Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Watkins a prisoner at HMP Birmingham on 9 December 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Watkins died in hospital after having been found hanged at HMP Birmingham. He was 35 years old. I offer my condolences to Mr Watkins' family and friends.

Mr Watkins' time at Birmingham was dominated by issues about his medication and detoxification. While he did not always comply with his treatment plan, I am concerned that he did not receive the level of individual support he needed. I am also concerned that little was done to investigate evidence that he was in debt to other prisoners and support him accordingly.

Mr Watkins claimed to have taken an overdose less than a week before he hanged himself. I am concerned that prison staff ended suicide and self-harm prevention procedures within 24 hours, without any proper healthcare input and without fully considering or resolving his problems.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2017**

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Summary

Events

1. On 6 June 2016, Mr Daniel Watkins was remanded to HMP Birmingham. He had reportedly tried to take his life a few days before, and reception staff began Prison Service suicide and self-harm prevention procedures, known as ACCT. Prison staff stopped ACCT procedures three days later.

2. Mr Watkins used heroin in the community and began an opiate detoxification programme. He struggled with his detoxification and sometimes used illicit opiate medication on the wing to supplement his prescription. Staff also saw him concealing medication rather than taking it as prescribed. Other prisoners said that Mr Watkins was in debt for drugs and concealed medication to pay off these debts.

3. On 1 December, Mr Watkins told an officer that he had taken an overdose. The officer began ACCT procedures. A unit manager assessed Mr Watkins and recorded that he felt frustrated by his detoxification. Mr Watkins also said that he did not feel safe at Birmingham. The next day another unit manager, acting alone, ended ACCT monitoring. There was no healthcare representative at the review and the issues Mr Watkins had raised were not resolved.

4. On 6 December, Mr Watkins ran from the wing medication hatch with his medication. When he tried to collect the next dose the next morning, the nurse told him that a prison GP had stopped his prescription. Later that morning, a prisoner found Mr Watkins hanging from the stairs at the back of the wing. Staff removed the ligature and began cardiopulmonary resuscitation. Paramedics arrived and took Mr Watkins to hospital, where he died on 9 December.

Findings

5. The clinical reviewer was concerned about Mr Watkins' detoxification, and concluded that he did not receive the individual care and support he needed. It was commonly known that Mr Watkins concealed medication, and some staff knew he was in debt, yet little was done to support him or to investigate his issues.

6. We are concerned that the very brief period of ACCT monitoring ended too early on 2 December, without full consideration, action to address, or resolution of Mr Watkins' documented issues and without proper input from healthcare staff.

Recommendations

- The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
    - First case reviews are multidisciplinary and always include a member of healthcare staff.
    - Case reviews assess risk in line with ACCT guidance.
    - ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved.
    - Case managers receive effective ACCT training and understand their responsibilities to hold effective case reviews in line with national guidelines.

- The Head of Healthcare should review Birmingham's guidelines for the treatment of prisoners prescribed opiate substitute medication to ensure that they provide person-centred care.

- The Director should ensure that:
    - All information about bullying, intimidation, debt and the use of drugs is fully co-ordinated and investigated.
    - Staff consider whether victims are at increased risk of suicide or self-harm.
    - Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situations.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Watkins' prison and medical records.

9. The investigator interviewed 13 members of staff and three prisoners at Birmingham in February 2017.

10. NHS England commissioned a clinical reviewer to review Mr Watkins' clinical care at the prison. She joined the investigator for interviews with clinical staff, and interviewed additional staff separately.

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

12. One of the Ombudsman's family liaison officers contacted Mr Watkins' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Watkins' mother told us that he frequently asked her to send money to his and other prisoners' accounts, and she thought other prisoners were bullying him.

13. Mr Watkins' mother received a copy of the initial report. She did not make any comments.

Background Information

HMP Birmingham

14. HMP Birmingham is a local prison, principally serving the West Midlands courts, and holds up to 1,450 men. G4S Care and Justice Services manage the prison. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour health services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Birmingham was in February 2017. The report has not yet been published but, in feedback to the PPO, inspectors reported that the number of incidents of self-harm had increased substantially since their last inspection. They found that, while work had been done to investigate the nature and causes of self-harm, the care for individual prisoners at risk of self-harm was not as good. Inspectors reported that assessments and identification of issues for prisoners subject to ACCT monitoring was good, but case reviews were poorly attended and did not always deal effectively with these issues.

