A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in April 2014, while in the custody of HMP Birmingham

Our Vision

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

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Birmingham in March 2014. He died two days later in hospital. He was 36 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Birmingham was undertaken. The prison cooperated fully with the investigation.

The man had been released from a prison sentence on conditional licence in September 2013, but recalled to prison on 27 March 2014, after the police charged him with a violent offence against his partner. Prison staff did not consider him to be a risk of suicide or self-harm. He reported being dependent on alcohol and a doctor prescribed medication to relieve withdrawal symptoms. He appeared to settle, but told his cellmate he was anxious about his relationship with his partner. On the afternoon of 31 March, his cellmate said he was upset after difficult telephone calls with his partner and family, but prison staff were unaware of this. Later that afternoon, an officer found him hanging in his cell, just four days after he had arrived at the prison. Prison staff and paramedics managed to establish a pulse, but he never recovered. He died in hospital, two days later. A post-mortem examination found that he had a high level of diazepam in his body, above that he had been prescribed. We have not been able to establish the source of the medication.

While I consider it would have been difficult to have anticipated the man's actions, as in another recent investigation into a death at Birmingham, I consider that the prison staff should have recognised his risk of suicide and self-harm when he first arrived at the prison and considered whether he needed additional support. As in many cases my office investigates, the staff relied too much on his personal presentation and his assurances that he did not intend to kill himself, rather than his evident risk factors. Although I am satisfied that it would not have affected the outcome for him, the investigation found a need to improve emergency response procedures at Birmingham, including ensuring that families are informed as soon as possible when a prisoner is taken to hospital in a serious condition.

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

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

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SUMMARY

1. On 11 May 2013, the man was sentenced to 18 months imprisonment and went to HMP Birmingham. A pre-sentence report stated that he had been depressed for three years and had suicidal thoughts most days. His record indicated that he had attempted suicide in police custody in 2011. Prison staff did not consider he was at risk of suicide or self-harm and he settled well at the prison. On 13 September 2013, he was released on licence.

2. On 15 February 2014, the man allegedly committed a violent offence against his partner. He was recalled to prison. On 27 March, the police arrested him and he went back to HMP Birmingham.

3. When he arrived at the prison, the man consistently told prison staff that he had no thoughts of suicide or self-harm. However, he had a range of factors known to increase the risk of suicide and self-harm, including an alleged violent offence against his partner, recall to prison, previous suicide attempts and he was apparently withdrawing from alcohol. Staff at the prison did not share information appropriately and relied too much on his presentation and his assurances that he would not harm himself. They did not request his community GP records. There is little evidence that staff considered all his known risk factors when assessing his risk, an issue we have raised with Birmingham before. While we consider it would have been difficult to predict his actions in March, the prison needs to improve its assessment of risk for new prisoners when they arrive.

4. During the afternoon on the day of the incident, the man made several calls from the telephone in his cell, to his partner and family. He was apparently upset and told his cellmate about difficulties in his relationship with his partner. The staff did not know about this. At 6.00pm, his cellmate left the cell for an association period and he was left alone. At 6.55pm, an officer found him hanging in his cell. The officer, helped by a prisoner who was nearby, managed to remove the ligature from his neck. The officer's radio battery was flat. This led to a delay of four minutes before someone called an emergency code blue to alert healthcare and other staff.

5. Prison staff at the scene attempted resuscitation quickly and competently but it is apparent that there is a need to improve emergency procedures to ensure more effective communication within the prison and with emergency services. The control room called an ambulance when they heard the code blue call, but they were unaware of the details of the incident and did not inform paramedics that they were responding to a hanging. Paramedics took the man to hospital but, sadly, he did not regain consciousness. He died in hospital on 2 April. A post-mortem examination found that he had a high level of diazepam in his body, above that he had been prescribed. We have not been able to establish the source of the medication

6. The prison had no recorded telephone contact details for the man's family which led to a delay in informing them that he had been taken to hospital as no telephone contact had been recorded. Support for his cellmate after his death was inadequate.

7. We make six recommendations about these issues.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at Birmingham informing them of the investigation and inviting anyone with information to contact her. No one responded.

9. The investigator obtained all relevant documents from the man's time in prison. On 7 and 8 May, she interviewed ten members of staff and two prisoners. After the interviews, she informed the Director about the emerging findings of the investigation. She spoke to the man's offender manager at Birmingham Probation Centre.

10. NHS England commissioned a clinical reviewer to assess the clinical care the man received at Birmingham. He participated in the interviews with the investigator.

11. We informed HM Coroner for Birmingham and Solihull of the investigation and we have sent the Coroner a copy of this report.

12. One of our family liaison officers contacted the man's family, who identified no specific issues for the investigation to cover. They received a copy of the draft report. They did not make any comments.

HMP BIRMINGHAM

13. HMP Birmingham is a local prison, principally serving the West Midlands courts. It holds up to 1450 remand and sentenced men. G4S Care and Justice Services have managed the prison since 1 October 2011. Birmingham and Solihull Mental Health Foundation Trust run healthcare services. The healthcare centre operates 24 hours a day.

HM Inspectorate of Prisons

14. HM Inspectorate of Prisons' most recent inspection of Birmingham was in March 2014. Inspectors noted that high prisoner turnover and movements because of overcrowding meant that prisoners often arrived at reception late, putting first night and induction procedures under great strain. Despite this, inspectors found that first night staff were caring and generally did a good job keeping prisoners safe.

