

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Saul Thomas a prisoner at HMP Hewell on 19 May 2019

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 Saul Thomas was found hanged in his cell at HMP Hewell on 19 May 2019. He was 42 years old. I offer my condolences to Mr Thomas's family and friends.

Mr Thomas was remanded in prison custody on 15 April 2019 and was sent to HMP Birmingham. It was his first time in prison. Two weeks later, he was moved to the prison's mental health inpatient unit after he became increasingly paranoid that people were going to harm him. On 16 May, he appeared in court and was then sent to Hewell. He was found hanged three days later.

The investigation found that the mental health care Mr Thomas received in prison was not equivalent to that which he could have expected to receive in the community. There is no evidence that healthcare staff at Birmingham ever carried out a formal risk assessment, which would have informed Mr Thomas's future care, and they did not hand over his care when he was moved to Hewell. Healthcare staff at Birmingham also failed to properly assess Mr Thomas's risk of suicide and self-harm, particularly when he appeared to become more paranoid that something was going to happen to him.

There were failings with the reception procedures at both prisons. Reception staff at Birmingham did not review all the documentation that arrived with Mr Thomas and therefore failed to properly assess his risk of suicide and self-harm. The reception nurse at Hewell did not access Mr Thomas's medical record and so failed to identify his mental health issues.

Overall, we found that the passing of information between Birmingham and Hewell was poor, and when Mr Thomas arrived at Hewell, staff there failed to identify that he had serious ongoing mental health issues.

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

January 2020

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Summary

Events

1. On 15 April 2019, Mr Saul Thomas was remanded in prison custody, charged with a violent offence against a family member, and sent to HMP Birmingham. This was his first time in prison. His Person Escort Record (PER) said that he was a cocaine user and suffered from drug-induced paranoia.
2. On 2 May, Mr Thomas was moved to the prison's mental health inpatient unit after he became increasingly paranoid that people were going to harm him. On 11 May, he gave a nurse a note addressed to his partner and asked her to put it on his file in case something happened to him.
3. Mr Thomas appeared in court on 16 May, and was then sent to HMP Hewell.
4. Shortly after 9.00am on 19 May, an officer went to unlock Mr Thomas's cell and saw he was hanging from the toilet door in his cell. The officer radioed a code blue medical emergency and entered the cell. Staff cut Mr Thomas down and tried to resuscitate him. When ambulance paramedics arrived, they assessed that Mr Thomas was already dead. They recorded his death at 9.24am.

Findings

5. We found failings in staff's assessment of Mr Thomas's risk of suicide and self-harm at both prisons.
6. The reception nurse at Birmingham failed to consider the information contained in Mr Thomas's PER and wrongly recorded that he had no issues with drug use. After Mr Thomas was moved to the mental health inpatient unit at Birmingham, healthcare staff failed to properly assess Mr Thomas's risk of suicide and self-harm, particularly when he handed a nurse a note addressed to his partner.
7. When Mr Thomas arrived at Hewell, the PER from Birmingham just said that his mental health was 'under investigation' and did not mention his stay in the inpatient unit for paranoia. The reception nurse did not view Mr Thomas's medical record so did not identify his mental health issues. Staff also failed to review the Cell Sharing Risk Assessment (CSRA) form from Birmingham, which mentioned his mental health issues.
8. The clinical reviewer found the mental health care Mr Thomas received was not equivalent to that he could have expected to receive in the community. Healthcare staff at Birmingham failed to formally assess him and they did not hand over his care when he was moved to Hewell. They did not refer him to substance misuse services as they should have done.
9. When Mr Thomas self-isolated at Birmingham, staff failed to apply the prison's Self-Seclusion Strategy. While healthcare staff recorded details of his self-isolation in his medical record, no one noted his prison record, which meant that prison staff at Hewell did not have access to this information.
10. Staff attempted to resuscitate Mr Thomas when he was clearly dead, which is against resuscitation guidelines.

11. Prisoners remained on the landing, freely moving around the vicinity of Mr Thomas's cell after he had been discovered. This was not acceptable.

Recommendations

- The Head of Healthcare at Birmingham should ensure that staff conducting the reception health screen always examine and consider the Person Escort Record that arrives with the prisoner, to assess whether the prisoner has any risk factors for suicide and self-harm.
- The Head of Healthcare at Birmingham should ensure that all healthcare staff:
 - receive full SASH awareness training;
 - have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm and share relevant information about risk; and
 - document the risk information considered and the reasons for a decision not to start ACCT procedures.
- The Head of Healthcare at Hewell should ensure that medical records are always accessed, along with any other evidence that arrives with a prisoner, during the reception process and that healthcare staff follow the agreed contingency plans if the electronic medical record system is not available.
- The Governor and Head of Healthcare at Hewell should produce clear guidance to prison and healthcare staff completing reception assessments to ensure all available information is considered and decisions are evidenced and recorded on the CSRA.
- The Governor at Hewell should ensure that every prisoner receives a full induction.
- The Head of Healthcare at Birmingham should ensure that there is a formal handover of care when a prisoner is moved from the mental health inpatient unit.
- The Head of Healthcare at Birmingham should ensure that all prisoners who are identified as having issues with substance misuse are referred for further assessment and support.
- The Governor and Head of Healthcare at Birmingham should ensure prisoners who self-isolate are managed in accordance with the prison's strategy and that staff update their prison record.
- The Governor and Head of Healthcare at Hewell should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.
- The Governor at Hewell should ensure operational managers are familiar with local contingency plans after a death in custody and that they ensure the immediate area is cleared of all but essential staff and the integrity of the scene is preserved.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Hewell, informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
13. The investigator visited Hewell on 28 May and obtained copies of relevant extracts from Mr Thomas's prison and medical records and visited Houseblock 3. One prisoner asked to speak to her during her initial visit, but only provided hearsay information and declined to provide further details.
14. NHS England commissioned a clinical reviewer to review Mr Thomas's clinical care at the prison.
15. The investigator accompanied by the clinical reviewer, interviewed five members of staff and three prisoners at Hewell on 19 June and five members of staff at HMP Birmingham on 10 July. The investigator also interviewed seven members of staff by telephone and the clinical reviewer spoke to two members of healthcare staff.
16. We informed HM Coroner for Worcestershire of the investigation. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Thomas's next of kin to explain the investigation. Mr Thomas's family wanted to know if the prison was aware of his mental health issues; if he was prescribed medication; if Mr Thomas been identified as vulnerable; and how he took his own life.
18. Mr Thomas's next of kin received a copy of the initial report, but did not identify any factual inaccuracies.
19. The prison received a copy of the report. They provided information to the investigator, which had not previously been provided, which confirmed that healthcare staff had attended the debrief after Mr Thomas's death. Therefore, the recommendation that healthcare staff should attend a debrief and be provided with sufficient support after a death in custody, has been removed. An action plan for the recommendations is annexed to the report.

