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

December 2011

This is a report into the circumstances of the death of a man in February 2010 at HMP Birmingham. He was found hanging in his cell on B wing at 6.45am. He was pronounced dead by paramedics just over an hour later, at 7.50am. He was 44 years old.

I would like to offer this public expression of condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. His niece was written to by one of my family liaison officers, but there has been no contact since. I hope my investigation begins to offer answers to any questions the family may have. It is with regret that this report has been delayed and I offer my sincere apologies for this.

I assisted my colleague with this investigation. Another colleague prepared the draft report. A review of the man's medical care in custody was carried out by a clinical reviewer, on behalf of the local Primary Care Trust (PCT). I would like to thank all staff at Birmingham for their co-operation during the course of this investigation. .

The man was remanded to Birmingham on 25 April 2009. He had a significant history of mental health problems. On two occasions, he was placed on constant supervision and monitored under the Prison Service's procedures for suicide prevention and self harm management. My investigation considers whether he was appropriately managed under these measures and assesses the attempts that were made to revive him when he was found in his cell. I have made nine recommendations, many of which concern the ACCT process.

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 **December 2011**

CONTENTS

SUMMARY

1. On 26 June 2007, the man received an extended sentence of four years at Crown Court. He was released on licence in June 2008, but after concerns about his behaviour his licence was revoked on 24 April 2009, and he was remanded to HMP Birmingham the next day.

2. During the man's first day he was assessed by a number of prison staff who found he had prior mental health problems and a history of suicidal tendencies. He told staff that he would self harm or commit suicide. Consequently, he was placed on suicide prevention and self harm management, which included constant supervision and he was admitted to the healthcare unit.

3. Between 25 April and 30 June, the man was monitored by staff and the prison's psychiatrists. During this period his mood fluctuated. Constant supervision stopped after 17 days, but other procedures for suicide prevention and self harm management remained in place until 7 July. However, these were again started on 14 September, after he etched "death to (name)" on his arm. A week later, a prison psychiatrist concluded that there was no change in his mental state, but his condition could be managed on an ordinary wing.

4. The man was discharged from healthcare on 22 September, and moved to N wing and then to B wing two days later. However, on 8 October he was placed on constant supervision again after he presented as distressed and indicated that he would kill himself. He was subsequently transferred back to the healthcare centre on 13 October, after he had isolated himself, neglected his personal hygiene and became fixated on wanting to die. He continued to be reviewed by the prison's psychiatrists as well as a community psychiatric nurse (CPN). His mood continued to fluctuate and there were a number of occasions when he made superficial cuts or scratches on his arm.

5. On 1 December, the prison's consultant psychiatrist and Head of the mental health team jointly reviewed the man. They consulted with a governor and constant supervision was stopped after 53 days, but he again remained on other procedures for suicide prevention and self harm management. It was also agreed that he would be discharged from healthcare back to a normal wing. A meeting was convened on 27 January 2010, and it was confirmed that he would return to B wing, although no staff from the wing were present. (He acknowledged that he had previously said that he would kill himself if he went back to B wing.)

6. The man was discharged from healthcare on 29 January to B wing. There was no evidence of a handover or that his discharge plan was shared with staff on the unit. He continued to be monitored under the procedures for suicide prevention and self harm. This included checks by staff three times an hour. Over the course of the next few days there were no recorded

concerns and he stayed in his cell. One day in February he was checked regularly until 6.00am, but a further check was not done until 6.45am when he was discovered hanging. Prison staff made attempts to revive him until the paramedics arrived. He was taken to hospital, but he was pronounced dead at 7.50am.

7. Following the man's death, his niece was notified and prison staff were offered support. A memorial service was subsequently arranged by the prison and was attended by two members of his family.

8. The man received a significant amount of support and input from nursing staff, Birmingham's psychiatrists and a CPN. However, there are a number of areas where lessons could be learned. I am concerned about the location of the defibrillator and the absence of an emergency code. Both issues which have been highlighted in some of my previous investigations at Birmingham. This is reflected in two of my nine recommendations. I make a number of recommendations to improve the quality and frequency of ACCT and enhanced case reviews, and to improve the procedures for discharging prisoners from the healthcare centre.

THE INVESTIGATION PROCESS

9. My investigator opened the investigation on 8 February 2010. She collected all of the man's files and visited the cell where he died. Notices were issued which included an invitation to those who wished to submit information related to his death to make themselves known to the investigators. No one came forward as a result.

10. My investigator also wrote to the Coroner on 3 February, to inform him of the investigation and requested a copy of the post mortem report.

11. A clinical review of the man's health needs whilst he was in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust.

12. My investigator was given access to the man's prison file, including the medical record and she visited HMP Birmingham on a number of occasions. On 24 February, she interviewed three prisoners. In addition, she interviewed15 members of staff between 3 and 17 March. There were further meetings with two of the prison's family liaison officers, the Deputy Governor, and the Governor who acted as the Liaison Officer. She also spoke to three members of the Independent Monitoring Board (IMB) and two from the Prison Officers' Association. The investigation team met with the then Governor to discuss their preliminary findings which were confirmed in writing.

13. One of my Family Liaison Officers (FLO) wrote to the man's niece, who is recorded as his next of kin, on 3 March. This was to inform her of the investigation and invite his family to raise any issues they wished the investigation to address. My office has not received a reply from her. A copy of this report will be made available to her should she wish to see it and she will be given an opportunity to meet with the FLO and the investigators.

14. The man's family received a copy of the draft report as part of an extended consultation period. Having considered the investigation findings, the neice indicated to the family liaison officer that the report was informative although distressing. She explained she was unhappy with some of the interview transcripts. However, it was pointed out it would be more appropriate to raise these concerns at the inquest. Since the end of the consultation period, further correspondence has been received from another family member indicating that he is unhappy with some aspects of the report and felt a number of issues had been overlooked. It is felt, however, that the issues raised by the neice's partner are not within our remit to comment on within this report and would be more appropriately addressed separately. The investigator has sought to address these in separate correspondence to the family and recently appointed legal representative.

15. A draft copy of the report was sent to the prison service and their responses are repeated verbatim in the recommendations section of the report. All the recommendations were accepted.

HMP BIRMINGHAM

16. 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.

17. 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, G4S a private security firm, have been successful in their bid to run Birmingham. The company will take over the management of the prison in October 2011.

18. Primary healthcare services at Birmingham are commissioned by the local 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 accommodates individuals with physical conditions and the second is mostly used for prisoners with acute psychiatric problems. The prison has a Primary Care Mental Health Team as well as an In-Reach Team who deal with prisoners with more serious, severe and enduring mental illnesses.

19. 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 health services had improved. However, many ACCT reviews were not multidisciplinary and the quality of ACCT care plans "varied considerably".

20. The Independent Monitoring Board (IMB a body of people appointed to each prison by the Secretary of State for Justice to be independent watchdogs of the public interest) are required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern. The IMB report for 2009-2010, noted 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 in addressing these problems. The IMB concluded that the prison's mental healthcare team offered a "well integrated" primary service.

21. 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 high number of deaths in a short time. I have observed a similar cluster of self inflicted deaths at HMP Chelmsford in late 2007 and early 2008. The number and frequency at Birmingham in 2010 was unusual

and concerning. I have therefore considered whether there are any similarities between the deaths. The absence of an emergency code, the location of the defibrillator and the quality of ACCT reviews were concerns in the man's case and some of the other deaths.

KEY EVENTS

22. On 26 June 2007, the man was sentenced to an extended sentence of four years at Crown Court. He was released on licence in June 2008, but after concerns about his behaviour his licence was revoked on 24 April 2009. He was arrested and taken to HMP Birmingham the next day.

Assessment, Care in Custody and Teamwork (ACCT) monitoring from 25 April to 7 July 2009

23. During the man's first day at Birmingham he was assessed by a number of prison staff. A first reception health screen (a routine assessment for all new arrivals into prison) was completed. Amongst a number of issues, the nurse noted his previous admission into a psychiatric hospital, details of his medication for his mental health problems and that he was a "very heavy drinker". The nurse also identified that he had deliberately self harmed ten days previously and he had thoughts of hurting himself. He was urgently referred to the prison's mental health team and an appointment was made for him to see a prison doctor.

24. During an interview in the first night centre, the man said that he would try and harm himself or commit suicide by an overdose or any other means. Consequently, ACCT monitoring was started and an immediate action plan was put in place. He was placed in a single cell and arrangements were made for him to have access to a telephone and a Listener. (A Listener is a prisoner trained by the Samaritans to listen and offer support to their peers.) In addition, he was referred to the prison's mental health team and for an alcohol detoxification. As part of the ACCT procedures, he was also interviewed by Officer A who was a trained ACCT assessor. He repeated the information he provided during his reception health screen and confirmed that he felt suicidal. He explained that he had cared for a man who had later died and he was unable to come to terms with this death. The officer completed the ACCT assessment, but did not sign or date the form.

25. The clinical record showed that a doctor prescribed the man medication for an alcohol detoxification. In addition, he also approved the use of citalopram hydrobromide for depression, risperidone (antipsychotic medication) and procyclidine hydrochloride (to manage the side effects of the other drugs). The doctor noted that his use of the tablets had to be supervised.

26. Lastly, the man saw Registered Mental Nurse A (RMN), who completed a mental health reception screen. He told her he had suicidal tendencies, a history of taking overdoses, thoughts about dying everyday and depression. He added that he had been diagnosed with a personality disorder and psychosis. (Psychosis means that a person is unable to distinguish between reality and imagination.) He described himself as an alcoholic and said that he had already been assessed by the prison's detoxification nurse. He said that he had "nothing to live for" and he had heard voices for nine years that told him to harm himself or others. The nurse wrote on the clinical record that he showed no obvious signs of psychosis or intentions to harm others.

However, when she questioned him about any plans to harm or kill himself he said there was a “50/50” chance. The mental health nurse recommended that he was placed on constant supervision. (Constant supervision is where 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.) During the evening on 25 April, he was admitted to healthcare on constant supervision.

27. The following day, the first ACCT review took place. Prison Service policy says that when a prisoner is placed on constant supervision, the first review must be chaired by the duty governor, Head of Healthcare or another manager. However, none of these individuals were present. RMN B was the case manager and the man, Officer A and the constant supervision officer attended. He said that he felt like self harming all the time. Those at the review agreed that he was at high risk of harming himself therefore, it was appropriate to monitor him on constant supervision. A note was made to invite a governor grade to the next review.

28. In line with Prison Service Order (PSO) 2700, a care and management plan (care map) was also completed by Officer A on the same day. This form documents the nature of the self harm concerns and how these will be addressed by staff and/or the prisoner. The man’s care map recorded that he would be reviewed by the prison’s psychiatrist, administered medication for his mental health problems and provided with an opportunity to “ventilate” how he felt to staff. There is also a section on the form to identify a case manager, but it was left blank.

29. RMN B also reflected the outcome of the ACCT review on the clinical record on 26 April. She noted that a representative from chaplaincy had been invited to the next meeting.

30. A day after the first ACCT review, the man was assessed by the prison’s consultant psychiatrist on 27 April. The psychiatrist recorded in his clinical record that they talked about his suicide attempt and how he felt safe on healthcare. The psychiatrist said that he would remain on constant supervision and would be reviewed again the following week.

31. In interview for this investigation, the psychiatrist explained to my investigators that the man had multiple diagnoses that included depression, severe anxiety and a tendency to experience psychotic symptoms such as hearing voices. The psychiatrist added that prior to his remand to Birmingham he had been assessed by a community forensic psychiatrist (a specialist who deals with mental illness related to crime, prison and court procedures). He told my investigators that they concluded that he had an emotionally unstable personality disorder. The psychiatrist said this was coupled with “kind of” anxious and dependent traits. He explained that his main aim was to achieve “some sort of stability to make a remission from him [the man] hearing voices”.

32. When a prisoner is subject to constant supervision, extra safeguards are put in place. These additional requirements are set out in PSO 2700 and include daily case reviews for the first 72 hours of constant supervision. There was no record of an ACCT review on 27 April, or any indication why one did not take place on this date.

33. A case review was held on 28 April. The case review was chaired by RMN C who was also recorded as the case manager. The review was attended by the man and Healthcare Officer A (HCO), but neither chaplaincy nor a governor grade were present. During the review, he said he felt low and thought about suicide everyday. He added that he only tried to kill himself by drug overdoses, but he always looked for ways to hurt himself. The case manager noted that he had issues with alcoholism and mental health. Although encouraged by his interaction with staff and his peers, those present at the review concluded that he would remain on constant supervision.

34. The next ACCT review took place two days later, on 30 April. It was chaired by RMN D was also identified as the case manager, and attended again by the man and HCO A. He said he felt up and down, but he said that his mood had improved since he had been on healthcare. He added that he needed the support of constant supervision at night. He told staff that he wanted to see the prison doctor about his medication. He said that he was prepared to try relaxation sessions, but he felt apprehensive about attending day care (a facility in healthcare where patients can take part in activities). Those present at the review concluded that he would be taken off constant supervision during the day, but he would remain on it at night. His care map was not updated to reflect the change in his support plan.

