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

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Birmingham. He died in March 2010, having been discovered in his cell with a ligature around his neck. He was 36 years old and had been in prison for nine days. I offer my sincere sympathy and condolences to his family and friends.

The investigation was carried out by my colleague. A review of the man's medical care in custody was carried out by the clinical reviewer on behalf of the local Primary Care Trust (PCT). I am most grateful to him for his assistance.

I would also like to thank the Governor and staff of Birmingham for their co-operation during the course of the investigation. I am especially obliged to two members of staff for their help in liaising with the investigators.

The man had served in the Marines for ten years and was said to find it difficult to come to terms with aspects of his war service. Having been arrested on 1 March for the attempted murder of his partner the day before, he remained in police custody for the next three days. He was assessed as a high risk of suicide by the local hospital and also told the police he felt suicidal. This information was not passed to the prison. On 4 March, he appeared at Magistrates Court and was remanded to HMP Birmingham. While at court, a nurse assessed him as at risk of suicide and fortunately this information was appropriately forwarded to the prison.

On arrival at the prison, a reception officer and a nurse interviewed him. Due to the information from court and her own assessment of him, the nurse made an urgent referral to the mental health team but did not herself believe he was at risk of suicide. Later that evening, another nurse from the mental health team assessed him and concurred with his colleague's view. Suicide prevention measures were not started. It is my opinion that they should have been put in place to safeguard his welfare and I make a recommendation in this regard.

Following an initial delay obtaining his records from his community general practitioner (GP), he was assessed by a detoxification doctor and received the appropriate treatment to help him stop misusing heroin. However, in the morning of 13 March, he was discovered hanging in his cell and subsequent attempts to resuscitate him were unsuccessful.

Officers and nurses responded quickly to the situation. Nevertheless, I make recommendations regarding the introduction of a code system to be used in emergency situations, annual first aid training for officers and more clarity in determining who should call an ambulance, since there was a delay of 22 minutes until this occurred. I also ask the Governor to consider the appropriateness of family liaison arrangements and to ensure that prisoners receive the visits to which they are entitled.

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 **November 2011**

CONTENTS

SUMMARY

The man was arrested in the early hours of 1 March for the attempted murder of his partner the day before. He remained in police custody for three days and told the police medical examiner that he felt suicidal and had intentionally taken a heroin overdose the day before his arrest. During this time, he also attended hospital where he was assessed as highly suicidal. Crucially, this information was not passed to the prison and remains the subject of a misconduct investigation by the Professional Standards Department at West Midlands Police.

On 4 March, he appeared at Magistrates Court. While in the court cells he was assessed by a nurse, who was concerned about him and completed a suicide and self-harm warning form which accompanied him to the prison. On arrival at the prison, an officer and two nurses assessed him. None of them believed he was at risk of suicide and therefore suicide prevention measures were not started. He had been in prison before.

I have considered the reasonableness of this decision and whilst it is clear that he denied he was feeling suicidal, it is my belief that suicide prevention measures should have been started at this stage. He had expressed an intention to kill himself whilst at court earlier in the day and was facing a serious charge of violence against a partner. The National Offender Management Service's own research indicates that facing this type of offence increases a person's vulnerability to suicide or self-harm.

Over the following few days, he was assessed by the detoxification doctor and was treated for his drug misuse. Staff did not have any concerns regarding his risk of suicide or self-harm. Late in the evening on 11 March he called staff to his cell as he said he had accidentally fallen over and hit his head on the sink. Staff had no concerns about his mental state at the time and he remained in the cell on his own. However, letters written by him, which were found in his cell after his death, describe this injury as occurring as a result of a failed suicide attempt and that he intended to try to kill himself again the following evening.

At 7.55am two days later, he was found hanging in his cell. Staff responded quickly and professionally in their resuscitation efforts although I make a recommendation regarding first aid training. I also suggest the introduction of a code system to be used by staff in the event of an emergency. An ambulance was not requested for 22 minutes after he was found, seemingly since all the staff assumed that one of their colleagues had already made the request. I do not believe that ambulance staff would have been able to save him. Nevertheless, a lack of clarity about who should call an ambulance has been an issue in previous deaths in Birmingham and I am disappointed to repeat the recommendation. The paramedics arrived at 8.30am and pronounced him dead one minute later.

Following his death, the Governor went to his mother's home to tell her the news, while the police simultaneously visited his partner. However, due to police advice that it was not appropriate for the victim of the alleged offence to act as next of kin and the family's feelings towards his partner at the time, she was not subsequently contacted by the prison. I remain unconvinced that this was an appropriate decision,

especially following his partner's letter to the Governor expressing her concerns about his death.

Despite trying to book a visit to see him from the day he was remanded, his mother was unable to do so until 18 March. Indeed, he did not receive any visitors during the nine days he was remanded. I therefore make a recommendation that the Governor ensures the system at Birmingham allows prisoners to have the visits to which they are entitled.

THE INVESTIGATION PROCESS

1. The investigation was allocated to a senior investigator on 15 March 2010. On her behalf, two days later, another senior investigator and an assistant ombudsman opened the investigation at HMP Birmingham and issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No one came forward as a result.

2. The investigator was given access to his prison files, including his medical record. She went to Birmingham on 11, 12 and 27 May to interview staff. Another senior investigator interviewed three prisoners on her behalf. She submitted a number of questions to a member of healthcare staff via email. She also spoke to the Reliance Custodial Services Area Manager regarding his care whilst he appeared in court. The Independent Monitoring Board (IMB) and the Prison Officers' Association (POA) did not have any specific issues to raise with her.

3. A clinical review of the management of his health needs in custody was carried out by the clinical reviewer on behalf of the local PCT. He accompanied the investigator to some of the interviews on 11 and 12 May.

4. One of my family liaison officers wrote to both the man's partner and his mother in April, to explain the investigation process and invite them to raise any issues they wished the investigation to address. Both she and the investigator met his partner and her mother on 23 April. His partner raised the following issues:

    - She said the court and police were aware of recent suicide attempts by him. She therefore wanted to know what information was passed onto the prison and what precautions were put in place as a result by the prison?
    - What psychiatric assessments were completed on him?
    - She had heard that two prisoners had asked to be moved into the same cell as him but he was on his own. Why was this the case?
    - What checks were made on him throughout the night before he died, what time was he found and what attempts were made to resuscitate him?
    - She understood from police that he had a wound on his neck when he died which had required stitches. How did this injury happen and who had treated it?
    - Why did he not have any visitors?
    - Why was there a delay in her finding out about his death later that day and why was there no contact from the prison apart from a very brief letter from the Governor?
    - Given that she was the victim of his alleged offence, why was he allowed to write to her and was his mail checked?

5. The investigator and family liaison officer also visited the man's mother and brother on 13 May. They raised the following issues:

- What information had the police given to the prison regarding his risk of suicide? If this was insufficient, what action was being taken?
- Were prison staff aware that he had been hospitalised due to taking a heroin overdose the week before he went into prison?
- Why was his cell still locked two months after his death?
- Did he use the broken hatch on his door as a ligature point?
- Why was it so difficult to book a visit to see him?
- Why were suicide prevention measures not started following his suicide attempt the night before he died?
- Why did it take three to five days for letters to be delivered to him?

6. I have attempted to answer the questions above in the report. The man's mother and partner received a copy of my draft report as part of the consultation process. The partner made written representations in response to the findings of the investigation. My Senior Family Liaison Officer, together with an investigator, visited the partner and mother who raised additional issues, including a number concerning his clinical care.

7. I have considered the issues raised and referred the clinical matters to the the local PCT. Both my own and the PCT's response have been addressed outside of this report in separate correspondence. This has been sent to the man's partner and mother and other stakeholders with this final report.

HMP BIRMINGHAM

8. Built in 1849, Birmingham is one of the largest prisons in the country, accommodating a maximum population of 1,450 adult male sentenced and unsentenced prisoners. It accepts prisoners from local courts and its main function is to hold prisoners who are awaiting sentencing, being held on remand or facing a trial. Originally a Victorian prison, in recent years it has expanded and modernised.

9. Birmingham is a category B prison. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

10. Healthcare is provided by the local Primary Care Trust (PCT). The PCT contracts Birmingham and Solihull Mental Health Trust to provide mental health services within the prison, including staffing and running the 34 bed in-patient unit.

11. The former Chief Inspector of Prisons completed a full and unannounced inspection of Birmingham in December 2009. She found that:

> " … while some progress had been made, there was still a considerable amount to do to ensure a safe, decent and effective prison … There was a good senior management attention to safer custody, though some of the operational aspects of support for prisoners at risk of suicide needed strengthening."

12. The most recent annual report published by the Independent Monitoring Board (IMB) at Birmingham covers the year from July 2007 to June 2008. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.)

13. The Board noted that the personal officer scheme was not functioning well, something the former Chief Inspector of Prisons also drew attention to. The IMB praised the safer custody team's efforts.

