Investigation into the circumstances surrounding the death of a man at HMP Birmingham in August 2007

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is a report of an investigation into the death of a man who was 32 years old. He was found hanging in his cell at HMP Birmingham on 18 August 2007. He had been in custody there for three months.

I would like to offer my sincere condolences to the man's family on their loss.

I must also apologise for the delay in issuing this report. The first clinical review raised issues that needed to be clarified and it took some time for a more comprehensive clinical review to be commissioned, completed and forwarded to my investigator. However, I must also acknowledge delays within my own office that reflect the heavy caseload faced by my investigators. I am all too aware that it is nearly a year since the man died and that his family and representatives have anxiously awaited the outcome of this report.

The investigation was undertaken by one of my investigators. We would both like to thank the Governor of Birmingham and his staff for their participation and assistance. We are particularly indebted to the prison's liaison officer.

Three healthcare professionals were involved in conducting clinical reviews and I thank them sincerely for this. However, I have mentioned on previous occasions that I believe clinical reviews should not be carried out by staff who are responsible for the delivery of healthcare at the prison concerned. I again draw this to the attention of those in the Department of Health responsible for prison healthcare.

I believe that both wing and healthcare staff were trying their best to ensure that the man received the care he needed. However, it is unfortunate that a breakdown in communications meant that he did not receive an appointment to see a psychiatrist or community psychiatric nurse whilst at HMP Birmingham, and nobody ever checked that he had. It is of course impossible to say whether the outcome would have been different had the man spoken to somebody.

My report shows that the man gave away his belongings shortly before he was found hanging. This is a phenomenon that I have encountered in other investigations, and I think it can be said to be a clear indicator of increased risk. The Prison Service's Safer Custody and Offender Policy Group may wish to offer advice to all establishments on this matter.

I make four recommendations to the Governor.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2008**

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SUMMARY

The man was remanded into custody at HMP Blakenhurst on 18 May 2007. He transferred to HMP Birmingham, following a court appearance, on 24 May.

The man was in the process of completing a drug detoxification programme when he left Blakenhurst. However, after assessment by a doctor in healthcare at Birmingham, it was found that he was suffering from mild opiate withdrawal and should be treated for his symptoms.

During his time at Birmingham, the man rarely came to the attention of staff. He was a quiet and polite man, who spent time with a small circle of other prisoners and attended education classes.

On 13 July 2007, the man self harmed. An Assessment, Care in Custody and Teamwork (ACCT) document (which is used to monitor and support prisoners thought to be at risk of self harm) was opened that day and it remained open until eight days before his death. It came to light during this investigation that this was not the first time he had tried to harm himself, but it is uncertain whether staff were aware of these instances until after his death.

On 10 August, an ACCT case review was held to determine whether the man should continue to be monitored and assessed. The review panel decided that the ACCT should be closed as he told staff that he had no problems and wanted the document to be closed. A further review to check his progress was planned for 24 August.

In the early hours of the morning of 18 August, staff on A wing were alerted by frantic banging on the door by the man's cell mate. On arrival, his cell mate told staff that the man was hanging. Upon entering the cell, they saw that he was suspended from a ligature made from a bed sheet which was tied around his neck and the bars of the window. Despite the efforts of staff, the man could not be revived. He was pronounced dead by paramedics at 3.14am.

My report includes four recommendations.

THE INVESTIGATION PROCESS

1. I appointed one of my investigators to conduct the investigation on my behalf. Notices were issued both to prisoners and to staff inviting anyone who had information relating to the man's death to make themselves known to the investigator. However, no additional witnesses came forward.

2. My investigator was given access to all the man's prison records, including his medical records and police statements. All of these documents were forwarded to my investigator within a week of her initial visit on 23 August 2007.

3. My investigator visited HMP Birmingham to carry out taped interviews with staff and an untaped interview with a prisoner on 16, 17, 24 and 25 October. She also visited the cell where the man died.

4. One of my Family Liaison Officers (FLOs) contacted the man's next of kin (his brother) to explain the role of the Prisons and Probation Ombudsman and to offer him the opportunity to participate in the investigation process. The man's brother raised some concerns and asked that my investigator consider these as part of the investigation.

5. The man's brother believed that the man's personality changed when he went to prison, that he had become mentally unwell and had harmed himself by cutting his wrist a few weeks before he died. He believed the man should have seen a psychiatrist and felt that his concerns about his brother's mental health were not taken seriously by prison staff. The man's brother said he mentioned these concerns to a staff member when he visited the prison on 13 July. The man's brother had also heard that the man had been told that two of his friends had been arrested and imprisoned. He wanted clarification of why the man was told this, as it was not the case.