35. According to PSO 2700, prisoners who remain on constant supervision for eight days or more should be managed through enhanced case reviews. Such enhanced reviews must be attended by senior manager and an appropriate member of the multi-faith chaplaincy team and a member of the Independent Monitoring Board (IMB) must be invited to attend.

36. Ten days after the man was placed on constant supervision, his fourth scheduled review was held on 5 May, and it was chaired by Governor A, who was identified as the case manager. The record of case review shows that the man, RMN B, RMN E from the prison's Primary Care Mental Health Team (PCMHT) and the officer carrying out constant supervision were all present. There is no evidence that members of either chaplaincy or the IMB attended the meeting or had been invited. He repeated that he felt low especially because he had received some documentation about his recall to prison. The review noted that he was on antidepressant medication that would take time to stabilise his condition. Staff agreed that he would be on "full" constant supervision (day and night) and that a community psychiatric nurse or the PCMHT were to be invited to the next review. His care map was once again not updated.

37. A further review was held three days later on 8 May, and was again chaired by Governor A and RMN E, the man, a healthcare officer and the officer

carrying out constant supervision attended. The record shows that he appeared to be more stable and he interacted with his peers during 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.) He said that he felt more comfortable in the day, but he repeated that he was apprehensive during the night. He discussed his mental health with the nurses and said that he understood that his medication would take time to take effect. He was placed on intermittent observations (these are checks made by staff) three times an hour during the day, but he remained on constant watch in the night. The record of case review noted that the PCMHT should attend the next review. His care map was not updated to reflect the change in his support plan.

38. On the same day, the clinical record shows that RMN B wrote to the CPN team and requested their attendance at the next review with a view to adding the man to their caseload.

39. The man saw a prison psychiatrist on 11 May. He told the psychiatrist he felt low in mood during teatime and he said that he would prefer if some of his medication was either increased or remained the same. He was told that he was on “a reducing scale”. Whilst he reported that he heard voices, he said that it was getting easier to cope with. The following day, on 12 May, it was recorded in his clinical record that during the night, he was aggrieved that the psychiatrist did not increase his medication. He said that he would throw himself out of a window and threatened “to do something” if a doctor was not called, but he eventually slept.

40. The next day on 13 May, Governor A chaired the review for the last time. The record of case review shows that the man, a member of staff and RMN D attended the meeting. No one from the PCMHT attended the meeting. He said that he saw the prison psychiatrist, but his medication issues had not been resolved. The review felt that he was more comfortable interacting with staff and his peers. After 17 days of constant supervision, his level of support was reduced. He was to be observed four times per hour and spoken to three times a day (these are supportive interactions when a member of staff has a conversation with a prisoner). The clinical record shows that he also saw the psychiatrist on the same day about his medication, but no changes were made to it.

41. On 19 May, the man was reviewed for the first time by another prison psychiatrist. She wrote on the clinical record that he said that he felt anxious around teatime, his urges to self harm were stronger and he still heard voices. She prescribed him lorazepam (medication to treat anxiety disorders).

42. An ACCT review was held that day, chaired by RMN B and attended by the man, Officer A and a student nurse. He said that his antidepressant medication was not working very well and he still felt like self harming. No changes were made to his observations.

43. On 25 May, another ACCT review took place. Chaired by RMN D, the man and Officer A were also present. He said that he required medication to settle him down. Whilst he still felt like self harming from time to time, he said that he could talk to staff when he was agitated. He also described the environment on healthcare as "therapeutic". His observations were reduced to three times an hour, but there was no record of any change to the number of his conversations. His care map was updated to reflect that at times he felt agitated and that he would be administered prescribed medication.

44. The doctor reviewed the man's medication on 29 May, and wrote on the clinical record that he reduced the dosage of diazepam (medication to treat anxiety disorders). He saw the second psychiatrist on the same day. He complained that he felt anxious, restless and there were arguments inside his head. He questioned why his diazepam had been reduced. The psychiatrist documented on the clinical record that he would remain on the same medication and he made no changes to it.

45. The first psychiatrist saw him for the third time on 1 June. He again complained that he felt highly anxious and added that he had experienced panic like attacks, irritability and sleep problems. He told the psychiatrist that he got no relief from his regime of lorazepam and diazepam. The psychiatrist increased the dosage of the diazepam. On the same day, RMN D wrote on the clinical record that the psychiatrist would be looking to send him back to a normal wing.

46. An ACCT review was also held on the same day, chaired by RMN B. The man mentioned that he felt agitated and an argument had started in his head. He said that he would rather talk than be checked every 15 minutes. The record of his case review noted that his conversations were in fact decreased to one per shift.

47. The following day on 2 June, the man told RMN F that his diazepam had not helped him and he wanted to see a psychiatrist the next day. The psychiatrist noted in the man's clinical record that he encouraged him to continue to talk to staff. The next day, he told RMN D that he heard voices in his head and repeated that he wanted to see another psychiatrist because the first psychiatrist did not listen to him.

48. The ninth ACCT review took place a few days later on 6 June. Chaired by RMN F, the man told the multidisciplinary review that he felt "not too bad". He added that his mood fluctuated, but he was able to vent how he felt to staff. However, he continued to have thoughts about self harm. His conversations were increased to two per day.

49. The first psychiatrist reviewed the man's medication two days later on 8 June, and reduced some of the doses. He wrote on the clinical record that there were no major issues in relation to his mood or psychosis. On the same day, RMN D described him as "upset" because his medication was reduced. She said that he told her that his "head was racing" and he had arguments with the "voices". The psychiatrist saw him again four days later on 12 June. He

noted on the clinical record that he explained to him the need to change the diazepam to clonazepam (medication to treat anxiety) for “long term maintenance”.

50. An ACCT case review also took place on 12 June. Chaired by RMN C, the man said his condition had improved, but his psychotic thoughts had got worse that week. The first psychiatrist had already reviewed his medication, but the man indicated that a change would be helpful. His support level remained at two conversations per day.

51. A third prison psychiatrist saw the man on 16 June and reflected his observations on the clinical record. He explained that he experienced anxiety symptoms and occasional panic attacks that tended to get worse in crowded places. The psychiatrist added that he was not sleeping properly and he had nightmares in the early hours of the morning, as well as thoughts of self harm. He told the psychiatrist that he had been unable to get away from the depressive symptoms and he had previously coped by taking overdoses. The psychiatrist concluded that the man had a “generalised anxiety disorder” and “co-morbid [unrelated] depression”. He described his mood as “euthymic” (neither elated nor depressed) and said that he had a good insight into his difficulties.

52. Around the same time, the first psychiatrist also saw the man and he complained of persistent voices. The psychiatrist documented on the clinical record that he appeared to be preoccupied with the same issues as before. He added that the man was “not able to appreciate any benefit” of his medication and there was “some resistance to treatment”. The psychiatrist said that he had “severe alcohol dependence syndrome” and this was coupled with “persistent and co-morbid psychosis”. However, he noted no risk issues were identified that required immediate attention.

53. On 22 June, a further ACCT review took place. Only RMN F and the man were at the review which noted no significant changes. A further review was held three days later on 25 June and attended by RMN D, the man and HCO A. He said that he was not thinking about things and this had a positive effect on his interactions with his peers. However, he reported problems with his sleep because his mind ticked over all the time. He was described as “cheerful” and the record documented that there was “a lot of banter” during the meeting.

54. The first psychiatrist saw the man again on 26 June. He wrote on the clinical record that the man was on antipsychotic medication and he had numerous diagnoses in the past. He added that he had a personality disorder with alcohol dependence and he had been on risperidone since 2003. The psychiatrist said that no acute or new issues were identified.

55. The thirteenth ACCT review took place on 30 June chaired by the Ward Manager. The man said that his medication was changed, he felt a bit more settled, less agitated and he was able to mix with people on the ward. He

added that he was happy with his current level of observations and he was able to approach staff.

56. At the beginning of July, the first psychiatrist documented on the clinical record that the man had shown an "initial positive response to his medication". A few days later, on 6 July, he was reviewed by the second psychiatrist. He said that the man complained that he was "all over the place" and he felt unsettled. In addition, he had some paranoid thoughts, disturbed sleep and he repeated that he heard intense voices at night. However, he described his progress as "gradual". The psychiatrist concluded that he would continue with his current treatment regime.

57. On 7 July, the Ward Manager again chaired the ACCT review, attended by the man and HCO A. He said that he was not suicidal and he was able to talk to staff, but added he had not felt the effect of his new medication. The record noted that he interacted with his peers, ate well and went out to exercise. It was therefore agreed that the ACCT would be closed.

Events following the closure of the ACCT

58. Almost a week after the ACCT was closed the man was reviewed by the second psychiatrist on 13 July. According to the clinical record that he presented with "heightened anxiety based symptoms and complained that his hands shook due to the antipsychotic medication. He was still not sleeping properly, but he denied any paranoid or delusional thoughts. The psychiatrist noted his concern about him developing a dependency on his medication. Nevertheless, no changes were made to his treatment regime.

59. A post closure ACCT review took place two days later on 15 July. The man said he preferred to see the first psychiatrist rather than the other prison psychiatrists. He was encouraged to find alternative people that he could trust to develop a wider support network. It was also suggested that a change in activity or location may help address his depression, but he said that "healthcare is the right place".

60. The third psychiatrist saw the man again on 20 July, and said he felt low, the diazepam had not helped with his anxiety and he suggested that an alternative like lorazepam may help. The psychiatrist noted that his description of his mood was at odds with his presentation during the day when staff thought he was calmer and he interacted well with other prisoners. The psychiatrist said that he presented as "extremely anxious" during the review, although he denied any thoughts of self harm. He repeated his earlier diagnosis of "generalised anxiety disorder" and again made no changes to his medication. The psychiatrist wrote on the clinical record that a possible discharge from the ward could be explored.

61. On the same day, the man asked to attend Rethink (Rethink is a national mental health charity who run courses in Birmingham looking at issues such as depression, anxiety and self harm) and he was referred. He subsequently attended a Rethink session on 31 July.

62. On 7 August, the third psychiatrist reviewed the man once more and he again complained about similar issues. He had recurring thoughts about his past and these continued to overwhelm him. However, the psychiatrist concluded that he had no "florid psychotic symptoms", his thoughts were more anxiety based and he made no changes to his medication.

63. The man saw the third psychiatrist again three days later on 10 August. He repeated his complaints about sleeping and medication. The following day, the psychiatrist again reviewed him. He repeated that his medication was not helping him. The psychiatrist recorded that he continued to be overwhelmed by "anxiety based symptoms and he struggled to cope with day to day events. However, he said that there was no significant change in his mental health and he denied any thoughts of harming himself.

64. During the man's daily clinical evaluation on 22 August, he told a mental health nurse that the prison's psychiatrist was planning to move him to a normal wing. The clinical record noted that he appeared to be anxious about this prospect, but the nurse reassured him that a care plan would be put in place to help him manage the transition. Two days later on 24 August, RMN F recorded that he said he was concerned about the move. He added that the first psychiatrist had "promised" that he would get a single cell. He was told that there were currently no spaces on the main prison wings. The RMN said that she passed the information onto the psychiatrist and he confirmed that he was fit to be discharged from healthcare.

65. The first psychiatrist subsequently saw the man on 3 September, and encouraged him to make plans for his transfer to the wing. The psychiatrist also suggested that he planned some activities to occupy his time. He noted that the man was on the waiting list for Rethink, although it was unclear why this was the case as he had attended a session three days before. He concluded that the man had remained settled and maintained good progress. However, he said that the man had a "poor ability to cope" on ordinary location due to his "high anxiety" and his difficulty with handling group situations.

66. Four days later on 7 September, RMN G saw the man about his pre-discharge plan. The RMN indicated on the clinical record that there was a discussion about the preparations for a possible move that week and the management of his integration into a normal wing. He talked about some of his expectations which included a single cell on a wing that was not "densely populated". He repeated that he wanted to start the Rethink course. He was reassured that wing staff would offer him support and monthly reviews would be arranged with the prison's psychiatrist.

ACCT monitoring from 14 September

67. A week later, the man self harmed at night. HCO A said that he had used a staple to etch "death to (name)" (on his arm). The next morning, on 14 September, she opened another ACCT document. He also told the healthcare officer that he had looked for a way to hang himself in his cell. He said he felt depressed, paranoid and had frequent nightmares. An immediate action plan was put in place, including hourly observations pending his first ACCT case review. RMN B also wrote on the clinical record that several large staples were "recovered" from his cell.