16. Inspectors found that a significantly higher number of prisoners felt unsafe at Birmingham compared to prisons with a similar function. They found that violence had increased and that much of this was because of drugs and debt.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to June 2016, the IMB reported that they had ongoing concerns about the quality of ACCT documents, but that the safer custody team had recognised this and made it a priority area for improvement.

Previous deaths at HMP Birmingham

18. Mr Watkins was the seventh prisoner to die at Birmingham in 2016. All of the other deaths were of apparent natural causes. He was the first prisoner to take his own life at Birmingham since 2015.

Assessment, Care in Custody and Teamwork

19. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the

ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Background

20. Mr Daniel Watkins served several relatively short prison sentences during his life. He had been managed under ACCT suicide and self-harm prevention procedures once, for three days in 2010. Prison healthcare staff prescribed buprenorphine (medication used to treat opiate addiction) during each of these previous sentences. Mr Watkins served part of a sentence in 2014-15 in HMP Birmingham. He spent some of this time living on the lower landing of G Wing which, at the time, held prisoners who had accumulated significant debts.

HMP Birmingham

21. On 6 June 2016, Mr Watkins was remanded to Birmingham, charged with attempted murder and arson with intent to endanger life. (His ex-partner and her daughter were the victims.) Mr Watkins' person escort record (a form that accompanies prisoners on all journeys to communicate information including about risk factors) said that he had attempted suicide and drunken petrol three days earlier, and that he had taken an overdose in 2013. When he arrived at Birmingham, Mr Watkins said he intended to kill himself. Reception staff began ACCT procedures.

22. A nurse assessed Mr Watkins and recorded that he had recently tried to take his life, but no longer had thoughts of this. Mr Watkins said he drank around 150 units of alcohol each week and used heroin. A prison GP prescribed medication for withdrawal from alcohol.

23. On 7 June, a nurse prescriber prescribed a course of methadone (medication to treat opiate addiction) when Mr Watkins tested positive for heroin. Mr Watkins began a 35-day detoxification programme (where the prescription is slowly reduced until no longer required). Later that day, a nurse referred Mr Watkins to the prison's mental health team because of his recent suicide attempt.

24. Prison staff closed ACCT procedures on 9 June, as Mr Watkins said he felt good and had no thoughts of harming himself.

25. On 17 June, Mr Watkins told a nurse that he experienced side effects from methadone and had previously taken buprenorphine without any such problems. She referred Mr Watkins to the nurse prescriber who, on 21 June, changed his prescription to buprenorphine.

26. On 22 June, a mental health nurse assessed Mr Watkins. Mr Watkins said he sometimes felt like harming himself. The nurse recorded that his mood was low because he expected to spend a number of years in prison. The nurse referred Mr Watkins to the prison GP to consider antidepressant medication. On 28 June, a prison GP prescribed mirtazapine (an antidepressant).

27. On 13 July, Mr Watkins told a prison GP that he was struggling with his opiate detoxification. The GP agreed to extend his prescription for two more weeks. On 18 July, a GP extended the detoxification by another month.

28. On 3 August, Mr Watkins moved to G Wing, the vulnerable prisoners' unit. (Vulnerable prisoners are those who have asked to live apart from the main population for their own safety.) An operational manager approved vulnerable prisoner status for Mr Watkins, which he had requested because he thought other prisoners knew that a child was a victim of his offence.

29. On 9 August, a nurse created a buprenorphine care plan. She told us that it was a standard care plan and that Mr Watkins refused to sign it.

30. On 14 August, prison staff identified that Mr Watkins had concealed rather than swallowed buprenorphine when he collected it from the G Wing medication hatch. (A prison nurse and officer supervise the consumption of buprenorphine and methadone, due to their high value in prison. Prisoners are required to swallow the medication in front of the nurse, who checks their mouth to ensure they have done so.) An officer charged Mr Watkins with the disciplinary offences of possession of an unauthorised article (the medication he had not swallowed) and using threatening and abusive language to the reporting officer.

31. The nurse prescriber reduced Mr Watkins' buprenorphine dose on 16 August because the officer had observed him trying to conceal the higher dose.