Background Information

HMP Hewell

20. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Care UK provide health services and there is a 20-bed inpatient unit.

HMP Birmingham

21. HMP Birmingham is a local prison covering the courts of the West Midlands. At the time of Mr Thomas's death, it held up to 1,450 men and was managed by G4S Care and Justice Services, who had run it since 2011. In August 2018, HMPPS took over the running of the prison after concerns were raised about conditions, safety and management issues by HM Chief Inspector of Prisons. In July 2019, the government ended the G4S contract and Birmingham came under permanent HMPPS control.

HM Inspectorate of Prisons

HMP Hewell

22. The most recent inspection of HMP Hewell was in June 2019. Inspectors reported that there had been a marked decline. Hewell was graded as poor for safety for the third time and HM Chief Inspector of Prisons considered issuing an Urgent Notification (UN), requiring the Secretary of State to produce an action plan for improvement within 28 days. However, the Chief Inspector did not invoke the process because Hewell had already been in 'Special Measures' for some considerable time. The Chief Inspector, having reviewed the Special Measures Action Summary concluded that it was highly unlikely the UN process would achieve the required improvements.
23. Inspectors found most prisoners spent too long in reception and the cell-sharing risk assessment was not always carried out in private. First night risk assessments were not always completed, putting prisoners at risk during their early days in custody. The delivery of the induction programmes was often delayed and weak, and management oversight of the process was poor. Not all staff working on the unit had received adequate training in first night procedures. Although most prisoners attended an induction, it was often delivered late and did not provide adequate or up-to-date information to new arrivals.
24. PPO recommendations following previous deaths in custody had not been fully implemented, and oversight of their progress was inadequate.
25. Inspectors found there was good local leadership of health services.

HMP Birmingham

26. The most recent inspection of Birmingham was in July and August 2018. Following that inspection, HM Chief Inspector of Prisons issued an Urgent Notification to the Secretary of State for Justice expressing serious concerns about the treatment and conditions of prisoners. The Chief Inspector was

shocked at the dramatic deterioration since the previous inspection in February 2017, and said that the prison had been assessed as 'poor' against all four healthy prison tests (safety, respect, purposeful activity, and rehabilitation and release planning). Inspectors had found a high level of violence and drug use, poor management of prisoners at risk of self-harm, squalid living conditions and a lack of control by staff.

27. HMIP carried out an Independent Review of Progress in May 2019. Out of the nine recommendations they followed up, reasonable progress had been made in five, insufficient progress had been made in three and no meaningful progress in one. Inspectors reported that the prison had worked exceptionally hard to address violence. Work to prevent suicide and self-harm was better resourced and there were some well-developed plans to improve practice, but ACCT procedures were not yet delivered well enough to provide effective care.
28. At the 2018 inspection, inspectors found mental health services were good, with adequate support available for those with both mild to moderate and more enduring mental health problems.

Independent Monitoring Board

29. 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.

HMP Hewell

30. In its latest annual report for the year to 30 September 2018, the IMB noted that staffing levels had improved, but many staff were inexperienced. Healthcare staff told the Board that occasionally there were not enough staff to deal with the number of new arrivals and the need for late working was not recognised by their employers.

HMP Birmingham

31. In its latest annual report for the year to 30 June 2018, the IMB noted that they had written to the Prisons Minister regarding serious deficiencies at the prison, including concerns there had been six deaths in a seven-week period. The Board noted that in the final three months of the reporting period, there were early signs of improved staffing levels.

Previous deaths at HMP Hewell

32. Mr Thomas was the 12th prisoner to die at Hewell since May 2017. Of the previous deaths, one was self-inflicted, six were from natural causes, three were drug-related and one was a homicide. There have been two deaths since, both self-inflicted. There were no similarities between the findings in Mr Thomas's case and the previous deaths.

Assessment, Care in Custody and Teamwork

33. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Managing prisoners at risk to self, to others and from others (Safer Custody)*.

Key Events

34. On 15 April 2019, Mr Saul Thomas was remanded in prison custody, charged with wounding (against a family member), possession of an offensive weapon and aggravated vehicle taking, and sent to HMP Birmingham. This was his first time in prison.