68. As part of the ACCT procedures, the man was interviewed on the same day by an ACCT assessor. His mood was described as "low" and he said that his medication was not working. He added that he felt like he wanted to die the previous night, but he could not find a way to do it so he resorted to self harm. He said he had become more isolated and he associated less with his peers. He said he had thought about getting a razor blade, but he said it was difficult to obtain.

69. The first ACCT review took place the following day, on 15 September. RMN D was the case manager, along with the man and Officer A. He said that he was ready to go to ordinary location, but he was experiencing "symptoms". A care map was completed, although the space to identify a case manager was left blank. The review concluded that his observations were to remain the same, with the addition of two conversations, and he would be referred to the prison's psychiatrist for his medication to be reviewed.

70. The third psychiatrist saw the man on the same day and recorded that his "anxiety symptoms had continued unabated" resistant to "pharmacological [drug] treatment". The psychiatrist also noted that he struggled with nightmares and he was sleeping very badly. He also complained that he heard voices that said "death to (name)", his appetite had been "greatly affected" and he had "fleeting" thoughts of self harm. He said that the man was told about his transfer to ordinary location. He agreed to the move, but wanted most of his medication at night. He recorded the concern that the man would not manage on ordinary location as he had a "low threshold for coping". Nevertheless, the move was planned for the following week and he remained on the same prescribed medication.

71. A scheduled ACCT review took place three days later, on 18 September. Chaired by the Ward Manager, the man said that he was "not too bad" but still had nightmares. There was a discussion in the meeting about his "coping strategies". He was a "bit annoyed" about the lack of progress with his transfer to ordinary location which he felt had increased his anxiety. He repeated that night times were more difficult due to his nightmares and consequently he stayed awake. His observations were changed to once an hour during the night and three conversations per day were added.

72. On 21 September, the third psychiatrist reviewed the man again and his case was also discussed in the ward round. (This is clinical team meeting usually

with the patient to discuss issues such as diagnosis, management plans, prognosis and placement.) The psychiatrist wrote on the clinical record that there was no change in his mental state and described him as "highly anxious". The ward round concluded that his condition could be managed on ordinary location and he would be discharged from healthcare. It was agreed that he would have follow up appointments with the prison's in-reach team and the third psychiatrist every fortnight.

Transfer to N wing and B wing

73. The next day, on 22 September, a review was held to discuss the man's discharge from healthcare and chaired by RMN D. The record of the meeting shows it was attended by the man and HCO A. In interview for this investigation, the RMN said that wing staff are always invited to healthcare to speak to prisoners who are due to be discharged. However, there was no representative from the wing or any evidence that they had been contacted or invited to the pre-discharge review on this occasion. The record noted that he had been aware of his discharge plan for the "past five weeks". He admitted he felt anxious. It was agreed that he would have fortnightly appointments with the prison's psychiatrist and Community Psychiatric Nurse (CPN). In addition, arrangements were made for him to be seen in the outpatients clinic.

74. A RMN wrote on the clinical record that the man was transferred to N wing on the same day, and that he would attend Rethink. However, there was no indication about whether the discharge plan was shared with the wing or if there was a handover. Two days later, on 24 September, the ACCT ongoing record shows that he was then moved to B wing, but there was no explanation for this move in his record.

75. The first ACCT review on B wing took place on 27 September. The man told the senior officer chairing the review that he felt reassured by the current plans and supported by staff. Whilst he continued to have concerns about his situation, he said he could cope. No changes were made to his observations which remained once an hour during the night and three conversations a day.

76. The first psychiatrist saw the man in the outpatients' clinic for his scheduled appointment on 2 October. He described him as "struggling" to come out of his cell during association and that officers had reported that he tended to isolate himself. He said he heard his name mentioned when he was out of his cell, but he denied any self harm or suicide plans. The psychiatrist concluded that there was a "partial remission of psychosis" and that he was fit to remain in a single cell on ordinary location. However, he said that there was an "acute worsening" of his anxiety and "delusions" since his discharge. The psychiatrist noted that he changed his medication and said that he would contact the in-reach CPN team to arrange for them to see him.

77. Three days later on 5 October, a CPN in the in-reach team completed a mental health assessment for the man. He told her that he had not slept well and he found the adjustment to ordinary location difficult. He said he felt paranoid, drained and he continually heard "good" and "bad" voices. He

reported he saw “evil faces” and he did not like the television as it communicated with him. He said he had thoughts of self harm, but he did not want to discuss it. He agreed to try day care and Rethink. She referred him to both programmes and arranged to see him again.

78. She also reflected her mental health assessment on the ACCT ongoing record. She wrote that he had fleeting thoughts of self harm and she felt it was appropriate to increase his observations from once an hour during the day and night. She added that this would be discussed this with the wing staff. The ACCT ongoing record confirmed that a B wing SO subsequently spoke to her. Her concerns were noted and as a result his scheduled ACCT review was brought forward to take place that day.

79. In the SO’s record of the case review, the man was described as “talkative” and said he was “jittery” due to his medication. The review confirmed that his observations were increased to once every hour throughout the day and night.

80. According to the ACCT record on 6 October, an officer told the man that he would start the Rethink course in two weeks. On the same day, he attended day care and saw the CPN, who wrote on the clinical record that he denied any self harm or suicidal thoughts. He told the CPN that he heard the pleasant voice of his friend. She indicated that he had been accepted on the Rethink course.

Transfer to K wing and constant supervision

81. Two days later, on 8 October, the CPN saw the man again. She documented on the clinical record that she spent some four hours with him. During this time, she said he appeared highly anxious, distressed and agitated. She also noted that his whole body was shaking. He said that the “voices” had told him not to take his medication or tell staff when he felt like ending his life. He added that he planned to kill himself when he got the chance and he needed to find peace. She said that he believed that he would not get better and he was unable to cope with the voices. He complained that his tablets were not working. She noted that he seemed to be responding to “unseen stimuli”. She said that the dosage of his diazepam was increased and arrangements were made for him to see the first psychiatrist for his medication to be reassessed.

82. She told my investigators that due to the man’s presentation, she asked a member of staff to get her manager, the Head of the prison’s Mental Health Team, and they jointly assessed him on the same day. She added that he was unable to explain why he was so anxious.

83. The Head of the Mental Health Team documented her observations about the joint assessment on the clinical record. She wrote that the man appeared “slightly agitated” and that he repeated some of the information he had disclosed earlier to the CPN. He said he had “plans”, he had “measured up the window” and he was going to hang himself. She said that attempts were

made to identify what had triggered these thoughts. However, he described "a good feeling" when he spoke about wanting to die and smiled.

84. She said that he did not seem concerned about being on the wing, but refused to see the third psychiatrist because he did not trust him. She also noted that he said he would also decline some of his medication. Due to the concerns about him, she wrote that the CPN would continue to monitor him and provide support. She said she liaised with the third psychiatrist who agreed to review his medication. In addition, she said that constant supervision was recommended and the approval of the DSM (duty senior manager) was needed for this to be arranged.

85. An ACCT review was subsequently held later that morning. A Senior Officer chaired the review, which was attended by the man, the CPN and an officer. The senior officer recorded that the Head of the Mental Health Team and a governor had agreed that he could be placed on constant supervision. At 12.00pm on 8 October, he was placed on constant supervision for the second time at Birmingham and moved to K wing (a residential wing). On the same day, his care map was updated to reflect the move to K wing, his complaint that he heard voices and that he wanted to end his life. Plans were also made for him to be reviewed by the first psychiatrist and referred to the use of constant supervision.

86. The CPN saw the man again the following day, on 9 October. In her entry in his clinical record, she said that he had difficulty answering questions; he also reported poor sleep and appetite. She said she asked him what she could do to help him and he told her he wanted to go back to B wing. She concluded that he was at high risk of suicide.

87. An ACCT review took place that same day. The review was chaired by a governor, attended by the man, the wing manager, a principal officer and a CPN. The record said that there were "grave concerns for the safety and welfare" of him. In addition, it mentioned for the first time that "he had tried to hang himself on several occasions" and "desperately" wanted to return to B wing "to be left alone to die". The meeting concluded that there was no "quick fix" and he would remain on constant supervision for a minimum of seven more days. His care map was updated to reflect that he was referred to healthcare for a full review of his current medication.

88. The first psychiatrist saw the man for his scheduled appointment on 12 October. He complained that he heard voices that told him violent things and said he was worried that he would end up listening to them. He admitted that he had not taken his medication for a day. The psychiatrist said that he presented as distressed about the "overwhelming experience" of staying on ordinary location. He documented on the clinical record that the man had made some progress and maintained it whilst he was on healthcare. However, since his move to ordinary location, the psychiatrist commented that the man reported "more psychotic experiences" and found it difficult to cope. He added that the man was on medication for "chronic and severe anxiety" and he made a number of adjustments to his prescribed drugs.

Transfer back to healthcare

89. During the course of 13 October, the man persistently complained to the constant supervision officers that he heard voices. Entries in his ongoing record reflected that he showed signs of withdrawal, he declined food as well as showers and he was described as "very subdued". A SO contacted the prison's in-reach team who advised that the CPN would see him the next day. In fact, the clinical record shows that the Head of the Mental Health Team subsequently assessed him the same day.

90. In her entry in his clinical record, the Head wrote that the man had isolated himself, failed to attend to his personal hygiene unless prompted by staff and was focused on dying. She noted that she liaised with healthcare and it was agreed that he would be readmitted for a two week period to enable him to be assessed, provided with support during his current crisis and to allow his medication to be effectively stabilised. That evening, he was transferred on constant supervision to healthcare and admitted to ward two (a ward for patients with acute mental illness).

91. During the man's first week on the healthcare centre, his allocated nurse told the investigators that he kept a low profile. When she spoke to him on a one-to-one basis there was no indication of suicidal thoughts. She added that he told her that he was "so happy" to be on the ward and that he "really liked it".

92. The second ACCT review was scheduled to take place on 16 October, seven days after the first one took place. However, neither the governor nor the deputy governor were available to chair it. Arrangements were made for the deputy governor to review the man the following day instead. Nevertheless, an interim meeting was held, chaired by RMN D. He said he felt the same as when he was first placed on constant supervision. He added that dying was the only way to stop his suffering and all the positive voices had gone. The review concluded that constant supervision would remain in place. In addition, the CPN's assessment that he was at high risk of harming himself was reflected in the ACCT document.

93. That same day, the man told the CPN that he did not want to be on healthcare and since he started his new medication the voices had got worse. Whilst he said that he had no appetite, she wrote that he agreed that he would try to eat. She updated his clinical record.

94. On 17 October, RMN D chaired the rescheduled case review, rather than the governor or the deputy governor. The record of case review indicated that it could not be fully completed due to the non attendance of the named CPN. The allocated nurse wrote on the clinical record that Governor B later saw him and explained she would do his review on 19 October, when his CPN was available.

95. Nine days after the man's constant supervision started, Governor B chaired the first enhanced case review on 19 October. He was not happy to talk and

he still heard voices which were both friendly and “bad”. He was described as agitated and close to tears. He said that he did not want to be on constant supervision. He said that he sometimes lied to staff so that he “could get them to do things” like move him off healthcare and stop constant supervision. Healthcare staff were asked to review his medication because he continued to complain that he heard voices.

96. The CPN also saw the man on 19 October. She described him as highly anxious, agitated, low in mood and tearful in his clinical record. She added that he seemed to respond to “unseen stimuli” during their meeting. She said that he confirmed that he heard voices, but told her all the “good voices” had gone and the “bad ones” were now his friends. He repeatedly asked the CPN to go back to ordinary location and he did not believe that he deserved to be on constant supervision.

97. The next day, the CPN described his mood as low, and noted in his clinical record that he complained that he had no appetite and his medication was ineffective. She said he told her that he had “gone past the point of no return” and could never see himself getting better. He added that the only way that he would find peace was through death. On the same day, he declined to attend Rethink.

98. Two days later on 22 October, the first psychiatrist reviewed the man. A RMN wrote on the clinical record that the man felt his review went well with the psychiatrist and he trusted him, but there were no further details. Following her contact with him that day, the CPN said that he appeared “brighter in mood”, calmer and less agitated, but added that he still wanted to end his life. He told her he found it difficult to trust people because the voices had told him not to do so. However, she described him as happy about an increase in his medication. She also said that his sleep and appetite had improved.

99. The second enhanced case review was held on the following day. It was chaired by a governor who was identified as the case manager. The man explained he was now on new medication, but he had thoughts of hanging himself. It was agreed that he would remain on constant supervision. The governor added that as no CPN had attended the meeting, he would reschedule another review when he wanted all people present.

100. The man’s allocated nurse saw him the following day, on 24 October. She wrote on the clinical record that he said he was doing well and associating with other prisoners. He told the nurse he was not sleeping well, he was “haunted” by voices in his head and he still felt suicidal.