15. The number of incidents of self-harm was not high taking into account the size and complexity of the population and support for those at risk was good. However, the inspectors commented on the need for greater attention to identifying risk of suicide and self-harm for newly arrived prisoners.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recent annual report, for 2012/13, the IMB reported that Birmingham's safer custody team continued to be pro-active but safer custody meetings were not well attended by prison staff. They noted that during the reporting period there had been 354 incidents of self-harm compared with 276 the previous year. The number of ACCTs opened had decreased from 684 to 328.

Previous self-inflicted deaths at HMP Birmingham

17. Since February 2010, there have been eleven apparently self-inflicted deaths at Birmingham including that of the man's. As with him, three of the previous deaths occurred shortly after the prisoners' arrival at the prison: one within five days and two within nine days. Four of these previous deaths involved a prisoner on remand for an offence of violence against a family member or partner. Both of these factors are known to increase a prisoner's risk of self-harm or suicide. We repeat a recommendation we have previously made to Birmingham about assessment of risk when prisoners arrive at the prison.

Assessment Care in Custody and Teamwork

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate

needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

19. The man committed an offence of grievous bodily harm against a friend of his partner on 11 June 2012. Four days later, he was arrested and remanded to HMP Birmingham. It was his first time in prison. A police officer wrote on his person escort record (PER) that he had thoughts of self-harm. (The PER is a document to communicate a person's risks and vulnerabilities when they move between police stations, courts and prison.) His prison record noted that he had attempted suicide in police custody in 2011. However, at his health screen, the nurse noted no health issues or history of thoughts of self-harm or suicide.

20. On 22 June, 2012, the man was released on bail. On 10 May 2013, the courts sentenced him to 18 months imprisonment. The pre-sentence report indicated that he had been depressed for three years and had "dark thoughts" most days including thoughts of jumping off buildings. He said that he had attempted suicide fourteen years previously by taking an overdose of prescription drugs with alcohol.

21. The man went to HMP Birmingham. He told an induction officer that he had never self-harmed, had no current thoughts of suicide or self-harm and that he had never suffered from depression. Another officer noted on a cell sharing risk assessment (CSRA) that his arrest warrant had a self-harm warning marker. (The CSRA is used to determine whether someone would present a risk of violence to another prisoner in a shared cell.) He told the officer and a nurse who completed his initial health screen that he had taken an overdose a long time previously and had considered suicide in the past but did not have any current thoughts of this nature.

22. Over the following months, the man was a co-operative prisoner who attended work and education. He was not identified as at risk of suicide and self-harm during his time at the prison. On 13 September 2013, he was released on licence. He reported fortnightly to an offender manager (probation officer) at Birmingham Probation Centre. His offender manager noted some concerns about his risk of suicide and self-harm but did not consider these were serious.

23. On 17 February 2014, the man was charged with an offence of battery against his partner and bailed to appear at Magistrates' Court on 14 April. On 20 February, Birmingham Probation Centre requested that he should be recalled to prison. The recall notice indicated that he might be vulnerable in custody as he had previously had thoughts of throwing himself off buildings.

Thursday 27 March

24. On 27 March, police arrested the man under the recall procedures and he arrived at HMP Birmingham at 2.40pm. Under the suicide and self-harm risk section on the escort record a police officer noted "Made ligature with shirt in cell 2011".

25. A reception officer completed the first section of a cell sharing risk assessment and indicated that there were no concerns. A nurse assessed the man for an initial health screen at around 3.30pm. She said that before

the initial health screen she receives a folder containing sentence or offence information, the partially completed CSRA and the PER but she does not have time to check all the paperwork or the prisoner's electronic medical record. However, she had read his CSRA and the PER and said nothing of concern stood out.

26. The nurse based her assessment on what the man told her. She noted that he had no medical, drug or alcohol issues and no current or past thoughts of suicide or self-harm. She said that if he had disclosed a history of suicide or self-harm she would have discussed this with him. She noted that he "appears calm and stable at time of reception and remains to have good eye contact throughout". She said that she would not ask a prisoner why they were in prison, as her duty was to look after prisoners' health and felt their offence was not her business. She told him that she had booked him in for the wellman clinic the next day and had no concerns about his mental health. She noted on the healthcare section of the CSRA that he was suitable to share a cell.

27. Healthcare staff did not request the man's community GP records while he was at the prison. The member of staff usually responsible for requesting these records was on leave at the time, and the person covering her work did not ask for them.

28. The man went to D wing, the prison's first night centre, and was allocated a shared cell. Officer A interviewed him as part of the first night procedures. He said he had seen his cell sharing risk assessment, but only reception staff saw his escort record. He said that any relevant information, such as his risk of suicide and self-harm, would then be transferred to the CSRA (although the purpose of the CSRA is not to identify risk of violence towards another prisoner, not risk of suicide and self-harm). He said he checked the CSRA to see if there had been any previous issues of self-harm but none had been listed.

29. The officer then completed a first night assessment from information the man gave him. He recorded that he had expected to come to prison that day and was not worried about being in prison. The officer noted that he said that he had never self-harmed and did not have any current thoughts of harming himself. He said that he had never been diagnosed with or treated for depression. He also said he had no problems with drugs or alcohol.

30. The man told the officer that his licence had been revoked. On the assessment form there is a generic note in bold type that "licence revokees are a high risk of self-harm". When asked whether he had considered this risk factor, the officer said the man was "quiet enough…no problem, just straight through". He could not remember whether he had asked him about the circumstances of his recall. He said that if he had, he might not have recorded it, as it would have just been part of a general conversation. The officer noted that he was polite and co-operative and he had no concerns about him.