HMP Birmingham

35. Mr Thomas arrived at Birmingham around 6.35pm. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose), court staff recorded that Mr Thomas had drug-induced paranoia, used cocaine and had asthma.
36. A nurse completed Mr Thomas's initial health screen. She noted Mr Thomas had no issues relating to drugs and alcohol, that he had no suicidal thoughts and was prescribed diazepam for anxiety. The reception doctor, prescribed Mr Thomas medication for asthma (salbutamol) and a one-off dose of diazepam.
37. At 8.28pm, an officer recorded in Mr Thomas's prison record that another officer had completed Mr Thomas's reception screening. She noted that Mr Thomas had declined a reception telephone call and said he had 'no detox or self-harm issues'. A First Line Manager (FLM) completed Mr Thomas's cell sharing risk assessment (CSRA) and recorded that he had seen the PER that arrived with Mr Thomas. Mr Thomas told the FLM that he had no thoughts of suicide or self-harm. A nurse noted on the CSRA that there were no factors that increased Mr Thomas's risk and against the question 'available medical records have been accessed', marked 'No'. Mr Thomas was assessed as a standard risk.
38. Mr Thomas declined to attend his secondary healthscreen on 16 April. That afternoon, an officer completed Mr Thomas's basic custody screening (BCS1) and noted that Mr Thomas had no concerns, no thoughts of suicide or self-harm, and no issues linked to drug use or his mental health. A FLM authorised the CSRA as standard risk.
39. On 24 April, a probation worker, completed Mr Thomas's pathways assessment (BCS2 - areas linked to preventing re-offending such as accommodation, education, training and employment, health, drugs and alcohol, finance, benefit and debt, children and families, attitudes, thinking and behaviour). She sent an email to the mental health team saying, 'Saul explained that since arriving in custody his anxiety has been 'okay' but would like to be referred to mental health to discuss his anxiety.'
40. The next day, a nurse completed an initial mental health assessment. The nurse noted that Mr Thomas was worried about his partner and child, and that he was anxious but had no thoughts of suicide or self-harm. The nurse referred Mr Thomas to the prison GP, to consider a low dose antidepressant. The prison GP prescribed a one-off medication to reduce Mr Thomas's anxiety (promethazine hydrochloride).

41. On 28 April, a nurse reassessed Mr Thomas after wing staff and his cellmate had noticed he was hypervigilant and his mental health appeared to have deteriorated. The nurse said that Mr Thomas was anxious, guarded and thought people were after him. Mr Thomas said he felt on edge, that he felt paranoid and had not been attending work as a wing cleaner because he preferred to stay in his cell. The nurse noted that Mr Thomas disclosed he had been using cocaine since his mother's death in 2016, and recently had become paranoid. He had referred himself to the community crisis team a few days before he had entered custody. Mr Thomas said he had no thoughts of suicide or self-harm.
42. The nurse diagnosed paranoia. She booked an appointment with the prison doctor for 1 May, and contacted Rugby Crisis Team for more information about their recent contact with Mr Thomas. The nurse noted on the CSRA form, 'Awaiting information regarding mental health history. His current presentation warrants single cell status at this time.' Mr Thomas's prison record was also updated to show that he was a high risk CSRA. Mr Thomas was moved to a single cell.
43. On 1 May, the nurse met with Mr Thomas to review his mental health. She noted that he had poor personal hygiene and appeared reluctant to leave his cell to shower, only leaving to collect his meals. Mr Thomas spoke of people bugging his electronic equipment, that his partner was involved in plans to harm him and that he had been followed into prison. He was unable to give any detail about the threats to harm him and said they were anonymous. Mr Thomas asked to move to the vulnerable prisoner unit for additional protection, but when the process was explained to him, he changed his mind. The nurse noted that Mr Thomas had no auditory or visual hallucinations, but that his thought process indicated paranoid and delusional thinking.
44. On 2 May, a forensic psychiatrist, and three doctors from the mental health team tried to assess Mr Thomas, but the wing officer refused to let them see him. The forensic psychiatrist noted that the officer told them that Mr Thomas was behind his door for his own protection because of trouble that had followed him from outside, and she was not willing to let him come out and talk to them due to risk issues. The forensic psychiatrist noted that to complete a full assessment of Mr Thomas, he should be moved to the mental health inpatient unit (Ward 2) on 6 May. Over the weekend the mental health team completed daily welfare checks.
45. On 6 May at around 3.30pm, Mr Thomas was moved to Ward 2. A nurse noted that Mr Thomas was quite tearful as 'everyone on the ward was being so nice to him'. Mr Thomas appeared to settle, had his meal and watched the television. Over the next few days, the mental health team continued to monitor Mr Thomas's mental health. They noted that he was always polite and complied with the regime on the ward. Despite Mr Thomas saying that he was very anxious and felt paranoid, staff did not observe any obvious signs of distress or paranoia. When discussing his feelings with staff, Mr Thomas recognised that his excessive use of cocaine may have affected his mental health.
46. On 11 May, Mr Thomas handed a note to a nurse addressed to his partner. Mr Thomas asked for the note to be kept on his file in case something should happen to him. Mr Thomas wrote, 'If this letter finds you then my time is up. I

know I've done some wrong things but please know that I love you so much and I'm so, so, sorry for everything. Please tell [next of kin's name] every day how much I absolutely loved her and I'm so sorry.' The nurse told the investigator that she had glanced at the note and placed it with Mr Thomas's prison records. She said she did not consider that there was an increase in the risk Mr Thomas presented to himself, as he was concerned about being harmed by other people. At 7.19pm, a nurse noted in Mr Thomas's medical record that she was aware that he had handed a letter to staff for his partner. She noted that Mr Thomas maintained he did not feel safe because he thought someone would hurt him and that he appeared anxious and shaky when approached.