6. The man's brother instructed solicitors to take forward these and other concerns on behalf of the family. The solicitors subsequently wrote to my investigator and she has been in correspondence with them to answer their questions.

7. A clinical review of the man's healthcare whilst he was in custody at Birmingham was undertaken by the former head of healthcare at the prison, on behalf of the local Primary Care Trust (PCT). As this review did not address all of the questions raised by my investigator, a further review was undertaken by a member of staff, also from the healthcare department at Birmingham. A third clinical review was completed by a doctor, acting clinical lead at Birmingham. This was forwarded to my investigator on 16 May 2008.

HMP BIRMINGHAM

8. HMP Birmingham is a large Victorian prison first built in 1849. It is a category B local prison for adult male offenders and holds 1,450 prisoners. A recent programme of refurbishment has provided new workshops, educational facilities, a new healthcare centre and gymnasium, as well as improvements to existing facilities. The prison has 11 accommodation units which are a mixture of Victorian four-landing wings from a centre point and more recent residential houseblocks.

A wing

9. A wing can accommodate 147 prisoners. These are mainly prisoners on remand or awaiting sentencing.

Anti-ligature knives (fish knives)

10. Anti-ligature knives, also known as 'fish knives' or 'cut down tools', are specially designed to cut ligatures.

Assessment, Care in Custody and Teamwork (ACCT)

11. ACCT requires any member of staff who identifies a prisoner they believe to be at risk of suicide or self harm to take action and to record those actions. The ACCT document should be available to all staff where the prisoner is located, including workshops and visits. Within 24 hours of an ACCT being opened, the prisoner is seen by an assessor and has a case review meeting. ACCT reviews are held at appropriate intervals and are attended by the prisoner and a case manager, together with other members of staff.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

12. There are drug workers based in most prisons from organisations specialising in the treatment of substance abuse. CARATS workers can run programmes, and offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary. A Charter of Rights and Responsibilities for prisoners who use the CARATS service is included as an annex to this report.

Drug Strategy

13. HMP Birmingham has a Drug Strategy that was published in March 2006. The objective is:

> "To reduce the harm suffered by individual prisoners misusing drugs, encouraging awareness and behavioural change whilst in custody that can be sustained on release"

The Strategy says:

"There will be systems in place to identify, assess and support prisoners with a drug misuse problem and which recognise the specific needs of particular groups including those from ethnic minorities."

The Drug Strategy Committee has clear terms of reference and meets on a monthly basis to monitor and evaluate the effectiveness of drug services. The committee is formed of a multi-disciplinary team, including governor grades and CARATS workers.

Foreign National Prisoners

14. HMP Birmingham has a Foreign National policy. Its aim is to provide equality of treatment for foreign national prisoners by identifying and addressing their specific needs, ensuring that they receive the same care and have the same access to all prison facilities and information that is offered to all prisoners.

15. The Foreign Nationals Committee meets bi-monthly to discuss any issues or concerns. These issues are also raised at the Race Relations Management meeting. Birmingham uses Language Line, a telephone support service (available 24 hours a day, 365 days a year) to interpret information for prisoners who do not speak, or speak little, English.

Healthcare

16. The provision of healthcare is the responsibility of the Primary Care Trust. Primary care clinics are delivered by doctors. The primary healthcare team comprises doctors and nurses, and there is an in patient facility (which has 34 beds) staffed by registered mental health nurses and discipline officers during the day and a nurse and discipline officer at night.

Keys for night staff

17. Operational Support Grades (OSGs) who are on night duty are given a sealed pouch containing a cell key. The local prison strategy (annexed to this report) gives instructions as to when an OSG can break the seal on the pouch and use the key. There are 15 numbered pouches and each wing has two pouches containing keys for use at night in an emergency. Not all night staff carry cell keys because of the threat to the security of the prison.

Listeners

18. A number of prisoners at each prison are trained and supported by the Samaritans to be Listeners and to offer peer support. Other prisoners can speak to Listeners in confidence about any issues that affect them. Listeners are bound by confidentiality rules, like the Samaritans, and are unable to disclose any details about conversations they have had (unless it is a matter which affects the security of the prison).

Independent Monitoring Board (IMB) report

19. The IMB is made up of local lay people appointed to each prison by the Secretary of State. They are not members of the Prison Service, nor are they part of the prison's management team. They are required to produce an annual report to the Secretary of State for Justice, highlighting good practice and flagging up areas of concern. The Birmingham IMB's report for the period 1 July 2006 to 30 June 2007 acknowledged problems created by overcrowding, lack of purposeful activity for prisoners, relationships between staff and prisoners and a failing personal officer scheme. With regard to healthcare, the IMB had concerns that there was still no primary mental health provision. The Board continued to have concerns that prisoners with mental health problems, and who in their opinion should not be in prison, were located in healthcare. The IMB also said that, although funding had been available for some months, substance misusers received no better support and care than they would have the year before.

