

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Carr a prisoner at HMP Birmingham on 29 March 2018

A report by the Prisons and Probation Ombudsman

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*



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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.

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

Mr Andrew Carr died on 29 March 2018 from the effects of taking a synthetic cannabinoid (a psychoactive substance) at HMP Birmingham. He was 24 years old. I offer my condolences to his family and friends.

It is unacceptable that Birmingham was unable to produce a full set of segregation records for Mr Carr. Segregation is an extreme and isolating form of custody and I am therefore particularly concerned that we cannot now know whether staff followed segregation procedures appropriately.

I am also very concerned that the officer who found Mr Carr lying on the floor of his cell in the segregation unit on the night he died, did not immediately radio for urgent assistance. As a result, there was a delay of about 23 minutes before Mr Carr received medical assistance.

Like HM Inspectorate for Prisons, I am concerned about the scale of the drug problem at Birmingham, and in this case that Mr Carr appears to have obtained drugs through the Victorian sewage system.

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

Sue McAllister CB
Prisons and Probation Ombudsman

April 2019

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Summary

Events

1. On 6 July 2017, Mr Andrew Carr was remanded to HMP Birmingham. On 3 August 2017, he was sentenced to three years and four months in prison for burglary and theft. After serving time in Stoke Heath and Oakwood, where he was frequently found using psychoactive substances (PS), he was moved back to Birmingham on 19 February 2018.
2. On 27 February, Mr Carr seriously assaulted an officer and he was taken to the segregation unit. Prison staff referred the assault to the police.
3. At about 10.00pm on 29 March, an officer saw Mr Carr lying on the floor of his cell in the segregation unit. He could not see Mr Carr's face through the cell door observation panel. The officer did not go in but returned about five minutes later to check on him. Mr Carr was lying in the same place. The officer called his name and kicked the door but got no response.
4. The officer left the segregation unit to find the night orderly officer. Unable to do so, he returned to the segregation unit and telephoned the communications room to find out where he was. The officer left again and found the night orderly officer with the response officers and a nurse, responding to another incident on another wing. He waited for about five minutes while they dealt with that incident, and they then went back to Mr Carr's cell.
5. The night orderly officer opened Mr Carr's cell door and found him unresponsive. An officer immediately called an emergency code at 10.23pm, and they moved Mr Carr onto the landing. The officers tried to resuscitate him. Paramedics arrived shortly afterwards and at 10.53pm, Mr Carr was pronounced dead.
6. Police officers recovered a 24-foot rope-like line made of twisted bed sheets from Mr Carr's cell, with two plastic bags attached at the end (which were allegedly used to carry drugs). They also recovered a ball point pen, with a burnt end which had traces of a psychoactive substance (PS).
7. A post-mortem examination found that Mr Carr died as the result of taking a synthetic cannabinoid (a form of PS).

Findings

Mental health

8. While a nurse assessed Mr Carr's mental health, she did not review his medical record which would have given her a better understanding of his mental health needs.

Segregation and missing records

9. Despite repeated requests, Birmingham did not provide the investigator with all of Mr Carr's segregation documents. The segregation unit's filing system was inadequate and the CCTV system was partially broken. In the absence of documentary or other evidence, we cannot know whether segregation staff

regularly checked on his welfare, whether Mr Carr had a personal officer or whether his initial segregation review was carried out in line with national instructions. There is no evidence that a doctor visited him at least every three days or that a nurse visited him on the other days, as they should have done.

Emergency response

10. When the officer on duty in the segregation unit saw Mr Carr lying on the floor, he should have communicated with him and radioed a medical emergency code when he did not obtain a response. We are very concerned that it took 23 minutes from the time that the officer saw Mr Carr lying on the floor to the time that he called an emergency code.

Illicit substances

11. The evidence indicates that Mr Carr obtained PS in the segregation unit through the sewage pipes connecting cells on different landings.