47. The next day, a nurse noted in Mr Thomas's medical record that he was presenting as anxious and paranoid. He appeared shaky when he attended the medication hatch. He had asked to speak to a nurse and an officer and told them he thought someone was going to harm him. The nurse noted that Mr Thomas had used the telephone, and had showed no signs of nerves or tension when other prisoners were walking around him on their way to use the wing computer. She noted that Mr Thomas became tearful when talking about his daughter and said he really wanted to see her again. He was given reassurance, encouraged to speak to staff when things were tough and told that he would see the psychiatrist on 14 May. There is no information in Mr Thomas's prison record about the letter or the subsequent conversation.
48. On 13 May, Mr Thomas told a nurse that he still felt anxious and paranoid. The nurse noted, however, that Mr Thomas's body language and general demeanour did not reflect that. The nurse noted that Mr Thomas spoke about his trial and possible sentence. Later, a nurse recorded that throughout the afternoon, Mr Thomas had expressed paranoid thoughts about someone harming him in his cell and had required constant reassurance that no harm would come to him. The nurse also noted that he had asked her how he could avoid having to go to court, which gave the impression that avoiding court was his aim.
49. The next day, Mr Thomas told a nurse that the pamphlets he had read on anxiety were not useful. Mr Thomas asked her whether making himself unconscious would help. Mr Thomas then stuck a note on his door which said, 'I don't deserve to be murdered, I have a young daughter.' The nurse noted that the prison doctor had spoken to Mr Thomas about events leading to his arrest and that he had been assessed as fit to attend court on 16 May. There is no entry on the medical record by the doctor.
50. On 15 May, Mr Thomas told the nurse that he still felt anxious and that he was going to be killed. The nurse noted that Mr Thomas's behaviour was changeable, as he could appear anxious as he kept peering out of his cell, but at other times was relaxed on his bed. That evening, a nurse completed Mr Thomas's PER for his court appearance the next day.
51. On 16 May at 6.36am, a nurse noted in Mr Thomas's medical record that he was chatting to an officer at his hatch and had asked if he was going to die, although did not show signs of distress or panic. There is no information recorded on Mr Thomas's prison record. Although Mr Thomas said he had not slept all night, the

nurse noted that he had been asleep when checked between 11.30pm and 6.00am.

52. At 8.20am, Mr Thomas left Birmingham for his court appearance at Leamington Crown Court.

HMP Hewell

53. Mr Thomas arrived at HMP Hewell at 5.48pm on 16 May after his court appearance. On his PER from Birmingham, a nurse had noted that Mr Thomas had health issues and that his mental health was under investigation. There was no record on the PER that Mr Thomas had asthma or that he had been on the mental health ward at Birmingham because of his paranoia about being under threat.
54. A nurse completed Mr Thomas's initial health screen. (She updated his medical record at 7.34pm. She told the investigator that the assessment took place earlier, but the electronic medical record system was not working at the time.) The nurse noted Mr Thomas had no issues with alcohol or drugs, and no thoughts of suicide or self-harm. She noted that he was under the mental health team at Birmingham and queried whether this was linked to his single cell status. The nurse recorded that she had not reviewed Mr Thomas's medical record. Mr Thomas was taken to Houseblock 3, the induction wing.
55. The same evening, a nurse at Birmingham noted in Mr Thomas's medical record that she had contacted reception on several occasions to check if Mr Thomas had returned to Birmingham, but was told he was still at court.
56. An officer recorded on a new CSRA form that Mr Thomas 'states no thoughts of s/h [self-harm] or suicide. States under threat but doesn't have any names & doesn't know why'. Another unidentified person wrote on the form 'Tx [transferred] via Birmingham prison. Current cell share medical high risk.' The officer did not answer the question on the CSRA asking whether healthcare had assessed Mr Thomas as increased risk. The officer assessed Mr Thomas was a standard risk and his prison record was updated. A nurse marked the CSRA healthcare assessment that there were no factors that increased Mr Thomas's risk. She recorded that she had not accessed the available medical records and in the comments section wrote 'DR' [doctor].
57. At 8.48pm, an officer completed Mr Thomas's first night interview. The officer noted that Mr Thomas said he was 'a little nervous due to his paranoia', but had no concerns. The next day at 10.08am, an officer noted on Mr Thomas's prison record that she had completed the third day of Mr Thomas's induction. This was the last entry in his prison record before he died.
58. A prisoner told the investigator that he arrived in reception with Mr Thomas, who told him he thought he was going to have trouble from other prisoners. He said he reassured Mr Thomas that arriving at a new prison always creates anxiety and that they would look out for each other. He said that he spoke to Mr Thomas several times on the wing and he never had the impression that Mr Thomas was depressed and said that he appeared to get on well with the other prisoners on his landing.

