Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rifat Mehmet, a prisoner at HMP Birmingham, on 15 February 2022

A report by the Prisons and Probation Ombudsman

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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 Rifat Mehmet was found dead in his cell at HMP Birmingham on 15 February 2022. He died from an overdose of amitriptyline, his prescribed medication. Mr Mehmet was 56 years old. I offer my condolences to Mr Mehmet's family and friends.

Mr Mehmet had been attending court for his trial in the week before his death. On 14 February, he was convicted. He was due to be sentenced the next day but was found dead in his cell that morning.

I am concerned that Mr Mehmet's risk of suicide and self-harm was not properly assessed when he returned from court on 14 February. Staff did not identify that his status had changed from remand to convicted prisoner and so they did not consider that his risk of suicide might have increased or refer him to be assessed by healthcare staff as they should have done.

Mr Mehmet was allowed to keep and administer his prescribed medication (amitriptyline) at Birmingham. Since Mr Mehmet's death, the prison has reviewed its in-possession medication policy and prisoners are no longer allowed to keep amitriptyline in their possession.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **September 2022**

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Summary

Events

1. Mr Rifat Mehmet was recalled to prison custody on 21 January 2021, after he was charged with further offences. He was sent to HMP Stoke Heath.

2. Mr Mehmet was prescribed amitriptyline (used to treat pain and depression) at Stoke Heath as he had been prescribed it in the community. However, he was not allowed to keep it in his possession and had to collect it daily.

3. Mr Mehmet was moved to HMP Birmingham on 8 September 2021. A prison GP continued Mr Mehmet's amitriptyline prescription.

4. Following an in-possession medication risk assessment, a nurse asked a GP to approve that Mr Mehmet could keep a seven-day supply of his medication in-possession. The GP approved this.

5. Mr Mehmet's trial started on 7 February 2022. He attended court daily.

6. On 14 February, Mr Mehmet was convicted. He was due to attend court the next day for sentencing. Staff who saw him when he returned to Birmingham on the evening of 14 February were not aware of his change in status. They said he was the same as usual and had no concerns about him.

7. Shortly after 6.40am on 15 February, during a roll check, an operational support grade (OSG) saw Mr Mehmet on the floor of his cell. She fetched another member of staff to take a look. They were not sure if Mr Mehmet was breathing, so they called a custodial manager (CM), the senior officer in charge, for advice. When he arrived, he entered the cell and called a medical emergency code. There were clear signs that Mr Mehmet was dead, so he did not start CPR. Ambulance paramedics confirmed Mr Mehmet's death when they arrived.

8. After Mr Mehmet's death, a prisoner told staff that Mr Mehmet had said he would take an overdose if found guilty at court.

Findings

9. When Mr Mehmet returned from court on 14 February, staff were unaware he had been convicted and was due to be sentenced the next day. Mr Mehmet's change in status from remand to convicted prisoner should have triggered a reassessment of Mr Mehmet's risk of suicide and self-harm and a referral to healthcare staff. This did not happen. We are concerned that reception staff seemed unaware of the actions required when a prisoner's status changes from remand to convicted.

10. The clinical reviewer noted that guidance to GPs recommends that amitriptyline is not prescribed in prison for depression and if prescribed for pain, is given in small doses. She was concerned that the GP at Birmingham prescribed amitriptyline without knowing why it had been prescribed. She said that while she was not suggesting it was the wrong decision, she would have expected more professional curiosity so that it was properly risk assessed.

11. The OSG should have tried to get a response from Mr Mehmet when she saw him on his cell floor and then called a medical emergency code when she got no

response. There was a four-minute delay in calling the code, which was not done until the CM arrived. It made no difference in this case as Mr Mehmet was dead when found but, in a future case, such a delay could be critical. Staff should call a code immediately when they find a prisoner unresponsive.