Recommendations

- The Head of Healthcare at HMP Birmingham should ensure that after a prisoner has a mental health assessment, a full clinical entry is recorded in the prisoner's medical records including relevant historical information and details of the prisoner's current clinical presentation, current risk issues and a clear plan of action agreed with the prisoner.
- The Governor should ensure that staff manage prisoners held in the segregation unit in line with national instructions, including that:
 - completed segregation records about each prisoner are maintained and kept for three years;
 - the CCTV system is upgraded so that it provides and records full coverage of the landing of the segregation unit; and
 - the Prisons and Probation Ombudsman is promptly provided with all requested documents after a death in custody in line with PSI 64/2011.
- The Governor should commission a disciplinary investigation into Officer A's failure to radio for urgent assistance or to radio a medical emergency code when he saw Mr Carr lying unresponsive on his cell floor
- The Governor should ensure that staff are given clear guidance and understand when they should radio a medical emergency code.
- The Governor should commission an appropriately-skilled person to review and address the risks posed by the sewage system, to prevent illicit substances being moved around the prison.

The Investigation Process

12. 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.
13. The investigator visited Birmingham on 16 April. He obtained copies of relevant extracts from Mr Carr's prison and medical records.
14. The investigator interviewed six members of staff and a prisoner at Birmingham between 16 April and 7 June.
15. NHS England commissioned a clinical reviewer to review Mr Carr's clinical care at the prison.
16. We informed HM Coroner for Birmingham and Solihull of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Carr's mother's, to explain the investigation. She asked about Mr Carr's induction, his segregation, the emergency response and what support he received for his mental health and substance misuse needs.
18. We shared the initial report with the Prison Service. There were no factual inaccuracies, but two of the recommendations have been edited, this report has been amended accordingly and their action plan has been appended to this report.
19. Mr Carr's mother received a copy of the draft report. The solicitor representing Mr Carr's mother wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Birmingham

20. HMP Birmingham is a local prison which holds up to 1,450 prisoners. It was managed by G4S Care and Justice Services at the time of Mr Carr's death but is now managed by HMPPS. Birmingham and Solihull Mental Health Foundation Trust continue to provide 24-hour healthcare services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit. The segregation unit at Birmingham is known as the Care and Separation Unit, and comprises 13 cells.

HM Inspectorate of Prisons

21. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham during the week of 30 July 2018, which found the prison to be fundamentally unsafe. On 16 August 2018, HMIP invoked the Urgent Notification (UN) process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. Key findings from the inspection included:
- Levels of violence had increased and when measured over the last 12 months, were the highest for any local prison in the country.
 - 71% of prisoners said that they felt unsafe at some time in Birmingham. 37% felt unsafe at the time of the inspection and many reported being bullied or victimised.
 - Prisoners were isolating themselves in their cells, refusing to emerge because of their fear of violence. Virtually nothing was being done to support them.
 - There was a tenuous lack of control. Accounting for prisoners was poor, with wing staff often not knowing where prisoners were.
 - Many prisoners were under the influence of drugs and the smell of cannabis and other burning substances pervaded many parts of the prison. Over half the population thought that drugs were easy to obtain. One in seven said that they had developed a problem with illicit drugs since they had been in Birmingham. The trafficking of illegal substances was blatant. It was shocking that many staff did not seem prepared to tackle the drugs misuse.
 - Many staff lacked both confidence and competence in key prison skills. Wings were poorly supervised and prisoners routinely disregarded rules, even to the extent of open drug use.
 - Living conditions were as poor as seen anywhere in recent years and staff and managers appeared to have become inured to the decay in standards.

Independent Monitoring Board

22. 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 2017, the IMB reported

that healthcare managers had reviewed practices and liaised with prison managers to resolve some of the problems caused by a shortage of staff. Waiting times to see a GP were comparable to those in the community.

Previous deaths at HMP Birmingham

23. There have been 24 deaths at Birmingham in the last three years, four of which were self-inflicted and 18 of which were from natural causes. There were two other deaths in the same week that Mr Carr died; PS was found in toxicology tests in both cases.
24. We made a recommendation in March 2018 about the need for prison staff to use a medical emergency code when they find a prisoner unresponsive. We also made a previous recommendation that Birmingham should provide us with prison documents promptly and the prison accepted our recommendation in August 2017.