101. On 26 October, the first psychiatrist saw the man, who appeared to be “slightly brighter in mood”. He said his night medication had helped. In interview, the psychiatrist explained to my investigators that he took the opportunity to change some of his medication to see whether it would “take away” his anxiety which may have stemmed from his personality disorder or alcohol misuse.

102. Following her daily review of the man, the CPN recorded that he told her that he was happy with his current medication. However, he said he still had suicidal thoughts and was not ready to come off constant supervision.

103. An enhanced case review took place on 26 October, chaired by a governor, and attended by the man, the CPN, the Head of the Mental Health Team and an officer. It was agreed that he seemed to have improved and his medication was having a good effect. However, there were still concerns about self harm and it was concluded that he would remain on constant supervision. Once again, his care map was not updated.

104. The next day, the ACCT ongoing record shows that the constant supervision officer noticed a superficial cut on the man's wrist. When the officer asked him about it, he said that it was nothing new and the wound was an old one.

105. When the man was reviewed by the first psychiatrist on 27 October his mood was low and he did not respond verbally. The clinical record shows that he wanted his antidepressant medication to be changed, but the psychiatrist declined this request. When the psychiatrist tried to talk to him, he stood up and walked away. The following day on 28 October, the clinical record indicated that he told nursing staff that he would not take his medication, but he gave no reason for his refusal.

106. A governor chaired the fourth enhanced case review on 29 October, 21 days after the man's constant supervision started. His behaviour had deteriorated and this was related to his antidepressant medication. His recent self harmed was also taken into consideration. It was therefore concluded that he would remain on constant supervision.

107. During one of her daily reviews on 5 November, the man told the CPN that he continued to have suicidal thoughts and plans. However, he told the CPN that his medication was working, the voices were not so intense and his sleep had improved. She went on to say that he also felt incredibly low, in a "black hole of depression" and repeated that he would not get better. She recorded that she did not consider that it was appropriate for him to come off constant supervision

108. The same day, the governor chaired an enhanced case review, 28 days after the man was placed on constant supervision. The CPN could not attend because of a last minute change of time. It was agreed that there was no change in him and this was supported by the CPN. He was encouraged to be more active in the day, but that he would remain subject to constant supervision.

109. The following day, the constant supervision officers wrote on the ACCT ongoing record that the man felt like he was "slipping further down a black hole" and his mood was described as very low. However, during the morning on 7 November, the record shows that he declined his medication because he said he felt better that day, but later on his mood was considered to be very

low again. According to his ongoing record, he refused all his meals and association on this day.

110. The CPN saw the man again on 9 November, when he described his self harm and suicidal thoughts as “strong”. He told her that self harm was “not enough and it made him feel nothing”. She wrote that he showed her some recent marks of self harm on his arm, but there was no indication whether he had received medical attention. She went on to say that he appeared to be responding to “unseen stimuli” and he was seeing things.

111. The third psychiatrist reviewed the man on 10 November, two weeks after the first psychiatrist had declined to change his antidepressant medication. He repeated that he still heard voices. The psychiatrist agreed to change his antidepressant medication.

112. The next day, the man told the CPN that he did not trust healthcare staff and it was not the appropriate environment for him. She wrote that he said that he was in a “very dark place” and he “enjoyed” how it felt. She said that he wanted to come off constant supervision and repeatedly told her that he had no suicidal or self harm thoughts at that time. She wrote that she found it “quite difficult” to engage him on that occasion.

113. A governor chaired the next case review when the man said he wished to come off constant supervision and he was not suicidal. HCO A told my investigators that she recalled attending the enhanced case review on 11 November. She explained that whilst he had told the CPN that he wanted to come off constant supervision, his body language at the review indicated otherwise. The HCO added that this was not typical and due to his contradicting demeanour he remained subject to constant supervision.

114. That same day, the third psychiatrist wrote on his clinical record that there were no significant changes in the man’s mental health. He said that the man continued to hear voices, experienced fleeting thoughts of self harm and he had difficulties sleeping. The psychiatrist said that he planned to reduce his citalopram (an antidepressant) and to start him on venlafaxine (medication to treat depression).

115. On 16 November, RMN B described the man as agitated in the morning due to his antidepressant prescription. She said that he started to shout that the psychiatrist was “incompetent”. However, he was calmed down and assured that staff would speak to the doctor. She wrote on the clinical record that staff were told that the psychiatrist needed to read his notes to establish the details of his previous antidepressants. She added that this was so that a more informed decision could be made about his future medication.

116. According to his ongoing record, at 3.00pm on the same day, the man started to get paranoid about his medication and he said that “they keep getting” it “wrong”. He added that it was “making him ill” and he would “tell a pack of lies” at his forthcoming review. A further entry at 9.50pm, added that he claimed “minor self harm was not his intention and he intends to end it all”.

He went on to say that he would convince the CPN that he was ready to come off constant supervision and “carry out his plan”.

117. On 17 November, the CPN recorded that the man’s depression had “worsened”. He repeated that he wanted his antidepressant medication to be changed, although denied any self harm or suicidal thoughts and said he had “lost track” of when he last felt this way. He added that he had not self harmed since he saw her and said he wanted to come off constant supervision. She wrote on the clinical record that she did not consider that this was appropriate.

118. A governor chaired an enhanced case review that day. The issue of the man’s medication had not still been resolved and there was no progress in this area. Therefore, a note was made for the Head of the Mental Health Team to be invited to the next review, although a date for the meeting was not arranged.

119. Later that day, the man’s allocated nurse wrote on the clinical record that he wanted to be taken off constant supervision and only seen by the first psychiatrist. The next day, on 18 November the record shows that he was told that he had been prescribed venlafaxine by a psychiatrist.

120. On 19 November, the man approached RMN B and told her he would cut the veins in his elbow instead of his wrists. He went on to say he had recently used paper clips to self harm. He showed her a few superficial scratches on his arm. She explained to him that this would be documented in his notes. However, he asked her not to disclose the information and added that he only trusted her, but this would change. The ACCT ongoing record show that a cell search was carried out at 2.27pm, but there was no indication that anything inappropriate was found. Later that afternoon, the same record documented that he said that he “blamed his CPN for not getting removed” from constant supervision. He added that he would self harm on his upper arm and he “will succeed”.

121. Despite evidence that one was scheduled, no enhanced case review took place on 24 November. Later that day, a HCO reflected the man’s concerns about his medication on the ACCT ongoing record. He told the HCO that he had experienced bouts of anger and frustration that had caused him to self harm. He said this was because his “medicinal requirements” had not been met. He also complained that he had not seen a psychiatrist to resolve the matter.

122. An enhanced case review took place on 25 November, chaired by a governor. Despite being requested at the last review, the Head of the Mental Health Team did not attend. The man displayed poor eye contact and he also indicated that he felt worse. His medication was discussed and it was agreed he would remain on constant supervision. A note was again made to invite the Head to the next review.

Events in December 2009

123. On 1 December, the first psychiatrist and the Head of the Mental Health Team jointly reviewed the man. It was noted on the clinical record that he continued to self harm superficially despite being on constant supervision and he had threatened to cut a vein in his right arm. His main concern remained his medication. They planned to discharge him from healthcare to ordinary location. In consultation with the governor, his observations were reduced to four times an hour and he was moved to ward two. He would continue to receive support from the prison's in-reach team and he agreed to engage with Rethink.

124. The man also told the psychiatrist that he struggled to cope when he was bored, although there was "no clear intention of ending his life". He said that he increased his dosage of venlafaxine and started him on zopiclone (medication for sleep problems) for two weeks.

125. An ACCT review was held on 1 December, attended by the man, the Head of the Mental Health Team and the first psychiatrist. Although he was not present, the Governor made a verbal contribution. He was described as anxious and agitated. During interview for this investigation, the Head told my investigators that he was more stable and settled compared to her initial contact with him on 8 October. She explained that after a while constant supervision is no longer therapeutic as prisoners become reliant on officers or can become isolated from their peers because an officer is with them at all times.

126. During the first psychiatrist's interview with my investigators, he repeated that they were satisfied that the man had been stable over a period of time. He added that although he self harmed after his second admission to healthcare, he described this as "superficial scratch marks". The psychiatrist said that it was felt that his needs could be managed on ordinary location with "a tighter care package". He told my investigators that the man was reassured that his initial anxiety about being discharged from the healthcare centre would pass. He considered that it was safe to discharge him and he did not believe there was "any risk at all". He was taken off constant supervision. The Governor subsequently agreed to the decision.

127. On 2 and 3 December, the clinical record described the man as calm and settled. However, two days later on 5 December, he self harmed by scratching his arm overnight. He used a staple to make three superficial cuts on his forearm. According to a nursing entry on his clinical record, the injuries did not require treatment and that he said that the "voices told him to do it".

128. At an ACCT case review on 7 December, the man said he felt much better, although he was distressed by "unseen stimuli" and was concerned about "drowsiness". The review concluded that the psychiatrist would be asked to review his medication, but he was settled and his observations were reduced to two per hour and three conversations a day.

129. The following day, the CPN recorded that the man was “settled in mental state” and there was no evidence of him responding to “unseen stimuli”. She described him as calm, relaxed, alert and she added that he interacted well. He told the nurse that his medication was changed (venlafaxine was increased) and he was pleased about it. However, he said he wanted two zopiclone tablets at night to help him sleep. Despite showing her several superficial scratches on his arm, but he did not talk about suicidal or self harm thoughts.

130. At an ACCT case review on 12 December, the man said that little had changed in relation to his mental health but he continued to get “command hallucinations”, which put him under pressure. He said he felt paranoid and that he preferred to isolate himself and resort to self harm. His level of risk and support remained the same.

131. Two days later on 14 December, the man asked to be reviewed by the mental health team. The Head of the Mental Health Team said he appeared low in mood and he had thoughts of self harm since he restarted his antidepressants. He reported sleeping badly, increased paranoia and that he felt “drained” and “a bad person”. He talked about thoughts of self harm and his discharge from the healthcare centre. He told her that he needed to “cut”, but he did not have the means to do it. He told her that he would “succeed in his suicide” and he was thinking about hoarding his medication until he had enough to kill himself. She recorded that she told staff in the healthcare centre about the conversation.

132. An ACCT review was held the next day. The man told a RMN that he still felt suicidal, “fed up”, depressed and things had got worse. He said he had “serious thoughts of how I would do it today” and “the easiest way”. He told the meeting that if he could not stop his head, he would stop his body and he had a plan, but would not disclose it. He said that he needed people to talk to him and “press the button” to find out how he was getting on as it got things out of his head. His level of risk and support remained the same.

133. On 18 December, the man was unlocked from his cell at 8.45am to have a “clean out” and shower. Five minutes later, a SO gave him a razor to shave and he took it back to his cell and closed the door. However, an officer retrieved the razor. When he asked if he was going to do anything with it, he replied “no”. On the same day, RMN A wrote on the clinical record that when staff asked him if he was okay he showed them three small superficial cuts. However, he declined to have them cleaned and dressed.

134. Later that day, the man told the first psychiatrist that he had felt more stressed over the previous few days and he showed him superficial cuts on his forearm. He said he was angry and had self harmed to deal with it. He said that he felt more agitated during the evening, but could not explain why. The psychiatrist prescribed an increased dose of pregabalin (treatment for anxiety) medication in line with his treatment plan.

135. At an ACCT review on the same day, the man said he still felt like self harming, but he would not elaborate. He indicated that he was “happy” to be discharged, but he was still unsettled. No changes were made to his observations or conversations.

136. The CPN assessed the man on 23 December, described him as “settled”. However, she commented that he appeared low in mood, he continued to have self harm thoughts and he heard “nasty voices. He told the nurse that he saw many people from his past in his cell. She recorded that he did not believe that the pregabalin was helpful.

137. The next day, a RMN wrote on the clinical record that the man complained that he was not having the number of conversations specified by his ACCT. The RMN advised him that these did not necessarily have to be with a nurse. An ACCT review was also held on 24 December at 3.30pm. He repeated that he was unhappy with the amount and quality of his conversations. In addition, he said that his “head is gone” and things had got “rapidly worse”. He added that the first opportunity he got he would attempt suicide. He reported that the voices had got worse and his paranoia and depression had “hit an all time low”. Due his presentation, his observations were increased to three times an hour, but no changes were made to the number of his conversations which remained at three a day. The ACCT ongoing record showed no evidence of any conversations on 24 December.

138. According to his ACCT ongoing record, the man had a brief conversation at 9.30am on 25 December, and there was a management check at 2.10pm. However, there were no further documented conversations. The following day, there was a management check at 9.20am, but no record of any conversations throughout the day.

139. During an ACCT case review on 27 December, the man said he felt more in control of the “situation”, although he continued to have thoughts of suicide rather than self harm. He told staff he felt safer in the healthcare centre rather than on ordinary location where he had access to items such as razors. He said he was having more visual hallucinations in his cell at night and asked for a review of his medication, which was agreed would be referred to the psychiatrist. His observations were reduced to once an hour and his conversations remained the same.