Her Majesty's Chief Inspector of Prisons report

20. The HM Chief Inspector of Prisons made an announced inspection of HMP Birmingham in February 2007. The subsequent inspection report noted that the prison had seen significant change over the previous five or six years, including a considerable amount of new building work.

21. Overall, inspectors were disappointed with what they found at Birmingham and attributed this partly to the pressures of an overcrowded prison system. However, the Chief Inspector's report said that the prison was not responding "proactively and robustly" to the challenges it now faced and that some of the old culture was "reasserting itself". Nevertheless, it was a credit to staff and managers that the prison remained a much better place than when inspected in 2000.

KEY FINDINGS

22. The man was remanded into custody at HMP Blakenhurst on 18 May 2007. Whilst there, he began a detoxification programme for withdrawal from opiates. He left Blakenhurst on 23 May 2007 to attend Birmingham Magistrates' Court. He spent the night in police custody before he was moved to HMP Birmingham on 24 May. He had been charged with drug-related offences and was found guilty on 13 August. He was awaiting sentencing when he died.

First reception

23. A Prisoner Induction Checklist showed that the man was seen by healthcare on the day he arrived at Birmingham. The note made in his Inmate Medical Record (IMR) says that the man had received detoxification medication whilst he was detained in police cells the night before, had no thoughts of self harm or suicide and should be referred to "detox and GP for script".

24. The man was also seen in the Detoxification and Treatment Unit where a staff member completed a Withdrawal Monitoring Chart and noted that there were no typical detoxification symptoms such as rhinorrhoea (sniffing), agitation or restlessness, shivering, lactorrhoea (watery eyes), nausea and vomiting, piloerection (hairs standing on end), diarrhoea or stomach cramps. It was also noted that the man had last used heroin (although Blakenhurst's medical record records this as opium use rather than heroin) a week before, was not on any prescribed medication and did not have any current physical or psychiatric problems. The recorded actions for the man were that he was to drink plenty of fluids to avoid dehydration, that he was to be offered symptomatic relief for his withdrawal and would be referred to the detox doctor's clinic. (This meant he should receive medication to treat the symptoms of his drug withdrawal, such as episodes of diarrhoea and aches and pains, when or if they occurred.)

25. The man had also been risk assessed for sharing a cell, been issued with a smoker's pack, a Pin number so he could use the prison's phones, and had been allowed a two minute telephone call. The Cell Sharing Risk Assessment noted that he had a history of drug use and was currently dependent on drugs. It was also noted that he spoke limited English. He was assessed as a low risk and fit to share a cell with another prisoner.

26. The man also attended a "Day One Interview" intended to assist staff in assessing whether a prisoner is at risk of self harm and to highlight any issues or problems a new prisoner might have. During this interview it was noted that the man said he spoke English, was a "drug addict" who had last used opium that month, was expecting to receive medication for detoxification, and had never committed an act of self harm.

27. The staff member who conducted the interview also noted that the man did not feel that he would self harm at that time and had never suffered or been

treated for depression or any mental health problems. He had, though, recently suffered bereavement, as his father had died in April.

25 May to 12 July

28. On the man's second day at Birmingham, the Induction Checklist shows that he met the prison doctor, a CARATS worker, an officer working with foreign national prisoners and also with the prison chaplain. The prison doctor noted that the man had "no ongoing medical problems", had last used opium ten days before and was on lofexidine (for drug withdrawal) whilst at Blakenhurst. The doctor wrote that the man should be treated "symptomatically" (treated for his symptoms due to drug withdrawal).

29. An officer who works with foreign national prisoners also saw the man on 25 May. My investigator spoke informally to this officer during her visit to Birmingham. The officer said that approximately 17 per cent of prisoners at Birmingham were foreign nationals. He recalled that he and the man had discussed the issue of deportation as this was concerning him, but it was unlikely he would have been removed due to his nationality. The officer said he told the man he would see him again once he had been sentenced.

30. The man also attended a "Day Two Interview". At this interview he expressed slight concern at being in prison but did not feel he was at risk of harming himself.

31. The man was also seen on 25 May by a CARATS worker, who completed a Drug Intervention Record. It was noted that the man presented no issues that required immediate attention such as vulnerability, a history of self harm or special health needs. It was also recorded that he had last used opium on 15 May, and that he was not currently receiving any treatment for his drug use. The CARATS worker summarised the meeting by saying that the man spoke limited English and had "very little reading and writing" and wanted to attend education classes to improve his skills. The CARATS worker wrote that she had referred the man to a Drug Intervention Programme for support once he had been released from prison. They also discussed minimising harm, overdose and tolerance levels.