Assessment, Care in Custody and Teamwork (ACCT)

25. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive Substances (PS)

26. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
27. In July 2015, we published a Learning Lessons Bulletin about the use of PS (at that time, known as NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
28. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Segregation

29. Segregation units are used to keep prisoners apart from other prisoners. This might be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings.
30. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.
31. Prison Service Order (PSO) 1700 on the segregation of prisoners requires prisons to keep full segregation records for three years, including details of staff on duty and visitors to the segregation unit, the activities of prisoners in segregation, a record of disciplinary hearings and significant events in the unit. Prison Service Instruction (PSI) 64/2011 on safer custody requires that all documents about a prisoner who has died in custody are retained for 20 years after the conclusion of the inquest.
32. PSO 1700 states that:
 - a multidisciplinary team, including a chairperson, a healthcare representative, a segregation officer, a personal officer, a chaplain and a psychologist, should review a prisoner in person within their first 72 hours in segregation;
 - a review board should look at why a prisoner was segregated, his behaviour after segregation, any concerns about how a prisoner is coping with segregation and set behavioural targets for the prisoner to be able to return to a normal location;
 - a designated officer should engage in purposeful conversation with a prisoner in segregation;
 - healthcare staff and doctors should visit the segregation unit regularly and check prisoners' physical and mental health to ensure that they remain fit to be segregated; and
 - a doctor should visit each prisoner in segregation as often as their individual health needs dictate, and at least every three days. A nurse should assess the prisoner on all other days.

Management and security of nights

33. Prison Service Instruction (PSI) 24/2011 on the management and security of nights requires that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and that at least two (or three, subject to local risk assessment procedures) members of staff must be present to open a cell door, one of whom should be the night orderly officer. The PSI also says that the preservation of life must take precedence over the standard unlock procedures. Where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff may enter the cell on their own. However, night staff

should not take action that they feel would put themselves or others in unnecessary danger.

34. The PSI says that, before going into a cell, staff should make every effort to obtain a verbal response from the prisoner. This, together with what the member of staff can observe through the cell door observation panel and any knowledge of the occupant, should inform a rapid dynamic risk assessment of the situation and a decision on whether to enter immediately or wait for assistance.
35. Birmingham's local policy for opening cells at night is the same as the PSI.

Key Events

36. On 6 July 2017, Mr Andrew Carr, who had been in prison many times since 2012, was remanded to HMP Birmingham and on 3 August 2017, he was sentenced to three years and 4 months in prison for burglary and theft.

HMP Stoke Heath

37. On 18 August, Mr Carr was transferred to Stoke Heath, where he told healthcare staff that he had panic attacks, was hearing voices and seeing shapes. Between August and December 2017, while Mr Carr was at HMP Stoke Heath, he was found under the influence of PS and twice damaged his cell and items in his cell. On 26 August, prison staff started ACCT procedures which they stopped on 28 September. There were a number of occasions when Mr Carr was aggressive towards prison staff and a nurse. He was twice sent to the segregation unit, where prison staff decided that his cell should only be opened with three officers present for the safety of staff.

HMP Oakwood

38. On 10 January 2018, he was transferred to Oakwood, where he was prescribed diazepam to control his anger and agitation. In February 2018, Mr Carr was found under the influence of PS three times. Officers twice called a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing) because of their concerns for his health. He was placed on report for being under the influence of an illicit substance and his incentives and earned privileges level (a system which rewards prisoners for good behaviour) was downgraded to basic. Mr Carr allegedly assaulted another prisoner after which prison staff took him to the segregation unit and placed him on report.

HMP Birmingham

39. On 19 February, Mr Carr was transferred to Birmingham.
40. That day, a nurse saw Mr Carr for his initial health screen. Although Mr Carr's medical records showed that he had a mental health assessment scheduled to take place at Oakwood on 22 February, the nurse noted that he had no outstanding appointments. She noted that she had no concerns about Mr Carr's mental health and did not refer him to the mental health team. A prison GP re-prescribed his diazepam.
41. On 20 February, a clinical team manager saw Mr Carr for his second health screen. She referred him for a mental health assessment which a nurse completed on 22 February. Mr Carr told her that he did not have a history of deliberate self-harm or attempted suicide. She noted that Mr Carr had no mental health problems.