140. No conversations were recorded on 27, 28 and 29 December, although there were management checks every day. On 30 December, a “chat” with the man about football was recorded in his ongoing record at 9.45am and then at 11.30am he said he was “ok”.

141. The next day, the man attended an ACCT case review and said he remained suicidal and that it was “things to do with his head”. He said he had not used a razor because he was being “watched”. He again asked for his medication to be reviewed. He said that he interacted well during association as he had made up his mind to “get off” healthcare. He added that he had not self harmed for a few days because he wanted to kill himself. He explained that

he had used self harm to release his frustration, but it no longer worked. His observations and level of risk were reviewed and it was agreed that they remained the same.

Events in January 2010

142. On 3 January 2010, the man complained to a RMN that he was not getting the support that he required from staff and that his mental health had deteriorated since he had been in the healthcare centre. The RMN said that he was reassured but asked to "meet staff half way" and to try and take responsibility for his own actions.

143. The man was moved to a different part of the healthcare centre on 7 January, following a discussion with officers about the most suitable location. His ACCT review was also held on the same day and he said there was no change. He repeated that he saw people in his cell at night and they told him to hurt himself and others, which stopped him sleeping. He said that he had "no peace" in his head and he continued to have suicidal thoughts. He requested to see the first psychiatrist about his medication so that he no longer saw "bad people".

144. The man repeated that he saw people, but said that he was coping during an ACCT case review on 14 January. No changes were made to his level of observations and the quantity of his conversations. On 19 January, the CPN and a psychiatrist discussed his treatment and agreed it was likely that he would be discharged from healthcare "soon".

145. The CPN next saw the man on 21 January when he looked physically much healthier. He told her that he still heard voices and had visual hallucinations, although he said that he was "ok". He did not report any current self harm or plans of suicide. However, he said that there were three possible ways to kill himself when he went to the wing.

146. At an ACCT review the next day, the man said that no one had talked to him "to cut the voices out" of his head and the psychiatrist had not listened. Staff observed that when he was asked to meet staff halfway, he got up and walked away. He said "send me to the main jail and I will kill myself". When asked why only two members of staff were present, RMN D explained that it was sometimes difficult to get enough people to sit on reviews because the prison was short staffed. The RMN said his comment about killing himself did not alter the way she dealt with him. She added that she continually tried to speak to him to establish what was going on and how he felt. When he was reluctant to engage she told my investigators that she would leave him and then try and talk to him the following day.

147. The man's allocated nurse reviewed him the next day, on 23 January. She wrote on the clinical record that there were no changes in his presentation. She added that he engaged well with his peers. However, she said it was not easy to establish a relationship with him because he said that no one on the ward ever listened to him. She noted that he told her that this mainly related

to the ACCT reviews. She indicated that he still heard voices and he was anxious when staff talked about his mental health. However, she said that he was given reassurance. No conversations were recorded in the ongoing record on 23 and 24 January.

148. The man asked to see someone from the mental health team and the clinical record shows that the Ward Manager saw him on 25 January. He told her that he did not like it where he was and he wanted to go to a different ward, where he was more likely to see the first psychiatrist. He added that he had not seen him for a few weeks and was he "fed up" with the situation. He repeated that he thought that his medication should be reviewed. He complained that staff had not spoken to him although they were required to have three conversations a day. She reassured him that she would contact the psychiatrist the next day and establish when he could see him. He became increasingly angry during the discussion and made offensive remarks about staff and the third psychiatrist. She said he shouted he "should not be on here" and "you can get me discharged, just get me off here. I'll go onto B wing and I'll sort it out myself".

149. Later that evening, the man pressed his cell bell and he requested to see a psychiatrist or to be provided with a television. She tried to explain to him that one was not available. However, he told her that if she did not get him a psychiatrist he would get one at hospital. RMN D said that he later pressed his cell bell again. On this occasion, she said that he showed staff a blade and said he would cut his hand "from top to bottom". Due to his behaviour and his refusal to talk to staff, she said that the orderly (duty manager) was contacted. The orderly officer subsequently saw him and asked him if he intended to cut himself and he said no. He denied that he had a blade and he agreed to wait for the doctor the next day. The RMN told my investigators that he eventually calmed down and he later apologised for his behaviour. As a result of his behaviour, his ACCT review was brought forward and held at 8.25pm that night. He was not at the meeting. His observations were increased to three times an hour and there was no change to the number of conversations which remained three a day.

150. The next day, on 26 January, the man's cell was searched by two officers. She said that they discovered a piece of metal which was confiscated. The first psychiatrist also reviewed him that day. The Ward Manager was present during the review and she told the psychiatrist about the events on 25 January. During his interview with my investigators, the psychiatrist acknowledged that he had not seen him for just over five weeks. He explained that this was because he was clinically stable, awaiting discharge and there was no need for any "robust input". He repeated some of his previous concerns. He talked at length about his paranoia particularly during the evenings. He asked for his medication to be changed. He again said that he had enough and was fed up with the voices. The psychiatrist reassured him that he was on the "optimal medication", but he disagreed. He told the psychiatrist that he was "trying really hard" not to act on his thoughts to harm himself or others. The psychiatrist said that he would return later in the afternoon with a view to discharging him back to ordinary location.

151. The man told the CPN in a meeting later that day that the psychiatrist had said he was due to be discharged. Initially, he told her he was not ready for this to happen, but he then said he was glad to go to the wing as he would be able to end his life. She noted that he did not want to discuss his current self harm or suicidal thoughts or plans. He repeated that his medication was not working. She said she reassured him that she would regularly visit him on the wing, but he said there was no need as he would "no longer be here".

152. The first psychiatrist also completed the man's discharge summary on 26 January. He said that since his admission to healthcare he presented with issues of anxiety and dependence on both staff and the systems on the wards. The psychiatrist added that he had a tendency to "idealise" or "undermine" other staff and mental health team members. He noted that he had previously coped poorly on ordinary location, but the psychiatrist said that he had always remained well adjusted, except during clinical consultations. His sleep and appetite were fine and he interacted normally with others. He commented that he had made "suicidal expressions and gestures" as soon as discharge plans were mentioned. The psychiatrist said that the man avoided discussion about his mental health and setting goals for his recovery, but he remained insightful about his condition. He concluded that the man was at high risk of self harm, but a low to moderate risk of attempting suicide.

153. A review prior to discharge from healthcare took place the next day on 27 January was chaired by the Ward Manager. She invited an officer from B wing, but was told that there was no one available. When discussing his discharge, the man said that he needed people to press the "right buttons" in "his head" as well as needing someone he could "open up to". He agreed to go to day care and Rethink and he asked for his observations to be reduced to once an hour. However, because he was moving to the wing, he remained on three observations per hour and three conversations a day. He acknowledged that he had said he wanted to move to the wing to kill himself, but would not elaborate. He said that he would like to be transferred to HMP Ranby as he had a good rapport with staff there. The agreed discharge plan included twice weekly reviews with the CPN, an appointment with the first psychiatrist on 29 January and fortnightly thereafter, attendance at day care and Rethink and prescribed medication. The next review was scheduled to take place on 2 February.

154. On 28 January, the man's allocated nurse completed a discharge plan, signed by him. She was designated his named nurse, and recorded follow up appointments, medication and the early warning signs of deterioration. She also described his "ligature making" and the piece of metal found in his cell two days earlier. The nurse wrote on the clinical record that he said that he was "ready" to be transferred to B wing, but he was "not happy" about it because he still believed that he was unwell.

155. HCO A told my investigators that she worked on healthcare and explained that she provided a "service of security" on the wards. She believed that he wanted her or other staff to "get his temper up" so he could have a "good rant

and tell you how he felt". She described how one day, she started a "row" with him to challenge him about things he had said to "sort of get his temper up". However, there was no indication when this occurred or if this was linked to the incident mentioned by a prisoner. During the exchange, HCO A said she suggested to him that he did not want to get better, he held on to his illness because it benefited him and that he was unable to do his "bird" (slang term for prison sentence). She noted that she felt that she had got nowhere, but said she ended the conversation with some banter. On reflection, she told my investigators that this approach had not worked and that it was also open to misinterpretation.

156. Three prisoners who were in the healthcare centre before the man's transfer described his mood as variable. One said that he had never seen him so low and he "let himself go". However, none said he spoke of killing himself on the wing. Another HCO told the investigators that he did not witness any change in his demeanour in the days prior to his move. He said that on a day to day basis he was a "very sullen type person", although his mood fluctuated.

Transfer from healthcare to B wing

157. The man's allocated nurse told my investigators that she was not at work when he was moved back to ordinary location, but she anticipated that another healthcare colleague would telephone B wing in her absence to share the discharge plan. RMN D confirmed that she was on duty on 29 January when he was moved to B wing. She said that she asked him if he was going to be alright and he said yes. She added that he was taken over to B wing by a healthcare officer, but my investigators were unable to identify this member of staff. There was no evidence that healthcare contacted B wing to share the information in the discharge plan.

158. The man was moved to cell B2 24 which is positioned furthest away from the wing office. The first psychiatrist told my investigators that his planned appointment with him did not take place on 29 January, as the move occurred on this day and he usually reviews patients two or three days after discharge. The investigators asked an officer whether she knew about his transfer to B wing on 29 January. She believed that she saw HCO A on the wing and she told her that he was "coming over", but she was unable to recall when this occurred.

159. According to his ongoing record, the man said that he felt suicidal and "happy to be on B wing". Officer B, moved him to B1 02 (nearer the wing office) as the night light in his cell was not working. After the problem was rectified, he returned to B2 24 the next day. He told the officer that he was happy to be back as the cell was nice and warm. He declined association and later told a member of staff that he liked his own company.

160. The officer described the man as "very much a loner". He added that he was uncomfortable with mixing with others and he did not openly engage in conversation. The officer told my investigators that he was aware that the man was on an ACCT and that he had been on constant supervision. He also

remembered him from when he was previously on B wing. The officer felt that his presentation was "very much the same". He recalled that he appeared to be "quite happy" in his own cell and mainly listened to the radio.

161. Officer C spoke to the man on a number of occasions during the course of the day on 31 January. In the morning, he said he was "ok" and that he had slept well. He told the officer that he was "glad" that she was in that day. She also approached him when he did not come out of his cell. She encouraged him to do so, but he declined as he said it was too crowded. During the afternoon, he said that he no longer wanted a television in his cell and she removed it.

162. She could not recall exactly when she spoke to him but remembered talking to him on 30 and 31 January. She told my investigators that they talked about him getting a shave and haircut. She suggested he saw the prison barber, but he declined because he did not want a "machine" on his face, so she offered to do a supervised shave the following day.

163. The man again did not come out of his cell for association on 1 February, and he said that he was "fine". He slept for much of the afternoon and indicated that he was "ok", although he expressed concerns about the how many people were on the wing.

Events from 9.00pm on 1 February

164. HMP Birmingham enters night state from 9.00pm to 7.30am the following day. At the beginning of the night, all prisoners are accounted for and secured in their accommodation. An orderly officer is in charge of the prison, accompanied by an assist night orderly. In addition, the prison also has a response team who are available to assist with any incidents. During the prison's night state prison officers or operational support grades (OSG) patrol the residential wings. To show that they have undertaken the required checks a pegging system is in place. Night staff press buttons located outside a prisoner's cell and this then registers on a computer. A pegging log is generated and identifies each cell bell that was pressed, the landing and the time this was done during the night state.

165. The OSG started night duty on B wing at 9.00pm. She explained to my investigators that she is required to periodically check each of the four landings and all prisoners on an ACCT. When she arrived on duty she said she was not given any specific information about the man, but she was told that there were three prisoners on ACCT's. According to the pegging log and the ACCT ongoing record, she observed him sleeping in cell B2 24 at 9.00pm and then three times an hour until 4.55am on 2 February.

166. Officer D told my investigators that he had two conversations with the man early that morning, although these were not recorded on the ACCT ongoing document. The first was at 5.20am when he collected the night packs (these are documents that are issued to each wing to record various information during the night state). He said that as he left B wing, the man's light came on and it startled him as it was dark. He noticed that he was on an ACCT

because he saw an orange card outside his cell (an orange card is used at Birmingham to identify prisoners on ACCT monitoring). Whilst the officer said he did not open the cell or the observation panel, he asked him if he was alright. He replied “yes boss” and said that he was using the toilet. The officer said he gave him no cause for concern and he continued with his duties.

167. Five minutes later at 5.25am the ACCT ongoing record shows that the OSG observed that the man was on the toilet. (The pegging log also indicated that he was checked at 5.31am.) She did not speak to him as she considered it was inappropriate given the circumstances.