32. On 18 August, a psychiatrist assessed Mr Watkins. He diagnosed Mr Watkins with an emotionally unstable (borderline) personality disorder (a condition characterised by rapid mood shifts and impulsivity). He recommended that Mr Watkins increase his dose of mirtazapine, but Mr Watkins declined and said he found the current dose helpful.

33. The next day, Mr Watkins asked the nurse prescriber to increase the buprenorphine prescription to his previous dose, to support him through his upcoming trial. Mr Watkins said he would prefer to complete his detoxification programme after his trial. The nurse agreed to his request.

34. On 5 September, Mr Watkins was convicted of the charges against him. He returned to Birmingham to await sentencing.

35. On 16 September, Mr Watkins told a prison GP that he no longer wanted to take buprenorphine. The reason why is not recorded. Mr Watkins asked for a course of diazepam (a benzodiazepine medication used to reduce anxiety), which the GP prescribed.

36. After three adjournments, Mr Watkins' disciplinary hearing took place on 26 September. An independent adjudicator found him guilty and added 18 days to the sentence Mr Watkins would later receive.

37. On 3 October, Mr Watkins' cellmate assaulted him. Mr Watkins' cellmate told an officer that he found Mr Watkins using drugs and that he no longer wanted to share a cell. Mr Watkins moved to a new cell the same day.

38. The next day, Mr Watkins told the nurse prescriber that he was using illicit buprenorphine on the wing. He had recently told a nurse that he was struggling to cope with his opiate withdrawal. The nurse prescriber put Mr Watkins on the waiting list for the GP clinic.

39. On 9 October, an officer recorded that Mr Watkins was in debt for drugs. She was Mr Watkins' personal officer, and told us that staff had strong suspicions that Mr Watkins used illicit buprenorphine and was involved in dealing drugs on the wing. She recorded that Mr Watkins' former cellmate had told her that Mr Watkins was dealing and taking drugs. Mr Watkins asked to move to another wing, but the officer told him that his vulnerable prisoner status meant this was not possible. She said that Mr Watkins did not say why he wanted to move and never admitted to being in debt. The G Wing manager said that Mr Watkins occasionally asked to stay locked in his cell (rather than mix with other prisoners, indicating he might be in debt to others). He said that the issue would resolve itself a day or two later, presumably when Mr Watkins had repaid his debt.

40. On 13 October, Mr Watkins told a prison GP that diazepam was not helping his withdrawal and he therefore used illicit buprenorphine. He tested positive for buprenorphine. The GP prescribed a low dose of methadone to stabilise Mr Watkins and stop him using illicit medication.

41. On 15 October, a nurse completed a methadone care plan. As before, this was a standard care plan that was not tailored to Mr Watkins' needs.

42. On 4 November, Mr Watkins was sentenced to 14 years in prison. Two days later, his personal officer recorded that he seemed to be "okay" with his sentence.

43. On 11 November, a prison GP reviewed Mr Watkins, who said he wanted to stop his methadone prescription and asked for diazepam to help him do so. The GP agreed to his request. He noted that Mr Watkins said he wanted to transfer to another prison, but did not record if Mr Watkins explained why he wanted to move.

44. On the morning of 1 December, Mr Watkins told a prison GP that he still used illicit buprenorphine and said he did not think he had ever been given a proper detoxification. He asked for a course of buprenorphine, but the GP said he should discuss this with the integrated drug treatment system (IDTS) team at a scheduled review the next day.

45. At lunchtime, Mr Watkins told an officer that he had taken an overdose of codeine. (Mr Watkins had been prescribed codeine for a month because of chest and rib pain after a fall from his bunk bed.) The officer began ACCT procedures. Mr Watkins told a nurse that he had taken an overdose because he was unhappy with his detoxification plan. She admitted him to the healthcare inpatient unit for observation.

46. That afternoon, a unit manager assessed Mr Watkins as part of ACCT procedures. She recorded that Mr Watkins thought prison staff had not taken his detoxification seriously and he said the overdose was an attempt to highlight this. Mr Watkins said he did not intend to take his life but felt frustrated by his detoxification. He also said he wanted to transfer to another prison as he did not feel safe on G Wing. She said Mr Watkins would not disclose why he felt under threat or from whom. She recorded that Mr Watkins' key issue was his detoxification, and listed this as a potential trigger for suicide and self-harm.