59. On 17 May, an administrator in the safer custody team, completed the second day CSRA assessment. She authorised that Mr Thomas was standard risk.
60. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to the calls Mr Thomas made between 16 May and 18 May, when he made his last call. He made eight calls totalling over 26 minutes, to his partner, next of kin and several friends.
61. At 11.09am, Mr Thomas telephoned a friend and said that he was 'not good... it's as dodgy as hell in here ... I don't know if I will make it out'. His friend reassured him that details of Mr Thomas's offence had not been in the paper and that nobody knew he was in prison. He told Mr Thomas that he sounded better than when they had last spoken. Mr Thomas then spoke to his cousin for just over two minutes around 11.30am. They spoke about arranging to have some clothing sent in and a visit.
62. At 11.33am, a nurse at Birmingham sent an email to a consultant psychiatrist at Birmingham, saying that Mr Thomas had not returned to Birmingham from court. She said, 'I did not have any concerns about him when he left the ward. Is there anything you would like me to do for him?' The consultant psychiatrist responded at 12.46am, saying, 'Can you please make sure that mental health in-reach at HMP Hewell are aware of him and that he was being assessed on the ward due to his paranoia?' There is no evidence of any formal handover between healthcare teams at Birmingham and Hewell.
63. At 4.21pm, Mr Thomas phoned another friend and said he had moved to Hewell. He said he was waiting for a psychiatric assessment and the prison were assessing his mental health linked to his drug use. They chatted for just over four minutes and Mr Thomas ended the call laughing and joking with his friend about football. At 4.42pm, Mr Thomas left a voicemail message for another friend and said that he missed him and would call him back.
64. Mr Thomas made two telephone calls to his partner. The first was made at 4.44pm and lasted for just over six minutes. Mr Thomas told his partner that he missed her and their daughter. She asked why he was telling everyone that she was behind a plot to kill him. Mr Thomas said he was not well, that he had seen the mental health team at Birmingham and was waiting to see a doctor at Hewell. He said he did not think he would get out and that prison was scary. He kept apologising to his partner and said that he had made mistakes that he deeply regretted but that he would never hurt her or their daughter. Mr Thomas's partner reassured him and said that he had mental health issues. Mr Thomas repeated that he did not think he would get out of prison.
65. Mr Thomas made a second phone call at 5.13pm, which lasted just over five minutes. Mr Thomas's partner reassured him that she knew he was mentally ill and he told her that he would not stop calling to apologise to her. Mr Thomas said he was frightened, that he was just calling to say goodbye and that he will miss his family. Mr Thomas's partner reassured him that he will get professional help. Mr Thomas said that he hoped it would be quick when 'they do it [kill him]'. His partner encouraged him to speak to someone. Mr Thomas said he was

frightened he would not be around in a week. He then said a prisoner had walked past him while he was on the phone with a chair with his postcode written on it. Mr Thomas told his partner that he was scared and that he loved her.

66. On 18 May at 8.57am, Mr Thomas phoned his partner and they spoke for nearly four minutes. He told her that he was much better, and she asked if he had taken his medication. Mr Thomas then told her that another chair was being carried past with his postcode on it and that he did not think he would be alright. Mr Thomas told his partner that he loved her and would miss her if anything happened to him. Mr Thomas's partner reassured him and told him that nobody would kill him. This was the last call he made.
67. An officer told the investigator that prisoners were unlocked for most of the day. She said Mr Thomas came out of his cell when unlocked and spent most of the day chatting with other prisoners on the landing. She said she spoke to Mr Thomas and had no concerns about him.
68. A prison Insider (an Insider assists other prisoners with prison issues and making applications) told the investigator that he spoke to Mr Thomas several times while he was at Hewell and described him as nervous and stressed and appeared paranoid. He said Mr Thomas told him that he feared being attacked by other prisoners, but gave no details. He said he tried to reassure Mr Thomas and offered to help him if he needed it.
69. The prison Insider said that during association time, he had asked Mr Thomas if he had seen the doctor as he thought he needed help with his mental health issues. Mr Thomas completed an application form with his help asking to see the GP. Mr Thomas wrote, 'See GP for asthma medication and mental health.' This application was not processed before Mr Thomas died. He said he spent about 40 minutes with Mr Thomas, who left his cell in a good mood. However, he said Mr Thomas returned about 10 minutes later and said he was stressed. He said he made Mr Thomas a cup of tea, reassured him that he would be seen by the prison doctor and assessed by the mental health team. He said he asked Mr Thomas directly if he felt suicidal, but he assured him that he did not.
70. At around 5.00pm, an officer locked Mr Thomas in his cell. Mr Thomas was watching his television (FA Cup football match) and he asked her if he would be getting a cellmate. The officer told him that he would not get a cellmate as he was a high risk for cell sharing. The officer said she did not check Mr Thomas's record as Mr Thomas was high risk when he arrived on the houseblock as she remembered reading the front of his CSRA form which said 'medical high risk'. The officer said she thought nothing of Mr Thomas's question as prisoners on the induction unit often asked if they would be sharing a cell and often wanted to be in a cell on their own.
71. An officer started his night shift at around 8.45pm and he completed a welfare check at 9.02pm. Closed circuit television (CCTV) shows the officer went to Mr Thomas's cell at around 10.21pm and 18 seconds later he walked away (the timings on the CCTV are around 15 minutes slow; we have used actual time in this report). He returned to Mr Thomas's cell at 10.23pm and stayed there for just under a minute before walking away. The officer said that he responded to Mr Thomas pressing his emergency cell bell and that when he got there the first

time Mr Thomas showed him some pictures and asked the officer if he liked them and the second time asked him what was on the television. The officer said that he did not think Mr Thomas was being difficult and that he did not think his behaviour was unusual as he got asked lots of different questions during a night shift.

72. Prisoners on the houseblock told the investigator on her initial visit that they heard Mr Thomas asking for a Listener (prisoners trained by Samaritans to support other prisoners). A prisoner said he could not hear what was being said but heard an observation flap being slammed by an officer who sounded 'like someone's a bit pissed off'. The officer said Mr Thomas did not ask for a Listener and that he did not raise his voice.