14. The National Offender Management Service is responsible for the management of prisons in England and Wales. Every three months it publishes an assessment of each prison's performance against 34 measures. Prisons can gain a rating of between one (serious concerns) and four (exceptional performance). Birmingham has scored two (requires development) for the last four quarters.

15. The Ombudsman assumed responsibility for investigating deaths in custody in 2004. Since that time, this office has investigated 28 other deaths at Birmingham, of which ten were apparently self-inflicted. Most recently, there have been nine deaths at the prison since December 2009 (including that of

the man), of which four were apparently self-inflicted. A common theme to emerge from these recent and some earlier investigations was the lack of a proper code system when officers needed to communicate with colleagues over the radio net in an emergency. Another similarity is a delay requesting an ambulance, which was an issue in deaths in 2008 and 2010. I repeat my recommendations in this regard.

KEY FINDINGS

16. In the months before the man's arrest, his partner said that his mood had become increasingly bizarre and erratic and he had lost two stone in weight. The clinical reviewer notes that he was being prescribed methadone by his general practitioner (GP) during this time, which he did not want to disclose to his partner. His GP described him as, "well dressed, putting on a brave positive face, but not very forthcoming with the truth about his inner feelings". He was not communicative during appointments with his GP, who believed that he did not disclose many of his concerns and it was difficult to gain his trust.

17. On 10 February, he told his GP that he was not sleeping, had a poor appetite and was losing weight. He also said he had relapsed to heroin misuse and a drug test indicated he had also misused crack cocaine. He failed to go to subsequent appointments with his GP but continued to collect his methadone prescription.

1 to 4 March, in police custody

18. On 1 March 2010 at 1.20am, he was arrested for attempting to murder his partner the day before. Later that morning, whilst in police custody, he became disoriented, struggled to speak and said his face felt numb. He was taken to hospital by ambulance and returned to the police station that evening at 5.20pm, having been deemed fit to be detained.

19. Further information about his hospital admission came to light after his death. On 29 March, his GP surgery received an undated discharge letter, via fax, from a nurse at the hospital. It said that the police had brought him to the hospital's Accident and Emergency Department after he attempted suicide the day before. The date of admission is not specified but my investigator has confirmed with West Midlands Police Professional Standards Department that only one admission to hospital is noted in his police custody record, that of 1 March.

20. His mental health in the hospital was assessed as having depressive symptoms with a high risk of suicide and the nurse wrote that he:

> "regretted he did not succeed in killing himself, and had nothing left for himself in the future. He said there is no point in working and repeated no point in living anymore. Objectively, actively expressed suicide ideation, feeling of hopelessness and not looking forward to the future."

The nurse indicated that the home treatment team would visit him in hospital, prior to discharge, to devise a treatment and management plan. There is no evidence that this occurred and it is not known if the nurse passed this information to the police.

21. Over the next two days, 2 and 3 March, he was kept in police custody and interviewed regarding the alleged offence on a number of occasions. He told

the police that the night before his arrest he had injected £50 worth of heroin in order to take his own life. He tested positive for opiates and cocaine. He also said that he had taken an overdose of paracetomol five years ago but had known at the time that he would not die. He denied the offence stating that he and his partner had tried to commit suicide by hanging themselves in their home. He also told the police medical examiner that he felt suicidal.

4 March, appearance at Magistrates Court

22. He was taken from the police station to Magistrates Court, arriving around 8.00am. The first five sections of the Person Escort Record (PER) had already been completed by the police. (The PER is a form that accompanies each prisoner between police station, court and prison. It provides information about the prisoner's needs and the risk he poses to others and himself.) The police had noted that he was violent and concealed weapons but that there was no other known risk. The box indicating a risk of suicide or self-harm was not ticked and no information about his suicide threats was recorded on the form.

23. Having been placed in a cell at court, he was checked every 30 minutes by officers from Reliance Custodial Services. My investigator spoke to the Reliance Area Manager, who said that the police had sent a fax regarding him to the Reliance control room, as is routine. It was flagged with markers for mental health, suicide or self-harm, drugs and weapons and entered onto the Reliance computer system. She told my investigator that the PER form and fax to the control room are not routinely cross-referenced as the warning markers often vary between the two.

24. Staff at the Magistrates Court added the information to the board in the court cells by his name. No other information regarding his risk of suicide was passed from the police to Reliance staff.

25. Community Psychiatric Nurse (CPN) A was working in court that morning. Having noted the information on the board that the police had concerns about his mental health and risk of suicide and self-harm, the nurse assessed him in his cell at 10.20am. The Reliance Area Manager said that, had the CPN relied solely on the information on the PER form, he would not have interviewed him. During the CPN's assessment, he was tearful and upset, speaking of his intention to harm or kill himself given the opportunity. The nurse did not diagnose him with any other mental illness.

26. The nurse was also concerned about his reaction to the alleged offence. Although he reported no history of self-harm during their conversation, the nurse recommended that he should be constantly observed by staff whilst he was in court custody. He was placed in an observation cell, which has a full glass door and is watched by two escort officers. The CPN recorded his assessment on a suicide and self-harm warning form, which accompanied him, along with the PER, to the prison.

Thursday 4 March, HMP Birmingham

27. Following his appearance in court, he was remanded to HMP Birmingham and arrived around 2.30pm. This was not his first time in prison, although it was the most serious offence he had been charged with. Officer A signed section seven of the suicide and self-harm warning form to indicate that it had been received.

28. Officer B was working on the front desk of reception that day. Whilst he told the investigator that he could not remember him specifically, he was responsible for opening the cell sharing risk assessment (CSRA) at the front reception desk. (The CSRA assesses the risk of harm a prisoner presents to a cellmate if they are required to share a cell.) When completing his section of the CSRA, the officer said he would also have had the PER, suicide and self-harm warning form and warrant, with details of the alleged offence, available to him.

29. During the assessment, Officer B noted details of his previous convictions and current alleged offence. Since the officer had the suicide and self-harm warning form, he said that he specifically asked him if he had any intention in this regard, which he denied. Knowing the non-verbal signs of a risk that a prisoner might harm himself, such as a lack of eye contact, the officer did not have any concerns about him. He disclosed that he was "currently addicted to drugs and on methadone". The officer assessed him as presenting a low risk of harm to others and suitable to share a cell. He gave his mother's details as his next of kin.

30. Officer B then gave his paperwork to Nurse A, who was responsible for completing the healthscreen in reception. The nurse said that each healthscreen is conducted in a private room and the interview takes about ten minutes. The purpose is to obtain a prisoner's GP details and gather information about any physical or mental health issues and drug or alcohol misuse, as well as their history or current feelings of self-harm or suicide.

31. He told the nurse that he had misused heroin in the past and was being prescribed methadone (a heroin substitute) and citalopram (an anti-depressant) in the community before his remand. She passed this information to Prison Doctor A who prescribed one week of citalopram until this prescription was confirmed with his GP. The doctor also prescribed five days of zopiclone (a benzodiazepine derived sedative), which is standard practice for drug misusers when they first come into prison to help counteract any drug withdrawal symptoms.

32. The nurse said that he was mainly concerned that his partner, who worked for the NHS, would be able to access the information they discussed. She assured him that his information would remain confidential. The nurse referred him to the detoxification team due to his disclosure regarding drug misuse. He named his partner as his next of kin and this was noted in the health record, while his mother remained noted as next of kin in the reception paperwork.

33. Nurse A said she had read the suicide and self-harm warning form, but he repeatedly denied any thoughts of suicide or self-harm. He told her that he was "fine" and would ask for help if he needed it. However, despite his assertions, she still had concerns since she observed he was not making good eye contact and appeared "withdrawn and down". She said because of this, and the form she had received from court, she made an urgent referral for him to be seen by the mental health team that evening. She said that she was not sufficiently concerned to begin the Assessment, Care in Custody and Teamwork (ACCT) procedures. (ACCT is the suicide prevention system used by prisons to identify and support prisoners who are thought to be at risk of self-harm and/or suicide.)

34. The nurse completed the healthcare section of the CSRA and also assessed him to be a low risk of harm to others. He was then offered a shower and a telephone call before he moved to D wing, the first night centre. It is not known if he telephoned anyone at this point. His CSRA was signed off as low risk to others by the allocating officer. (Despite requests by my investigator, staff at Birmingham have been unable to confirm whether he was located in a single or double cell and, if he shared, who his cell mate was. This is also the case following his subsequent cell moves. This is because the new computer system can only link prisoners to cells, but not to each other.)

35. As a result of Nurse A's referral to the mental health team, at around 8.00pm he was assessed by a Registered Mental Nurse (RMN). The nurse no longer works at the prison and was not available for interview by my investigator. The following assessment is taken from the nurse's notes in the medical record.

36. He denied the alleged offence and said he had never had any mental health problems. He related some difficulties with his partner and said due to frustration on the night of the alleged offence he had tied a noose around his neck and jumped from the balcony. He said he had not meant to kill himself but wanted to show his partner how it felt when someone acted in that manner.