32. The CARATS worker saw the man again on 2 July. She noted that he was "fine", was adamant that he would not use drugs again and did not require any further intervention. She completed a Comprehensive Substance Misuse Assessment on the same day. In a section entitled "Summary of physical and mental health" she recorded "no evidence shown of either physical or mental health issues". There is no further record of the man's meeting with CARATS after 2 July.

33. Until 13 July, there is little else in the man's prison records of note. He attended court on 20 June, 28 June and 10 July. He was described in the wing history sheet as a polite individual who had settled in well and seemed to socialise with a small number of other prisoners. He visited healthcare on

26 June complaining of heartburn and was prescribed omperazole to relieve this. He attended education classes and seemed to be progressing well.

34. My investigator spoke to a prisoner who gave an insight into the man and how he had been feeling. The prisoner said that the man tended to ask other prisoners about what length of sentence he could expect and that this was weighing on his mind. He also remembered that the man had often said he was going to kill himself, because of the possible length of his sentence and for other reasons relating to his offence.

35. The prisoner recalled an incident (although he was not sure when it took place) when he shared a cell with the man. The man had attempted to swallow a bottle top. However, he asked the prisoner to help him as he was choking and he smacked the man on the back until the top came out. However, the man did the same thing about 15 minutes later and the prisoner said he told him that if he did it again he would alert staff. The prisoner said he told officers about this the next morning but they just laughed. He could not recall their names. The prisoner said that he asked to change cells shortly after this incident and did so. On the day the prisoner moved, the man collected his stereo from reception and gave it to him. He said he did not need it as he was going to kill himself.

36. The prisoner, who was sharing a cell with the man when he died, was released from Birmingham before my investigator was able to interview him, but he gave a detailed statement to the police. In this statement, he recalled meeting the man when they attended the same education classes. The man told him that he had tried to harm himself and attempted suicide and that he thought he might receive a 20 year sentence. The cellmate remembered that the man had always seemed very sad and spent a lot of time sleeping or with his friends.

13 July – The man's act of self harm

37. On 13 July 2007, at approximately 10.00am, the man made a cut to his left wrist with a blade from a razor. The cut was deep and measured about four centimetres. He was seen at 10.14am by a doctor who referred him to the Accident and Emergency Department of the local hospital for treatment and to assess any tendon injury. He left the prison at 11.30am and returned from the hospital at 4.41pm later that day.

38. An officer had opened the ACCT document before the man was taken to hospital. The officer noted in the Immediate Action Plan that the man should be located on A2 landing and initially placed on five observations an hour. The ACCT document travelled with the man to hospital where the observations were carried out.

39. The man's brother had a pre-booked visit the same day. A Principal Officer (PO) was called to the Visitors Centre following a call from a member of staff who worked there. They had checked that local prison computer system and seen that the man had been taken to hospital and so would not be available

for the visit. The man's brother appeared very distressed because he was concerned about the man's health due to a number of telephone calls he had received from him that week. Before he left for the Visitors Centre, the PO checked the man's computerised prison record and confirmed that he had been taken to hospital that morning. As he was still there, he was unable to receive the visit.

40. The PO met the man's brother for approximately 40 minutes in the Visitors Centre along with the Centre's Customer Services Manager. They began to tell him that the man had harmed himself and was in hospital. The man's brother immediately asked whether he was dead. The PO explained what had happened and asked why he had questioned whether the man had died. His brother said that at a previous court hearing the man had told his solicitor he intended to take his own life. He also said that the man had harmed himself on several occasions and had a substance misuse history. The PO asked whether he had advised anyone of this, but his brother said he had not as he had expected the solicitor to say something. The PO assured the man's brother that the information would be passed on to the relevant departments in the prison. He gave him his direct office telephone number in case he had any further concerns or the man repeated this intention to him. The man's brother also called his wife during the meeting to obtain the man's solicitor's number so he could speak to them about his concerns.

41. After his meeting with the man's brother, the PO returned to the prison and rang A wing. He spoke to a Senior Officer (SO) and asked whether an ACCT document had been opened for the man. The SO confirmed that it had. The PO then telephoned the treatment room in healthcare and asked them to book a psychiatric referral for the man. The PO confirmed to my investigator that he had previously made psychiatric referrals by telephoning healthcare. However, healthcare told my investigator that they only accept written referrals and would not accept a telephone request. A copy of the Initial Referral Process procedures was viewed. It does not say that referrals must be made in writing.