168. The second conversation with the officer took place at 5.40am. He explained that when he returned to B wing from doing his rounds he noticed that the man’s light was still on. The officer thought it was strange that he would still be using the toilet twenty minutes later. So he opened the cell flap and saw that he was fully dressed and sat on his bed. The officer asked him again if he was alright and he said “yes boss”. He queried whether he had a court appearance and why he was up at that time. He repeated that he was fine and indicated that he had just got up early. The officer noted that he was rolling a cigarette. He once again asked him if he was sure that he was alright. He answered “no, I’m fine, not a problem” at which point the officer said he closed the cell flap and left. The officer told my investigators that he then went to the office on B wing and spoke to the OSG. He told her about his conversations with him and asked her whether she wanted him to record this on the ACCT document. She said no as she was “going to peg him”. The officer said that this occurred at 5.45am.

169. The OSG observed the man minutes later at 5.50am and also pegged at 5.51am. She recorded that he was sat on his bed having a cigarette. She said she asked him whether he was smoking a “fag” (slang term for cigarette) and he responded “yes”. At 6.00am, she did a further observation and noted on the ACCT document that he was again sat on his bed.

170. The OSG discovered the man hanging at 6.44am, 44 minutes after the previous check. In interview for this investigation, she acknowledged that there should have been at least one further observation during this time as he was on three per hour. However, she was unable to account for the gap.

171. After the OSG found the man hanging she told my investigators that she immediately radioed for healthcare assistance, although no particular code was used. She said that a SO, the Assist Night Orderly, was already on the landing at the time and she shouted for the PO who was in charge of the prison, who was also in the nearby centre. The man was hanging from the window bars having made a ligature from bed sheets.

172. The PO told my investigators that he was in a meeting with the SO and a nurse discussing the night’s events. The PO said he heard a “cry” from the OSG and she called his name. The SO and nurse immediately went to B

wing, while the PO radioed to ask for two response staff to attend B2 landing. He said that he then followed them and headed towards the cell.

173. In interview with my investigators, the nurse said she was in the nurse's base on B3 and not in the centre when a call came across the radio to attend B2 landing immediately. She was unaware of the nature of the emergency. She explained that she took a response bag with her that contained various medical supplies such as dressings, medication and an oxygen mask. She then went from B3 to B2 and saw the SO walking in front of her towards the man's cell. When they got there, the SO opened the cell door. She said that they were then joined by the PO and he cut the ligature that was holding up the man. However, the PO told the investigators that the nurse Kings and SO were "literally seconds in front of him" and as he got to the cell they were already trying to cut the ligature. He told the OSG to go to the wing office as she was visibly distraught. He said that he went into the cell at that point, as the SO and nurse had lowered the man against the wall.

174. The nurse said that as the man was being cut down she tried to find a pulse, but could not and there were no signs of breathing. Although her first impression was that his chances of survival were not good, as he was still warm she thought there was an opportunity to save him. He was put on his back on the floor and she said she again checked for any signs of life, but there were none.

175. In interview for this investigation, the nurse explained that she did not start Cardio Pulmonary Resusciation (CPR) after examining his condition (cardiopulmonary resuscitation is an emergency lifesaving procedure that is performed when a person's own breathing or heartbeat has stopped). She told the officers that she needed to get a defibrillator (an electrical device that is used to restore a normal heart beat by applying a brief electric shock) and further equipment. She added that she needed oxygen and the defibrillator to give the man the best chances of survival. The investigators asked the nurse whether it would have been possible for her to start CPR and for someone else to get the defibrillator. She explained that the defibrillator was located on the landing on wing B3, but the officers did not know where it was. She was worried that if they were unable to find it, resuscitation attempts would have been delayed so she went to get it herself. At this point no one was doing CPR nor did she instruct anyone to perform it.

176. The PO told the investigators that when the ligature was cut away, the nurse started CPR, doing both breaths and compressions. (CPR is a combination of rescue breathing, which provides oxygen to the lungs, and chest compressions, which keeps oxygenated blood circulating until an effective heartbeat and breathing can be restored). He confirmed that the nurse then left "literally for two or three minutes" to get another piece of equipment which he thought was the defibrillator. He said he had been trained in first aid and CPR continued with the compressions. He described the man as "very warm" and said his cheeks were "quite reddish".

177. The SO radioed the control room and asked for a “blue light” ambulance. The PO explained that the prison’s communication department will not call for an ambulance until they have the full details. The control room log shows that the prison called an ambulance at 6.55am, ten minutes after the OSG discovered the man hanging.

178. When the nurse returned to the man’s cell, she said she reassessed him to ensure that there had been no change. She added an ambulance had already been requested and it was on its way to the prison. The nurse said that it was a “real struggle” to fit the airway in as she could not get the man’s mouth open and this process seemed to take a long time. The PO did the chest compressions and the defibrillator was attached to the man, but it advised the nurse not to shock. (The defibrillator has sticky pads with sensors called electrodes that are attached to a patient’s chest. These send information about the heart’s rhythm to the defibrillator. It then determines if an electric shock is required and indicates when to give one.) The PO said he left after two more nurses arrived and another nurse then took over doing the chest compressions.

179. According to the prison’s control room log, eight minutes after the ambulance was called it arrived at the gate at 7.03am. The paramedics were escorted to the man’s cell two minutes later at 7.05am. They then took over the attempts to revive him. The ambulance left for the hospital at 7.38am with the man and a member of prison staff.

180. At 7.50am on 2 February, Birmingham was notified that the man had died. The prison’s family liaison officer later visited his niece who was listed as his next of kin. She was notified about his death and the available support.

181. The PO told the investigators that he looked around the man’s cell and found a number of letters. One appeared to be a suicide note. This was addressed to the CPN and it was dated 1 February. He said that the first psychiatrist (who he referred to as JP) had got it wrong when he said he would “take a chance”. He added that the voices were “so bad”, he would have them “for life” and he still saw people in his cell at night. He went on to write that he had told the psychiatrist his antidepressants were not working, but he did not listen. He said that the CPN had been “good” to him and noted he had told her he would not see the psychiatrist in two weeks. He asked the CPN to ensure that the radio was returned to HCO A. Finally, he thanked her for everything and for “trying her best”.

182. A memorial service was subsequently arranged by the prison and two members of the man’s family attended it. All the members of staff who were interviewed about his death confirmed that they had been offered and received appropriate support.

ISSUES

Clinical Care

183. The man had a long history of mental health problems, self harm and suicidal thoughts. He had complicated needs and his mood tended to fluctuate. At times he was described as restless, agitated and depressed. He reported that he had thoughts about suicide everyday, specifically hanging. He also heard voices, experienced nightmares and suffered from poor sleep. However, there were also occasions when he was considered to be stable, "feeling good" and less agitated.

184. Between 14 September and 18 December 2009, there were six occasions when the man self harmed. The most serious was when he used staples to scratch "death to (name)" on his arm.

185. The man was prescribed medication for his mental health problems while he was at Birmingham. This was an ongoing source of contention for him. At times he expressed concern that his tablets were ineffective. He also felt aggrieved or "upset" if his medication had been reduced or not increased. At other times, he appeared to be satisfied with it, but this was not for sustained periods.

186. The CPN explained to my investigators that it was normal to try different medication and dosages. She added that it was "trial and error" and it could take "forever really for someone's medication to be stabilised", because it was not like treating a physical condition. She said in the man's case the drugs worked for a while and then they did not. She told my investigators that she tried to encourage him to stay positive and talked with him about all the important things in his life. However, he did not believe that any medication would work.

187. The first psychiatrist recalled that the man was difficult to assess largely because of his personality disorder and his complicated needs. On the one hand, he told my investigators that the man would interact, play pool, joke and carry out his life as usual. He went on to describe him as warm, "very witty" and said at times they had a very good rapport. However, the psychiatrist explained that on other occasions, the man would threaten to kill or cut himself when he was not content with issues such as his medication or constant supervision. He considered this to be his "normal way of interacting…"

188. A clinical reviewer conducted a review of the clinical care that the man received. Unfortunately, the clinical review does not assess the appropriateness of the mental health treatment that he received while in custody. Neither does it comment on his complex medication and whether it met his needs.

189. I am not clinically qualified to determine whether the man's prescriptions were appropriate to his condition. However, I can see from the evidence gathered

throughout this investigation that many attempts were made to engage him with his treatment. Although he was often unhappy with the medication he was receiving, his concerns were recorded and efforts made to explain to him the reason for his prescriptions. His frequent contact with the mental health team is evidence that staff worked hard to support him through his mental health condition.

190. The clinical reviewer makes one recommendation about the frequency of ACCT observations. He also recognises two areas of good practice, resuscitation and the management of the man's risk of suicide. I will consider these matters in more detail below.

The man's ACCT case reviews

191. The man was on an ACCT for a prolonged period of time, and this inevitably is a difficult situation to manager. The quality of his ACCT reviews was variable. Some were completed to a high standard with records of in-depth reviews. However, there were other instances when this was not the case.

Chair of first the ACCT reviews

192. After the man was placed on constant supervision on 25 April, his first ACCT review took place promptly. PSO 2700 requires that in cases involving constant supervision, it must be chaired wherever possible by a member of the prison's senior management team. This should preferably be the duty governor or head of healthcare, or a manager nominated by them if neither are available. However, the first review was chaired by a registered mental health nurse.

193. In September, when the man was again placed on ACCT monitoring, without the use of constant supervision, the first review was chaired by a registered mental health nurse. This is despite PSO 2700 indicating that this must be done by the unit manager. I would therefore have anticipated that the ward managers to chair the first review. I understand that the registered mental health nurse was well informed about his care and therefore in a good position to determine his needs.

Lack of a consistent case manager

194. The care map form provides a space for the case manager to be identified, but it was left blank for the ACCT that started in April and ended in July 2009. During this period, a total of six different members of staff chaired the ACCT reviews and all were identified as the case manager. They consisted of registered mental health nurses, senior nurses, a ward manager and a governor who oversaw the reviews on 5, 8 and 13 May.

195. The same applied to the man's second ACCT document, started in September. The space on the care map form to name the case manager was also not completed. A total of 11 individuals who were governors, registered mental health nurses, senior officers, a nurse and two ward managers were

case managers throughout the duration of the open ACCT document. The only period when there was a consistent case manager was from 22 October to 1 December, when a governor assumed the role.

196. I am concerned about the lack of a consistent case manager. There was no record to show that one was appointed at the case first case review although PSO 2700 says that this is a requirement. In addition, Birmingham's local policy says that this should be the healthcare manager where the prisoner is an in-patient. Not only is it against their own local policy, but it is not the practice required by the prison service order. I therefore make the following recommendation to ensure that there is a consistent case manager:

The Governor should ensure that a case manager is appointed at the first ACCT review to manage an individual's support plan for the whole time they remain at risk of suicide and self harm.

Updating the man's care map

197. PSO 2700 states that the case manager must update the care map after each case review. During the man's first ACCT from 25 April to 7 July, he had a total of 15 reviews. Following the completion of his care map on 26 April, it was only updated once on 25 May. In relation to the second ACCT from 14 September and until 27 January 2010, when a new care map was completed, it was only updated on three occasions after reviews. However, there were a total of 29 meetings. I trust that the appointment of a consistent case manager will result in the effective use of care maps in future.

Lack of multidisciplinary ACCT reviews

198. Multidisciplinary input to prisoner care is valuable. The man's complex set of needs required input from healthcare staff, as well as officers and governors to ensure a rounded approach to his care. In 2009, HM Chief Inspector of Prisons concluded that many of the ACCT reviews at Birmingham were not multidisciplinary. I am concerned that this was evident in this case on occasion.

199. The record of case reviews showed that specific members of staff were to be invited to attend ACCT meetings, but on three occasions there was no evidence that this was done. This was notable on 26 April, when in line with PSO 2700, a representative from chaplaincy was invited to the next review, but there was no record that a similar request had been extended to a governor.

200. The absence of specialist staff was evident following the ACCT review on 8 May. RMN B wrote to the CPN team and invited them to the next meeting. However, they did not attend and there was no recorded explanation to account for their absence. Furthermore, there was no representative from the PCMHT although the record of the case review indicated that they should also attend.

201. Similarly on 17 November, the ACCT review concluded that the issue of the man's medication had not been resolved. It was noted that the Head of the Mental Health Team was to be invited to the next meeting, whilst she believed that she had been asked to attend some reviews, there was no record that this happened. A governor indicated that he sought the advice of the Head of Healthcare. This was entirely appropriate, but it would have been good practice if he had reflected this and the outcome in the record of the case review.

202. PSO 2700 specifies that the named case manager, a residential officer and an appropriate member of non-discipline staff must attend ACCT case reviews. However, there were numerous occasions when this did not occur. For example on 25 May, 12, 25, 30 June and 23 October, only two members of staff were present and on 22 June, there was only one.

203. The absence of multidisciplinary ACCT reviews in these instances could be partially a result of the lack of a consistent case manager. According to PSO 2700, the case manager should ensure that any specialist staff who have been asked to provide care to the at risk prisoner are invited to contribute to the case reviews. It is possible that because there were numerous case managers no one took overall responsibility for inviting relevant staff or following up the reasons for absences. In addition, RMN D told my investigators that there were times when the prison was short staffed and this impacted on the attendances at ACCT reviews.

