Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Saifur Rahman, a prisoner at HMP Birmingham, on 23 January 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

Our Vision

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

Our Values

We are:

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

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

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 Saifur Rahman died in hospital as a result of a brain injury caused by a lack of oxygen to the brain on 23 January 2021, three days after he was found hanging in his cell at HMP Birmingham. He was 39 years old. I offer my condolences to his family and friends.

Mr Rahman displayed difficult and challenging behaviour while in prison but did not give any indication to staff that he was at risk of suicide or self-harm. I am satisfied that staff could not have foreseen or prevented his death.

The clinical review into Mr Rahman's death identified several areas for improvement. Mental health staff did not conduct a mental capacity assessment when he refused medication or provide appropriate therapeutic intervention. The clinical reviewer considered that they placed too great an emphasis on Mr Rahman's compliance with medication when deciding whether to refer him to a secure psychiatric hospital.

Mr Rahman had spent 11 days in the cell in which he was found hanging. The cell had been out of commission for several years after a prisoner had damaged it but it was reinstated in June 2020. Although staff had identified that a wall-mounted mirror was needed to allow staff to see into the bathroom area and that a glass observation window was damaged, neither issue was addressed. I am also concerned that despite numerous requests, the prison failed to provide the investigator with several documents of significance to this aspect of the investigation.

There was a 13-minute delay in entering the cell while prison staff changed into personal protective equipment, which was in line with Mr Rahman's unlock requirement. I am satisfied that, given Mr Rahman's recent violent behaviour and the fact that he had not presented as at risk of suicide, they acted appropriately when deciding how to enter the cell. However, I am concerned that there was a short delay calling a medical emergency medical code.

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 **June 2022**

Contents

Summary

Events

1. On 16 November 2020, Mr Saifur Rahman was remanded to HMP Birmingham, charged with assault. He had a history of substance misuse and was referred to the mental health team after displaying unpredictable behaviour.

2. On 24 November, healthcare staff admitted Mr Rahman to the prison's inpatient mental health unit for assessment. They reviewed him frequently and a psychiatrist prescribed medication, including an antipsychotic, to treat mania.

3. On 7 January 2021, a psychiatrist changed Mr Rahman's antipsychotic and noted that he would consider a secure psychiatric hospital referral if Mr Rahman continued to refuse medication. On 12 January, the same psychiatrist reviewed Mr Rahman and decided not to refer him to a secure hospital as his medication compliance had improved.

4. On 16 January, a custodial manager (CM) increased Mr Rahman's cell unlock requirement to three officers after he assaulted staff. Later that day, Mr Rahman assaulted the CM and his unlock requirement was increased to a CM and three officers in personal protective equipment (PPE).

5. At 5.01pm on 20 January, two officers and a nurse went to Mr Rahman's cell to give him his medication but were unable to see him or get a verbal response. A CM attended and, at 5.03pm, she instructed officers to change into PPE. At 5.13pm, she led officers into the cell and they saw Mr Rahman hanging by a ligature. An officer unhooked the ligature and the CM radioed for oxygen, before starting cardiopulmonary resuscitation (CPR). At 5.15pm, an officer radioed a medical emergency code.

6. At 5.23pm, healthcare staff arrived at the cell and saw that oxygen was being administered and that a CM was conducting CPR. Paramedics took over resuscitation efforts at 5.30pm, and at 5.41pm, they confirmed that Mr Rahman had a faint pulse and took him to hospital.

7. At 1.04am on 23 January, hospital doctors pronounced that Mr Rahman had died.

Findings

8. Mr Rahman gave no indication to staff that he was at risk of suicide or self-harm. Although he often displayed challenging and unpredictable behaviour, he did not display any behaviour that might have indicated an increased risk of suicide. We are satisfied that staff could not reasonably have foreseen or prevented his actions.

9. The clinical reviewer considered that she was unable to draw a meaningful comparison on whether the care Mr Rahman received at Birmingham was equivalent to that which he could have expected in the community due to the unique circumstances that his location on the prison's mental health inpatient unit presented. However, she did identify several areas for improvement; Therapeutic intervention was minimal, staff failed to conduct a mental capacity

assessment when he refused his medication, and record keeping needed improvement. She also considered that healthcare staff placed too great an emphasis on Mr Rahman's compliance with medication when deciding whether or not to refer him to a secure psychiatric hospital.