42. The solicitor's first contact was also on 13 July 2007 when following the call from the man's brother they rang the prison. They initially spoke to somebody in the Discipline Office who transferred the call to the chaplaincy. There was no answer, so a message was left on the answerphone. They next telephoned the duty governor, but did not record whom they spoke to. During this conversation they were informed that the man had harmed himself and been taken to the local hospital.

43. My investigator asked the man's solicitor whether they had alerted the prison of any concerns about the man. They responded in writing, including copies of all notes of telephone conversations. There is no record of any contact between the solicitors and the prison about the man's mental health or any health concerns prior to 13 July.

44. The solicitors also forwarded a copy of a fax they sent to the prison on 13 July asking for information about the man and whether he had committed

suicide. This fax appears to have been sent after the man's brother met the PO and indicates that he was still unsure exactly what had happened to his brother.

45. An officer said at interview with my investigator that he was the duty ACCT assessor on 14 July. The ACCT assessor met the man and they talked about why he had harmed himself. The man told him that he was worried about receiving a long sentence and being deported back to his home country, and that his father had recently died. He also told the ACCT assessor that he had been thinking of harming himself for about two weeks and had told his brother and solicitor that he intended to do so. However, he said he had not intended to kill himself and his actions had scared him. The ACCT assessor noted that the actions on the ACCT plan for the man were that he was to continue to attend education classes, remain in contact with his brother, and be assessed by a Community Psychiatric Nurse (CPN).

46. A further case review was held on 14 July, and attended by the ACCT assessor, a second SO and the man himself. It was recorded that the man should be seen by the doctor and a CPN and this was to be arranged on 17 July. It was also noted by the second SO on the Caremap part of the ACCT that the man wanted to see the CPN as he kept thinking about receiving a long sentence. This appointment was to be arranged by wing staff on 17 July. The next ACCT review was due on 20 July.

47. His brother visited the man approximately three days after he had harmed himself. At this meeting the man would not stop talking and his brother believed he was mentally ill. (This was the last time he saw the man as he stopped accepting visits three weeks before he died.)

48. Whilst at Birmingham, the man received co-amoxiclav (an antibiotic) and ibuprofen for five days from 18 July. This was for the cut to his wrist. He was also prescribed paracetamol from 19 July, and given it daily from 20 July to 10 August. The man was also prescribed omperazole (an antacid) for heartburn, which he was given from 20 July to 9 August, and had a five day prescription for zopiclone (sleeping tablets) from 19 to 23 July.

49. On 20 July, a case review was attended by a third SO, an officer and the man. The SO noted that the man was not very communicative and the man said he thought he was mentally ill. It was noted that a referral was made to the doctor, but there are no further details.

50. The man's solicitor informed my investigator that they had a legal visit with their client on 25 July. The man had seemed "volatile, confused and emotional". This information was not relayed to the prison.

51. The next case review was held on 27 July, and attended by the first SO, the ACCT assessor and the man himself. It was noted that he seemed in good spirits and denied telling his cell mate he intended to kill himself. There was no mention of whether he had yet seen a doctor or CPN.

52. It is recorded on the medication chart that the man was given paracetamol for flu-like symptoms on 2 August, and again for wrist pain on 5 August.

53. On 3 August, another case review was held. This was attended by a fourth SO, the ACCT assessor and the man. It was recorded that he seemed in good spirits and had no thoughts of self harm.

54. After a further legal visit on 3 August, the solicitor noted that the man seemed much more alert than on the previous occasion but that he remained at risk of harming himself if he were to receive a lengthy custodial sentence. The man still had stitches in his cut wrist and told the solicitor that he felt he had let his family down and so had decided to commit suicide. He also said that his bouts of anxiety and depression were as a result of having to go "cold turkey" in the prison.

55. A final case review was held on 10 August, and was attended by the second SO, two officers, and the man. It was recorded that the man said he had no problems and wanted the ACCT closed. He also asked to move to share a cell. The ACCT was closed and a review was to be held on 24 August. There was no mention of his referral to a doctor or a CPN, or a note to chase up whether an appointment had been made. The ACCT assessor said at interview that he knew the man had seen a doctor, but was unsure about a CPN. There is no note in the man's on-going record in the ACCT to say he had been seen by anyone from healthcare other than to receive painkillers for his wrist or a sleeping tablet. Nor is it recorded in his Inmate Medical Record (IMR) that he ever saw the doctor or a CPN after the ACCT was opened.

56. The last time the solicitor saw the man was in the court cells on 13 August. An interpreter was present for this meeting. The man's wound was still visible and he discussed this at length with the interpreter in his own language. A translation was requested but the interpreter said that the man was feeling very depressed and under pressure.