204. A PO explained to my investigators that due to the size of Birmingham and the number of departments, it is difficult to always arrange a review when all the relevant people can attend. He added that most individuals usually work shifts and it is therefore always going to be quite "a difficult logistical task". However, he said that the advice both nationally and from within Birmingham is that reviews should be multidisciplinary. He went on to say that there are never one-to-one reviews with a manager and a prisoner, although the one on 22 June would suggest otherwise.

205. I am mindful that there will be occasions when staff cannot attend reviews for the reasons identified by the PO. However, PSO 2700 says that where attendance is not possible staff must provide input in writing or by telephone to a particular review or any subsequent ones if requested. I am concerned that this did not take place on any of the occasions that have been highlighted.

206. PSO 2700 specifies that prisoners who have been on constant supervision for eight days or more must be managed through enhanced case reviews, including a member of chaplaincy and the IMB must be invited, there was no record that this occurred during either of the periods when the man was placed on constant supervision.

207. During one governor's interview he told my investigators that he was the allocated case manager. He said that he found the man a "very difficult person" to assess. This was partly attributed to his presentation which he

described as withdrawn and inconsistent. He explained that he was not satisfied that the man's medication had been stabilised or that it had worked. Therefore, he was not content to remove him from constant supervision until the matter had been resolved. Consequently, the governor said he sought advice from the Head of Healthcare and also invited the Head of the Mental Health Team to a review. My investigators asked the Head of the Mental Health Team if anyone contacted her about attending any reviews. She said that she had probably been invited to a few, but was unavailable at the times that the meetings took place.

208. The governor's dissatisfaction about the man's medication between 23 October and 25 November was evident during his interview with my investigators and documented on the record of the case reviews. I appreciate that he believed that the information that the CPN provided was "very good", but despite this input he remained unsatisfied about the issue. The matter might have been resolved if the Head of the Mental Health Team had attended the review.

209. The governor was asked by my investigators whether the prison psychiatrist's presence at the reviews would have helped address the medication issue. He said that it would have added to the confusion and ended up in a debate between the man and the psychiatrist. Furthermore, he considered that the information provided by the CPN about his medication was "very good".

210. During the first psychiatrist's interview he confirmed that he had received ACCT training, but he also did not consider that there was a need for "robust input" from a psychiatrist at an ACCT review. He explained that a nurse would speak to him or the third psychiatrist and then contribute to the review.

211. Both the first psychiatrist and the governor did not consider that the presence of a psychiatrist would have been beneficial. However, PSO 2700 says that the enhanced case review team will involve all relevant disciplines and include more specialists than a typical ACCT case review team. It specifies that wherever possible the involvement of a number of professionals, including a doctor, ought to be facilitated. Due to the governor's level of concern and his difficulty in assessing the man, I was surprised that as the case manager he did not directly consult or invite the first psychiatrist to the ACCT reviews. This would have afforded him an opportunity to directly address the medication issue.

212. The CPN told my investigators that when she saw the man, he always presented as anxious, but on the ward he was described as settled. She explained that she "fought each time [during the reviews] to keep him" on constant supervision. She acknowledged that he was on it for a significant period of time compared to other people in the prison. However, she believed that he needed it, to "save his life" because she considered that he was at acute risk of suicide. She noted that he was not always a high risk. She said he had "peaks and troughs" which were dependant on his state of mind, medication or sleep pattern. She added that he also interacted differently with members of staff. During some of the ACCT reviews, she said he would

present as really anxious and then at others he would be calm. When the investigators questioned her about his self harm, she said that he did "nothing really major" and she acknowledged that he tended to talk about what he was going to do.

The Governor should ensure that ACCT case reviews are multi-disciplinary. If staff are unable to attend, they should make their contributions by telephone or in writing.

Missed ACCT reviews

213. The man was due to have an ACCT review on 16 October. However, neither the Governor nor the Deputy Governor was available to chair it, although this meeting had been arranged on 9 October. Arrangements were then made for the Governor to do the review on the following day. However, on 17 October, I am surprised that it was instead chaired by RMN D. There was no reference to the Governor on the record of case review only that the review could not be fully completed because of the absence of "the named CPN".

214. A review was also scheduled for 22 October and 11 December, but these did not take place. There may have been understandable reasons why this occurred, but there were no documented explanations.

215. At the enhanced case review on 17 November, no date was arranged for the next meeting. This is despite Birmingham's suicide prevention and self harm management policy specifying that this should be done and recorded. Arrangements were only made for another review after the Ward Manager contacted a governor seven days later, on 24 November. Whilst she indicated that staff were told that a review was due to take place that day, there was no record on the ACCT document to show that this was the case.

Frequency of the man's ACCT reviews whilst he was on constant supervision

216. PSO 2700 specifies that for the first 72 hours of constant supervision a review must be held every day. In relation to the April ACCT, reviews took place on 26 and 28 April in line with the policy, but one was not convened on 27 April. When the man was placed on constant supervision again on 8 October, a review was held on 9 October, but there were none on either 10 or 11 October.

217. The PSO goes on to say that where the "crisis lasts" beyond 72 hours, it is for the review to decide how often future reviews must be held. Where it is less often than daily, the reasons for holding less frequent reviews must be entered in the ACCT plan. Between 29 April and 12 May, the man only had three reviews, although he was on constant supervision for a further 14 days. The absence of daily reviews is more notable during the second period of constant supervision. Over a 50 day period, from 12 October to 30 November, there were only ten reviews. There were no documented reasons on either of the ACCT plans to explain why the reviews were held less than daily.

The Governor should remind staff of the additional safeguards required when a prisoner is subject to constant supervision, in accordance with the requirements of PSO 2700.

The length and rationale for the man's constant supervision

218. The man was twice placed on constant supervision. Although I do not criticise the decisions to use constant supervision, I am concerned about the length of time he was subject to it. On the first occasion, this was for a total of 17 days between 25 April and 13 May 2009. This included a short period when it was reduced to nights only on 30 April. The second constant supervision lasted for 53 days, between 8 October and 1 December.

219. PSO 2700 also advises that constant supervision beyond 72 hours should only occur in "exceptional circumstances". PSO 2700 describes constant supervision as a "temporary arrangement that must only be used for the shortest time possible". I appreciate that this is a matter of judgment.

220. Where a prisoner is still on constant supervision beyond a week, PSO 2700 says that this may be a sign of lack of confidence and fear of blame in staff and/or a particularly challenging and difficult to manage prisoner. The first psychiatrist's observation that the man's constant supervision was more to contain "the anxiety rather than a real risk" suggests that this may have occurred. I have no doubts that he was difficult to engage and manage. This was compounded by his complex needs and his fluctuating mood. He frequently spoke about suicide and wanting to die, which was bound to raise anxieties amongst staff. However, there was no record of self harm during his first constant supervision. There were five incidents in the second period, but these were relatively minor and consisted of superficial cuts or scratches.

221. Using PSO 2700, I have considered the governor's rationale for keeping the man on constant supervision. I appreciate that it was reasonable for him to be concerned about his medication. However, I am concerned as to whether his dissatisfaction about it was justifiable grounds to continue with constant supervision.

222. I have been cautious not to apply the benefit of hindsight and taken into account the information that was available at the time. Constant supervision is a labour intensive and an expensive resource. It is also a very intrusive measure. PSO 2700 clearly set out the framework for the use of constant supervision. I understand that staff were cautious about the risk that the man would attempt suicide. However, I am worried at the first psychiatrist's suggestion that constant supervision might have been used to manage staff's anxiety, rather than his risk. I therefore recommend:

The Governor satisfies himself that constant supervision beyond 72 hours is only used in exceptional circumstances.

The man's complaints about insufficient conversations

223. On 24 December, the man complained to a RMN that he was not getting the required number of conversations. He repeated this during his ACCT review on the same day at 3.30pm. At this stage, his support plan required three conversations a day. As a key part of his support plan, his concerns should have been investigated. An examination of the ACCT ongoing record on 24 December would have established that no conversation had taken place prior to the review.

224. Only one conversation took place on 25 December. There was no record of any on 27, 28 and 29 December. This was despite management checks during those three days. The man also made a similar complaint to the Ward Manager on 25 January. A check of the ACCT ongoing record would have shown that there were no documented conversations on either of the two previous days.

225. It is evident that the man received significant input from nursing staff, the prison's psychiatrists and the CPN. I am satisfied that overall the required number of conversations took place.

The man's referral to Rethink

226. On 20 July, the man first mentioned that he was interested in attending Rethink and he was referred to the programme. He attended a session 11 days later on 31 July. However, there was no further reference to Rethink for over a month until 3 September, when the first psychiatrist noted that he was on the waiting list. A few days later, in his pre-discharge meeting on 7 September, he repeated that he would like to start Rethink. His allocated nurse recorded on 22 September, that he would attend the course, but there was no record of when this would take place. Subsequent attempts were made to engage him with the programme, but were not successful, despite being a part of his discharge plan from the healthcare centre.

227. It would appear that Rethink was considered to be appropriate for the man given his history of self harm and anxiety. It was also an attempt to try and engage him in some purposeful activity. No individual member of staff had the responsibility of referring, overseeing or encouraging his attendance. Therefore, he did not have an opportunity to benefit from the course.

The man's discharge from healthcare in September 2009 and January 2010

228. I am not critical of the decision to discharge the man from healthcare or of the plans that were put in place. He was not progressing and I understand that a different tack to give him normality was required. However, I am disappointed by the way that his moves were managed for a number of reasons.

229. PSO 2700 set outs the procedures for discharging prisoners from healthcare. It says that a pre-discharge case review must be held before a prisoner is

returned to ordinary location from being resident in the healthcare centre. In addition, the unit manager from the receiving residential unit must be invited to this review. If it is not possible for them or a representative to attend, the reason why must be noted in the ACCT plan.

230. The man's first pre-discharge review was held on 22 September 2009. However, there was no representative from the wing or any evidence that they had been contacted or invited to the meeting. After almost six months on healthcare, he was moved to N wing. However, due to concerns about his increasingly subdued mood, evidence of self-neglect and his fixation on wanting to die, he was moved back to healthcare less than a month later on 13 October.

231. A second pre-discharge case review was held on 27 January 2010. On this occasion, the Ward Manager indicated that she spoke to a SO on B wing and asked him to send a representative to the meeting.

232. The CPN told my investigators that the review was unusually lengthy, detailed and it lasted for about an hour. She said that the man did not deny or confirm that he told her that he would kill himself if he went back to B wing. However, he spoke very positively about the prospect of going to HMP Ranby. She described him as "quite cool, "laid back" and "collected". She explained that the psychiatrist had decided that he should be discharged. She said it was not "clinically positive" for him to stay on healthcare as it had limited impact on his interactions with others and he stayed in his cell. Furthermore, he had been assessed for a very long time and it was considered that it was time for him to move on.

233. During HCO A's interview with the investigators she also said that the ACCT review on 27 January, was very lengthy, involved a lot of exchanges and she considered that it was a positive meeting. She added that she may have known that the man was going to B wing. She said she was aware that it could be difficult to move from healthcare so she tried to reassure him everything would be alright. She indicated that an officer, who he knew because she had previously worked on healthcare, was located on the wing and she would "look after him". She considered that his mood indicated that he should be discharged from healthcare. She said he was fine, he communicated well and there were no visible signs of depression or distress. In addition, she said that he had one episode of self harm and he did not present a "threat in our eyes" of harming himself. However, she was unable to recall the CPN's comment about him wanting to go to B wing to take his own life, but she acknowledged that as it was documented he must have said it. She concluded that he was "quite happy" with the plans that had been put in place and he left the review "laughing".

234. The man's allocated nurse said that prior to the ACCT review on 27 January, he had told her that he did not want to go to ordinary location and he would kill himself if he was moved, but he laughed about it. She noted that he was not actually ill at that time. He played pool and he really engaged very well. The investigators specifically asked her whether he repeated his intentions during

the review on 27 January. She replied that he said it at the meeting and that "everyone" in their team knew he had habitually said if he was moved to another wing he would kill himself.

235. The Head of the Mental Health Team's overall recollection of the review was that it was positive. She described the man as "a little bit negative" about the move, but he was also constructive about it as well. In addition, she told my investigators that they were happy with the transfer to B wing due to the presence of Officer C. He was also content with the location given he was familiar with it. She was asked whether she recalled his comment that he would kill himself if he went to B wing. She noted that he always said that he would kill himself, but what he said was at times at odds with his presentation. However, during the review she said she never felt that he planned to kill himself.