37. The RMN assessed that he:

> "appeared to be functioning well mental health wise but is concerned with his case and the risk of losing his livelihood. He reiterated that he does not intend to end his life nor does he have any thoughts of deliberate self-harm … He has however expressed he might need psychological input in a an attempt to ventilate his concerns … he states he does not want to be perceived as someone with mental illness fearing it might impact negatively on the court process … He presented as settled in mental state at time of interview but there are possibilities of his mental health deteriorating due to thoughts of the nature of his charge."

38. The nurse did not start the ACCT measures either. He referred him to a forensic mental health nurse who assesses the mental health of every prisoner charged with murder or attempted murder. She works at the prison three days a week and normally interviews prisoners within seven to 14 days of them being referred. She did not have the opportunity to assess him before he died.

Friday 5 March

39. The following day, 5 March, he was interviewed by an officer as a continuation of the induction process. Having denied any thoughts of suicide or self-harm, he said he was not concerned about being in prison and had no problems after spending his first night in custody. He again gave his next of kin details as those of his partner. He was also interviewed by the resettlement department, to whom he denied having any housing concerns. He was moved to another cell on the same wing. My investigator has been unable to establish why this happened.

40. Prison Doctor B works within the Integrated Drug Treatment Service (IDTS) in the prison and provides clinical care for prisoners with drug and alcohol problems. He assessed him later that morning, who told him that he had last misused heroin three days ago, along with unprescribed benzodiazepines. The doctor recognised his drug withdrawal symptoms. He tested positive for methadone, morphine, cocaine and benzodiazepines. His treatment and prescription of methadone was confirmed over the telephone with the Swanswell community drug project. The doctor prescribed methadone and diazepam (used to treat anxiety and insomnia), which he said he had been taking illicitly and so the doctor wanted to gradually wean him off it.

41. The doctor also discussed the alleged offence with him and reassured him regarding his concerns about the confidentiality of their appointment. The doctor described his mood as “normal” and “affable”, with good eye contact. He disclosed that he had harmed himself years ago but did not have any current intention to do so.

42. The doctor was unaware that Prison Doctor A had prescribed citalopram to him the night before. However, he said this would not have affected his assessment since he knew that the mental health team were already involved in his care and had completed their assessment the day before. The doctor had access to the assessment which was in the medical record.

43. Later that day, he was interviewed by a worker from the Counselling, Assessment, Referral and Throughcare service (CARATs, the prison drug misuse service) team. He told the CARATs worker that he had last misused heroin on 28 February (the day of the alleged offence). This is slightly different to the date he gave to Prison Doctor B, but does not seem significant in the circumstances.

6 – 10 March

44. Although he could not yet be moved to the detoxification wing since it was full, he received his medication each day from the nurses who visited D wing. No significant events were recorded on 6 or 7 March.

45. On 8 March, the Offender Health Administrator sent a fax to his GP to obtain further details regarding his medical history. She deals with routine requests and works standard weekday office hours, apart from Fridays when she finishes work at 1.30pm. She explained that, due to the number of new prisoners daily at Birmingham, it was likely that she did not start processing the request for his records until Friday 5 March or Monday 8 March. She would have to ensure that she had received his signed disclosure form, as well as details of his community GP before requesting the information. She said a delay of around four to five days to request the records would be expected.

46. However, if a doctor in reception or elsewhere urgently needed the community GP records, this request would not be processed by herself. The prison doctor would contact the appropriate surgery directly themselves. Later that day, he asked a nurse for a reduction in his methadone prescription which she agreed to discuss with Prison Doctor B.

47. His partner gave my investigator a copy of a letter he wrote to her, dated 8 March. From the letter, it is clear that he found it difficult to cope in prison and wrote that he "just wants to die". He wrote a similar letter the following day in which he says "Fact. My mind is made up. I love you and cannot live without you". He told her that he had made her his next of kin. She did not contact the prison since she had told the police that he was highly suicidal and expected that the information would have been passed to the prison. His mail was not being monitored by staff who were unaware of the contents.

48. On 9 March, he moved to a cell on the induction wing, N wing. His CSRA was reviewed by an officer and he remained assessed as a low risk of harm to others. He asked for a reduction in his methadone prescription since he wanted to be weaned off it completely.

49. The fax sent by the Offender Health Administrator was received by the community GP surgery at 10.43am that day. Surgery staff told the clinical reviewer that they replied the same day with a summary of his medical history. Despite requests, my investigator has been unable to gain access to this response and it is not clear whether the prison received it.

50. On 10 March, Prison Doctor B assessed him and agreed to a slight reduction in his methadone prescription. The doctor had tried to dissuade him from reducing his methadone intake after such a short time in custody. However, he told him that he had only been prescribed methadone for around four months in the community and did not want to take it in the long-term. The doctor described him as "determined, focussed and positive" and gave him no cause for concern.

51. He wrote a letter to his family at 7.20pm that evening which was found in his cell after he died. He said that he "cannot go on" and will "watch over you". He tells his family to "be strong and remember to celebrate my life and not mourn my death". He also wrote to his mother that he has "waited from the 8 March so it would not fall on your birthday".

Thursday 11 March

52. He appeared at Crown Court for a preliminary hearing. He left the prison at around 7.15am and returned at 1.50pm. The PER which accompanied him indicated that there were no concerns in relation to suicide or self-harm.

53. My investigator listened to a recording of a telephone call he made to his mother around 6.30pm that evening. He said he had been in court, and they went on to discuss other practicalities which had arisen because of his arrest, such as the location of his car. He did not voice any intent to harm himself and talked about the future. (This is also true of earlier telephone calls he had made to his mother on 7 and 10 March, which my investigator also listened to.)

54. He wrote another letter to his partner in which he says "all I think of is ending it all". He says he tried to "end it" last night and woke up on the floor with "scuff marks on the floor". Staff were unaware of this attempt since he did not bring it to their attention.

55. That evening, at 11.46pm, he rang his cell bell. (Each cell has a bell to be used by prisoners in the event of emergency or if they require staff attention.) Officer Support Grade (OSG) A was working on N wing on his own. He went to the cell two minutes later and looked through the observation hatch. The man had blood on his head and told the OSG that he had slipped over and hit his head on the sink. The OSG immediately used his radio to request the assistance of Oscar Two, Senior Officer (SO) A, and Hotel Two, Nurse B. (Oscar Two and Hotel Two are the emergency response radios which are carried by the nurse and SO on duty during the night.)

56. The OSG carried on talking to him through the hatch to ensure that he remained conscious and was not losing too much blood. The nurse and SO arrived around five minutes later. As is standard procedure at night, the SO requested permission to go into the cell from the control room. This was given, and the nurse and SO went into the cell together. The OSG remained outside the cell.

57. Nurse B said when she went into the cell she noticed a "considerable amount" of blood on the left side of his head and blood on the sink. She also said that he was "alert, oriented and talking". The nurse cleaned his head and treated the wound on his chin with Steri-strips. (Steri-strips are thin adhesive strips which are used to close small wounds.)

58. He told the nurse that he had got up to go to the toilet, twisted his ankle and fallen over. This seemed a plausible explanation to her. She checked for any symptoms of a more serious head injury and completed a report of injury to prisoner form. She noted that he "reports falling in his cell but unclear how injuries occurred". By this she meant that he could not explain exactly how he had cut his chin or bumped his head. She said this would be normal if he had been unconscious for a short period.

59. She had no other concerns about him and said that he "was chatting throughout, he was bright, didn't appear upset or anything like that and he was just very compliant with treatment". As with every unexplained injury, she said that she considered whether he had inflicted it himself. When asked, he denied this. Since she found his explanation plausible, she did not consider him to be at risk of suicide or self-harm.

60. Once he had been treated, the SO locked his cell and informed the control room. The nurse gave the SO the form she had completed regarding his injury, which he put in the inbox in the safer custody office. She left the wing and made a note that she would review him in an hour to confirm that there were no signs of head injury.

Friday 12 March

61. At around 1.20am, the nurse returned with the SO and completed her review of him. She had no further concerns and told him he would be reviewed again later that morning but, if he felt any other symptoms in the meantime, he should inform staff. He told her he felt "fine" and wanted to go to sleep. She described his mood as "bright, chatty and pleasant". She had no further contact with him.

62. The OSG checked him at hourly intervals throughout the night, firstly by talking to him through the hatch but, after he had fallen asleep, by checking that he was breathing. (The checks of his wellbeing were good practice on the part of the OSG.) The OSG recorded what had happened in the wing observation book and gave a verbal handover to the day staff at 7.00am, at the end of his shift. Nurse B also gave Nurse C a verbal handover at this time, requesting that she review him later that day. The nurse then went off duty and left the prison.

63. At 9.35am he moved to M wing, the detoxification wing. This is where all prisoners who are prescribed methadone or Subutex (a heroin substitute) should ideally be placed. They will remain here until they stop taking this medication. However, as SO B explained, the wing is usually full so new prisoners often have to wait until a space becomes available. This accounts for the delay of a few days before he was able to move to the wing.