47. The G Wing manager said he spoke to the unit manager on the evening of 1 December. She told him that Mr Watkins' issue related to his detoxification and that she did not believe he had tried to take his life. Mr Watkins voluntarily discharged himself from the inpatient unit and returned to G Wing that evening.

48. On 2 December, the G wing manager held the first ACCT case review. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that the assessor attend with, wherever possible, the member of staff who raised the initial concern, and a member of healthcare staff. If those invited cannot attend in person, they can exceptionally give a written account of their input. There was no other member of staff present at the case review.

49. The G wing manager recorded that Mr Watkins said he had problems with his detoxification and that the overdose was a result of frustration and a vehicle to get the help he needed. He recorded that Mr Watkins' issue was now resolved, but did not ask him what had been done to resolve it. (There is no record that Mr Watkins had seen a member of the IDTS team since the ACCT procedures began.) They did not discuss Mr Watkins' statement that he felt threatened on G Wing. The manager concluded that Mr Watkins was at low risk of suicide and self-harm and that it was appropriate to end ACCT monitoring, as he was satisfied that Mr Watkins' issues were resolved and that he had not intended to take his life.

50. The afternoon, Mr Watkins saw the nurse prescriber for a review. Mr Watkins asked the nurse to prescribe buprenorphine, but the nurse refused because of the risk that Mr Watkins might try to conceal the medication. Instead, he increased Mr Watkins' diazepam prescription from once to twice a day.

51. The personal officer spoke to Mr Watkins on 4 December, and recorded that he was unhappy because his diazepam prescription had not yet changed. (The nurse prescriber had dated the increase to begin on the evening of 4 December.) She said she spoke to Mr Watkins again the next morning and he was happy, as he had now received the increased dose.

52. On 6 December, Mr Watkins collected diazepam from the nurse at evening medication. He did not take the medication but ran from the treatment hatch with it. She said she reported this to a wing officer. There is no record that anyone spoke to Mr Watkins afterwards and he was not charged with a disciplinary offence. She reported the events to a prison GP, who stopped Mr Watkins' prescription.

53. On the morning of 7 December, Mr Watkins went to the medication hatch, but Nurse Sheil told him that his diazepam had been stopped and explained the reason for this. Nurse Sheil said that Mr Watkins was unhappy but did not become angry.

54. Mr Watkins' cellmate said that Mr Watkins was upset and began shouting and screaming when he returned to their cell. He said that Mr Watkins needed the medication to pay off debts he owed to other prisoners. He said he then saw Mr Watkins cut his wrist with a razor blade. At 7.55am, Mr Watkins telephoned his mother. All prisoners' calls are recorded and we listened to recordings of Mr Watkins' calls. He told his mother that he had "sliced" his wrists and had done so

because his medication had been stopped. Later, Mr Watkins returned to the medication hatch and asked a nurse for a plaster and an appointment with the prison GP. She said she did not have a plaster and advised Mr Watkins to book a GP appointment through the usual computerised application process.

55. The cellmate said he reported Mr Watkins' cut wrists to a male and female officer, but they did not take any action. One officer said that the cellmate said to him, "If he's going to cut up again today, I want him out of the cell". He said he assumed that the cellmate meant that Mr Watkins had cut his wrist a few days beforehand, when ACCT procedures were opened. He told the cellmate that he could not decide whom he should share a cell with and that he would speak to Mr Watkins later. (He said he did not have the opportunity to speak to Mr Watkins before the later events.) The personal officer was the only female officer assigned to G Wing on 7 December. She told us that she did not remember speaking to the cellmate and spent much of the morning helping on A Wing.

56. A prisoner told the police that, at around 9.00am, Mr Watkins told him he was upset because his diazepam prescription had been stopped. He said that Mr Watkins then took him into his cell, showed him a bed sheet and said, "That will take my weight … I'm going to do something serious". He told the police that Mr Watkins often said similar things if he did not get what he wanted and he did not believe Mr Watkins would try to take his life.

57. At around 9.30am, a prisoner began cleaning the stairs at the back of G Wing and when he reached the bottom level found Mr Watkins hanging from a ligature made from a bed sheet. He pressed the general alarm button (at 9.34am) and shouted to prison staff for assistance. An officer, who had just entered G Wing through a door near the back stairs, told him to support Mr Watkins' body while he removed the ligature. He was carrying a radio but said he did not make a call for emergency medical assistance as he was focused on removing the ligature.