Sunday 19 May

73. At 4.45pm, the officer completed his welfare check and roll count. He said that when he looked through Mr Thomas's observation panel, he was sitting on his bed. The officer said he did not speak to Mr Thomas and said that he looked like he had just got out of bed.
74. At around 8.57am two officers started to unlock prisoners on Houseblock 3. CCTV shows an officer looked through the observation panel of Mr Thomas's cell, shouted to the other officer and radioed an emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties). An officer immediately entered Mr Thomas's cell.
75. Mr Thomas was hanging by a towel attached to the toilet door. Prisoners who had already been unlocked and were close by shouted to staff for help. An officer used her anti-ligature knife to try to cut through the towel, while the other officer and a prisoner supported Mr Thomas's weight. Because the towel was so thick, the officer struggled to cut the ligature and other prisoners who assisted in supporting Mr Thomas's weight used the knife to cut the ligature. Mr Thomas was placed on the floor and an officer started cardiopulmonary resuscitation (CPR).
76. A Supervising Officer (SO) and a Custodial Manager (CM) responded to the emergency code, along with a nurse who was already on the houseblock dispensing medications. The nurse arrived at Mr Thomas's cell at 8.59am, shortly followed by a prison paramedic. The automatic defibrillator, which had been taken to the cell did not have the correct equipment (missing pads). The healthcare manager collected another defibrillator from an adjacent wing. The defibrillator indicated that Mr Thomas had no shockable rhythm but staff continued CPR until paramedics arrived. All staff that responded to the emergency described Mr Thomas as cold, grey in colour and that his body was stiff.
77. West Midlands Ambulance Service records show they received a request for an ambulance at 8.59am. When paramedics arrived at 9.09am, they assessed Mr Thomas and at 9.24am they declared that he had died. Paramedics noted that rigor mortis was present in his jaw, that Mr Thomas's neck appeared to be broken and that he had bruising around his neck from the ligature.

Contact with Mr Thomas's next of kin

78. The prison appointed a member of staff as the family liaison officer (FLO) and another staff member as her deputy. The FLO, the deputy governor, and the prison chaplain, travelled to Mr Thomas's partner's address to break the news of his death in person, but she was not there. They tried to contact Mr Thomas's partner, but when they were unable to, travelled to his step-father's address and broke the news to his family. On their return journey, Mr Thomas's partner contacted them by telephone and they told her of his death at around 3.20pm. The prison provided ongoing support and contributed towards the costs of Mr Thomas's funeral, which was held on 6 June, in line with national policy.

Support for prisoners and staff

79. The duty governor spoke to prison staff directly involved when Mr Thomas was discovered and healthcare staff were supported by their healthcare provider. Most staff said they felt support could have been better. After our initial investigation report was published, during the consultation period, the prison provided evidence to the investigator that a hot debrief had been held with all those involved in the emergency response.
80. The prison posted notices informing other prisoners of Mr Thomas's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Thomas's death.

Post-mortem report

81. The pathologist concluded that Mr Thomas died from hanging. The toxicology report noted risperidone (an antipsychotic drug) was detected in blood and urine, but below limits which suggested prior use. Mr Thomas was not prescribed risperidone during this time in custody and there is no evidence from medical records that he was previously prescribed this medication. The half-life of risperidone is 3-6 days (the time it takes for the liver to metabolise a substance). Given the relatively short half-life of this drug, Mr Thomas would have taken this drug in custody.

Findings

Assessment of Mr Thomas's risk of suicide and self-harm

HMP Birmingham

Reception procedures

82. We are concerned that when Mr Thomas arrived at Birmingham on 15 April 2019, reception staff failed to properly consider the information that arrived with him and therefore failed to properly assess his risk of suicide and self-harm.
83. Prison Service Instruction (PSI) 07/2015, *Early Days in Custody*, says that all prisoners should be risk assessed for potential harm to themselves, to others and from others and that prisoners assessed as at risk of suicide and self-harm should have support identified and managed. It says that the PER and any other available documentation must be examined in reception to assess the risk of self-harm or harm to others by the prisoner, or harm from others. It also says that all newly arrived prisoners must be assessed as part of the reception health screen process to assess whether they are at risk of suicide or self-harm.
84. A nurse told the investigator that she did not look at Mr Thomas's PER, which contained relevant information about his mental health and recent drug use. She incorrectly recorded on Mr Thomas's medical record that he had no history of drug use. The nurse said that although PERs were available to healthcare staff when prisoners arrived, they were routinely not considered. We find this very worrying and we make the following recommendation:

The Head of Healthcare at Birmingham should ensure that staff conducting the reception health screen always examine and consider the Person Escort Record that arrives with the prisoner, to assess whether the prisoner has any risk factors for suicide and self-harm.

Considering risk factors

85. Mr Thomas told staff at Birmingham on numerous occasions that he thought people were going to harm him. On 11 May, Mr Thomas gave a note, addressed to his partner, to a nurse, in case something happened to him. The nurse told the investigator that she only glanced at the note and did not read it. We consider that the nurse should have read the note and considered whether its contents indicated that Mr Thomas was at risk of suicide and self-harm. The nurse told the investigator that Mr Thomas always told her that he had no thoughts of self-harm and his thoughts were only about other people hurting him. Nevertheless, we consider that the nurse should have considered the contents of the letter and recorded her decision on whether ACCT procedures should be started. Other staff were also aware of this letter but nobody submitted an intelligence report or discussed the contents of the letter with a senior member of staff.
86. Healthcare staff told the investigator they were not familiar with some of the factors that might increase a prisoner's risk of suicide and self-harm, such as first time in custody, offence against a family member and substance misuse (all of

which applied to Mr Thomas); they said they did not want such information to affect their clinical judgement.