Recommendations

- The Governor should ensure that reception staff:
  - understand what constitutes a change in status and are aware that this may increase a prisoner's risk of suicide and self-harm;
  - ask prisoners returning from court whether they were convicted or sentenced; and
  - refer prisoners who have had a change in status for a healthcare assessment.
- The Governor should review the PER system in use to ensure that reception staff have access to all relevant information.
- The Head of Healthcare should review the processes for highlighting high-risk medication at medication reconciliation so it can be properly risk-assessed in accordance with the in-possession policy and Royal College of General Practitioners guidance.
- The Governor should ensure that staff radio a medical emergency code immediately when they find a prisoner unresponsive.

The Investigation Process

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

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

14. NHS England commissioned a clinical reviewer to review Mr Mehmet's clinical care at the prison. The investigator and clinical reviewer interviewed seven members of staff and a prisoner. The investigator interviewed another four staff members.

15. We informed HM Coroner for Birmingham and Solihull of the investigation who gave us the results of the post-mortem examination and toxicology. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Mehmet's family, to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

17. We shared our initial report with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies.

Background Information

HMP Birmingham

18. HMP Birmingham is a local prison which holds up to 1,054 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.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham in July 2018. They noted a dramatic deterioration since the previous inspection. They judged outcomes for prisoners to be 'poor' against all four of their healthy prison tests – safety, respect, purposeful activity and rehabilitation and release planning. HMIP reported that in the 18 months since their last inspection, three prisoners had taken their own lives. They said that not all investigations by the PPO had been completed but early indications suggested that the PPO had significant concerns about the standards of care at the prison. HMIP issued an Urgent Notification to the Secretary of State for Justice, seeking immediate improvements. In August 2018, the running of the prison was transferred from G4S to HM Prison and Probation Service (HMPPS).

20. HMIP also carried out a scrutiny visit of HMP Birmingham (a shortened inspection during the pandemic) in November 2020 and January 2021. HMIP reported that prison leaders at Birmingham had made progress against many of their recommendations, with significant work done to restore order to the prison. Inspectors reported that COVID-19 had created significant challenges for leaders at the prison. Inspectors reported that the prison had worked to improve prisoner safety, but not all self-harm was reported or investigated.

Independent Monitoring Board

21. 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 2021, the IMB reported that the prison was safer than previously, and that prisoners were treated fairly and with respect. They were concerned that the COVID-19 pandemic had resulted in a regime that left prisoners too long in their cells.

22. The IMB said they had been assured that one instance of a delay in calling an emergency code blue, identified by the PPO, had been addressed, although the delay did not affect the prisoner's outcome. They expressed concern that the prison had been advised about their emergency response before.

Previous deaths at HMP Birmingham

23. Mr Mehmet was the twelfth prisoner at Birmingham to die since February 2020. Of the previous deaths, nine were from natural causes and two were self-inflicted. We

recommended in two recent investigations that staff are reminded about calling medical emergency codes promptly when they find a prisoner unresponsive.

Key Events

24. In February 2019, Mr Rifat Mehmet was sentenced to 24 months in prison for burglary and possession of an offensive weapon. He was released on licence in March 2020, but was recalled on 21 January 2021, charged with further offences (including robbery and aggravated vehicle taking). He was sent to HMP Stoke Heath.

25. While at Stoke Heath, Mr Mehmet was prescribed amitriptyline (used to treat nerve pain and depression). He had been prescribed this intermittently in the community since 2010. Mr Mehmet was not allowed to keep his medication in his cell, as Stoke Heath's medication policy prohibited prisoners holding amitriptyline in possession. (Amitriptyline is highly tradeable in prison due to its sedative effects and is highly toxic if overdosed.)

26. Mr Mehmet was moved to HMP Birmingham on 8 September 2021. A GP re-prescribed Mr Mehmet's medication, although he did not see him. The GP noted Mr Mehmet was not to keep the amitriptyline in his possession. However, a nurse saw Mr Mehmet and using a medication screening tool in line with Birmingham's medication policy, assessed Mr Mehmet as low-risk and suitable to keep and administer seven days of amitriptyline (50mg twice a day). The nurse asked another GP to approve this, which they did.