64. Just over an hour later, he was reviewed by Nurse C, following his injury the night before. The nurse checked his head and chin and took his blood pressure. He reported no further symptoms but wanted to see Prison Doctor B. The nurse therefore spoke to the doctor and made an appointment for him

later that day. She did not have any concerns that he was at risk of self-harm or suicide since she thought that his explanation of the injury was believable and she described his mood as “bright and happy”.

65. He had remained in contact with his ex-partner, who was the mother of his two children. In a letter to her dated 12 March, which was found in his cell after his death, he wrote that he tried to take his own life the previous night but the shoelace snapped and he hit his head on the sink. He also made it clear that he could not face a long sentence and wanted to die. He wrote that he wanted a single cell, so when they put him in a double cell, he was difficult to his cellmate and so they were separated. He also referred to seeing his ex-partner the following week when she was due to visit, saying that “it would be the last time he would ever need money”. Again my investigator has been unable to confirm who he was sharing a cell with and there is no note of anyone being moved from his cell in the wing history sheet.

66. He wrote to his partner the same day, again stating that he had tried to commit suicide the night before and he “was devastated I was still alive”. He added “I am going to try again tonight”, referring to making her his next of kin and his wish to be cremated.

67. On another sheet of paper recovered from his cell after he died, he has seemingly weighed up the consequences of taking his life. He listed the issues in his life which included losing his children, losing his partner, upsetting her family, having no plans, facing a long prison sentence, putting his partner through a trial and not being strong enough. He also wrote, under a column labelled “positives” that he would be able to meet his “nan” and watch over his partner, children and family.

68. At his appointment that afternoon, he asked Prison Doctor B if he could be weaned off methadone, since he did not want to take the drug for long. The doctor noted in the medical record that he remained “motivated, focussed and well oriented”. The doctor agreed to further reduce his dose of methadone at the end of the current prescription. The doctor told my investigator that he did not notice the wound on his chin, nor did he have an opportunity to review the paperwork regarding the injury before their appointment.

69. At Birmingham, personal officers are allocated according to the cell in which a prisoner is placed. (The personal officer scheme allocates a named officer to each prisoner who they can approach for advice or to resolve complaints.) During the nine days that he was in Birmingham, he changed cells four times. My investigator was told that he would not have had the opportunity to get to know a particular personal officer. He did have a named personal officer following his transfer to M wing but she did not have the opportunity to introduce herself.

70. Officer C works on M wing. He first met the man around 2.30pm, after he had returned from his doctor’s appointment. The officer described their conversation as “jovial” and said he was happy because the doctor had

agreed to start reducing his methadone prescription. He said he did not like being on the detoxification wing and hoped to move in about a week.

71. As was routine on Fridays, he was locked in his cell between 3.00pm and 4.00pm, while medication was issued. The prisoners were unlocked and served their evening meal at 4.00pm. At around 4.45pm Prisoner A asked two officers if he could move into his cell as they knew each other from outside the prison. The man was in a double cell on his own at that time. The prisoner told my investigator that he was concerned about him as he had known him for a long time and thought that he was not his "usual self". However, he did not believe that he would harm himself and says he would have told staff if he thought this was the case.

72. Officer C said that such requests are frequent and, because they were finishing serving dinner and preparing to lock the prisoners into their cells for the 5.00pm roll check (count of prisoners), they were too busy to deal with it. The officer said that the prisoner did not give him any reason to think he was worried about the man's welfare or that the request was urgent. He therefore told him that he would deal with his request the following day. The officer said neither the prisoner nor the man himself gave him any reason to be concerned that the latter would harm himself.

73. The officer said that he and the prisoner spoke about the conversation the next day, after the man's death, and the prisoner acknowledged that he had not expressed the urgency of his request which he now regretted. In a letter to my investigator, the prisoner wrote that he had always found Officer C to be a "firm, but fair" officer and believed that if it had not been nearly 5.00pm, the officer would have moved him into the man's cell that day. He also regarded the other officer as a "fair and pleasant" officer.

74. Prisoner B, overheard Prisoner A's request. He told my investigator that he never thought the man would "go that far". He said he seemed "chatty and had a normal life". He thought maybe he put "a front" on things to hide his feelings.

75. Prisoner A said that as a result of his concerns about the man's anxiety, he spoke to a Listener. (Listeners are selected prisoners who are trained by Samaritans to provide confidential emotional support to fellow prisoners who are in distress.) The Listener immediately talked to the man but told my investigator he did not have any concerns about his welfare. He had not got the impression from Prisoner A that he was concerned about any risk of suicide or self-harm, more that he was anxious. The man confirmed that he would like the prisoner to move into his cell with him, which the Listener repeated to the prisoner. The Listener told the investigator that he found officers on the wing to be reasonable and willing to move prisoners as appropriate. He said he had always been able to access help when he needed it.

76. Prisoner C on M wing, knew the man from outside prison and felt it was clear that he was at risk of suicide. However, he did not talk to staff about this. He

spoke to him during the evening and said he would talk to him again the following day. He also said that he did not believe he should have been in a cell on his own but that, earlier in the day, he had said that he did not want a cellmate. Prisoners were locked back in their cells at 5.00pm and a roll check was completed. A further roll check took place at 8.00pm.

77. Nurse D began work at 9.00pm that evening. A member of staff told her that the man had not received his medication at 5.00pm since his drug chart had not been available on the wing. All the drug charts for M wing prisoners are kept on the wing but, since he had moved wings earlier that day, his drug chart had mistakenly not been moved with him.

78. At around 11.00pm that evening, the nurse managed to confirm his medication with the nursing staff on his previous wing. He had received his methadone earlier in the day but was waiting for his prescription of diazepam and citalopram. The nurse therefore asked OSG B to unlock his observation hatch so she could give him his medication at around 11.30pm. They went to the cell to find that the lock was not working on his hatch so the nurse could open it without a key. He took the medication. (The nurses' response to the earlier medication omission was good practice.) Having had a brief conversation with him about his medication, which lasted less than a minute, the nurse did not assess that there was any reason to be concerned for his welfare and described him as "calm". In the medical record she noted he, "had good eye contact, engaged well in conversation, appeared physically and mentally stable". He had no more contact with staff overnight.

The man's death

79. Around 5.00am, OSG B completed the checks of all the cells on M wing, including that of the man, and nothing untoward was reported. Officer D began his shift at 7.45am, and received a verbal handover from the OSG who said that there had been no problems overnight. The officer then started to complete his checks of all the cells. When he got to the man's cell ten minutes later, he looked through the observation hatch and saw that he was hanging from the back of the door.

80. The officer said he immediately radioed the control room with a message for urgent assistance that he had found someone hanging and asked for Hotel Two to come to the cell. The control room log indicates that they received an initial message for "urgent assistance" from Officer D, with no details of the hanging. Not all the staff who responded to the call were aware they were attending a hanging. An emergency code system was not in place in the prison at the time.

81. Officer C was on the landing below the officer and heard his call for assistance. He immediately went to the cell and the officers unlocked and tried to open the door. This was difficult as he had threaded the ligature, which was part of a bed sheet, round the top corner and hinge of the door. He was in a sitting position, almost touching the floor behind the door. (His brother understood that the broken hatch had been used as a ligature point. I

can confirm that this was not the case and, furthermore, SO B said that he did not think it would be possible to do so, due to the way the hatches open.)

82. Officer D managed to put his arm round the door and used his cut-down tool to cut the sheet. (Cut down tools are provided for cutting ligatures. Staff in closed and semi-open prisons who have contact with prisoners are issued with and must carry their own tool.) Both officers went into the cell and Officer D noticed a plastic bin which had been turned upside-down and placed by the corner of the door. He assumed he had stood on the bin before hanging himself.

83. Both officers were trained in first aid a number of years ago but had received no annual refresher training since that time. They thought that he was slightly stiff but warm to the touch. The officers laid him on the floor and Officer D cut the ligature from his neck. He had also tied part of a bed sheet round his hands. Both officers tried to find a pulse. SO B had also arrived at the cell by this stage and, having initially thought he could detect a pulse, realised that this was not the case. The SO had not received recent first aid training either.

84. Officer C went outside the cell, since it was cramped, and checked over the radio that healthcare staff were on their way to the cell. He again requested urgent assistance and said that they had found a prisoner hanging. He confirmed that whilst there is no code system at Birmingham, but if staff hear the words “urgent assistance”, they immediately go to the requested place. He asked if anyone had an ambubag (used to aid resuscitation) but no one did. He therefore began chest compressions at the ratio of five chest compressions to two breaths. (This ratio is incorrect, which I deal with later in my report.)

85. Two nurses (Oscar Two) and (Oscar Fifteen – the emergency back-up radio) were in the general office together when they heard the request for urgent assistance. They immediately went to the cell and, on the way there, were told by an officer that he had stopped breathing. Nurse E turned back to get the defibrillator and oxygen while Nurse F continued to the cell. (A defibrillator is a portable electronic device which measures electrical activity in the body and advises on the action to be taken.)