10. We are concerned that Mr Rahman's cell did not have a wall-mounted mirror to enable staff to see into the bathroom and that a ligature risk assessment failed to identify the disused showerhead and the damaged observation window as risks. While we cannot know if Mr Rahman's death could have been prevented if these issues had been addressed, staff may have seen him hanging.

11. Although we are satisfied that there was no evidence to indicate that Mr Rahman was at risk of suicide and that the CM took account of this when deciding to wait until staff could enter the cell in PPE, we are concerned that not all staff were aware that they could enter a cell without meeting the unlock requirement in an emergency situation.

12. We are concerned that the radio available to staff was not used immediately to call a medical emergency code.

13. The prison was unable to provide the PPO with several documents, including documentation about the reinstatement of Mr Rahman's cell and a copy of the living standards database.

Recommendations

- The Head of Healthcare should review the model for delivering therapeutic intervention and ensure that it is available to all prisoners admitted to the inpatient mental health unit.
- The Head of Healthcare should ensure that healthcare staff:
  - receive training about the Mental Capacity Act and its implementation in practice;
  - promptly record actions and decisions about a prisoner's ongoing care in their medical record; and
  - discuss whether to refer a prisoner to a secure psychiatric hospital at multidisciplinary meetings and clearly evidence the reason for the decision.
- The Head of Healthcare should share this report with a consultant psychiatrist, so he is aware of the Ombudsman's findings.
- The Head of Healthcare should review the ligature risk assessment process for the inpatient mental health unit to ensure that all risks are identified.
- The Governor should ensure that each stage of the process is documented when cells are taken out of use, and that a cell is not used until any required modifications have been made.
- The Governor should ensure that damaged observation panels are reported and replaced as soon as possible.
- The Governor should ensure that all evidence relevant to a death in custody is retained and made available to the PPO, in line with PSI 58/2010.

- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that:
  - an emergency medical code is used to communicate effectively the nature of an emergency at the earliest possible opportunity; and
  - appropriate medical emergency equipment, such as a defibrillator, is applied and used promptly.

The Investigation Process

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

15. The investigator obtained copies of relevant extracts from Mr Rahman's prison and medical records.

16. The investigator interviewed 10 members of staff between 29 and 30 April. NHS England commissioned a clinical reviewer to review Mr Rahman's clinical care at the prison. They jointly interviewed healthcare staff. All the interviews were conducted by video link and telephone because of the restrictions in place during the COVID-19 pandemic.

17. We informed HM Senior Coroner for Birmingham and Solihull districts of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Rahman's brother, to explain the investigation and to ask if he had any matters that he wanted us to consider. Mr Rahman's brother asked:

    - why Mr Rahman was located on the healthcare unit;
    - why his mental state changed so rapidly;
    - what his medication was meant to treat;
    - how often staff checked on him;
    - why prison staff did not update his family about his health condition;
    - was he subject to suicide and self-harm monitoring;
    - why his bedsheets were not made from paper;
    - why he moved cells;
    - whether a cell risk assessment was completed; and
    - whether there was evidence that he used drugs in prison?

    We have addressed these concerns in this report and in separate correspondence.

19. Mr Rahman's family received a copy of the initial report. The solicitor representing Mr Rahman's family wrote to us raising a number of concerns that do not impact on the factual accuracy of the report. We have provided clarification by way of separate correspondence to the solicitor.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Birmingham

21. HMP Birmingham is a local prison which holds up to 977 prisoners. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contracts Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit.

HM Inspectorate of Prisons

22. The most recent full inspection of HMP Birmingham was in July/August 2018. Following the inspection, HM Chief Inspector invoked the Urgent Notification process on 16 August, informing the Secretary of State for Justice that there were significant concerns about the conditions and treatment of prisoners at the prison. Inspectors reported that conditions had deteriorated dramatically since the last inspection in February 2017, and that the prison had failed all four healthy prison tests – safety, respect, purposeful activity, and rehabilitation and release planning.

23. In May 2019, HMIP conducted an Independent Review of Progress to follow up the key recommendations of their 2018 inspection. They reported that prison leaders had made progress against many of their recommendations, with significant work done to restore order to the prison.

24. On 1 July 2019, HM Prison and Probation Service took over the management of Birmingham from G4S (who had operated it since 2011).