27. On 17 November, a prison GP saw Mr Mehmet as his ankles had swollen. Mr Mehmet needed a blood test and an ECG and was prescribed aspirin and furosemide (blood pressure medication) which he also kept in his possession. Mr Mehmet remained on these, and amitriptyline, until he died. Mr Mehmet's blood test and ECG were both normal. A month later, a prison GP prescribed Mr Mehmet antibiotics for dry and flaky skin on his ankles. Mr Mehmet was also reviewed in the asthma clinic. There were no issues.

28. Mr Mehmet's trial at Birmingham Crown Court started on 7 February 2022. He attended court daily that week. Healthcare staff assessed that he was fit to attend court daily before he left the prison. There were no issues about Mr Mehmet's health or fitness to attend court. Mr Mehmet's accompanying Person Escort Record (PER) from Birmingham to the court did not raise any concerns about his risk of suicide or self-harm but noted he had depression and was taking medication.

29. On 14 February, Mr Mehmet was convicted. He returned from court that evening, at around 6.15pm, and was processed through reception as usual. Mr Mehmet's accompanying PER from court to prison was sent electronically and did not alert staff that Mr Mehmet had been found guilty and was due to attend court for sentencing the next day. This information was not passed on verbally by GEO Amey escorting staff, nor offered by Mr Mehmet. Mr Mehmet spoke to some prison officers, including one officer, who said that Mr Mehmet seemed fine and no different to usual. He was then taken to his cell and locked in for the night.

30. At 7.09pm, Mr Mehmet rang his son from his in-cell telephone. Mr Mehmet said that he had bad news and had been found guilty at court. Mr Mehmet gave his son instructions about what to do if he was ever taken to hospital and said he had been late back from court as he had experienced breathing difficulties. This was not true. Mr Mehmet said he might be sentenced to ten years but said he did not know if he

would be alive in ten years and spoke about his wishes for his funeral. He said he would telephone again the next day.

31. Half an hour later, Mr Mehmet telephoned his wife. He told her that he was expecting a sentence of ten to 16 years. Mr Mehmet said an ambulance had been called to the court as he had been experiencing breathing difficulties. This was not true. Mr Mehmet sounded tearful and said he would call her the next day.

32. At 8.03pm, Mr Mehmet telephoned his mother. Again, he said that an ambulance had been called for him at court. He said that if anything happened to him, he wanted to be cremated. His mother asked whether he was planning anything. Mr Mehmet said he was not but wanted her to know his wishes if anything happened to him. He telephoned his mother again two hours later. They spoke generally about television programmes and he said he would call her the next day.

33. At approximately 10.00pm, an Operational Support Grade (OSG) carried out a security patrol on L Wing. She had no reason to check Mr Mehmet. She had not worked on L Wing before and did not know him.

15 February

34. At 6.43am on 15 February, during the morning roll check, the OSG saw Mr Mehmet lying on his cell floor. She could not see his head and was not sure if he was asleep. She went to another wing nearby and asked another OSG for a second opinion. The second OSG looked into the cell and thought Mr Mehmet was breathing but was unsure. She went to the wing office and telephoned the Custodial Manager (CM) (the senior officer in charge) for advice.

35. The CM arrived at Mr Mehmet's cell at 6.47am. He went into the cell with two prison officers whom he had radioed on the way to meet him there. When he saw Mr Mehmet, he immediately radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

36. The CM said that Mr Mehmet felt cold, and his arms were rigid, a sign that rigor mortis (stiffening of the body that occurs two to six hours after death) had set in. He decided not to start CPR as it was clear that Mr Mehmet was dead. A nurse arrived shortly afterwards and agreed with the CM.

37. Paramedics arrived at Mr Mehmet's cell at 7.05am and confirmed Mr Mehmet's death.

38. Mr Mehmet had left a note in his cell. It said "320 tabs", that he was sorry and where he wanted his ashes buried.

39. After Mr Mehmet's death, a prisoner told staff that Mr Mehmet had told him if he was found guilty, he would overdose on little blue tablets (amitriptyline) that he had been saving. Staff were unaware of this.