86. Nurse F arrived at the cell about three minutes after the initial call for assistance, and the SO then stepped outside the cell to give her more room. As Officer D continued with chest compressions, the nurse tried to insert an airway into the man’s throat, which was difficult since his tongue had swollen. The nurse said that his hands were cold to the touch and he looked purple. She tried to use an ambubag to administer breaths but this was difficult as his neck was slightly stiff. The nurse asked Officer D to cut his clothes so that she could apply the defibrillator and also cut the sheets which he had used to tie his wrists together. The officer was then relieved from doing chest compressions by Officer E and he too left the cell.

87. Nurse E had arrived at the cell two minutes after Nurse F. She attached the defibrillator to him which advised that they should continue cardio pulmonary

resuscitation (CPR). The nurses and Officer E continued rotating between completing chest compressions and administering breaths.

88. SO C had just arrived at the prison at around 8.00am and picked up the Oscar Three radio when he heard the call for assistance on M wing. Oscar Three is responsible for responding to any emergencies which happen on the East side of the prison. Oscar One (held by Principal Officer (PO) A) is in charge of the whole prison and Oscar Two (held by PO B) is responsible for responding to emergencies on the West side of the prison. The SO went first to his office to leave his belongings and collect his belt (to which his cut-down tool was attached), then he went straight to M wing. On arrival, around five minutes later, he saw the nurses were already trying to resuscitate the man and he therefore remained outside.

89. The Duty Governor and PO B also arrived at the cell around this time. They were responsible for managing the emergency. They checked that an incident log was being completed, informed the governing Governor of the situation and checked on staff welfare.

90. At 8.17am, which was 22 minutes after he had been found, SO C asked how much longer the ambulance would be by telephoning the control room from a wing office. The control room told him that an ambulance had not been requested. The SO therefore asked control to call one immediately. The paramedics subsequently arrived at 8.30am and took over CPR. They attached their defibrillator to him, which advised that nothing more could be done for him and they pronounced his death one minute later.

After the man's death

91. The Duty Governor asked SO B to ensure that all the prisoners were immediately told by wing staff what had happened . All those on open ACCTs were reviewed that morning.

92. The governing Governor held a hot debrief at 9.45am which 12 members of staff attended. (A hot debrief is a meeting for staff to discuss any lessons learned and their feelings following serious events such as deaths in custody, hostage situations or escape attempts.)

93. There are three family liaison officers (FLOs) at Birmingham. Due to their high workloads at the time of the man's death, the Governor appointed himself as the FLO. The man had named both his mother and partner's as his next of kin. Following a conversation between the Governor and the police after the death, he decided to treat his mother as next of kin. The police thought that it would be inappropriate for his partner to act as next of kin given that she was the victim of the alleged offence.

94. The Governor therefore agreed with the police that they would tell the man's partner of his death at the same time as he told his mother. The Governor went to the mother's home immediately after the hot debrief, but only his brother was there. The brother telephoned his mother, who insisted that the

Governor tell her the news over the telephone. She returned home a short while later. (In the meantime, the police had also told the man's partner of his death.) I am told that any delay in giving the news was due to the Governor having to ensure that issues at the prison had been adequately dealt with, travelling to the home and then waiting for the man's mother to return.

95. The Governor gave the family the direct telephone line to his secretary and also his personal telephone number so that he could be contacted by them 24 hours a day. He said he received one telephone call from the man's brother requesting information about where to view him following his death. One of the prison FLOs contacted the family to offer to assist with the funeral expenses and two FLOs from the prison attended the funeral.

96. At the time of the death, the Governor said the family were upset with his partner, blamed her for his death and did not want her to be involved in the funeral arrangements. He decided to respect these wishes, rather than further upset the family by contacting her. He said she was not informed of the funeral arrangements for this reason. The police were also concerned that the ex-partner and mother of his two children blamed the man's partner for his death and presented a risk to her. The Governor said that he did not want to worsen this situation either.

97. On 17 March, the man's partner wrote to the Governor making it clear that despite the alleged offence, she did not want to be excluded and believed she had been listed as his next of kin. She was particularly concerned that she had received a number of letters from him stating his intention to commit suicide. She had not contacted the prison as she thought he would be safe there and wanted to know what measures had been taken to protect his welfare. It is clear from the letter that she was distressed.

98. The Governor replied to the letter on 15 April, writing: "Thank you for your letter, dated 17 March, 2010, the contents of which have been noted". The letter was signed by his secretary. The Governor had no further contact with her.

99. A further debrief for staff was held two weeks after the death. All the staff said they were happy with the support and care they had been offered, apart from one OSG who felt that more could have been done to check on her welfare. Nurses E and F reported that, since they were the only permanent nurses on duty that day, they had to keep the emergency response radios which they found difficult in the circumstances. Nurse F questioned whether agency nurses could also be tasked with holding the emergency response radios and being in charge of prison keys.

100. At the time of writing, the post-mortem report was not yet complete. However, I understand the doctor responsible has given the provisional cause of death as hanging. The man's partner said she had heard from the police that he had a wound on his neck requiring stitches. She wanted to know how this had happened. None of the staff my investigators spoke to had noticed a wound on his neck. It may have been confused with the wound on his chin but, until

the post mortem is complete, I am unable to comment further and the question can be resolved at the inquest.

101. I have not had sight of the toxicology report but have been told that he tested positive for methadone, diazepam and citalopram which were all within therapeutic levels and had been prescribed to him. Mirtazapine (an anti-depressant) was also found in his system at a therapeutic level, although it had not been prescribed to him and it is not clear where he got it from. He did not test positive for any other drugs or alcohol.

102. The man's mother asked my investigator why his cell had remained locked for two months after his death with his belongings inside. The cell did remain locked for this time, although there does not seem to be a particular reason other than to ensure that all investigations had been completed. His belongings were taken to the Governor's office very soon after his death. They remained in the Governor's charge until the prison received the police and coroner's permission that they could be returned. (I understand her concern but the matter is outside the Terms of Reference of this investigation and should be addressed to the police and coroner.)

ISSUES

Information sharing about the man's risk of suicide

103. On 1 March, police took the man to the Accident and Emergency Department at hospital where he was assessed as highly suicidal. The clinical reviewer comments:

> "The discharge letter with this information was not faxed to the man's GP until 29 March. No date was on the letter. This discharge letter was not communicated to HMP Birmingham as a result of this failure. The nurse, in the discharge letter, states she was going to liaise with the Home Treatment team but this did not happen probably as a result of being in custody."

104. I welcome the clinical reviewer's recommendation to the hospital liaison psychiatry department regarding the timeliness of information sharing in relation to a patient's risk of suicide.

105. Whilst it is unclear whether the police had access to this assessment, they did have other significant information about the man's risk of suicide. He had told the police medical examiner that he felt suicidal. He had also said that he tried to kill himself when committing the alleged offence and again by taking a heroin overdose shortly afterwards. The suicide and self-harm warning marker was ticked on a fax sent by police to the Reliance Head Office on 4 March and was subsequently annotated on the board in the cells at Magistrates Court when he appeared there. Because of the warning marker, he was assessed by a CPN based at the court and again assessed as at risk of suicide. A suicide and self-harm warning form was appropriately completed and forwarded to the prison.

106. However, the police failed to record that he was a risk of suicide on the PER. They also failed to pass on any of the above information in relation to his recent suicide attempts and current feelings in this regard. My investigator spoke to a Detective Inspector in the Professional Standards Department at West Midlands Police. He said that the police had made an error by not sharing this information and that a misconduct investigation had been started as a result. At the time of writing, this investigation is ongoing. As the investigation by West Midlands Police falls outside of my remit, I am unable to comment further and trust that this matter will be effectively investigated by the police.

Delay requesting the man's medical records from his community doctor

107. He arrived at Birmingham on Thursday 4 March. That evening, Prison Doctor A prescribed citalopram and zopiclone. The following day, he was assessed by the detoxification doctor and prescribed methadone (a previous prescription confirmed with the local community drug project) and diazepam.

108. A fax was received by his GP surgery five days later, on 9 March, requesting his medical history. The prison's offender health administrator said it was likely that she did not make the request for his records until a few days after he arrived. She explained that because of the volume of new prisoners, a delay of around four to five days to request the records would be expected. However, if the community records were urgently needed, there was provision for the prison doctor to approach the community surgery directly.

109. Whilst the GP said they replied on 9 March, I have not seen evidence of their fax in his medical record and he was prescribed citalopram until he died. Medication was therefore seemingly issued to him without any confirmation from his community GP. He had not previously been prescribed citalopram, as he claimed to the prison doctor. The clinical reviewer was concerned by the delay obtaining the doctor's records and I endorse his slightly amended recommendation that:

The Head of Healthcare should ensure that requests for medical information from the community doctor are made within one working day of a prisoner's arrival, particularly when the prison doctor expects to prescribe medication.