236. Officer C confirmed that she worked on B wing, but she had previously been located in healthcare where she had met him. She explained that it was general practice for prisoners to be discharged from healthcare back to their initial wing. She said that he knew some of the cleaners on B wing. He previously told her that he had no problems going back, as he knew that she would "look after him". She said that she contacted healthcare about an unrelated matter and the Ward Manager asked her why she was not at the review. She said she told her that she had not been invited to it.

237. During the first psychiatrist's interview, he said that the man had not directly told him that he would kill himself if he went to B wing. However, he confirmed that he was aware that he had said this to nursing staff. He noted that he did say that he was anxious about the move and that he had been set up to fail.

238. During the man's allocated nurse's interview with my investigators, she confirmed that he told her he did not mind being transferred and that he was prepared to go. In addition, he said that no one wanted to listen to him and he wanted a quick move. She explained that normally on the day of a transfer the relevant wing would be contacted (by healthcare) and this would be recorded on the plan. However, she explained that as he had not yet been transferred and there was no space on 28 January, she could not contact the wing. In relation to the "ligature making", she clarified that she was in fact referring to the piece of mental that was found in his cell.

239. The investigators spoke to three prisoners who were located on healthcare and knew the man, particularly during the time leading up to his move to B wing. A prisoner said the man told him about the transfer and that he had disclosed to the first psychiatrist that he felt suicidal. However, the psychiatrist said that he would have to take a risk with him. Whilst he indicated that he was alright with this, but the officer believed that he did not want to be moved.

240. Another prisoner told my investigators that the man had "good" and "bad" days. There were occasions when he did not come out of his cell sometimes

for days at a time. However, just prior to his move he felt that he did not seem "that bad". The prisoner said he was aware that the man had signed some paperwork to confirm his move. He also believed that he did not want to be transferred, although he did not specifically say this to him. However, he repeatedly complained to him that he had insufficient conversations.

241. The final prisoner said that the period leading up to the man's death was the worst that he had seen him and he had "totally let himself go". He told my investigators that he had not shaved or showered and had "outbursts". The prisoner explained that an argument broke out when the man said he wanted to speak to someone about not getting three conversations a day. He added that an officer, who he declined to name, told him that he could not do his "bird" and a row ensued. The prisoner said that there was a further altercation with the Ward Manager about the same issue. He noted that the man also mentioned that he told the first psychiatrist that he still felt suicidal, but the psychiatrist replied that he would "take a chance". He said that the man did not indicate that he would harm himself.

242. Despite the man being reassured by Officer C's presence on B wing, no one attended from that wing. There was no recorded reason. After just over three further months on healthcare, he was moved to B wing on 29 January.

The Governor should ensure that a representative from the receiving unit is invited to healthcare pre-discharge reviews. If their attendance is not possible the reason for their absence should be recorded on the ACCT.

243. The investigators asked the Safer Custody Manager about the arrangements for moving prisoners on an ACCT from one location to another. He said that prior to the transfer he would generally expect a prisoner to be taken over to the new wing during association and a representative from the wing to be part of the pre-discharge review. He added that it was important that the care plan and the individual's needs were discussed as a change of environment could create problems.

244. On both occasions that the man was discharged from the healthcare centre, there does not seem to have been any attempts for gradual integration onto the wing. This is surprising given the length of time that he had spent on healthcare. It was also well documented that he was anxious about the moves. In addition, two psychiatrists recorded their concerns about his ability to cope on ordinary location. He had already had one unsuccessful attempt at reintegration and this should have emphasised the need for a gradual and structured move. As healthcare were aware of the transfers weeks prior to them taking place this should have given healthcare ample time to manage the transition better.

The Governor should ensure that prior to discharge from healthcare provisions are in place to gradually integrate prisoners to ordinary location.

245. Lastly, PSO 2700 says that when a prisoner on an ACCT is relocated to another unit the receiving unit manager must appoint a case manager, or confirm that the existing one retains responsibility, or undertake the role themselves. However, there was no record on the ACCT document to show that this was done.

The man's ACCT observations between 6.00am and 6.44am

246. At the time of the man's death he was on three observations an hour. During the course of the night on 1 February, and until 6.00am the following day, the ACCT ongoing record indicates that this was done. However, when the information from both documents is taken into account they show that there was a 44 minute gap when there is no record of any observations.

247. The OSG was unable to account for this gap and my investigators could not determine why this may have happened. She agreed with my investigators that there should have been at least one further observation between these times. She explained that she was "prompt" when she did the observations and she "did not normally miss anything". She was sure she did an observation at 6.30am, but said that perhaps she forgot to press the cell bell.

248. During the OSG's interview, the investigators explored whether there was any other activity on the wing around 6.00am. She said that between 6.00am and 6.30am, she would usually alert prisoners about their court appearances. The day staff start to come on shift and prisoners "shout at you from different cells". However, she said that she would continue to do the ACCT observations until she handed over to the day staff.

249. Whilst the OSG thought that she had carried out an observation, neither of the records confirm that the man was checked. I am concerned that he was not checked in line with the required number of observations. There is no way of knowing whether he may have survived if the observation had been done. As soon as they became aware of this issue, the investigators brought it to the attention of the Governor on 24 March 2010. ACCT checks are essential and the Governor will need to have satisfied himself that these were carried out effectively by the OSG.

Code system for emergencies

250. When the man was discovered hanging in his cell, no code system was used to communicate the nature of the emergency. This is a common theme to emerge from my recent investigations at Birmingham. The nurse told my investigators that she was not provided with any details and such information was rarely supplied, so she did not know what she was going to. She said that a code system would be beneficial so that staff could be alerted about the nature of the emergency.

251. Despite my recommendations in other investigation reports at Birmingham the Governor at Birmingham had decided not to implement a code system. He explained that all equipment was contained in one emergency bag and

therefore managers had agreed that a radio call of “emergency assistance” was sufficient. However, the emergency bag does not contain a defibrillator.

252. There is no mandatory requirement for prisons to use a particular code, but 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, I repeat my previous recommendation:

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

Location of the defibrillator

253. The location of the defibrillator was evidently an issue in the man’s case. Whilst the nurse said that it was on the wing landing, I am concerned that it appears that officers not know what the bag was and where it was located. This was partially confirmed by the PO’s account. I am particularly surprised that he felt that it was unlikely that the SO would not have known where to find the defibrillator. This seems rather disturbing as he is a member of the prison’s response team. In interview, the PO told my investigators that the SO was “an established member of staff” who had undertaken night duties for the last four to five years. Given the SO’s role within the prison and his level of experience, I would have anticipated that he would know the location of the defibrillator. I am concerned that there was apparently no consideration whether either the SO or PO could get the defibrillator.

254. Prompt access to a defibrillator is crucial to increase the chances of resuscitating a prisoner who has stopped breathing. The nurse explained that the bag containing the defibrillator is heavy and it is not required for the majority of calls. Therefore, it is not routinely taken to emergencies. I consider that the introduction of a code would at least give clinical staff the option to take it en route to an emergency. However, since the man’s death the nurse told my investigators that the location of emergency bag, containing the defibrillator, has been changed. She explained that at night time it is taken to the centre and officers know where to find it. However, this system is wholly reliant on staff remembering to move the bag on a daily basis. The nurse did add that there is a defibrillator located in every wing, although it was unclear if these were in fixed positions. I am pleased that Birmingham has taken action to rectify the matter. However, I make the following recommendation to reflect my concerns and the unsatisfactory arrangements that were in place at the time of the man’s death:

The Governor should ensure that defibrillators are accessible at all times and that staff know their locations.

Attempts to resuscitate the man

255. There are some discrepancies between the PO and nurse's accounts of what took place in order to try and revive the man. The nurse said that the PO cut down the noose and then the man was placed on his back and checked for signs of life. She also recalled that the ligature was not cut, but just moved. However, the PO said when he got into the cell the SO Mitchell and nurse had already cut him down. He added that he cut the ligature because it was deeply embedded in his neck.

256. The PO said that the nurse started CPR doing both chest compressions and breaths. She then left to get the defibrillator and in her absence he continued with chest compressions. The nurse said that CPR was not started on the man until after her return with the defibrillator. I cannot account for the conflicting accounts between the PO and the nurse. However, the clinical reviewer concluded that the attempt to resuscitate the man seemed to be "well coordinated", with "good team work".

257. The clinical reviewer does not comment on the nurse leaving the man's cell. I am concerned that she was the only qualified medical member of staff present and she left him. Furthermore, the PO's account suggests that she was absent for two to three minutes. This is a significant period especially as she said that she did not instruct anyone to perform CPR. In this instance, changes to the location of the defibrillator and ensuring that staff know its location, would reduce the likelihood of similar situation reoccurring.

Emergency ambulance

258. An ambulance was not called for ten minutes after the man was found hanging by the OSG. The OSG understood the situation to be sufficiently serious as to call for assistance immediately. The orderly officer, his senior officer and a nurse were nearby and arrived at the scene within seconds of her raising the alarm. Nevertheless, no effort was made to call an ambulance until a full assessment of the man's condition had been made. The PO explained that the control room will not call an ambulance until they have the full details of the medical emergency.

259. I am concerned at the delay in calling an ambulance. I understand that the local ambulance service would not want to be called to the prison unnecessarily and that the control room would therefore be cautious about calling without more information. However, from staff's account of the events of that morning, there was a sufficient understanding of how critical the man's condition was very quickly. Nevertheless, an ambulance was not called.

260. The attendance of an emergency ambulance in a life-threatening situation is critical.

The Governor must ensure that an ambulance is called at the earliest opportunity in a life-threatening situation.

CONCLUSION

261. The man already had a significant history of mental health problems and suicidal tendencies when he was remanded at HMP Birmingham. This was quickly identified by the prison and the procedures for suicide prevention and self harm management were appropriately started. However, the length of both periods of his constant supervision, particularly the second, is a concern and did not appear to be in keeping with PSO 2700.

262. The quality of the man's ACCT reviews varied considerably. In some instances, these were of a good standard, but on other occasions they were unsatisfactory. In particular, some were not multidisciplinary, his care map was rarely updated and there was a notable lack of a consistent case manager.

263. I am not critical of the decisions and the plans that were put in place when the man was discharged from healthcare in September 2009 and January 2010. However, his moves were not satisfactorily managed. I have no doubt that he received a great deal of support and input from staff whilst he was on healthcare. However, there appears to have been a notable lack of exchange of information when he was discharged and no involvement from the receiving wing prior to the moves. This is particularly disappointing given his complex needs and him repeatedly saying that he would end his life on B wing.

264. On the day of the man's death, I am satisfied that the required number of observations took place until 6.00am. Between this time and when he was discovered hanging at 6.45am, he should have been checked again. However, I found no evidence to show that this was done. In addition, I have been unable to account for why this did not take place.

265. The location of the defibrillator and the absence of an emergency code are both identified as issues in the man's case. I am concerned about this as these have also been highlighted in some of my previous investigations. This is reflected in two of my nine recommendations.

RECOMMENDATIONS

1. The Governor should ensure that a case manager is appointed at the first ACCT review to manage an individual's support plan for the whole time they remain at risk of suicide and self harm.

   Accepted. Case manager is allocated at first review.

2. The Governor should ensure that ACCT case reviews are multi-disciplinary. If staff are unable to attend, they should make their contributions by telephone or in writing.

   Accepted. Reviews are multi disciplinary and when departments are unable to attend their input is obtained by phone or email.

3. The Governor should remind staff of the additional safeguards required when a prisoner is subject to constant supervision, in accordance with the requirements of PSO 2700.

   Accepted. An operational manager is appointed to all prisoners who are placed on Constant Supervision and attends all reviews subsequent to the intial review. These reviews are done within the timescales of PSO 2700 and if outside of these justified in the review paperwork.

4. The Governor satisfies himself that constant supervision beyond 72 hours is only used in exceptional circumstances.

   Accepted. Prisoners are only left on constant supervison for longer than 72 hours when their presentation and need is that they remain on constant supervision.

5. The Governor should ensure that a representative from the receiving unit is invited to healthcare pre-discharge reviews. If their attendance is not possible the reason for their absence should be recorded on the ACCT.

   Accepted. All patients that are going to be discharged from the healthcare in patients are reviewed and the manager from the wing to which they will be discharged to is invited to attend the review. Should they not be able to attend the reasons recorded in the ACCT document.

6. The Governor should ensure that prior to discharge from healthcare provisions are in place to gradually integrate prisoners to ordinary location.

   Accepted. Staff from the wing that the prisoner is allocated to attend the discharge review prior to discharge and if there is no cell available will maintain daily contact until a cell becomes available.

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

Accepted.

8. The Governor should ensure that defibrillators are accessible at all times and that staff know their locations.

   Accepted. Debrillators are now positioned at strategic points within the prison and staff have been infomed of the locations.

9. The Governor must ensure that an ambulance is called at the earliest opportunity in a life-threatening situation.

   Accepted. Requests for an ambulance are made by anyone on the scene who asks for an ambulance to be called.