31. As part of reception procedures, the officer allowed the man a two-minute telephone call. At 6.25pm, he rang his ex-partner, the mother of his children. He admitted that he had assaulted his partner, but said that they had both

been in the wrong. He spoke to his children and told them he would write and call the next day. The officer then took him to his cell.

Friday 28 March

32. At 8.10am on 28 March, a doctor assessed that the man was suitable to keep medication in his possession. The doctor did not see him, but reviewed his initial health screen and noted that he had not previously held medication in possession. The doctor recorded, as part of a drop down menu of questions, that he had either no history of self-harm or overdose or that it was more than five years ago. The doctor prescribed one tablet of promethazine hydrochloride (a sedative) to assist him settle into prison that evening. The doctor thought a nurse had asked him to prescribe this, but there is no record of this in his medical record.

33. The man was expected to attend a wellman clinic that day for a secondary health assessment but did not attend and no reason was recorded. An officer completed his induction that morning and noted that he was not concerned about being in prison and had no thoughts of self-harm.

34. At 9.35am, the man rang his partner. He asked her to be careful with his bank card and money and said he hoped that she could visit soon.

35. A member of the Drug and Alcohol Recovery Team (DART) saw the man as a routine assessment of all new prisoners. Although he had previously said that he did not misuse alcohol, he said that he did have a problem with alcohol and would like help. The DART worker referred him to the doctor's detoxification clinic that morning. He told the doctor that he thought he had been recalled to prison for 28 days but was not completely sure. He said he had been misusing alcohol for six to eight months and drank four cans of lager and a bottle of wine daily. He had last drunk alcohol two days previously and said he had not slept well on his first night due to having no alcohol. The doctor noted in his medical record that he seemed settled, alert and oriented and had a slightly flushed appearance.

36. The doctor prescribed 25ml of diazepam twice a day to help reduce any alcohol withdrawal symptoms. This was a gradually reducing dose to be completed by the sixth day. Because of the risks of misuse, prisoners have to collect diazepam and take it in front of pharmacy staff.

37. The doctor said the assessment had been straightforward and he had no concerns about the man's mental health or risk of suicide or self-harm. He said that he had talked normally and made good eye contact. The doctor had not reviewed his entire medical record before assessing him but said that if he had been aware of the entry about his overdose and suicide attempt twenty years before, it would not have changed his assessment of his risk that day. The doctor did not know why he had been recalled to prison as this information was not available to him.

38. The DART cluster manager was also present during the doctor's assessment. She discussed the relaxation group with the man as she thought this might have been beneficial for him.

39. Shortly after 2.00pm, a healthcare assistant assessed the man using a standard Alcohol Use Disorder Identification Test (AUDIT). She had no access to any of his records before she completed her assessment. He said he had no previous or current thoughts of suicide or self-harm. She also assessed whether he had any withdrawal symptoms using the Clinical Institute Withdrawal Assessment (CIWA) for alcohol. His only symptoms were a moderate tremor and mild headache, scoring 6 out of a possible 67, indicating an absent or minimal withdrawal from alcohol. She then sent her assessment to DART to consider whether he needed any further support. She said she had no concerns about him and that he had seemed very relaxed. She did not record the assessment in his medical record and said she would normally only do this if she had concerns about a prisoner's withdrawal symptoms or his risk of suicide or self-harm.

Saturday 29 March

40. At around 10.00am on 29 March, the man rang his brother and left a voicemail, asking him to hide a bag of pornography at his flat from his partner. At lunchtime, after he had completed his induction, he moved to a general residential wing. Officer B was allocated as the man's personal officer. (Personal officers are expected to get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress.) The officer introduced himself to him, took him to his cell and introduced him to his cellmate.

41. After lunch, the officer took the man to get a new mattress for his bed. The officer said that he seemed to know some of the prisoners on the wing and that he appeared to be in good spirits.

42. The cellmate told the investigator that the man had seemed all right but a bit down about being recalled. They had spent the rest of the weekend talking about football, among other things, and he had seemed okay. The man told him that he had been recalled to prison due to criminal damage connected to his partner and arguments with her and that he was "gutted" to be back in prison, as he had recently served five months. His offender manager had told him on 24 March that they would revoke his licence and recall him to prison, so he had packed a bag, including tobacco and other items and had waited to be arrested and taken back to prison.

43. The man told his cellmate that he had "blagged" a prescription for diazepam. He said he did not misuse alcohol but he had wanted diazepam to "knock him out". The cellmate said he never saw him with any diazepam or other medication. He said the man had to collect his medication and that he slept a lot after he had taken it.

Sunday 30 March

44. On Sunday 30 March at 11.16am, Officer B wrote in the man's record, "He has only just arrived on M Wing; he appears polite and was mixing well on association. I have introduced myself as his personal officer, no concerns". The officer said he did not know that he had been recalled to prison or that he had been charged with a violent offence against his partner. He said it was

usually possible to tell if a prisoner was not coping very well, but he did not come across as someone who was struggling with his situation. He did not have any further significant conversations with him.

Day of the incident

45. Officer C unlocked the man to go to work at 8.00am and he was unlocked for an association period at 8.30am. (Association is when prisoners are able to socialise with each other, take showers and undertake domestic tasks.) He was offered some time in the open air in the exercise yard between 10.00am and 11.15am but there is no record of whether he went out. The man's cellmate said he had seemed all right during the day.