25. In November 2020 and January 2021, inspectors conducted a Scrutiny Visit, focussing on how the prison was recovering from the COVID-19 pandemic. They reported that the prison had been running a restricted regime for ten months to minimise the spread of COVID-19. This had the potential to affect the well-being of the prisoners. The majority did not receive any regular meaningful contact from staff unless they were in crisis. They were concerned that the gradual deterioration of prisoners could go unnoticed due to the lack of meaningful welfare checks or contact with staff. They found that although prisoner self-harm had reduced in the early stages of the pandemic, incidents had started to rise and acts of serious self-harm had doubled. Inspectors noted that mental health services were effectively led and that waiting times were not long, except for the clinical psychologist.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to June 2020, the IMB reported that although there had been some serious assaults and incidents of violence, overall, the prison was much safer than in previous years. Most of the accommodation was of an acceptable standard and prison staff used a living standards database to track cell damage and repair. The IMB also found that the restricted regime in place due to the COVID-19 pandemic had had a negative

impact on prisoners' mental health and that the number of self-harm incidents had increased.

Previous deaths at HMP Birmingham

27. Mr Rahman was the ninth prisoner to die at Birmingham since January 2019. All the previous deaths were from natural causes and there have been three natural causes deaths since. There were no similarities between the circumstances of Mr Rahman's death and those of the previous investigations.

Key Events

28. On 16 November 2020, Mr Saifur Rahman was remanded into prison custody, charged with assault. Shortly afterwards, court staff phoned HMP Birmingham to alert staff to his unpredictable and aggressive behaviour.

29. At 5.45pm, Mr Rahman arrived at Birmingham. The person escort record (PER) that accompanied him did not indicate any suicide or self-harm risk factors. A nurse conducted an initial health screen and noted that Mr Rahman presented as agitated and talkative. Mr Rahman mostly spoke about the royal family and the nurse requested a mental health review.

30. Later that evening, a mental health nurse conducted a triage assessment and recorded that Mr Rahman presented as very elated and said that he had used alcohol and psychoactive substances (PS) before his arrest. He referred him for a full mental health assessment.

31. On 17 November, a substance misuse recovery worker visited Mr Rahman to complete an initial assessment but he declined and said that he had no issues with drugs or alcohol. She explained the risks of using PS and told him that he could refer himself to the service at any time.

32. On the same day, a community psychiatric nurse conducted a mental health assessment and recorded that Mr Rahman presented as elated and with delusional thoughts. She noted that she was unsure whether he had illicit substances in his system and provisionally accepted him onto her caseload.

33. Over the next few days, Mr Rahman tried to get onto the netting between landings, kept other prisoners awake by shouting and banging at night, spat at an officer, urinated out of his cell door and threatened to kill staff. At a disciplinary hearing on 21 November, a prison manager imposed a punishment of 14 days of cellular confinement. However, the community psychiatric nurse reviewed Mr Rahman and found that he was not fit to be segregated. He was instead admitted to the prison's inpatient mental health unit for observation.

34. On 24 November, a consultant psychiatrist reviewed Mr Rahman. On 26 November, he made an entry in Mr Rahman's medical record and diagnosed mania (a condition that causes a person to experience unreasonable euphoria, intense moods, hyperactivity and delusions). He said that the probable cause was substance misuse. Later that day, he phoned a mental health nurse to tell her that he was going to prescribe Mr Rahman a short course of diazepam (used to treat anxiety) and zopiclone (a sleeping tablet).

35. On 2 December, a nurse reviewed Mr Rahman with a consultant forensic psychiatrist and noted that he presented as manic. The consultant forensic psychiatrist reviewed Mr Rahman's prescription and increased the diazepam, continued the zopiclone and added olanzapine (an antipsychotic).

36. On 8 December, a nurse reviewed Mr Rahman with the consultant forensic psychiatrist and recorded that he appeared slightly irritated. He changed Mr Rahman's antipsychotic to aripiprazole. He also prescribed valproic acid (used to treat bipolar disorder) as Mr Rahman continued to present as elated.

37. Over the next three weeks, prison and mental health staff monitored Mr Rahman frequently and recorded a noticeable improvement in his mood. A member of the chaplaincy also spoke to him during their weekly visits to the unit.

Events from 1 to 19 January 2021

38. On 1 January 2021, a nurse recorded that Mr Rahman had misused his cell bell throughout the afternoon and presented as elated. She also noted that he had declined his medication as he felt it was not helping him sleep.

