search of the prisoner as quickly as possible. Mandatory drug tests should also be conducted.

2. The Director and Head of Healthcare should ensure that all the known risk factors of a prisoner are fully considered when determining their risk of self-harm or suicide.

3. The Director should ensure that staff clearly record the frequency of agreed checks for each segregated prisoner and staff check prisoners at the required intervals.

4. The Healthcare Manager should ensure that an appropriately wide range of medicines are available outside standard hours.

5. The Director should ensure that Birmingham's emergency response procedures are consistent with Prison Service Instruction 03/2013 and that all staff are aware of their responsibilities during a medical emergency through an emergency response protocol which:

   - Provides clear guidance to staff on efficiently communicating by radio the nature of a medical emergency;
   - Ensures there are no delays in calling, directing or discharging ambulances;
   - Ensures that staff called to the scene bring the relevant equipment; and
   - Ensures that staff are aware that, subject to a personal risk assessment, they should enter a cell in a life-threatening situation.

ACTION PLAN: The Man – HMP Birmingham April 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Director should ensure that when there is clear evidence a prisoner is in possession of illicit drugs, staff carry out a cell search and a search of the prisoner as quickly as possible. Mandatory drug tests should also be conducted.	Accepted	Systems are currently in place that should staff suspect or have intelligence that a prisoner is in possession of an unauthorised drug or item, they can carry out a target search. They can also submit an Intelligence Report requesting that a target search is carried out if one cannot be immediately completed. A process is also in place to allow staff to submit a mandatory drug test referral form if they suspect anyone of being under the influence of any substance and a MDT will be carried out.	Immediate	
2	The Director and Head of Healthcare should ensure that all the known risk factors of a prisoner are fully considered when determining their risk of self-harm or suicide.	Accepted	Healthcare staff must ensure they read system1 and RIO (if appropriate) notes for prisoners before assessing them, as this will support an accurate reflection of risk factors and intent When a patient presents regularly i.e. in excess of three times or each day over a three day period, healthcare professionals must call a multidisciplinary case review to ensure that all risk factors are taken into account, when a management plan is being formulated.	Immediate	A three month audit to be undertaken of all high risk prisoners to ensure MDT reviews are being called appropriately January 2014
3	The Director should ensure that staff clearly record the frequency of agreed checks for each segregated prisoner and staff check prisoners at the required intervals.	Accepted	All prisoners located in the CSU are subject to mandatory minimum checks of one observation within each hour. Should the need arise for observations to be increased, this will be clearly recorded in the unit observation book and prisoners care plan.	Immediate	A three and six month compliance check to be carried out by the internal performance and compliance team
4	The Healthcare Manager should ensure that an appropriately wide range of medicines are available outside standard hours.	Accepted	All hatches within the prison have a well-stocked general drug store cupboard for day to day drug usage. There is an on-call pharmacy service available for any drugs that are	Immediate	Quarterly audits are to be carried out on the use of on-call pharmacy

			required immediately but are not held as part of general stock both in and out of hours.		deliveries January 2014
5	The Director should ensure that Birmingham's emergency response procedures are consistent with Prison Service Instruction 03/2013 and that all staff are aware of their responsibilities during a medical emergency through an emergency response protocol which: a) Provides clear guidance to staff on efficiently communicating by radio the nature of a medical emergency; b) Ensures there are no delays in calling, directing or discharging ambulances; c) Ensures that staff called to the scene bring the relevant equipment; and d) Ensures that staff are aware that, subject to a personal risk assessment, they should enter a cell in a life-threatening situation	Accepted	Operational order 001/2013 Code Red/Code Blue Emergency Procedure published in accordance with PSI03/2013 that highlights the requirements of staff during emergency medical incidents.	Immediate	Reviewed as part of the daily operational reporting process to include the requirements to report all incidents on the Incident reporting system IRS.