46. Around 3.30pm, during an association period, the man told the officer that he did not have a PIN number to use the telephone in his cell and he was not sure if his family knew where he was or how he was. He said that he wanted to ring his son as it was his birthday. The officer obtained a PIN number within about thirty minutes and gave it to him, by which time he and his cellmate had been locked back in their cell. The officer told the investigator that he did not appear to be upset that he had not had a PIN number before this time, but he seemed eager to make a call and was grateful. The officer said that he seemed quiet but fairly happy.

47. Some of the newer wings at Birmingham have telephones in their cells and the man's cell had one. From 4.10pm, he made several calls from the telephone in his cell. He called his partner first but was not connected. A minute later he called his brother, who told him that his partner had found the bag of pornography and was angry about it. He tried to call his partner again, but did not get through.

48. At 4.19pm, the man called his ex-partner and, after a brief conversation, he spoke to his children. He told them he had written them a letter and that he would speak to them soon. His ex-partner later told police that he did not seem his usual self when she spoke to him. She said that he did not misuse alcohol and that he had never disclosed to her any feelings of suicide or self-harm.

49. Two minutes later, the man tried to call his partner again but did not get through. He then called his brother again, who told him that his partner had taken £200 from his bank account. He became angry and told his brother to tell his partner that he would be informing the police. He wanted to know if his partner intended to visit him in prison. His brother said that she had originally intended to, but they had not spoken about it again since she had found the pornography.

50. At 4.30pm, the man spoke to his partner. She was angry and said she did not want to talk to him anymore. He apologised but his partner said she could no longer trust him. He rang her again and told her, "It's hard in here". They argued and when he asked his partner if she would visit him, she said that she never wanted to see him again. However, by the end of the telephone conversation they appeared to have resolved the situation. His partner said that she would visit him if he did not tell the police about the money she had stolen from him. She was crying and telling him he had been dishonest, when

the telephone cut out. The man's cellmate said that he thought his telephone credit must have run out at this point.

51. The cellmate said the man seemed anxious and upset after the calls and thought that his partner finding pornography at his flat was worse than him cheating on her. He was also angry about the money she had taken from his bank account and was worried that his partner was going to be unfaithful. He said he tried to sympathise and told him that the situation was not too bad. (Prisoners' telephone calls are recorded, but unless specifically targeted for security reasons, staff do not listen to them all. They routinely listen to a random selection of 5% of calls. No one listened to his calls before he died.)

52. After the phone calls, the man and his cellmate collected their dinner and returned to their cell. The cellmate said that the man did not eat much and seemed to have lost his appetite. He tried to reassure him and take his mind off things by telling him about his own problems. They watched a quiz show on television together. The cellmate thought he was trying to put on a brave face and seemed a little happier.

53. At around 6.00pm, Officer C unlocked the man's cellmate for an association period. The man asked the officer if he could also come out but the officer explained that this was not allowed. This was because he did not have a prison job and had already had his association period that day. He said that he appeared to accept this with good grace. The officer said that he seemed fairly quiet but that this was not unusual for a prisoner new to a wing. He thought another member of staff had told him that the man had been recalled to prison, but he did not know the circumstances. He did not ring his cell bell over the next hour.

54. At 6.55pm, Officer C went to unlock the man so he could go to get his medication. When he unlocked the cell, he found him hanging by a ligature made from a sheet attached to a shelving unit. His radio battery had run out earlier in the evening, so he blew his whistle and shouted for help. Staff told the investigator that it is rare to hear a whistle blown in the prison and it indicates that an officer needs urgent assistance.

55. Officer C went into the cell and put his arms around the man's torso to support his weight. He tried to cut the sheet from his neck with the anti-ligature knife which officers carry, but could not do this while he was also supporting the body. Another prisoner was standing near the cell. He saw that the officer needed help, so he went into the cell and tried to untie the sheet. The prisoner managed to loosen the sheet and pulled it up over his head, while the officer lowered him to the floor. The officer estimated it took them around 15 seconds to get him down. He said he looked very pale and was floppy. He was concerned that he had not supported his head sufficiently as it made a noise as it contacted the floor.

56. Officer C blew his whistle again at the cell door. He could not find a pulse in the man's neck and assessed that he was not breathing as his chest was not rising. He began chest compressions and heard the general alarm bell sound.

57. Officer D had been on another landing on M Wing when he heard Officer C's whistle. He said he immediately went towards the man's cell and had pressed the general alarm bell on his way. Records indicate the alarm was pressed at 6.58pm. Officer D said that this would inform the control room and rest of the prison that there was an emergency and the control room would ask staff to attend M Wing as a result.

58. Another officer arrived at the cell after Officer C had completed the first set of chest compressions. Officer C estimated this was about a minute after he had first found the man. The prisoner left the cell at this point. The responding officer was not carrying a radio. The officers took turns doing chest compressions and checking whether the man had a pulse. Officer D arrived at the cell shortly afterwards. He then radioed a code blue to indicate a life threatening situation, when a prisoner is unconscious or is not breathing. It was 6.59pm. As a result of the code blue call, the communications room automatically called an ambulance and asked the first healthcare emergency responder and the backup to attend the wing. Officer D checked him but could not detect a pulse.