Mr Carr's segregation

42. When Mr Carr went to Birmingham, he completed the induction process and was placed in a single cell on a standard wing. At 10.20am on 27 February 2018, Mr Carr threw a bucket of boiling water over an officer. He ran from the landing and went onto the safety netting, where he was aggressive, threatened prison staff

and refused to leave. Officers forcibly removed Mr Carr after spraying him with PAVA (an incapacitant spray) and took him to the segregation unit. Because of the officer's injuries, prison staff referred the assault to the police.

43. A nurse saw Mr Carr because he had been sprayed with PAVA. She noted that Mr Carr was removed from the netting and escorted to the segregation unit's exercise yard for fresh air due to the effects of the spray. She noted that Mr Carr deliberately hit his head on the floor to make it look as though officers had injured him.
44. The nurse noted that Mr Carr was bleeding above his left eyebrow, where there was a cut. She glued the cut and the bleeding stopped. Mr Carr also had bruising and swelling around his left eye. She noted that although Mr Carr was polite to her, he was verbally and physically aggressive towards the officers who were present. A prison GP saw Mr Carr and prescribed him a one-off dose of diazepam to calm his behaviour.
45. At 7.00pm, a mental health nurse saw Mr Carr in the segregation unit. She noted that he showed no signs of mental health problems. Mr Carr told her that he had taken drugs when he was on the wing. She completed an initial segregation health screen and noted that Mr Carr was fit to cope with a period of segregation and did not need intervention from the healthcare team at that time. She asked a prison GP for a painkiller because Mr Carr had punched the wall and banged his head. (There is no evidence to say whether he received it.)
46. At 7.05pm, a safer custody manager signed the initial segregation health screen and noted that segregation was appropriate for operational reasons and arranged an initial segregation case review.
47. At 8.30pm, Mr Carr spat at two officers through the cell door.
48. On 28 February, a residential manager held a disciplinary hearing about Mr Carr's alleged assault of an officer. Later that day, the safer custody manager held a disciplinary hearing for Mr Carr going on to the netting. The hearing was adjourned until 13 March. On 1 March, a manager held a disciplinary hearing because Mr Carr spat at two officers through the cell door. The hearing was adjourned because the assault had been referred to the police.
49. On 2 March, an operations manager held an initial segregation review board (within the required 72-hour period). A community psychiatric nurse and an IMB member attended. Segregation unit staff did not attend and neither did Mr Carr because there were not enough staff to unlock him. A manager said that Mr Carr was segregated under Prison Rule 53(4) (awaiting a disciplinary hearing) and planned to meet Mr Carr the following week. He said that Mr Carr was confrontational and refused to engage with staff for the first week. Birmingham did not provide us with a complete record of the review. (We received a single sheet of records.)
50. On 5 March, a nurse saw Mr Carr and noted that Mr Carr was fit for the segregation unit, and prescribed him promethazine, a sleeping tablet.
51. On 9 March, the safer custody manager held a segregation review. Two IMB members, a nurse and an officer from the segregation unit were present. Mr

Carr remained subject to a three officer unlock. It was noted that he had no mental health issues and that he wanted to leave the segregation unit. He was told that this was not possible because he had allegedly seriously assaulted a member of staff.

52. On 13 March, an independent adjudicator held the second disciplinary hearing for the charge that Mr Carr went onto the netting. He found that because, Mr Carr was absent, the hearing was unlawful so was not pursued.
53. There are no entries in Mr Carr's medical records from 27 February to 29 March, to say whether nursing staff or a prison GP assessed his health.
54. The investigator asked Birmingham for all of Mr Carr's segregation records. He was given documents for the reason why Mr Carr's was segregated, the disciplinary hearing documents and Mr Carr's daily history sheets. However, prison staff did not provide him with the segregation review board documents, the daily diary (which records staff who are on duty and visitors to the segregation unit), the daily log (which contains details of individual prisoners and their daily activities), the complete disciplinary hearings record or the daily memo notes (which record significant events in the segregation unit).
55. The daily history sheets note that Mr Carr did not always comply with instructions from staff but that he was frequently offered the opportunity to shower, take exercise and make telephone calls. There is no evidence to indicate whether regular welfare checks were made.