58. The officer radioed for the response nurse to attend (control room staff recorded the call as being made at 9.34am) and, shortly afterwards, radioed a code blue medical emergency, indicating a life threatening situation. The control room operator called an ambulance. The manager and officer began cardiopulmonary resuscitation. A nurse arrived and attached a defibrillator, which found no shockable heart rhythm. The staff continued chest compressions until paramedics arrived at 9.55am. At around 10.40am, the paramedics took Mr Watkins to the intensive care unit at the hospital, where he died at around 1.05pm on 9 December.

Contact with Mr Watkins' family

59. The duty operational manager telephoned Mr Watkins' mother, his nominated next of kin, at around 10.45am on 7 December, and told her that Mr Watkins had been admitted to hospital. Mr Watkins' mother was present when he died.

Support for prisoners and staff

60. The Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

61. The prison posted notices informing other prisoners of Mr Watkins' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Watkins' death.

Cause of death

62. HM Coroner for Birmingham did not request a post-mortem examination. Hospital specialists gave the cause of death as hypoxic brain injury due to a cardiac arrest caused by attempted hanging. Photographs taken after Mr Watkins' death showed numerous scratches on his left wrist.

Findings

Management of risk of suicide and self-harm

63. Mr Watkins was managed under ACCT procedures very briefly, less than a week before he hanged himself. We are concerned that the procedures were cursory, poorly managed and did very little to support him. More effective ongoing support might have helped address Mr Watkins' underlying risk of suicide.

64. A unit manager, acting alone, ended ACCT monitoring on 2 December, less that 24 hours after Mr Watkins said he had taken an overdose. Prison Service Instruction 64/2011, on ACCT suicide and self-harm prevention procedures, requires case reviews to be multidisciplinary where possible and says that, for the first case review, among others, the assessor, the person who raised the initial concern and a healthcare representative must attend. The G wing manager held the case review on his own. We are particularly concerned that the case review did not include a member of healthcare staff given that Mr Watkins' main issue appeared to be frustration with his detoxification.

65. Guidance in the ACCT document says that staff can end ACCT procedures at the first case review, if the case review team believe it is safe to do so and if all issues identified in the assessment interview are resolved. At the assessment, a unit manager identified that Mr Watkins was frustrated by his detoxification. The manager said that Mr Watkins told him that this issue was now resolved. However, he did not ask what had happened to resolve the issue and there is no record that Mr Watkins had had an IDTS review or change of medication since ACCT monitoring began. (The nurse prescriber changed Mr Watkins' prescription in the afternoon, after the manager closed ACCT procedures.) There is no record that the manager considered keeping ACCT procedures open over the following days. This might have ensured that any change to Mr Watkins treatment plan had helped him to manage his withdrawal from drugs and eliminated the frustration of which he had spoken.

66. The unit manager also recorded that Mr Watkins did not feel safe on G Wing. The G wing manager said he did not recall seeing this in the assessment and did not therefore consider it at the case review.

67. The G wing manager recorded that Mr Watkins was at low risk of suicide and self-harm, as he was satisfied that Mr Watkins had not intended to take his life. We consider that this underestimated Mr Watkins' risk. Guidance in the ACCT document is that risk is low when there has been no self-harming behaviour. Current self-harming behaviour, even if there is no immediate intent or a specific plan, indicates that risk is raised.

68. The G wing manager told us that he stopped ACCT monitoring because he was satisfied that Mr Watkins' issues were resolved and that he had not intended to take his life. We are concerned that he made this decision alone, less than one day after Mr Watkins' apparent self-harm and at an ACCT case review which was not multidisciplinary. Even when multidisciplinary attendance is not possible, it is implicit that decisions at ACCT case reviews, which are based on teamwork, involve more than one member of staff. We are not satisfied that he properly discussed and resolved the two issues Mr Watkins' raised at his assessment

before he ended ACCT procedures at the case review, and he did not properly consider Mr Watkins' risk.

69. HM Inspectorate of Prisons, in their inspection of February 2017, also found that ACCT case reviews were poorly attended and did not always address the issues identified at assessments. We are concerned that the failings in the ACCT process we have highlighted in our investigation are symptomatic of a wider issue at Birmingham.