59. Officer D took over chest compressions and asked Officer C to get the bag containing emergency equipment, including a defibrillator, from the wing office so that it was ready when the nurse arrived. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.) Officer D radioed another code blue and requested a nurse. A first line manager arrived at the cell next. The manager had turned his body worn camera on as he was expected to do when attending an incident, but once he realised that the man was not breathing he turned the camera off, out of respect. He estimated that it had taken him two minutes to get to the cell after hearing the whistle alarm. The manager took over chest compressions.

60. A nurse was the healthcare first responder. She did not hear the code blue call but heard the request for Hotel 2 (her radio call sign) to attend M Wing. (She assumed she did not hear the code blue because of the noise on B wing where she had been giving out medication.) The nurse immediately went to M Wing and estimated it took her about five minutes to get to the cell. She did not know the nature of the emergency but took an Ambu bag mask with her to assist resuscitation.

61. As soon as the nurse arrived at the cell she requested the back up nurse to attend. She checked the man's pulse and established that he was not breathing. She could not see any signs of life. Officer C had returned with the emergency bag shortly after the nurse had arrived. She attached the defibrillator pads to his chest, and the defibrillator advised not to shock. The manager continued with chest compressions and two more nurses arrived.

62. One nurse inserted an airway and another attached an Ambu bag with oxygen. Staff continued chest compressions rotating between the officers and nurses. The man vomited a white substance three times and a nurse suctioned it away.

63. A senior manager was responsible for running the prison that evening. He had heard the code blue call over the radio and was waiting for further updates about the situation. He said he did not go immediately to the cell

because he might have needed to carry out other responsibilities, and he knew the orderly officer was already on his way.

64. The senior manager said he soon realised from the requests over the radio for healthcare staff and the urgency in staff voices that he needed to go to the cell. While he was on his way, he heard two further requests for the healthcare first responder to attend M Wing. He got to the cell about 7.05pm, shortly after the orderly officer with responsibility for attending every emergency in the prison. The senior manager, who is well qualified in first aid, explained that he was satisfied that chest compressions were being undertaking correctly and staff were working very well as a team.

65. The ambulance arrived at the main prison gate at 7.07pm and, at 7.15pm, the two paramedics got to the cell. The senior manager said he did not think this was an exceptionally long time to get from the main gate to the cell as there were a number of internal gates to open and M Wing, where the cell was, is one of the furthest wings from the main prison gate.

66. When they arrived at the cell, the paramedics were surprised to discover the nature of the emergency as they had been told they were attending a prisoner with chest pains. One of the paramedics went back to the ambulance to get the correct equipment and a stretcher. The nurses and officers continued chest compressions while the paramedics assessed the man. At the paramedics' request, staff helped put him on a stretcher and carried him to the ambulance at 7.35pm. It was not possible to continue chest compressions on the way to the ambulance but once they were inside, the paramedics restarted the chest compressions. They said that they had detected a faint pulse but that he was still not breathing on his own. The ambulance left the prison at 7.45pm. He was escorted by two officers. No restraints were used.

67. During the emergency response, Officer C had spoken to the cellmate, who told him that the man had received some bad news on the telephone and had seemed down as a result. However, the cellmate said he had not thought he was a risk to himself, otherwise he said he would have stayed in his cell with him or told staff. Until then, staff had been unaware that he had made any telephone calls that afternoon. After the ambulance left, Officer C went to the other prisoner's cell to let him know about the man's condition. He noted in the wing observation book that staff should observe the prisoner throughout the night. Staff offered him counselling.

68. The man had nominated his sister as his next of kin, but his records showed only the names and addresses of his sister and his partner and not their telephone numbers. The senior manager therefore contacted the police and asked them to inform his sister and his partner about what had happened. At 8.00pm, the senior manager held a hot debrief for staff who had been involved in the emergency response.

69. At 10.30pm, the police told the prison that they had been unable to contact anyone at either address. The security manager had now arrived at the prison which meant that the senior manager was able to obtain the telephone numbers the man had recently rung. His last telephone call had been to his partner and he telephoned her at 11.30pm. He told her about her partner's

critical condition in hospital, and she said that she would contact his family and go to the hospital.

70. The man's partner and other family arrived at the hospital in the early morning. He remained in a critical state, sedated and ventilated. Tests indicated that he had a potentially fatal level of diazepam in his system. A fatal level of diazepam is between 5 and 20mg/ml. He had 30 mg/ml which later peaked at 33mg/ml.

71. A senior officer acted as the prison's family liaison officer (FLO) and she and the Director and the senior manager went to the hospital at 9.15am on 1 April. They met the man's family and the FLO remained with them until 7.15pm.

72. A hospital consultant asked whether it was necessary to have officers guarding the man. The FLO spoke to a prison manager, who said that as he was still in prison custody an officer had to be present. Because of the seriousness of his condition, he felt that two officers were necessary to support each other.

73. During that evening, the man's condition deteriorated. The hospital switched off his life support and he died at 11.15pm. His partner and his family were present. A post-mortem examination recorded the cause of death as hanging. The FLO remained in contact with the man's partner and family. The prison contributed to the cost of the funeral in line with national guidance.

74. After the man died, prison staff found a letter in the wing post box to his ex-partner. In the letter, he said that he thought he would have to stay in prison until June, but would know for certain in two weeks. He included a letter to his children and said he would call and write soon.

75. The man would have remained in prison until June unless it was decided he was suitable for a fixed-term recall and re-released after 28 days. On 31 March, the National Offender Management Service wrote to his community offender manager asking for a recommendation about whether he should be released after 28 days in custody. This would then have informed a decision about whether he would be released at this point or remain in custody until June.