87. The healthcare manager (explained that the early learning review undertaken by the prison after Mr Thomas's death had highlighted that healthcare staff had not been required to complete the full six modules of suicide and self-harm awareness (SASH) training. G4S, who were responsible for managing Birmingham at the time, only required them to complete Module 3 as part of their induction and some staff also completed Module 6 (mental health awareness). She said all healthcare staff are now required to complete all six modules and that training was due to start at the end of July 2019.

88. We make the following recommendation:

The Head of Healthcare at Birmingham should ensure that all healthcare staff:

- **receive full SASH awareness training;**
- **have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm and share relevant information about risk; and**
- **document the risk information considered and the reasons for a decision not to start ACCT procedures.**

HMP Hewell

Reception procedures - Person Escort Record (PER)

89. The PER completed on 15 May by a nurse at Birmingham, for Mr Thomas's court appearance on 16 May, said Mr Thomas's mental health was 'under investigation'. It did not mention that he had been on the mental health ward at Birmingham because of his paranoia about being harmed by others, or his asthma. The investigator was told that PER forms were routinely completed without setting out specific information about a prisoner's medical issues because of 'medical in confidence'. We find this unacceptable as the lack of information could place a prisoner and staff at risk.

90. Reception staff at Hewell reviewed the PER that arrived with Mr Thomas but key information about his mental health was missing. This meant it was not properly considered when assessing Mr Thomas's risk of suicide and self-harm.

91. The healthcare manager at Birmingham, told the investigator that because Birmingham had moved from the public (HMPPS) to the private sector (G4S), 'there had been an eroding of clear understanding amongst staff about what should be recorded'. She said it was unacceptable not to record crucial medical information as it was in the prisoner's interest.

92. She provided evidence that she had produced new guidance notes which had been sent to all healthcare staff and the safer custody team, which were to be implemented with immediate effect. The new guidance state that PER forms should be completed on the day of travel (if appearing in court) by the night nurse,

that they must include relevant and specific information about a prisoner's physical and mental health and that the PER will be checked by the reception nurse prior to the prisoner leaving the establishment.

93. Given the swift response from Birmingham in reviewing the process for completing the PER forms, we do not make a recommendation.

Reception procedures – accessing medical record

94. A nurse told the investigator that the electronic medical record system was not working when Mr Thomas arrived at Hewell. The contingency plan was for healthcare staff to contact a nurse on the other Hewell site (The Grange) who could access the electronic medical record there. The nurse did not contact a nurse at The Grange and said she relied on Mr Thomas's presentation and responses to her questions during the reception screening. As a result, crucial information about Mr Thomas's mental health, contained in his medical record, was not identified. We make the following recommendation:

The Head of Healthcare at Hewell should ensure that medical records are always accessed, along with any other evidence that arrives with a prisoner, during the reception process and that healthcare staff follow the agreed contingency plans if the electronic medical record system is not available.

Reception procedures - Cell Sharing Risk Assessment (CSRA)

95. PSI 20/2015, *Cell Sharing Risk Assessment*, sets out the process for risk assessing prisoners for their potential to murder or violently assault a cellmate. Prisoners who are assessed as 'high risk' are subject to restrictions on cell sharing.
96. On 28 April at Birmingham, a nurse reviewed Mr Thomas's CSRA and noted that he was high risk while his mental health was being assessed. Mr Thomas's prison record was updated to show his CSRA had changed. When Mr Thomas arrived at Hewell on 16 May, staff completed a new CSRA. An officer and a nurse both noted Mr Thomas was standard risk, despite having access to the previous CSRA form.
97. The officer told the investigator that the prison assessment of risk indicated Mr Thomas was a standard risk and it would have been up to healthcare to increase the risk if there were specific medical reasons. The nurse said that she ticked 'no increased risk' on the form, as nothing had changed from the previous CSRA. Mr Thomas's prison record was updated on 16 May, to show that he was a standard CSRA, with no explanation for the change.
98. We found that information from the previous CSRA assessment at Birmingham was not properly considered or explored by either an officer or the nurse. The decision to revert to standard risk was not adequately documented and there was a missed opportunity to identify that Mr Thomas had struggled with his mental health at Birmingham. We therefore make the following recommendation:

The Governor and Head of Healthcare at Hewell should produce clear guidance to prison and healthcare staff completing reception assessments

to ensure all available information is considered and decisions are evidenced and recorded on the CSRA.

Induction

99. Mr Thomas had his first night interview around three hours after he arrived at Hewell. An officer noted that Mr Thomas was nervous, but there is no evidence he considered any other information to inform his assessment, other than what Mr Thomas told him. The next day, an officer recorded she had completed his third day of induction, which was clearly an error. We found no evidence that Mr Thomas had a full, comprehensive induction at Hewell. We therefore make the following recommendation:

The Governor at Hewell should ensure that every prisoner receives a full induction.

Clinical care

100. PSO 3050, *Continuity of healthcare*, says that ensuring continuity of care and effective communication with colleagues is essential to patient care and thus central to good practice. It says that patients with more complex healthcare needs may require more detailed planning, such as communicating directly with the receiving healthcare team in advance of transfer. While Birmingham did not know for certain that Mr Thomas was not returning to them from court, they should have made more proactive attempts to contact Hewell to provide a handover. Hewell should have accessed Mr Thomas's medical records when he arrived in reception, but did not. The clinical reviewer concluded that the healthcare Mr Thomas received at both prisons, was not equivalent to that which he could have expected to receive in the community.