The events of 29 March

56. At about 8.35pm on 29 March, Officer A, who had just started the night shift in the segregation unit, went with a day shift officer to each of the cells in the segregation unit, handing out hot water to prisoners. He opened Mr Carr's cell door and spoke to him. He said that Mr Carr looked fine, did not appear to be under the influence of a substance and told him that he had made a hat out of prison clothing.
57. When all the prisoners had received their hot water, the day shift officer left the segregation unit and another officer completed some paperwork. At about 9.30pm, Officer A said that he heard Mr Carr talking to another prisoner through the cell door but he did not listen to the conversation.
58. At about 10.00pm, Officer A did his first round of checks. He looked through the observation panel of Mr Carr's cell and saw him lying on the floor, with his back to him. He said that the view was poor through the observation panel. He could not see Mr Carr's head because it was behind a chair. He did nothing further to get a response.
59. In his witness statement to the police, the officer said that a lot of prisoners were taking 'mamba' (a form of PS) at the time and he thought Mr Carr might have taken 'mamba' and collapsed from the effects. In his interview with the PPO investigator, however, he said that there was nothing to indicate that Mr Carr had taken anything and that he considered that Mr Carr was simply lying on the floor. He said that it was not unusual to see prisoners lying on the floor and he was not concerned at that time so he continued with his checks.

60. Officer A said that he completed his checks and the paperwork and returned to Mr Carr's cell about five minutes later to check on him. He said that he kicked the door and called his name to see if he could get a response but he could not. He said that he was still not "over concerned" because there was nothing to suggest Mr Carr had taken anything.
61. Officer A walked upstairs to the night orderly officer's office which was about a minute away. A first line manager, the night orderly officer, was not in the office so the officer returned to the segregation unit and telephoned the communications room to ask where he was. The night orderly officer was on C Wing which is next to the segregation unit, dealing with another incident. The officer went there and told the night orderly officer that he had found Mr Carr lying on the floor. He said that he did not use his radio because it had not immediately concerned him.
62. Officer A said that he waited for the night orderly officer for about five minutes, and then returned to the segregation unit with him, the night shift response officers and a nurse, who collected an emergency response bag on the way. The night orderly officer said that he could get anywhere in the prison from between 30 seconds to one minute.
63. When they arrived at Mr Carr's cell, the night orderly officer looked through the cell door observation panel and tried to get a response from him. He used his cell key to open the door. He said that he went over to Mr Carr, he saw that his eyes were wide open and that he still had some colour in his cheeks. The nurse saw that Mr Carr was not breathing, had no pulse and no signs of life. She told the officers to call a code blue and to get him out of the cell. At 10.23pm, the night orderly officer radioed a code blue and officers moved Mr Carr out of his cell and onto the landing.
64. An officer immediately started cardiopulmonary resuscitation (CPR). The nurse used a defibrillator, inserted a tube through Mr Carr's mouth into the airway and used oxygen through a bag.
65. At 10.36pm, an ambulance arrived at the prison and paramedics went promptly to the segregation unit. The night orderly officer said that staff made a screen out of shields and blankets for privacy. At 10.53pm, an emergency doctor pronounced that Mr Carr had died.

Police investigation

66. The police recovered a 24-foot rope, made of twisted bed sheets, from Mr Carr's cell. There was a plastic bag attached to it, with another bag attached to that. A piece of residue-covered cling film was also taken from the cell which was thought to have contained traces of the contents of the double-bagged package attached to the rope.
67. The police also found a ballpoint pen, the end of which was burnt and had traces of a residue on it, in Mr Carr's cell. The pen was found to have traces of 5F-ADB, a PS, on it.
68. On 24 August, a Detective Inspector said that the police had concluded their investigation and no prisoners were to be charged.