76. The cellmate said that he had not received any support after the man was taken to hospital. He said that a nurse came to see him shortly after the man had died and told him that they would book an appointment for counselling, but this had not happened. He said at the time he felt he needed to talk to someone but when he spoke to the investigator on 8 May he said he was now okay. No one had suggested a Listener should see him (Listeners are prisoners trained by the Samaritans to offer support to other prisoners in distress) and no one came to tell him in person that the man had died.

77. When the investigator interviewed the cellmate his belongings, including his clothes, pictures of his son and items from the prison shop delivered on 31 March, were still in the cell he had shared with the man. He had not been allowed access to them. He said that when he had asked about his tobacco, he was given some but charged for it. The prison did not reimburse him until he complained about this.

ISSUES

Clinical care

78. The clinical reviewer concluded that the note keeping and actions taken by the healthcare staff were accurate, concise and very thorough and that the care the man received was equivalent to that he could have expected to receive in the community. However, no one obtained his community GP records, which could have provided useful background about his reported alcohol misuse and his mental health and informed prescribing decisions and assessments of his risk of suicide and self-harm. Prison Service Instruction (PSI) 74/2011, Early Days in Custody, requires efforts to be made to retrieve any information required from the prisoner's GP, or other relevant service the prisoner has recently been in contact with. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff request community GP records when a prisoner first arrives at the prison

79. The prison doctor had prescribed diazepam in liquid form which had to be taken in front of a nurse. While not impossible, this would have made it very difficult to secrete and store it. When the man was admitted to hospital he had a potentially fatal level of diazepam in his system. We do not know where he had obtained this diazepam, but it is possible that he had smuggled it in, knowing he was due to be recalled to prison. He could also have obtained further diazepam illicitly in prison. There is no security information about this and his cellmate said he did not see him with any medication.

80. The clinical reviewer found there was good liaison between medical professionals and the Drug and Alcohol Recovery Team (DART) to help the man access services. The clinical reviewer was satisfied that the prison doctor had appropriately prescribed diazepam, based on his self-reported alcohol misuse. However, he noted that the healthcare assistant's assessment of his alcohol use was not entered on his medical record.

81. It is possible that, had the Clinical Institute Withdrawal Assessment (CIWA) score of 6, been entered on the man's medical record, a further review might have decided that, in the absence of significant withdrawal symptoms, the clinical detoxification programme should be amended. The clinical reviewer recommended that such assessments should be entered on the clinical record to help provide seamless care. We make the following recommendation:

    The Head of Healthcare should ensure that results of assessments completed by the Drug and Alcohol Recovery Team to measure withdrawal symptoms and other relevant assessments are entered on prisoners' medical records to provide continuity of care and appropriate, evidenced based treatment.

Assessment of the man's risk of suicide and self-harm

82. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011, about early days in custody, both list a number of risk factors and potential triggers for suicide and self-harm. The man had a

number of factors that were significant indicators of risk of suicide, including recall to prison; early days in custody; previous self-harm; drug/alcohol dependency; violent offences, particularly against family members; and relationship instability. There is little evidence that staff took these factors into account when assessing his risk.

83. When the man was remanded to Birmingham in June 2012, a note was entered on his electronic prison record that he had made a suicide attempt in police custody in 2011. When he was sentenced and taken to Birmingham in May 2013, he told an officer and a nurse that he did not have any current thoughts of suicide but had attempted suicide by taking an overdose around twenty years previously. He had told the pre-sentence report author that he had "dark thoughts" most days which involved him "jumping off things". On 27 March 2014, a police officer noted on his PER that he had previously made a ligature with a shirt in his cell in 2011. This related to the same incident noted in his prison record in June 2012 as a suicide attempt.

84. During the nurse's assessment when the man first arrived at Birmingham, she said she checked the cell sharing risk assessment (CSRA) to see if there were any issues for her to note. However, it is not the purpose of the CSRA to convey information about risk of suicide and self-harm. She said she did not have time to review the folder of information about him or his clinical record before assessing him. She had his escort record (PER) which noted a previous suicide attempt while in police custody in 2011 but did not refer to it. She said that if he had disclosed any history of suicidal thoughts she would have discussed these with him. She told the investigator that there was no information on his PER which caused her "immediate concern".

85. The nurse said that she did not want to know why prisoners were in custody and was unaware that the man had been recalled for an offence of violence against his partner. This approach means that nurses would never be aware of important factors about the nature of charges or offences which would impact on a prisoner's risk of suicide and self-harm. It is important that staff assessing risk have all relevant background information. It appears that the nurse's assessment was based almost wholly on the information he gave her and his presentation at the time.

86. Officer A, who completed the man's first night assessment, said he only had access to his CSRA and checked this to determine if there were any issues of suicide or self-harm. Again, this is a misunderstanding of the purpose of the CSRA and a misuse of the process. While the CSRA can contain useful additional information, the CSRA assesses a prisoner's risk of violence towards other prisoners when sharing a cell, not their own risk of suicide or self-harm. It is concerning that the officer did not appear to have access to any of the information from his person escort record.