39. Early on 2 January, an officer noted that Mr Rahman had "pushed the boundaries to the max tonight" and had screamed and shouted, banged his window and cell door and played loud music all night. This had upset the other prisoners in the unit who had been unable to sleep.

40. On 3 January, a nurse noted that Mr Rahman continued to decline his medication. She liaised with a prison GP, who prescribed diazepam to help him comply with his medication.

41. On the same day, Mr Rahman was placed on a disciplinary charge after punching an officer on the chin through the hatch in his cell door and then throwing boiling water at him.

42. On 4 January, the unit manager recorded that Mr Rahman continued to refuse medication and was talking to his TV and banging on his cell door. A CM (custodial manager) made a challenge support intervention plan referral (CSIP, a national case management model for managing those who are violent or pose a raised risk of harming others) and recorded two actions: for Mr Rahman to address his poor attitude and for mental health staff to discuss his presentation with a psychiatrist.

43. On 5 January, the CM conducted a CSIP review and recorded that Mr Rahman continued to display aggressive behaviour towards staff and presented as elated. He scheduled a follow-up review for 12 January and noted that he would ask another CM to conduct the review as he would be on leave. That day, a nurse noted that she had reviewed Mr Rahman with a consultant psychiatrist and that his mood fluctuated.

44. On 6 January, Mr Rahman was placed on a disciplinary charge after writing on the walls of his cell and smashing his television.

45. On 7 January, the consultant psychiatrist noted that he saw Mr Rahman with a nurse and that his mood fluctuated greatly. Mr Rahman told him that he had taken a wide range of illicit drugs, including heroin and crack cocaine, for 20 years. He agreed to change Mr Rahman's antipsychotic to amisulpride and prescribe zopiclone, as Mr Rahman refused to go back on his previous medication and complained of poor sleep. He also noted that he would consider a secure psychiatric hospital referral for an assessment if Mr Rahman continued to refuse medication.

46. On 8 January, staff noted that Mr Rahman said the TV had been giving him messages that his ex-wife had died and the snow that was falling was a message from her. He asked staff if they would tell him if something had happened. He

also said that he had been given tasks to hurt staff by the *Taskmaster* TV show but that he did not want to hurt anyone. He accepted his medication after some encouragement.

47. On 9 January, Mr Rahman was moved into a cell that had previously been used as an isolation cell for prisoners with infectious diseases. It had its own shower in the bathroom area to the right of the door and was situated at the end of the unit, through two double doors. The CM told the investigator that although the cell was no longer used for its original purpose, it was used to locate "more raucous" prisoners who created issues among other prisoners, particularly by making noise at night.

48. On 12 January, a CM and an officer visited Mr Rahman to conduct a CSIP review but he refused to engage. They scheduled a follow-up review for 26 January. Later that day, a nurse, the consultant psychiatrist and a psychiatrist, reviewed Mr Rahman through his cell observation panel. Mr Rahman was keen to return to a standard wing. The nurse noted that his compliance with medication had improved and that the consultant psychiatrist did not plan on making a hospital referral.

49. On 13 January, Mr Rahman was placed on report again after throwing a cup of hot water at an officer.

50. On 14 January, an officer tried to conduct a keywork session, but Mr Rahman was verbally abusive towards him. He noted that Mr Rahman appeared fixated with the fact that his in-cell television did not have a radio and felt that all staff were liars. On 15 January, Mr Rahman threw a cup of cold water at a nurse.

51. On the morning of 16 January, a CM increased Mr Rahman's unlock requirement to three officers in response to the recent assaults on staff. Later that day, a prison manager chaired a disciplinary hearing. The CM escorted Mr Rahman back to his cell afterwards and asked him to remove the paper that he had stuck to the walls. Mr Rahman responded by grabbing the CM's body-worn video camera and hitting him in the face with it, causing a cut to his eyebrow that required steri-strips. Prison staff restrained Mr Rahman so that they could secure him in his cell. During the restraint, an officer fell and broke a wrist.

52. At 9.00am on 17 January, Mr Rahman was placed on report after throwing a cup of cold water at an officer, hitting her on the shoulder and chest. Later that day, the Head of Safer Custody increased Mr Rahman's unlock requirement to Level A, the highest level, meaning that he could only be unlocked by a CM and three officers in full personal protective equipment (PPE) and body-worn video cameras (BWVCs).