Did staff miss any signs that the man was at risk of suicide or self-harm?

110. He was arrested in connection with an offence of violence towards his partner. Offences of this nature are recognised as likely to increase the risk of self-harm. He was in the custody of the police and prison for 12 days during which time he was assessed by numbers of custody and healthcare staff. Their opinions varied about the risk he presented to himself, as did the steps they took to ensure that the information was passed on.

111. Following his arrest on 1 March, he was admitted to hospital and discharged later that day. He told the nurse at the hospital that he regretted not killing himself the day before and said that he had nothing left to live for. He was assessed as a high risk of suicide.

112. He also told the police medical examiner that he felt suicidal and had tried to commit suicide twice the day before. This information was not forwarded to the prison and the suicide and self-harm marker was not ticked on the PER.

113. He was assessed by a CPN at the Magistrates Court who noted on a suicide and self-harm warning form that he was tearful, upset and described his intention to harm or kill himself, given the opportunity. This form accompanied him to the prison and those who subsequently interviewed him that day had access to it.

114. Officer B was the first at the prison to assess him. The officer did not have any concerns regarding his state of mind and he denied any intention of harming himself. However, this initial interview took place at the front desk and therefore was not private. In such situations it seems less likely that he would disclose any personal issues or concerns he was having. I note that

following the last inspection of Birmingham, the former Chief Inspector of Prisons reiterated one of her previous recommendations that such interviews should take place in a private room. I would also ask the Governor to ensure that the necessary arrangements are made for this to happen in future.

115. Officer B followed Birmingham's suicide and self-harm management policy, which states that when a prisoner arrives with a self-harm or suicide warning form this must be passed by the reception officer to the healthcare screener, who was Nurse A. She interviewed him for about ten minutes in a private room. Although he again denied any intention to harm himself, she was concerned that he did not make eye contact and noted he appeared "withdrawn and down". Whilst she did not have sufficient concerns to start monitoring under the ACCT process, she did make an urgent referral to the mental health team for a further assessment.

116. I have considered the reasonableness of the nurse's decision and believe that she should have started the ACCT support measures. Whilst I must be careful not to apply the benefit of hindsight, she knew that earlier in the day he had clearly stated his intention to kill himself given the opportunity. He was facing a serious charge of attempted murder against his partner and appeared withdrawn and down to the nurse. Regardless of his assertions that he was now "fine" and given that the early period in prison is known to be one of particular vulnerability, observations made under the ACCT process would have been a safeguard to check and observe his mental state.

117. Birmingham's suicide and self-harm management policy states that staff must be aware of the high suicide or self-harm risks associated with those charged with violent offences against a family murder or murder. He fell into both of these categories. The policy also states that often prisoners will "conceal their intent" to harm themselves.

118. As a result of the nurse's urgent referral to the mental health team, he was assessed a few hours later by a RMN. Again, he denied any thoughts of suicide or self-harm, although he did tell the nurse that he had tied a noose round his neck and jumped from his home balcony on the night of the alleged offence. He claimed that this was not an attempt to commit suicide but as a demonstration to his partner to show how it felt when someone acted in that manner. Regardless of his intentions, this represented an admission of risky behaviour which could have resulted in his death. He also told the nurse that he did not want to be perceived as someone with a mental illness as he feared this could impact negatively on his court case. This may therefore have been a reason for him to hide his true intentions.

119. Whilst it has not been possible to establish whether the RMN had access to the suicide and self-harm warning form, he did have access to the medical record where Nurse A had made an entry regarding the form and her assessment of him. The RMN therefore knew that he had previously stated his intention to kill himself. Given this and his other admissions to the nurse regarding hanging himself on the night of the offence, it again seems

advisable that the nurse should have opened the ACCT procedures, regardless of his assertions that he felt "fine".

120. The clinical reviewer concurs with my view, recommending that:

> "An ACCT should have been opened as there was clear evidence of a suicide attempt and mental health assessment within 24 hours of arrival to HMP Birmingham."

121. The following day, he was interviewed by an officer as part of his induction and again denied any feelings of suicide or self-harm. He was also assessed by the detoxification doctor who did not have any concerns for his welfare. Prison Doctor B described him as:

> "sort of not giving anything away, cheerful and all that, talking on and on, concerned about his family, concerned about this outside. Then we're not sort of thinking how are you yourself kind of thing. I mean that probably was a facade."

122. He wrote the first of several letters to his family and friends on 8 March stating his intention to commit suicide. (I deal later in my report with my concern that, despite his offence, his mail was not being monitored by prison staff.) None of the letters were read by prison staff and so they were unaware of their contents. However, they make it clear that he hid his true intentions from staff and seemed determined to end his life.

123. In the evening of 11 March, he injured himself, telling staff that he had fallen over and hit his head on the sink. However, in letters to his partner and ex-partner he said that this was an unsuccessful attempt to commit suicide. Nurse B had treated him following the cut to his chin and asked him directly whether the cut was as a result of him harming himself. He denied this and the nurse had no further concerns about him. She completed a report of injury to prisoner form (F213). He was appropriately reviewed throughout the evening. The following day he was assessed by Nurse C who again had no concerns about his welfare, describing his mood as "bright and happy".

124. Birmingham's violence reduction strategy states that every unexplained injury must be investigated. This includes incidents where prisoners say they have fallen out of bed or where the individual's explanation lacks credibility or the injuries do not support their account. The investigation process involves the injury being reported on a F213 form which is then followed up by the safer custody team. They will then complete an Unexplained Injury Investigation Form and the incident will also be reported to health and safety staff for them to investigate as an accident. The injury will then be investigated by the residential SO, in consultation with the security department, safer custody and a violence reduction officer.

125. I am satisfied that Nurse B complied with Birmingham's violence reduction strategy and his injury would have been investigated. It is impossible to determine what the outcome would have been. However, both nurses said

they did not consider that he was at risk of self-harm or suicide. The clinical reviewer concludes, “in an ideal world this injury should have been assessed as a possible suicide attempt if the risk had been highlighted”.

126. On balance, given that he had not been subject to ACCT measures, I do not find it unreasonable that both nurses did not assess there to be a risk of self-harm at this stage. From their point of view, this was an isolated incident, without precedent, he appeared cheerful and they found his explanation plausible. They would also have known that the injury would have been further investigated under the violence reduction strategy.

127. He moved to the detoxification wing on 12 March. He was apparently initially put in a double cell with another prisoner, although it has not been possible to confirm this with the prison. The information comes from a letter he wrote to his ex-partner in which he said he was deliberately difficult to the other prisoner who was therefore moved from the cell. There is no record of this in the wing history sheet.

128. I have considered whether to make a formal recommendation in this regard. Records of cellmates and explanations for cell moves are especially important as they cannot be determined from the computer system. It would seem prudent that the wing observation book and prisoners’ history sheets are used to record when cell mates are moved or do not get on. The Governor will wish to ensure that staff are reminded of their responsibilities.

129. Later that day at around 4.45pm, Prisoner A asked two officers if he could move into his cell, since he was concerned about him. However, having spoken to both officers, that prisoner and other prisoners who were present, it is my impression that Prisoner A did not give the officers any reason to think that his request was urgent. He himself told my investigator that he did not think the man was a risk of suicide. The officers said they were unable to move him at present but would consider his request the following day. In the circumstances and given the information with which they were presented, this seems like a reasonable decision.

130. In conclusion regarding the signs that the man was at risk of harming himself, it is clear that staff had a very difficult task to assess him. He was seemingly an easy-going and polite prisoner, who claimed that he had no thoughts of self-harm or suicide. He convinced several nurses, a doctor and numbers of discipline staff that he was coping within the prison environment. He was also concerned that any discussions regarding his mental health would be disclosed to his partner or affect his trial.

131. His letters make clear his determination to hide his true feelings from staff and his intention to kill himself. Furthermore, crucial information regarding his risk of suicide from the police and psychiatric department at a local hospital was not forwarded to the prison in a timely manner. This would have enabled staff at the prison to gain a more accurate reflection of his mental state. However, particularly following his initial arrival at the prison, there was evidence to suggest he was at risk of suicide and in my opinion an ACCT should have

been opened. It is impossible to determine whether this would have led to a different outcome. I recognise that the reception staff assessed him seven days before his first attempt to harm himself in prison. Nevertheless I make the following recommendation:

The Governor should satisfy himself that all staff are familiar with the suicide and self-harm management policy. In particular, they should be fully aware of indications of a risk of self-harm or suicide and start ACCT measures where appropriate.

Treatment for drug misuse and administration of prescribed medication

132. On his first night in prison, he was prescribed five days of zopiclone to lessen any drug withdrawal symptoms he was experiencing. The following day, he was assessed by the detoxification doctor and tested positive for methadone, cocaine, benzodiazepines and morphine. He was prescribed methadone. Despite no spaces being available on the detoxification wing, records indicate that he received this prescription as directed.