Contact with Mr Carr's family

69. The Deputy Director appointed an officer as the family liaison officer and the training manager as the deputy family liaison officer. At 8.30am on 30 March, the Deputy Director and FLO visited Mr Carr's mother, broke the news of Mr Carr's death and offered their condolences.
70. The family liaison officer remained in contact with Mr Carr's family. Mr Carr's funeral took place on 4 July, and Birmingham contributed to its cost in line with national instructions.

Support for prisoners and staff

71. After Mr Carr's death, the Deputy 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.
72. The prison posted notices informing other prisoners of Mr Carr's 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 Carr's death.

Post-mortem report

73. A post-mortem examination found that Mr Carr died of the effects of taking a synthetic cannabinoid (a PS), which was present in his bloodstream after his death. The PS was identified as 5F-ADB.

Findings

Mental health

74. Mr Carr had been in prison many times since 2012. His medical record indicated a history of illicit drug use, that he said he had self-harmed, and that he had anger and agitation issues (or which the prison GP re-prescribed diazepam the day he arrived at Birmingham). Healthcare staff frequently noted that his behaviour was odd and that he was agitated and angry.
75. Mr Carr had been scheduled to have a mental health assessment at Oakwood on 22 February, but this did not take place because he was transferred to Birmingham. This was recorded in his medical record. However, when he arrived at Birmingham on 19 February, the mental health nurse noted that he did not appear to have any mental health problems and discharged him back to the prison GP.
76. Mr Carr's history of odd behaviour, his agitation and anger in prison, and the fact that he had been scheduled to have a mental health assessment at Oakwood should have led the mental health team at Birmingham to monitor him to assess his behaviour and the state of his mental health. We make the following recommendation:

The Head of Healthcare at HMP Birmingham should ensure that after a prisoner has a mental health assessment, a full clinical entry is recorded in the prisoner's medical records including relevant historical information and details of the prisoner's current clinical presentation, current risk issues and a clear plan of action agreed with the prisoner.

Segregation and missing records

77. We are satisfied that a nurse completed the initial segregation health screen within two hours of Mr Carr's segregation and that healthcare staff contributed to his segregation reviews on 2 and 9 March. The Head of Healthcare said that nursing staff complete a daily round of the segregation unit and prison GPs do so three times a week. In the absence of records, we are concerned that we cannot know whether these important checks were made.
78. Despite repeatedly asking for a full set of segregation records for Mr Carr, Birmingham only provided documents for his three disciplinary hearings and the daily history sheets from 27 February to 29 March 2018. Birmingham told us that the records had not been filed properly because they had been moved to another part of the prison while works were being carried out in the segregation unit. PSI 64/2011 on safer custody requires prisons to retain and securely store all documents relating to a death in custody in a locked cabinet with signed access only. We are concerned that segregation unit managers did not have an appropriate filing and storage system to keep prisoners' segregation records for three years, as required.
79. The safer custody manager told the investigator that the CCTV system in the segregation unit was partially broken and the footage that was available did not provide a view of Mr Carr's cell. Without CCTV footage and other evidence, we

cannot know if staff checked on Mr Carr's welfare regularly or at all, and whether this was ever documented.

80. Segregation is an extreme and isolating form of custody and, without the segregation records for Mr Carr, we cannot know if staff complied with PSO 1700. The lack of records is particularly troubling in the context of Mr Carr having taken PS in the segregation unit and having been left lying on the floor of his cell for a prolonged period. We make the following recommendation:
- **The Governor should ensure that staff manage prisoners held in the segregation unit in line with national instructions, including that:**
 - **completed segregation records about each prisoner are maintained and kept for three years;**
 - **the CCTV system is upgraded so that it provides and records full coverage of the landing of the segregation unit; and**
 - **the Prisons and Probation Ombudsman is promptly provided with all requested documents after a death in custody in line with 64/2011.**