53. On 18 January, a prison manager conducted two disciplinary hearings and referred the matters to the police. On the same day, an officer from the safer custody team noted that Mr Rahman's sister had contacted the safer custody hotline and said that she wanted to be his telephone contact instead of his mother as his calls were causing their mother worry. The officer recorded that Mr Rahman was given a PIN phone application form and his sister's number and that he said he would contact his sister. However, there is no record that staff told his sister that this had been done.

54. On 19 January, Mr Rahman poured cold water over an officer. Later that day, the consultant psychiatrist and the psychiatrist reviewed Mr Rahman through his cell observation panel. A nurse recorded afterwards that the consultant psychiatrist, had given them no feedback and was going to discuss Mr Rahman with the psychiatrist. On 21 January (after Mr Rahman had been taken to hospital), the consultant psychiatrist recorded that he had seen Mr Rahman on 19 January, that Mr Rahman had been taking his medication for the last two weeks and said he felt as if his mental health had improved. Mr Rahman said he would like to return to a standard wing where he felt he would have more freedom. The consultant psychiatrist also recorded that he had spoken to nursing staff and that he agreed with them that Mr Rahman's presentation was related to behavioural issues due to maladaptive personality traits rather than mental illness, but that he should remain in the unit.

Events from 20 to 23 January

55. On the morning on 20 January, a prison chaplain visited Mr Rahman. He told us that although Mr Rahman had asked to see him, he refused to engage, said he was fine and did not want to talk any more. He said that Mr Rahman was calm throughout their interaction and that he felt his presentation had improved in comparison to previous weeks. He also said that in the 10 weeks that he had known Mr Rahman, he had not acted in a way that might have indicated he was at risk of suicide or self-harm.

56. At 1.44pm, a mental health nurse and deputy unit manager recorded that Mr Rahman was misusing his cell bell and refused to accept his medication despite encouragement from staff. He also noted that Mr Rahman remained in his cell due to his unlock requirement and that he appeared settled.

57. At 4.25pm, two officers handed Mr Rahman a meal through his cell door hatch.

58. At 5.01pm, BWVC footage shows two officers and a nurse arrive at Mr Rahman's cell to give him his medication. (The timing on the BWVC footage was 14 minutes slow and we have adjusted the timings in this report accordingly.) An officer looked through the observation panel and called out to Mr Rahman, but he could not see him or get a response. The second officer looked through a small observation window to the right of the cell door which covered the bathroom area, but it was obscured. They asked a CM to attend.

59. At 5.03pm, the CM looked through the observation panel and the window to the right but could not see Mr Rahman. She asked a nurse to take over from a third officer, who was monitoring a prisoner on constant supervision, so that she could ensure she met the unlock requirement. The CM and three officers went to the lower landing, where the PPE was located, to change. They returned to the cell at 5.13pm. BWVC footage shows that the CM told the officers to be prepared to withdraw from the cell as she suspected Mr Rahman would run at them once the door was opened.

60. An officer who was not wearing PPE, unlocked Mr Rahman's cell door. The CM led the officers into the cell and as she turned right, she saw Mr Rahman hanging by a ligature that was attached to a disused shower head. She held him by the waist to support his weight while an officer unhooked the ligature and they laid

him on the floor. She then checked for signs of life and the officer started cardiopulmonary resuscitation (CPR). CCTV footage shows that an officer ran out of the cell to collect a radio. BWVC shows that the CM radioed for oxygen at 5.14pm. At 5.15pm, an officer radioed a medical emergency code blue. Around 30 seconds later, a nurse entered a nearby room with an officer who left holding a medical emergency bag.

61. At 5.23pm, two nurses arrived at Mr Rahman's cell and saw that oxygen was being administered and that the CM was conducting CPR. They assisted with the resuscitation efforts and attached a defibrillator, but it did not detect a shockable rhythm. An ambulance arrived at the prison gate at 5.20pm and the first paramedics took over resuscitation efforts at 5.30pm. Paramedics confirmed that Mr Rahman had a faint pulse at 5.41pm and at 6.06pm, took him by ambulance to Birmingham City Hospital, unrestrained and escorted by two officers. At 7.35pm, hospital staff conducted a CT scan which showed that Mr Rahman had a brain injury caused by hypoxia (a lack of oxygen in the blood).

62. On 21 January, a nurse contacted hospital escort officers who told her that Mr Rahman was on a ventilator in the intensive care unit (ICU) but remained stable. At 10.20pm on 22 January, escort officers recorded that hospital doctors planned to test Mr Rahman for brain death and would notify his next of kin.