133. The clinical reviewer comments regarding the prescription of benzodiazepines:

> "HMP Birmingham staff had been told by the man himself that he was also taking illicit benzodiazepines. His urine confirmed the benzodiazepines but this was taken on 5 March the night after receiving benzodiazepines in reception. Although this was a reasonable clinical decision the picture was confused by the administration of sedation the night before causing positive urine."

134. The clinical reviewer recommends that prisoners should be tested for drugs in reception before any medication is administered, especially sedatives. I agree with the clinical reviewer that, where possible, a drug test should be conducted by the nurse in reception, prior to any drugs being prescribed. However, if a prisoner is experiencing withdrawal from drugs, their needs must be prioritised, rather than delaying to allow for a drug test. Therefore, I do not make a formal recommendation in this regard but suggest that the Governor and Head of Healthcare ensure that drug tests are completed at the earliest opportunity and in reception, where time and resources allow.

135. Following requests from him, the doctor agreed to reduce his methadone dose from 40mls to 35mls on 10 March. The clinical reviewer notes that "This is a very conservative reduction within the bounds of good practice". He was moved to the detoxification wing on 12 March. Whilst he makes no criticism of Prison Doctor B's practice, I note that the clinical reviewer makes an additional recommendation to the local PCT with regards to the appraisal system for prison medical staff.

136. The man's prescription charts could not be found on 12 March when the nurses were due to dispense his medication. Therefore, he did not receive his diazepam or citalopram medication until 11.00pm that evening. However,

none of the nurses or the doctor my investigator spoke to believed delays in administering medication were a frequent problem. In this case, the charts were found and he was given his medication, albeit late. Furthermore, the clinical reviewer and doctor believed that the delay in his medication by six hours would not have had a significant impact on his physical or mental well-being. The clinical reviewer considered, "This is unlikely to have had an adverse affect on his mental state, and he would have felt very comfortable after the dose."

Code system for emergencies

137. There was no code system in place for first responders to use in the event of an emergency. The staff involved all thought that a code would have helped them in different ways. Nurse F thought that a code system would be useful since it would help healthcare staff to know what equipment to carry to the emergency. She explained that, whilst they always take the general emergency bag to any request for assistance, if they knew, for example, that a prisoner had stopped breathing they could also collect oxygen on their way.

138. Conversely, Nurse E said she did not think a code system would have an effect on the equipment healthcare staff took to emergencies. However, she did think that it would be useful so that she could psychologically prepare for emergency situations.

139. SO C told my investigator that it would have been useful for him to have had more information initially. Had he known the emergency was a hanging rather than a violent incident, he would have gone straight to M wing rather than going to his office first to leave his belongings. Furthermore, a code system could alert the communications room to call an ambulance. The clinical reviewer also thought that a code system would be useful.

140. The Governor said that he had previously considered introducing a code system at Birmingham but that when he spoke to the nursing management at the time about this they did not think it would be beneficial. He subsequently became convinced of the advantages of such a system and, when my investigator spoke to him in May 2010, was in the process of introducing emergency codes.

141. However, my investigator made further enquiries to see if this had been completed in August 2010. The Head of Safer Custody said that Birmingham had decided not to implement a code system. This was on the basis that all equipment was contained in one emergency bag and therefore managers had agreed that a radio call of "emergency assistance" was sufficient. However, this bag does not include a defibrillator (although there are nine secondary first aid bags around the prison) and there are other advantages of having an emergency code system. For example, staff are more psychologically prepared to know what type of incident they are responding to. It may also help to make it clear when an ambulance needs to be called, which was an issue in the man's death and is discussed further later in the report. Investigations following deaths at Birmingham in 2006 and 2008 also

encouraged the introduction of a code system. I therefore make the following recommendation:

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

First aid training and equipment carried by staff

142. Having discovered the man hanging, Officer D wanted to use an ambubag to aid CPR and prevent any risk of infection when conducting mouth to mouth resuscitation. He was not aware of any staff having been issued with them. The officer said he would be keen to carry an ambubag or other resuscitation aid if they were provided by the prison and I therefore suggest that the Head of Healthcare looks into the feasibility of this equipment being offered to staff.

143. Neither of the two officers or SO who found the man and started CPR had been recently first aid trained. Staff are trained when they first start working in the prison but there is no system in place for regular refresher training in basic life support. Officer D incorrectly believed that the current recommended ratio of chest compressions to breaths to be five to two. Since 2005 the Resuscitation Council has recommended a ratio of 30 compressions to two breaths. The clinical reviewer was also concerned about the lack of training available for staff and I therefore make the following recommendation:

The Governor should consider providing annual CPR training for all staff in contact with prisoners.

144. Nevertheless, I believe that the officers generally reacted quickly and professionally when they found the man. The nurses arrived at his cell within minutes and Officer D continued to assist them with CPR until Officer E took over. Due to the delay calling an ambulance, these members of staff had to continue the resuscitation attempt for 30 minutes until the paramedics arrived. They should be commended for their efforts in this regard.

145. Staff were content with the debriefs held after the man's death and were generally satisfied with the support offered. However, Nurses E and F had to keep the emergency response radios which, understandably, was difficult for them. Nurse F suggested that agency nurses, as they are all registered, could also be tasked with holding the emergency response radios and being in charge of prison keys. I would ask the Governor and Head of Healthcare to consider this.

Calling an ambulance

146. Despite my positive remarks about several aspects of the response when the man was found hanging, I am concerned about the arrangements for calling an ambulance. The clinical reviewer was also concerned about the delay in calling an ambulance and recommended that staff are reminded that anyone

can call an ambulance and staff responding to an emergency should not assume someone else has done so.

147. Officer D discovered him at 7.55am. An ambulance was not requested until 8.17am, a delay of 22 minutes. The officer believed it was the control room's responsibility to call an ambulance or request more information if they needed it from those at the cell. He said that since he had communicated that there had been a hanging, he thought the control room would have automatically requested one and it was not his responsibility to do so. However, the control room log states only that he requested urgent assistance. Some other staff had also been unaware they were responding a hanging.

148. Officer C was unsure whose responsibility it was to call an ambulance but knew that he could have requested one himself. However, he said he was occupied with trying to enter the cell and checking for signs of life. Shortly afterwards, he was asked to complete the routine incident log (of the people entering and leaving the cell) and he therefore assumed that someone else had requested the ambulance.

149. Both Nurses E and F said they assumed that the officers who first discovered the man would have called an ambulance, since he was hanging and not breathing. On reflection, they said that they should have checked that this had been done when they arrived at the cell.

150. Other staff said they thought that either the nurses or the first officers to the cell would have called an ambulance.

151. An operational order issued at Birmingham on 5 May 2009 regarding medical emergencies states that:

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

152. I am aware that a recommendation was made in this regard in 2008, which was accepted by the prison. A delay requesting an ambulance is apparently an issue for another death earlier in 2010. On this occasion I do not believe that the earlier arrival of an ambulance would have altered the outcome for the man. This may not be the case in other circumstances and I am concerned to have to repeat my recommendation here. I therefore make the following recommendation.

The Governor should remind staff of the contents of his operational order dated 5 May 2009, emphasising that any member of staff can authorise the calling of an ambulance in an emergency and staff responding to an emergency should check that this has been done at the earliest opportunity.

Contact with the man's family

153. When he first got to Birmingham, he told the reception officer that he would like his next of kin to be his mother. After his death, the Governor appointed himself as the FLO, as he considered that the other three trained FLOs were already working to their full capacity. Whilst it is unusual for a governing Governor to appoint themselves as the FLO, I am satisfied that the man's mother was given adequate support and the opportunity to contact the Governor should she have wished to do so.

154. However, he also gave his partner's details as next of kin on two occasions. Following his death, the Governor spoke to police who did not believe it was appropriate for his partner to act as next of kin since she was the victim of the offence. He therefore decided to go to the man's mother's house to break the news, while the police simultaneously went to see his partner. This seems a reasonable decision and eliminated the possibility of the partner finding out about his death from a third party.

155. Following the news, the family were initially upset with his partner and did not want her to be involved in funeral arrangements. Furthermore, the police had assessed that his ex-partner presented a risk to her since she blamed her for his death. Due to this and the victim issues involved, the Governor therefore attempted to avoid antagonising the situation further by contacting her but would treat his mother as his sole next of kin.

156. The man's partner wrote to the Governor on 17 March outlining her concerns about his care. She received a one line reply to her letter, nearly one month later, which was signed by the Governor's secretary. It was clear from her letter that she did not want to be excluded by the prison, despite being the victim of the alleged offence. It was also clear from the man's letters how seriously he had regarded his relationship with his partner. He wrote about his intention to marry her and that he had made her his next of kin.

157. When my investigator and FLO visited her on 23 April she appeared vulnerable and had been further distressed by being excluded by the prison. She had questions, such as when he had been discovered, which my investigator was able to answer immediately. She also had a number of issues that she wanted to raise and had not been given the opportunity to do so until this point. They have already been detailed in this report.