57. There is no evidence to suggest that the solicitor raised any concerns about the man's mental health to anyone at the prison.

Events of 18 August

58. The man's cellmate recalled in his statement to the police that the man had seemed unusually happy on the night of 17 August. They had spent the evening watching television and then slept from approximately 11.00pm. The cellmate said he woke up in the early hours of the morning to go to the toilet (which is separated by a low partition). As he looked towards the man's bed, he saw that it was empty. He turned towards the cell window to see that the man appeared to be hanging from a green bed sheet attached to the window. The cellmate said that he thought by the man's appearance that he had died. He immediately pressed the cell bell and frantically began kicking the door.

59. An Operational Support Grade (OSG), who was on night duty on 18 August, was in the office on A wing at approximately 3.00am when she heard loud banging on a cell door. She followed the banging and this led her to the cell shared by the man and his cellmate. The OSG looked through the observation panel and could see that the man was suspended from a ligature and that his cellmate was frantic. The OSG immediately raised an urgent call for Oscar Two (the code for the senior officer in charge of the prison at night) and Hotel Two (the code for healthcare) to attend. By the time the OSG had radioed through the call, three officers had arrived at the cell door, alerted by the noise.

60. My investigator asked the OSG why she did not immediately break the seal on the pouch she was carrying and open the cell door. She said that, although OSGs carry a pouch containing cell keys, it is prison policy not to open cell doors and that is the duty of a more senior officer or a response team. The prison forwarded an extract from a local strategy which instructs staff when they are permitted to open a cell door. The relevant section says that cell doors must not be opened by a staff member at night when they are on their own, unless they judge that they can save life by doing so and are not endangering the lives of other prisoners or the security of the prison. In any such instance, the control room must be informed and an emergency alarm must be raised. The strategy also states that, under normal circumstances, no cell will be opened at night unless there are three members of staff present (one of these being Oscar Two).

61. Of the three officers who had arrived at the cell, officer one was in the library when he heard the banging on the cell door. He followed officer two up to the man's cell. When they arrived at the door, the OSG told them that somebody was hanging. Officer three also heard the banging and made his way quickly to the cell door.

62. Officer two looked through the observation panel and tried to speak to the man's cellmate who was obviously distressed. Neither Officer one or two had a cell key as they attended as response officers and did not carry a full set of keys (in line with the prison policy). They waited a matter of seconds for officer three to arrive and open his sealed pouch to take out his key. Officer three struggled to break the seal on the pouch and Officer one had to use his fish knife to break the seal.

63. As officer three opened the door, the cellmate pushed past and rushed out of the cell. Officer three attempted to calm him down whilst the other two officer entered the cell. Officer two attempted to lift the man to relieve the pressure of the ligature and Officer one cut the ligature with his fish knife. They then laid the man on a bed. In interview, officer one recalled that the man felt cold to the touch. Officer two remembered that the man appeared pale and clammy and his eyes seemed glazed. Officer one checked for signs of life, but could not find the man's pulse. Officer two touched the man's eyeball to see if there was any reaction, and also shone his torch into his eyes, but there was none.

64. Officer two began to administer Cardio Pulmonary Resuscitation (CPR) by carrying out chest compressions in an attempt to resuscitate the man. He continued to do so until a nurse arrived a few minutes later. The officers did not attempt mouth to mouth resuscitation as the man's tongue appeared swollen and filled the whole of his mouth, making it difficult to find his airway.

65. The nurse was on the Centre on the wing and had heard the banging on the cell door. She made her way to the cell, picking up a bag of emergency equipment on the way. The bag contained a cylinder of oxygen, resuscitation aids and a defibrillator. When the nurse arrived at the cell, the man was lying on the bed. She checked for his pulse, but found none. His eyes were open and his pupils were fixed and dilated. His fingernails were blue and he appeared to be discoloured. The nurse attempted to insert an airway, but was unable to do so as the man's jaw was stiff and she could not open it. The nurse administered oxygen with a face mask. At this point, officer one left the cell to call for an ambulance.

66. The SO whose role was as the Night Orderly Officer and Oscar Two (officer in charge of the prison) that morning, responded to the emergency call and arrived at the man's cell at 3.05am. He found officer two and the nurse carrying out CPR.

67. The nurse applied the pads of the defibrillator to the man's chest and switched the machine on. The defibrillator advised "no shock" which meant there was no shockable heart rhythm and indicated that he had already died.

68. The nurse and officer two continued with CPR until the paramedics arrived approximately 15 minutes later. The paramedics put their own defibrillator onto the man, but again it showed no shockable heart rhythm. Upon examination, they noted that he was cold, cyanosed (a blue colour to the skin) and that rigor mortis had set in around the jaw area. The paramedics pronounced him dead at 3.14am.