63. At 1.04am on 23 January**,** a hospital doctor pronounced that Mr Rahman had died. His family arrived shortly afterwards.

Contact with Mr Rahman's family

64. A short while after Mr Rahman was found hanging on 20 January, the Governor contacted his next of kin by phone to tell them what had happened and to arrange for a taxi to take them to the hospital. Later the same day, the prison appointed an officer as the family liaison officer (FLO) and a prison manager, as her deputy.

65. At 9.16am on 21 January, the deputy FLO phoned Mr Rahman's sister to introduce herself and to offer support. On 22 January, she spoke to Mr Rahman's sister by phone and noted that the family had decided that his brother would be the family's main point of contact. The deputy FLO and FLO provided ongoing support to Mr Rahman's brother. The prison offered to contribute towards the funeral costs, in line with national policy.

Support for prisoners and staff

66. On 20 September, the Governor debriefed staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. There is no record that a member of staff debriefed the officers present at the hospital when Mr Rahman died. We have asked Birmingham to confirm this on several occasions but we have still not received a response.

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

Post-mortem report

68. The post-mortem report concluded that Mr Rahman died of hypoxic/ischaemic encephalopathy (a type of brain injury caused by a lack of blood flow or oxygen) following external neck compression that was caused by hanging. Toxicology results identified low concentrations of diazepam and aripiprazole. Ketamine and lidocaine were also identified, but the post-mortem report concluded that these were likely to have been administered as part of the medical management. No illicit substances were detected in Mr Rahman's system.

Findings

Identifying risk of suicide and self-harm

69. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and to take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

70. Mr Rahman was not subject to ACCT monitoring at Birmingham. Although he often displayed aggression towards staff and had mental health issues, he did not report any thoughts of suicide or self-harm. No one who saw Mr Rahman in the weeks before his death saw any reason to consider that he was at risk and several members of staff, including the consultant psychiatrist told us that they felt his presentation had started to improve. In the hours before Mr Rahman was found hanging, he interacted with staff and did not report any concerns. We are therefore satisfied that there was no reason for staff to consider ACCT monitoring. We do not consider that staff could reasonably have foreseen or prevented his actions.

Clinical care

71. The clinical reviewer considered that although Mr Rahman was located on the prison's mental health unit, it was not comparable to that of a hospital ward. She therefore concluded that she was unable to draw a meaningful comparison on whether the care extended to Mr Rahman was equivalent to that which he could have expected to receive in the community.

72. However, she did identify several areas for improvement.

Mental healthcare

73. Mental health staff did not refer Mr Rahman for therapeutic interventions such as occupational therapy or psychology, and his main treatment was medication. A nurse told us that therapeutic interventions were limited due to the COVID-19 pandemic and that due to Mr Rahman's unlock requirement, intervention would have mainly been though distraction packs. A nurse told us that the daily psychology groups and out-of-cell activities, such as games and playing pool, did not take place due to COVID-19 restrictions. While the clinical reviewer accepted that some limitations were necessary, she considered that the lack of therapeutic intervention provided to Mr Rahman fell below the standard that could be expected in the community, even taking account of the pandemic.

74. The COVID-19 restrictions meant that Mr Rahman spent long periods of time in his cell without access to normal activities. This may have been particularly difficult for a prisoner who was subject to mood disorder, and may also have been exacerbated by the fact that in the days before he took his life, staff mostly interacted with him through his cell door. Mr Rahman twice told the consultant psychiatrist that he would like to return to a standard wing where he would have contact with other prisoners, which suggests that he may have been feeling isolated. While we appreciate that Mr Rahman displayed challenging behaviour

and that prison staff continued to offer him the opportunity to leave his cell for exercise and to shower, we consider that more meaningful contact and therapeutic intervention may have enabled staff to identify signs that his mood was deteriorating.

Mental capacity assessment

75. We are concerned that there is no evidence that healthcare staff assessed Mr Rahman's mental capacity when he began to refuse medication and his mental health deteriorated. The clinical reviewer considered that healthcare staff should have completed a mental capacity assessment to determine whether more restrictive interventions were needed to promote compliance, such as a depot injection (a slow-release form of medication). The clinical reviewer also noted that mental health staff appeared to have limited knowledge and experience in the application of the Mental Capacity Act, which is particularly concerning as they work in a mental health inpatient unit.