158. She said she found the Governor's response to her letter particularly upsetting, due to its brevity and lack of answers to questions she had raised. It compounded her feelings of being excluded by the prison. She also found it insulting that it had not been signed by the Governor himself. The Governor said he had forwarded her letter to the police officers involved in the man's death. He felt unable to elaborate further in his letter due to her being the victim of the offence and the advice he had received from police. However, the police did not allocate a family liaison officer in the case and therefore she was left, as she described it, feeling "isolated".

159. National prison guidance for liaison with bereaved families recognises the term “family” to include those:

> “chosen as well as biological and can include: husbands, wives, partners, significant others, parents, siblings, children, guardians and others who have had a direct and close relationship with the deceased.”

The guidance recognises that the FLO will need to take a flexible approach to who is regarded as family, as well as dealing with family “at odds amongst themselves”. They may have to deal with several branches of a family all with equal rights to information and use the services of more than one FLO in “extreme circumstances of family division”.

160. The Governor clearly had a finely balanced decision to make, given the family’s feelings towards the man’s partner at the time and the victim issues involved. However, it is clear from her letter written four days after he died that she wanted to be involved by the prison. It is my opinion that, particularly from this time, she should have been contacted by the prison. This could have been by a different FLO, as suggested in the guidance above or by the Governor himself. Indeed, by the time my investigator met the man’s mother on 13 May, she had resolved some of her negative feelings about the partner and they had visited his grave together.

161. I also believe that the Governor’s reply to the man’s partner’s letter could have been quicker and more personal so as not to compound her feelings of being insignificant as far as the prison were concerned. Whilst it is likely many of the issues she had raised could not have been answered at this stage, perhaps more explanation of why this was the case and letting his partner know that the letter had been forwarded to the police would have been helpful for her to know.

162. The Governor did not complete a family liaison log since he said his memory is systematic and he therefore did not need to write his decisions down. Birmingham’s family liaison policy states that:

> “The Family Liaison Officer must ensure that all contacts they have with the family are recorded. This information will be required for the investigation and will enable the Governor, FLO Co-ordinator and others to keep up to date and direct the future strategy.”

No doubt the Governor acted with the best of intentions when he took on the family liaison role. However, in light of his decision not to involve the man’s partner, I make the following recommendation:

Following a death in custody, the Governor ensures that national and local guidance available to FLOs is followed and that the prison involves all branches of a family as appropriate.

Letters to the man

163. The man's mother questioned why it took three to five days for letters to be delivered to him. The Duty Governor said that this was not an excessive amount of time given Royal Mail's delivery schedules and subsequent processes within the prison before mail is delivered to each prisoner. He was not aware of any issues which delayed mail being received by prisoners.

164. Since she was the victim of the alleged offence, the man's partner asked why he had been allowed to write to her. Birmingham's policy for reading mail states that only those prisoners who pose a threat to children, have been remanded for or convicted of an offence under the Protection From Harassment Act or of sending obscene mail will have their mail automatically routinely read. The policy does not refer to adult victims and the Governor may wish to consider whether it should be included. In addition, if the victim, police, probation services, social services or member of the public who no longer wants contact writes to the prison, they will restrict this mail. She had not made any such request. Therefore he would only have been subject to the random reading of five percent of his mail, as is the case with all prisoners.

Visits to the man

165. The man's mother said that from 4 March she repeatedly tried to book a visit to see her son. When calling, the telephone line repeatedly went unanswered or was cut off. After a few days she therefore sent an email to the visits department, to which they replied but told her they did not have any visits left for that week (commencing 8 March). The earliest visits they could offer her were on 17 or 18 March. She therefore booked a visit for the evening of 18 March. His ex-partner had also booked a visit for this day.

166. The visits booking scheme is run by an external company who control all the telephone and internet booking requests. The prisoner must first of all provide a list of people whom he wishes to visit him. On 5 March, he applied for his ex-partner, children, mother and father to be able to book visits. These names were entered on the computer system and forwarded to the company. Those wishing to visit then have to telephone the visits booking line or make an email request, as his mother and ex-partner did.

167. The Duty Governor confirmed that this system could be quite slow and a new computer had been ordered for the visits team. He said a visit could be prioritised if the person was put through to the duty governor. The Governor said that he thought the visits system had improved since the man's death but acknowledged that the visits slots were full on most days.

168. As a new prisoner, he was placed on a standard regime under the Incentives and Earned Privileges (IEP) scheme. (IEP rewards and encourages prisoners' good behaviour and has three levels – basic, standard and enhanced.) Birmingham's visits policy says that unconvicted prisoners on standard regime are entitled to three hours worth of visits per week.

169. Even though he was an unconvicted prisoner, he did not receive any visits in the nine days he was in prison. Given that the first days in custody are known to be a period of increased vulnerability for prisoners and, in some instances family contact can be a protective factor, this is particularly concerning. He shared his suicidal thoughts with his family but was unable to see them face to face. Had he been able to talk to them, circumstances may well have been different, and he may have been reassured. His family must now live with the distress of losing him, yet having been unable to see him between the alleged offence and his death. I therefore make the following recommendation:

The Governor ensures that the visits booking procedure is satisfactorily functioning and those wishing to book visits are able to do so in line with Birmingham's visits policy. Further, the Governor should ensure that the arrangements for new prisoners are satisfactory.

CONCLUSION

170. The man's behaviour had become increasingly erratic and he had lost a lot of weight in the months leading up to his arrest for the attempted murder of his partner. The circumstances of this offence in itself was cause for concern with regards to the risk of suicide he presented. There were also other indications of an intention to harm himself which did not get passed to the prison either by the police or a local hospital.

171. It is clear that once he arrived at Birmingham, he made every effort to conceal his true feelings from staff and other prisoners and was convincing in this respect. Whilst staff described him as "cheerful" or "likable", his letters to his family and friends indicated a man who was deeply distressed and talked of ending his life. One piece of paper found in his cell after he died, listed his concerns as losing his children, losing his partner, upsetting her family, having no plans for the future, facing a long prison sentence, putting his partner through a trial and not being strong enough. From his letters, it is apparent that he had made two unsuccessful suicide attempts in the two nights before he eventually died. Despite attempting to book visits, his family did not have the opportunity to see him face to face.

172. Whilst it is difficult to assess a prisoner's true intentions if they tell staff that they have no thoughts of suicide, there were indicators and information available to staff which, I believe, meant that suicide and self-harm prevention measures should have been started when he first went to prison. However, it would be complete speculation as to whether these measures would have allowed him to disclose his true feelings and intentions. It is also impossible to determine whether they would have had any success in preventing his death.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that requests for medical information from the community doctor are made within one working day of a prisoner's arrival, particularly when the prison doctor expects to prescribe medication.

   NOMS accepted this recommendation and responded:

   "Work has already commenced in this area."

2. The Governor should satisfy himself that all staff are familiar with the suicide and self-harm management policy. In particular, they should be fully aware of indications of a risk of self-harm or suicide and start ACCT measures where appropriate.

   NOMS accepted this recommendation and responded:

   "Work has already commenced in this area."

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

   NOMS did not accept this recommendation and responded:

   "HMP Birmingham have reviewed their emergency response procedures and are confident that the system in operation is now clear; known to all staff and fit for purpose."

4. The Governor should consider providing annual CPR training, such as Heartstart, for all staff in contact with prisoners.

   NOMS responded:

   "Due to the size of the staffing population at HMP Birmingham it is felt that that providing all staff with annual CPR training is unachievable. Training is provided to staff, however, the risk associated with emergency first response is mitigated by 24 hour healthcare staff and qualified first aid trained staff within the establishment. In addition nurses on nights are located centrally and are therefore able to attend incidents quickly."

5. The Governor should remind staff of the contents of his operational order dated 5 May 2009, emphasising that any member of staff can authorise the calling of an ambulance in an emergency and staff responding to an emergency should check that this has been done at the earliest opportunity.

   NOMS accepted this recommendation and responded:

   "Work has already commenced in this area with an update operational order."

6. Following a death in custody, the Governor ensures that national and local guidance available to FLOs is followed and that the prison involves all branches of a family as appropriate.

   NOMS responded:

   "This recommendation is already complied with at HMP Birmingham. This particular case involved multiple next of kins and a decision was made that they believe was defensible based on the information available at that time and intended to not antagonise individuals at what was obviously a difficult time. The decision was also made following consultation with the Police. Information received anecdotally may indicate a different action may have been taken but this is with the benefit of hindsight and new information coming to light, i.e. the partner of the man and his family dealing with their differences. This decision was taken with the Staffordshire police and HMP Birmingham feel it was the most appropriate decision at the time."

7. The Governor ensures that the visits booking procedure is satisfactorily functioning and those wishing to book visits are able to do so in line with Birmingham's visits policy. Further, the Governor should ensure that the arrangements for new prisoners are satisfactory.

   NOMS accepted this recommendation and responded:

   "This will be reviewed by the Head of Operations and incorporated into the local death in custody action plan."