Mental health

HMP Birmingham

101. On 2 May, prison psychiatrists went to Mr Thomas's cell to assess his mental health, but were prevented from doing so as the officer refused to unlock him because of the apparent risk he posed. There is no documented evidence of this visit on Mr Thomas's prison record, no record of what informed this assessment of risk and no evidence that the officer sought advice from the wing manager or considered an alternative. Denying access to crucial mental health assessments is unacceptable.
102. When Mr Thomas experienced increased paranoia at Birmingham and he was moved to Ward 2 for further review and assessment on 6 May. However, the clinical reviewer found no evidence of any formal assessment and the initial 72-hour care plan was not reviewed or updated. The mental health service manager at Birmingham, told the clinical reviewer that Mr Thomas was not assessed during the multidisciplinary ward review on 7 or 14 May, which meant there was no completion of a risk assessment or formal weekly review.
103. Although attempts were made by Birmingham to contact Hewell on 16 May, there is no evidence that there was any formal handover, and there is no evidence that Birmingham attempted to contact the duty governor when they were unable to

speak to healthcare colleagues at Hewell. There was no handover of care from Birmingham to Hewell. We make the following recommendation:

The Head of Healthcare at Birmingham should ensure that there is a formal handover of care when a prisoner is moved from the mental health inpatient unit.

Substance misuse

104. Mr Thomas arrived at Birmingham with a risk indicator that he had experienced drug induced paranoia because of cocaine use. A nurse incorrectly recorded during Mr Thomas's initial health screen that he had no issues with drug use and she did not refer him to substance misuse services. We make the following recommendation:

The Head of Healthcare at Birmingham should ensure that all prisoners who are identified as having issues with substance misuse are referred for further assessment and support.

Self-Seclusion Strategy and prison records

105. Birmingham did not follow its own Self-Seclusion Strategy (Isolated Prisoners), revised in January 2019, when Mr Thomas began self-isolating. The strategy says prisoners identified as self-isolating should be referred to safer custody (and noted on prison record alerts), investigated and supported under a Challenge, Support and Intervention Plan (CSIP). There should also be daily entries in the wing diary and a weekly summary on the prison record.
106. Mr Thomas was identified as a self-isolator on 28 April, and was moved to the mental health inpatient unit on 6 May. Although there were notes in his medical record about his self-isolation, this information was not recorded on his prison record. There were no entries at all in Mr Thomas's prison record at Birmingham after 6 May.
107. The healthcare manager told the clinical reviewer that healthcare staff's access to prison computers had been limited under G4S because of two different operating systems, but that now HMPPS had taken over management of the prison, new computers would enable greater access. Healthcare staff have been provided with clear details on how to complete PNOMIS (prison electronic record) e-learning.
108. While we acknowledge the difficulties faced by healthcare staff accessing the prison computers, prison staff also work in the healthcare unit and should have ensured information was properly recorded in Mr Thomas's prison record. We therefore make the following recommendation:

The Governor and Head of Healthcare at Birmingham should ensure prisoners who self-isolate are managed in accordance with the prison's strategy and that staff update their prison record.

Emergency Response

Resuscitation

109. In September 2016, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons and Immigration Removal Centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 which state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile.”
110. Ambulance paramedics recorded there were obvious signs of death when they assessed Mr Thomas. He had no circulation, was cold to the touch and had signs of rigor mortis and a broken neck, all indicators that he had been dead for some time. When interviewed, not all prison and nursing staff were aware of the guidance on when not to perform CPR. The prison paramedic, said that he was aware of the guidelines and that he and a nurse did consider the appropriateness of continuing CPR, but that they wanted to give Mr Thomas every opportunity for survival and waited for a second opinion from the ambulance paramedics.
111. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they should not carry out CPR where it would be futile. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We therefore make the following recommendation:

The Governor and Head of Healthcare at Hewell should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Management of incident

112. CCTV footage shows prisoners remained on the landing and were able to move around freely, often close to Mr Thomas’s cell, for around 18 minutes after the code blue was called. There appeared to be no coordinated response by staff to clear the landing or ensure prisoners were kept away from area near Mr Thomas’s cell. A SO and a CM, who was the operational manager, both assisted staff with the resuscitation attempt. While we acknowledge they were focused on Mr Thomas, someone should have taken responsibility for managing the incident. We therefore make the following recommendation:

The Governor at Hewell should ensure operational managers are familiar with local contingency plans after a death in custody and that they ensure the immediate area is cleared of all but essential staff and the integrity of the scene is preserved.

Staff support

113. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or, indeed, good practice). It also provides those directly involved with an opportunity to process events.
114. Although a debrief was held after Mr Thomas's death, healthcare staff said during interview that they did not attend a debrief and the post-incident care team only contacted prison staff. Prison and healthcare staff said that they felt support could have been better and having the opportunity on the day to discuss Mr Thomas's death would have been beneficial. However, after the publication of our initial investigation report, during the consultation period when all stakeholders have the opportunity to comment on the factual accuracy of the report, Hewell provided a copy of the debrief notes to the investigator, via the Safer Custody Casework Team, to evidence that all staff involved attended a debrief.
115. Officers who discovered Mr Thomas were spoken to by the duty governor, shortly after Mr Thomas had been discovered and were allowed to go home. However, healthcare staff remained on duty and were not given this option. A prison manager spoke to healthcare staff later that evening, but the officers who discovered Mr Thomas were not present. A critical debrief was facilitated by an external support provider on 28 May, which was attended by two officers and a nurse, all of who said this was helpful, but that it was too far removed from the day.
116. PSI 09/2014, *Incident Management Manual*, sets out that there should be a debrief for all staff involved in the emergency response. As Hewell have now provided evidence that a debrief was attended by all those involved, we do not make a recommendation.

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