70. In a PPO Learning Lessons Bulletin, published in March 2015, about the self-inflicted deaths of prisoners in 2013-14, we found that staff should ensure that prisoners at risk of suicide and self-harm are managed in line with national instructions and guidance, including holding multidisciplinary case reviews. We make the following recommendation:

The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **First case reviews are multidisciplinary and always include a member of healthcare staff.**
- **Case reviews assess risk in line with ACCT guidance.**
- **ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved.**
- **Case managers receive effective ACCT training and understand their responsibilities to hold effective case reviews in line with national guidelines.**

71. The cellmate said he told staff that Mr Watkins had cut his wrist on the morning of 7 December. An officer said that he was the member of staff to whom the cellmate spoke, but that he understood that the cellmate was referring to a previous incident. Without independent corroboration, it is not possible to know exactly what happened. Had a member of staff discovered that Mr Watkins had cut his wrist that morning, it would have been prudent to begin ACCT procedures.

Opiate detoxification

72. The clinical reviewer expressed concern about several aspects of Mr Watkins' detoxification. Advisory Council on the Misuse of Drugs guidelines recommend that clinicians should produce patient-centred opiate substitution care plans that are tailored to the needs of the individual. However, the clinical reviewer noted that Mr Watkins' two care plans were standard plans with no individual factors. She also noted that there were few entries in Mr Watkins' medical record to evidence interactions with IDTS nurses. Newly prescribed prisoners should have two reviews with an IDTS nurse in each of their first five days in prison, but she found that this did not happen for Mr Watkins.

73. The clinical reviewer noted that, although prescribers at Birmingham were flexible when Mr Watkins' struggled with his treatment, there was no co-ordination of this treatment. For example, in August 2016, Mr Watkins' buprenorphine dose was reduced when staff suspected he had concealed the medication, but was returned to the previous dose just a few days later. She highlighted that

consistency of prescribing is particularly important for patients diagnosed with a personality disorder.

74. Mr Watkins did not appear to cope well with his treatment plan and used illicit medication to supplement his prescription. The clinical reviewer commented that prisoners likely to receive a long sentence, such as Mr Watkins, normally begin a detoxification (reduction) programme when received into custody. However, she added that there is evidence that such prisoners should receive a maintenance prescription (to provide a period of stability before beginning reduction) until they have adjusted to their sentence. She commented that Mr Watkins might have coped better had he known he would be maintained on his prescription until after sentencing.

75. While Mr Watkins did not always comply with his treatment plan, the clinical reviewer found that he did not receive the level of support he needed. She concluded that his medical treatment was not equivalent to that he would have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should review Birmingham's guidelines for the treatment of prisoners prescribed opiate substitute medication to ensure that they provide person-centred care.

Bullying

76. Birmingham has a local violence reduction policy which highlights the process of raising, investigating and managing acts of bullying, intimidation and violence. It says that staff should be proactive and not wait for a violent incident to happen before taking action. It says that staff could use wing Violence Reduction Representatives (prisoners who have been selected and trained to help reduce violent behaviour) to help prisoners in debt to manage their debt and formulate a realistic payment plan. The policy also says that staff can open a Prisoner Support Booklet if they believe a prisoner is vulnerable.

77. The personal officer recorded that Mr Watkins was in debt for drugs. Mr Wakeman also described behaviour that might indicate Mr Watkins was in debt. It was commonly known that Mr Watkins had concealed medication although there is little evidence that anyone investigated the reasons why. Mr Watkins' cellmate told us that he concealed medication to pay off debts. Another prisoner said that it was widely known that Mr Watkins was in debt, was being bullied, and had been targeted by a particular individual.

78. There is no evidence that any of the supportive measures highlighted in Birmingham's violence reduction policy were initiated, or that anyone investigated the extent of Mr Watkins' debts or whether he was being bullied.

79. A PPO publication of June 2011 found there was evidence of bullying and intimidation in 20 per cent of self-inflicted deaths we investigated. In our PPO thematic report into self-inflicted deaths in 2013-14, we found that reports or suspicions that a prisoner is being threatened or bullied, or is vulnerable due to debt, need to be recorded, investigated and robustly responded to. We make the following recommendation:

The Director should ensure that:

- **All information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated.**
- **Staff consider whether victims are at increased risk of suicide or self-harm.**
- **Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situations.**

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