Emergency response

81. We do not criticise Officer A for not entering the cell when he saw Mr Carr lying unresponsive on the floor. Mr Carr was in the segregation unit following a serious assault on a member of staff and the officer had no way of knowing if Mr Carr was genuinely ill or feigning. He could have placed himself in danger if he had entered the cell on his own.
82. However, we are concerned that both Officer A and the night orderly officer said that there would be no circumstances in which an officer would open a door alone at night without the night orderly officer and two or three officers present. This is contrary to both PSI 24/2011 and Birmingham's local policy which say that the preservation of life must take precedence over the standard unlock procedures, and that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may enter the cell on their own after making a dynamic risk assessment. We are concerned that someone performing night orderly officer duties was not aware of this, as prompt action may make the difference between life and death in some cases.
83. We are also very concerned that Officer A did not call a code blue emergency when he saw Mr Carr lying on the floor. He said that it was not unusual to find prisoners lying on the floor in their cell so he carried on with his duties. We do not know if Mr Carr had previously been found lying on the floor because his segregation records are unavailable. He said that the view was poor through the observation panel and that he could not see Mr Carr's face. We do not understand why he left him lying on the floor, not knowing if he was ill or breathing, and made no effort at that time to communicate with him. This is particularly difficult to understand if, as he told the police, he suspected Mr Carr had collapsed from the effects of PS.

Officer A must have had concerns about Mr Carr because he returned to check on him five minutes later. When he still could not get a response from him, he did not appear to understand the gravity of the situation and failed to radio a code blue or at least call the night orderly officer for assistance. By leaving the segregation unit twice, the officer caused a significant delay of 23 minutes in responding to the emergency before a code blue was called. We cannot say whether the outcome may have been different for Mr Carr without this delay.

84. We make the following recommendations:

The Governor should commission a disciplinary investigation into Officer A's failure to radio for urgent assistance or to radio a medical emergency code he saw Mr Carr lying unresponsive on his cell floor.

The Governor should ensure that staff are given clear guidance and understand when they should radio a medical emergency code.

Illicit substances

85. Mr Carr had a lengthy history of substance misuse in the community and in prison. Although he took illicit substances at Oakwood and Stoke Heath, there is no intelligence or evidence from prison staff that Mr Carr used illicit substances at Birmingham before he went to the segregation unit (although he told a nurse that he had taken PS on the wing).

86. We cannot say for certain how Mr Carr obtained PS in the segregation unit but it is highly likely from the evidence we have seen that he used a pulley system through the sewage pipes.

87. A plumber said that Birmingham's toilet system was very basic. He said that the pipes went from the fourth landing straight down to the cells on the first landing and then into the main sewer pipe. He had previously found a rope made from torn material tied together and about 60 feet in length, elsewhere in the prison. He said that he could not say if such ropes (allegedly used for moving drugs) could be passed between adjacent cells but they could be passed vertically to cells on higher or lower landings.

88. The Head of Security said that passing illicit substances between cells through toilet cisterns was possible. She said that Birmingham was an old Victorian prison and the pipe system was interlinked.

89. Prison staff were aware that prisoners might pass illicit substances through the sewage system because lengths of twisted bedding had previously been found in cells. We appreciate that it would be expensive and impractical to re-design or replace the piping but we make the following recommendation:

The Governor should commission an appropriately-skilled person to review and address the risks posed by the sewage system, to prevent illicit substances being moved around the prison.

90. The investigation found that the prison is currently undertaking a number of measures to tackle the problem of PS, including the use of search dogs, cell

searches, processing mail and using fabric checks to look for illicit items in cells or suspicious behaviour of prisoners.

91. We accept that Birmingham has a drug strategy in place and staff are working hard to implement it. Nevertheless, the HMIP report indicated that drugs were easily accessible to prisoners, the trafficking of illegal substances was blatant and many staff did not seem prepared to tackle substance misuse. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS.
92. Birmingham is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view, there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.
93. In a recent investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive told us that HMPPS plan to issue a national drug strategy in the autumn of 2018.

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