69. The cellmate meanwhile, was very distressed and officer three took him to the end of A wing landing, away from the cell. The cellmate was shaking and began vomiting. Officer three took the cellmate to the Care Suite on C wing to sit with two Listeners. When the nurse left the man she went to see his cellmate. She found him with the Listeners, sitting on the floor sobbing. He refused to speak to the nurse and seemed frightened. A number of actions were taken in support of the man's cellmate.

70. The Deputy Governor rang the man's brother during the day on 18 August and asked whether someone from the prison could visit him. His brother realised something was wrong and asked if the man had died. The Deputy Governor confirmed that he had. It was agreed that he and other prison representatives would visit the man's brother the next day. At 9.00am on 19 August, three members of staff visited the man's brother. An aunt and uncle were also present. The Deputy Governor explained to them what had happened and that the prison would appoint a Family Liaison Officer whom

the man's family could contact if they had any questions. The prison also offered to contribute towards funeral expenses.

71. Staff directly involved in the discovery and attempted resuscitation of the man were asked by my investigator if they had felt supported, had been invited to attend a de-brief, and offered the opportunity to speak to the Care Team. There was a mixed response from staff. Some had been offered support services but had declined, whilst others, in particular officer two, appear to have been overlooked. The OSG attended a de-brief on the morning of 18 August, and spoke to a member of the Care Team, but nobody else had spoken to her since then. My investigator judged that some of those involved still seemed distressed about what had happened. However, the man's cellmate appeared to have been well looked after by staff.

72. A post mortem was carried out on 20 August, the cause of death was recorded as hanging.

73. Staff were not aware that the man had given away some of his possessions until a senior officer (SO) from the Security Department was called to A wing on 26 August to confiscate the man's stereo from the prisoner. The prisoner had visited reception that morning to ask for it to be recorded on his property card. When asked how he came by the stereo, he told officers that the man had given it to him two weeks earlier and said that he did not need it as he was going to hang himself. When asked why he had not reported this to staff, the prisoner told my investigator he had told staff on several occasions but they had laughed at the information. (Two officers from security told my investigator that the prisoner said "I just didn't" when asked why he did not inform anyone about what the man had said.) The prisoner also recalled that the man gave his flip-flops to another prisoner. The prisoner did not tell anyone about this.

74. On 5 September 2007, the Police requested a sample of the man's blood to be tested for the presence of alcohol, commonly abused drugs (amphetamine, ecstasy, opiate drugs, methadone, benzodiazepines, ketamine and metabolites of cocaine and cannabis) and over the counter medication. The results showed that he was not under the influence of alcohol, any commonly abused drug or any medication when he died.

ISSUES

Clinical care

75. His brother spoke to my Family Liaison Officer and his own legal representatives about questions he had regarding the man's treatment in prison. The overwhelming concern of his brother - and one shared by my investigator - was that he was not seen by a CPN despite the need being recognised by the PO and those involved in the man's ACCT reviews. The man's brother thought that the man had become mentally unwell whilst at HMP Birmingham.

76. The PO told my investigator he contacted healthcare after his meeting with the man's brother to book a referral for the man to see a CPN. He said he telephoned healthcare and always made referrals that way. It is also recorded in the ACCT document during the case reviews that the man needed to see a doctor and a CPN. The wing staff wrote in the ACCT document that an appointment was to be made on 17 July, but there is no evidence that this was followed up.

77. Healthcare told the investigator that they never received a referral from any member of staff. Their practice was only to take written referrals and there is no evidence that a written referral was ever made. The prison has recognised the breakdown in this system and that prisoners could slip through the net.

78. The Clinical Lead from Birmingham acknowledges this problem in her clinical review dated 16 May 2008. The referral policy was decided in January 2007 by the Mental Health Team and the information was disseminated to prison staff via the Suicide Prevention Group. In an attempt to clarify and simplify the situation, the Clinical Lead writes that the case manager involved in the ACCT process will in future take responsibility for acute mental referrals. The Suicide Prevention Group will be tasked with informing all staff of this arrangement.

The Governor should ensure that a system is put in place to identify prisoners who need to be referred to the mental health team and that checks are made to ensure that prisoners attend appointments.