87. The officer was aware that the man had been recalled to prison, although he could not recall whether he had asked him about the circumstances. On the first night assessment form there was a reminder that recalled prisoners were at high risk of self-harm. The officer said that the fact that he had returned to prison because his licence had been revoked would not have caused him any specific concerns as a large proportion of prisoners have been recalled. He therefore appears to have discounted a known risk factor. Had he enquired

about the circumstances and discovered that he was charged with a violent offence against his partner this should have raised concerns about his risk. The officer appears to have relied solely on how he appeared. He said "It's how they present to you at the time, he was as normal as can be".

88. It is not clear whether or not the man was actually withdrawing from a dependency on alcohol, but a doctor had accepted that he was and had prescribed medication as part of an alcohol detoxification programme. This is a further factor which would increase his risk of suicide and self-harm, but there is no evidence that anyone considered this.

89. On 31 March, the man had a number of telephone conversations which might have impacted on his state of mind. We accept that prison staff could not have been expected to know about these calls and whether they affected his emotional well-being. Although there was tension between him and his partner, there was little to indicate that he would take the action he did.

90. Staff judgement is fundamental to the ACCT system, but we are concerned that staff relied so heavily on the man's presentation, when he had a number of known risk factors when he arrived at the prison. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged.

91. While we accept that it would have been difficult to predict the man's actions on 31 March, this emphasises the need not to rely on how a prisoner appears and what he says at a particular moment. It is possible that a full consideration of all the risk factors, when he first arrived, would still have reached the conclusion that he did not need additional monitoring and support. However, the lack of any evidence that staff considered the range of risk factors indicates a need for the prison to improve its assessment of risk for all new prisoners. We make the following recommendation:

The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed any suicidal intent.**

Emergency response

92. When Officer C first found the man hanging, a nearby prisoner readily helped him remove the ligature from around his neck and remained with him until other staff arrived. We commend the prisoner's actions. The staff involved in attempting to resuscitate him reacted quickly and competently and made every effort to resuscitate him until paramedics arrived. It is testament to their professionalism that paramedics asked the staff to continue chest compressions after they had arrived and a faint pulse was detected when staff took him to the ambulance. We are satisfied that the resuscitation attempt was in line with national guidelines.

93. When Officer C discovered the man hanging, he blew his whistle to alert staff as his radio battery was flat. The battery had run out earlier in the afternoon and the officer had not replaced it. (A manager said that his expectation is that staff should replace a radio battery it at the earliest opportunity.) The officer said he went to unlock the man at 6.55pm. The general alarm bell was pressed at 6.58pm and the code blue announced over the radio at 6.59pm. There was therefore a delay of four minutes in summoning healthcare assistance and an ambulance due to the flat radio battery. While it is unlikely to have affected the outcome for the man, as staff began chest compressions very quickly, such a delay should not happen and could be crucial in other circumstances.

94. At the time of the man's death, staff told the investigator that there was an issue with a significant number of older radio batteries not lasting an entire shift. These have been replaced since his death and we understand that this issue has largely been resolved.

95. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires that after a code blue message, the control room should call an ambulance and await updates from the scene. After the code blue had been announced over the radio, staff gave the control room no further information and there is no evidence that the control room sought these details. The paramedics believed they were attending a prisoner with chest pains and, when they arrived, had to go back to the ambulance to get the correct equipment.

96. There is no evidence that this lack of communication adversely affected the man's treatment but, in another situation, it could cause unnecessary delay. There is a need to communicate effectively within the prison and with the emergency services. Once the ambulance arrived it took eight minutes to get to the wing from the gate. This was as long, if not longer, than it had taken to reach the prison. A senior manager said that this was not "exceptionally long" but this seems too long to get emergency help to an incident.

97. PSI 03/2013 indicates prisons must have a local protocol which ensures staff called to the scene bring the relevant equipment. An officer had the foresight to go and get an emergency bag and brought one just after the nurse arrived. However, there is no direction about who should do this in Birmingham's local policy and we would expect responsibilities in an emergency to be explicit.

98. In responding to the code blue, a manager turned on his body worn camera as he was expected to do when attending an incident. Once he realised that the man was not breathing he turned the camera off, out of respect. Birmingham's body worn camera guidelines indicate that, "recording should commence at the start of any deployment to an incident and should continue uninterrupted until the incident is concluded". We understand that he turned the camera off with the best intentions and out of sensitivity to the situation, but we consider that, just as with CCTV, camera evidence provides a helpful record of events in an emergency. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Birmingham's Medical Emergency Response code protocol complies with PSI 03/2013 and:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment;**
- **Ensures there are no delays in calling, directing or discharging ambulances and;**
- **Provides guidance on the use of body worn cameras in medical emergencies.**

Contacting the man's family

99. Prison Service Instruction (PSI) 64/2011, which gives guidance on safer custody, managing prisoners at risk of suicide and self-harm stipulates that, "prisons must record a next of kin or nominated person to contact for each prisoner during the reception/early days process". PSI 74/2011 which covers early days in custody, states:

> "Details of all newly arriving prisoners must be recorded in their personal record F2050 and on Prison-NOMIS … The information recorded must include the name and contact details of the prisoner's next of kin or nominated contact.

100. The prison had not entered any telephone number for the man's next of kin, his sister, in his records. This meant there was a delay informing his family that he had been taken to hospital in a very grave condition. It was only by chance, when the security manager arrived in the prison, that he was able to obtain the man's telephone records and his partner's telephone number and she agreed to inform his family. This was at 11.30pm; over four hours after he had first been found. This delay could have been avoided if a staff had recorded a telephone number for his next of kin. We make the following recommendation:

The Director should ensure that staff record telephone contact details for prisoners' next of kin.