Record keeping

76. The clinical reviewer considered that although the quality of healthcare record keeping at Birmingham was generally good, the timeliness of the consultant psychiatrist's entries in Mr Rahman's medical record fell below expectations. On three occasions between 24 November 2020 and 21 January 2021, the consultant psychiatrist made his entry two days after seeing Mr Rahman. The clinical reviewer noted that this was not in line with the General Medical Council's Good Medical Practice guidelines. He told us that he left the prison shortly after he saw Mr Rahman on 19 January and did not have access to his medical record. We did not ask about the other two occasions as we were not aware of them at the time.

77. While we recognise that nursing staff accompanied the consultant psychiatrist and made timely entries in Mr Rahman's medical record, it is critical that all healthcare staff promptly document their interaction with prisoners to ensure that continuity of care is maintained.

Secure psychiatric hospital referral

78. After seeing Mr Rahman on 5 January, the consultant psychiatrist changed his medication and decided to monitor his progress before making a secure hospital referral. He told us that on the one hand and with hindsight, he should have made a secure hospital referral at that point, but on the other hand, he wanted to ensure that he gave Mr Rahman the opportunity to accept treatment on the inpatient ward and see if he improved. While the clinical reviewer appreciated that the decision was finely balanced, she considered that Mr Rahman would have benefited from hospital treatment as he would have received increased therapeutic intervention.

79. The clinical reviewer identified several reasons for making a hospital referral in line with NHS England's good practice guidance for the transfer and remission of adult prisoners under the Mental Health Act 2019. These included that Mr Rahman presented a serious risk of harm to others, his mental health condition did not improve even when he did not have access to illicit substances,

therapeutic intervention was limited, and highly restricted practices were in place. We are also concerned that there is no evidence that staff considered these factors at multidisciplinary reviews and that their decision making appears to have been based on Mr Rahman's compliance with medication.

80. We make the following recommendations:

The Head of Healthcare should review the model for delivering therapeutic intervention and ensure that it is available to all prisoners admitted to the inpatient mental health unit.

The Head of Healthcare should ensure that healthcare staff:

- **receive training about the Mental Capacity Act and its implementation in practice;**
- **promptly record actions and decisions about a prisoner's ongoing care in their medical record; and**
- **discuss whether to refer a prisoner to a secure psychiatric hospital at multidisciplinary meetings and clearly evidence the reason for the decision.**

The Head of Healthcare should share this report with a consultant psychiatrist so he is aware of the Ombudsman's findings.

Cell safety

81. Our investigations show that prisoners who are determined to kill themselves will make use of anything to hand and that it is impossible to make a cell completely safe unless all furniture, bedding and clothes have been removed. While it is occasionally necessary to hold prisoners in such conditions for their own safety, this is likely to have a detrimental effect on their mental health and is therefore only permitted for short periods and under strict controls. As Mr Rahman had shown no signs that he was a suicide risk, there was no reason for him not to live in a standard cell with standard fittings.

82. In this case, however, Mr Rahman's cell had some defects. The mental health service manager, told us that the cell had been out of use since 2017 due to damage and that, as part of the reinstatement process, several modifications, including the addition of a mirror to enable staff to see into the bathroom area, were requested. However, there is no record that the prison considered installing a mirror before reinstating the cell in July 2020. The investigator made several requests for a copy of the living standards' database (used to monitor cell damage and repair) and for more details about the cell reinstatement process, but the prison failed to provide this information.

83. The Royal College of Psychiatrists' *Standards for Inpatient Mental Health Services 2017* recommends that a ligature risk assessment is completed in a mental health hospital setting at least annually. The mental health service manager told us that since 2016, a ligature risk assessment had been completed annually for the prison's mental health inpatient unit.

84. A ligature risk assessment was completed in July 2020 but it failed to identify the disused shower head in Mr Rahman's cell as a potential ligature point. While we have not been able to establish why this appears to have been overlooked, we agree with the clinical reviewer's conclusion that it raised concerns about the effectiveness of the current ligature risk assessment process. A CM told us that the disused showerhead in the cell had been identified as a potential risk as early as 2013 but was unable to say where this would have been recorded. In addition, The Head of Safety Custody also told us that he did not know why the showerhead had not been identified and removed.