79. His brother also expressed concern about the man's withdrawal from drugs and his detoxification once he arrived at Birmingham. Whilst he was at Blakenhurst, he was on a detoxification programme and had been prescribed medication as he was diagnosed with severe opiate withdrawal symptoms. This is documented in the Prescription and Administration Record Chart raised at Blakenhurst. The man was prescribed lofexidine (for opium withdrawal) and zopiclone (to help him sleep), which he began to take on 19 May until his last recorded dose administered at Blakenhurst on 22 May. The Prescription Record (which is annexed to this report) indicates that the man should have received lofexidine for 11 days until 29 May, and zopiclone for seven days until 25 May. He spent the night of the 23 May in police cells,

and was prescribed medication for his withdrawal that night. His detoxification came to an abrupt end when he transferred to Birmingham and before he had completed the whole programme.

80. When the man was assessed in healthcare at Birmingham on 25 May, it was noted in the IMR that he had been taking lofexidine whilst at Blakenhurst and that he should be treated "symptomatically c/o diarrhoea & aches & pains". In other words, the doctor was aware that the man had been prescribed lofexidine which he had last taken at Blakenhurst on 23 May but judged that he displayed no physical signs of opiate withdrawal. The doctor thus decided that his withdrawal symptoms should be treated symptomatically. This meant that he would be given medication for symptoms such as diarrhoea or aches and pains incurred as a result of his withdrawal, rather than being given medication for the withdrawal. The clinical reviewers seem to agree that this was the correct course of action to take with the man.

81. The Clinical Lead writes in her clinical review that the man was "suffering from fairly mild opiate withdrawal" and that, when he was assessed by the Detoxification Treatment Unit, he displayed none of the symptoms associated with withdrawal. There is no evidence that medical staff did not assess the man correctly at Birmingham, but it may be the fact he spoke limited English meant he was unable to fully explain to staff how he was feeling.

82. The ACCT document was opened immediately after the man harmed himself and regular reviews took place. However, a member of healthcare did not take part in any case review. It is good practice that they should, especially when a prisoner's mental health is a concern. There was also a lack of continuity amongst staff who assessed him. I understand it is not always practicable for the same staff to carry out reviews, but it would be helpful if the case manager at least had sight of all of the reviews for a particular prisoner.

The Governor should remind staff that, whenever possible, a member of healthcare staff should be present at an ACCT review. If a member of healthcare is unavailable, then a note about the prisoner should be forwarded by healthcare, in good time for the review.

83. It is also evident good practice that, when actions are noted on an ACCT document, they are followed up at the next review. As I have shown, it was noted in two ACCT reviews that the man should by seen by a CPN and that an appointment should be made on 17 July. However, there is no record that this was ever followed up by staff.

The Governor should satisfy himself that robust procedures are in place to ensure that all actions noted in an ACCT document are followed up by staff. Also, prisoner records should be checked to inform staff carrying out ACCT reviews whether the prisoner has any significant court appearances pending, for example the start of a trial.

Local night strategy procedures

84. Staff seemed unclear about when they are permitted to enter a cell in an emergency. The OSG said she thought she was not allowed to enter the cell. Officer two also held this view.

The Governor should ensure that staff are aware and fully understand the local night strategy procedures, particularly relating to unlocking a prisoner whose life may be in danger.

Aftercare for staff

85. There was a mixed response from staff when asked by my investigator about the support they received after the man's death. Some staff appeared to have been overlooked.

The Governor should implement a procedure to ensure that all staff involved in a death in custody are aware of the support available to them and that they are supported by the Care Team and senior managers should they need it.

Aftercare for the man's cellmate

86. The cellmate was clearly traumatised after discovering his cell mate hanging. I believe he was treated with care and respect by staff concerned. Out of respect for his right to privacy, I have not included the details in this report.

Further question from the man's brother

87. His brother believed that the man had been told that two of his friends had recently received a prison sentence. This was untrue and his brother wanted to find out if, and why, the man was told this. My investigator could find no evidence of this, and was unable to answer this question.

RECOMMENDATIONS

1. The Governor should ensure that a system is put in place to identify prisoners who need to be referred to the mental health team and that checks are made to ensure that prisoners attend appointments.

2. The Governor should remind staff that, whenever possible, a member of healthcare staff should be present at an ACCT review. If a member of healthcare is unavailable, then a note about the prisoner should be forwarded by healthcare, in good time for the review.

3. The Governor should satisfy himself that robust procedures are in place to ensure that all actions noted in an ACCT document are followed up by staff. Also, prisoner records should be checked to inform staff carrying out the ACCT reviews whether the prisoner has any significant court appearances pending, for example the start of a trial.

4. The Governor should ensure that staff are aware and fully understand the local night strategy procedures, particularly relating to unlocking a prisoner whose life may be in danger**.**

5. The Governor should implement a procedure to ensure that all staff involved in a death in custody are aware of the support available to them and that they are supported by the Care Team and senior managers should they need it.