Support for other prisoners

101. The man's cellmate had spent some time discussing his concerns with him and trying to reassure him about his situation. After the man was taken to hospital, he moved to another cell. He said a member of healthcare staff came to see him and told him he would be offered an appointment with a medical professional but this did not happen. He said that staff did not offer him the support of a Listener. Staff did not tell him personally when the man died, which we consider was insensitive. He was further upset by not being able to get any of his belongings from the cell he had shared with the man for several weeks and that he was charged for a replacement pack of tobacco. Again this did not show appropriate consideration to his position.

102. The prisoner, who had helped Officer C when the man was found hanging, appears to have been supported appropriately. But the cellmate needs seem to have been overlooked. Prison Service Instruction 64/2011 states that, "Appropriate care and support must be offered to the cellmate and any other persons directly affected by the death…" We are not satisfied that the prison appropriately supported the cellmate. We make the following recommendation:

The Director should ensure that after a prisoner dies, the prisoner's cell mate and others who were close to him, are informed of the death personally and offered appropriate ongoing support.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff request community GP records when a prisoner first arrives at the prison.

2. The Head of Healthcare should ensure that results of assessments completed by the Drug and Alcohol Recovery Team to measure withdrawal symptoms and other relevant assessments are entered on prisoners' medical records to provide continuity of care and appropriate, evidenced based treatment.

3. The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

   - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
   - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
   - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

4. The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Birmingham's Medical Emergency Response code protocol complies with PSI 03/2013 and:

   - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
   - Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment;
   - Ensures there are no delays in calling, directing or discharging ambulances and;
   - Provides guidance on the use of body worn cameras in medical emergencies.

5. The Director should ensure that staff record telephone contact details for prisoners' next of kin.

6. The Director should ensure that after a prisoner dies, the prisoner's cell mate and others who were close to him, are informed of the death personally and offered appropriate ongoing support.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that healthcare staff request community GP records when a prisoner first arrives at the prison	Accepted	There is an agreed standing operating procedure (SOP) in place which outlines the process to be followed to request GP notes, which requires the prisoner to complete a consent form in reception after which staff will faxes the GP practice to request the records. There is a nominated Healthcare administrative support officer to ensure that requests for GP notes are followed up.	Complete. Head of Healthcare	
2	The Head of Healthcare should ensure that results of assessments completed by the Drug and Alcohol Recovery Team to measure withdrawal symptoms and other relevant assessments are entered on prisoners' medical records to provide continuity of care and appropriate, evidenced based treatment.	Accepted	A notice to staff has been issued to all staff working in the IDTS service to remind them of the importance of ensuring that all relevant assessments carried out with patients are entered on SystmOne (the electronic healthcare record) to ensure consistence and continuity of care. This requirement was fed back through the healthcare Clinical Governance meetings, and all new staff will be made aware of this process.	Complete. Head of Healthcare.	
3	The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:	Accepted	Reception staff will undertake a screening of all prisoners who are received at the establishment. Any identified risks are shared with the clinical team, the mental health team and where opened, it will be recorded in the ACCT document by reception and/or First Night Centre staff. A		

	• Have a clear understanding of responsibilities and the need to share all relevant information about risk. • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. • Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.		NOMIS case note will additionally be made to record risk concerns. All Staff are aware of the ACCT process and will open an ACCT document when necessary. Safer Custody has a direct phone line where members of the public can contact the prison and raise their concerns. The Safer Custody meeting and weekly ACCT quality assurance management report monitor all newly opened ACCT's to ensure compliance with the above. ACCT refresher training will be provided as part of the Establishments Safer Custody training schedule.	Safer Custody Manager Ongoing Safer Custody Manager	
4	▪ The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Birmingham's Medical Emergency Response code protocol complies with PSI 03/2013 and: o Provides guidance to staff on efficiently	Accepted	All staff have been reminded of the emergency response procedures via a Notice to staff and		

	communicating the nature of a medical emergency; o Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment; o Ensures there are no delays in calling, directing or discharging ambulances and; ▪ Provides guidance on the use of body worn cameras in medical emergencies		Operational orders about the action following an emergency response code Red and code Blue. This includes Control room staff having been reminded of the need to request the following information to pass onto the attending paramedics: ➢ Patient Name ➢ Age ➢ Details if the patient is breathing ➢ Details if the patient is conscious ➢ Any know medication Brief description of the known circumstances This NTS is reviewed and reissued to all staff twice a year. Re- issue operational order in December 2014 about the BWC- body worn cameras – this will provide guidance to all staff on its use during medical emergencies.	01/12/14 Head of Safer Custody	
5	The Director should ensure that staff record telephone contact details for prisoners' next of kin.	Accepted	All prisoners are encouraged during the reception process to supply next of kin details. This information is also requested when an ACCT is opened. Where provided, the next of kin details are recorded on NOMIS, and staff will similarly record that there is no declared next of kin.	01/12/14 Head of Safer Custody	

6	The Director should ensure that after a prisoner dies, the prisoner's cell mate and others who were close to him, are informed of the death personally and offered appropriate ongoing support.	Accepted	Following a self-inflicted death all prisoners identified as potentially vulnerable on receipt of the tragic news are supported by staff, and advised of the support available from the prisoner Listener scheme and the Samaritans. A notice to both staff and prisoners issued the following day advise prisoners to raise any concerns with staff.	01/12/14 Head of Safer Custody	