85. An officer and a CM told the investigator that they could not see anything through the observation window covering the bathroom area and that it looked like a teabag had been placed over the window from the inside. The CM added that it was not unusual for prisoners to cover the observation window for privacy. The Head of Safer Custody told us that although he did not know whether the observation window was covered, it was possible to see through it, despite it being scratched and discoloured. While we cannot confirm whether a teabag was placed over the observation window, the reaction of staff on body-worn video camera footage and at interview indicated that they could not see anything.

86. The prison has told us that a mirror has now been installed, the old shower head removed and the toilet observation window replaced. While we appreciate that the prison acted swiftly to rectify these issues, we are concerned that it took a death in custody for these to be identified and addressed. Although we cannot know whether Mr Rahman's death could have been prevented if the changes had been made sooner, he may not have had such easy access to a ligature point and staff may have seen him hanging earlier.

87. We make the following recommendations:

The Head of Healthcare should review the ligature risk assessment process for the inpatient mental health unit to ensure that all risks are identified.

The Governor should ensure that each stage of the process is documented when cells are taken out of use, and that a cell is not used until any required modifications have been made.

The Governor should ensure that damaged observation panels are reported and replaced as soon as possible.

Record keeping

88. PSI 58/2010, *The Prisons and Probation Ombudsman (PPO)*, states that as a basic principle, the PPO must have unfettered access to documents during their investigation. We are concerned that Birmingham was unable to provide us with documentation about the reinstatement of Mr Rahman's cell or a copy of the living standards' database to enable us to see if staff reported the missing mirror, damaged observation window and disused showerhead. These records could provide crucial evidence for investigations, and we would expect the prison to ensure that these are easy to obtain after a death in custody to enable appropriate scrutiny and accountability. We make the following recommendation:

The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

Emergency response

89. PSI 64/2011 states that staff must be aware that the preservation of life is the priority when managing prisoners. It says that justifiable decisions about when to enter a cell when life is endangered must take account of the need to preserve life.

90. When a CM confirmed that Mr Rahman was not visible in the cell, she asked officers to change into full PPE before entering the cell. This caused a 10-minute delay. The CM told us that she had no reason to suspect that Mr Rahman was at risk of suicide and was conscious of the need to protect staff. She said that she was aware of the policy instructing staff to take immediate action if a prisoner's life was at risk and would have entered the cell immediately if she had seen Mr Rahman hanging. We are satisfied that there was no evidence to indicate that Mr Rahman was at risk of suicide or self-harm and that the CM acted appropriately.

91. PSI 03/2013 on medical response codes requires prisons to have a two-code medical emergency response system. Birmingham's local policy instructs staff to use a medical code blue to indicate an emergency when a prisoner is unconscious or has breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for a member of healthcare staff to attend with the appropriate equipment.

92. An officer left Mr Rahman's cell to collect a radio and call a medical code blue at 5.15pm. She told us that staff do not have their radios with them when dressed in full PPE because it would be inaccessible. However, body-worn video camera footage shows that a CM radioed for oxygen at 5.14pm. It is not clear how she obtained the radio, but it would indicate that there was a delay of around one minute before a code blue was called. While we are satisfied that the officer used the correct medical code and that control room staff called an ambulance in line with local guidance, we consider that staff missed an opportunity to radio the code sooner.

93. Two nurses did not participate in the resuscitation effort and waited for the emergency response nurses to arrive. A nurse told us that he was a "bit torn" between getting involved in the resuscitation effort and monitoring the prisoner on constant watch. We consider that the nurse's primary responsibility was to maintain the constant watch himself or to arrange for someone else to do so.

94. The nurse then asked the other nurse to take over the constant watch while he went through double doors separating the two cells and stood in the doorway of Mr Rahman's cell. He said that he decided not to get involved in the resuscitation effort as officers were doing "good quality" CPR. While we are satisfied that his decision not to take over chest compressions was appropriate, we consider that both nurses could have assisted by preparing a defibrillator. A defibrillator was available to them but was not used until the emergency response nurses arrived.

95. It took eight minutes for two other nurses to arrive at Mr Rahman's cell following the code blue. The unit manager told us that the emergency response nurses would have been working on other wings or issuing medication at the time and would have had to stop what they were doing and make their way to the healthcare unit. We are satisfied that there was no unnecessary delay.

96. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that:

- **an emergency medical code is used to communicate effectively the nature of an emergency at the earliest opportunity; and**
- **appropriate medical emergency equipment, such as a defibrillator, is applied and used promptly.**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141