Contact with Mr Mehmet's family

40. Staff at Birmingham contacted the chaplain at HMP Chelmsford (near to where Mr Mehmet's family live) to ask them to break the news of Mr Mehmet's death. The chaplain visited Mr Mehmet's mother to break the news. Subsequently,

Birmingham appointed an officer as the family liaison officer. She remained in contact with Mr Mehmet's family.

41. The prison contributed to the cost of Mr Mehmet's funeral, in line with national guidelines.

Support for prisoners and staff

42. After Mr Mehmet's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

43. The prison posted notices informing other prisoners of Mr Mehmet'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 Mehmet's death.

Post-mortem report

44. The post-mortem report concluded that the cause of Mr Mehmet's death was amitriptyline overdose. Traces of other medication that Mr Mehmet had not been prescribed were also detected.

Findings

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

45. PSI 07/2015, *Early Days in Custody*, sets out the procedures for assessing prisoners' risk of suicide and self-harm when they pass through reception. It says that the PER and any other available documentation must be examined, and the prisoner interviewed in reception, to assess the risk of suicide and self-harm. Annex D of PSI 07/2015 lists the categories of prisoners who may be especially vulnerable to suicide or self-harm. It says that healthcare staff should assess prisoners returning to the prison after a temporary absence if they fall into any of the categories listed. The list includes: *Those whose status has recently changed (e.g. from remand to convicted/sentenced)*.

46. On 14 February, Mr Mehmet was convicted at court. When he returned to the prison that evening, reception staff failed to identify that his status had changed and did not refer him to healthcare staff as they should have done. The reception officer said that the PER forms had recently changed from paper to digital and that there was nothing on the digital PER to say that Mr Mehmet had been convicted. He said that Mr Mehmet had seemed fine and did not mention that he had been convicted. When asked what he would have done had he known, he said that if a prisoner was facing a long sentence, he would refer them to a nurse. Other staff at Birmingham told us that only prisoners sentenced to over ten years would be referred to a nurse.

47. We are concerned that no one recognised that Mr Mehmet's risk of suicide and self-harm may have increased following his conviction. Reception staff said that they did not know he had been convicted because it was not on the digital PER. Regardless, we are concerned that reception staff did not properly screen Mr Mehmet for suicide and self-harm risk when he returned. They did not ask him what had happened at court and just said that he seemed fine.

48. We are also concerned that staff at Birmingham did not have a proper understanding of what constitutes a change in status. Several staff told us that a referral to healthcare staff was only required after a prisoner was sentenced to over ten years, which is not in line with policy. We recommend:

The Governor should ensure that reception staff:

- **understand what constitutes a change in status and are aware that this may increase a prisoner's risk of suicide and self-harm;**
- **ask prisoners returning from court whether they were convicted or sentenced; and**
- **refer prisoners who have had a change in status for a healthcare assessment.**

The Governor should review the PER system in use to ensure that reception staff have access to all relevant information.

In-possession medication

49. The clinical reviewer noted that the Royal College of General Practitioners (RCGP) guidance on 'Safer Prescribing in Prisons (2019)' recommends that amitriptyline is not prescribed in prisons as an antidepressant because it has a high toxicity risk if taken in overdose. The guidance recommends that if amitriptyline is prescribed for neuropathic pain, this poses a lower risk if given in small doses (around 10-25mg). Mr Mehmet was prescribed a much higher dose of 100mg per day, which suggests it was given for depression.

50. The prison GP who prescribed amitriptyline when Mr Mehmet arrived at Birmingham on 8 September 2021 said that he did so because Mr Mehmet had been prescribed it at Stoke Heath. He did not know why it had been prescribed. The clinical reviewer did not suggest that prescribing amitriptyline was the wrong decision, as Mr Mehmet had been taking it a long time and managing his withdrawal would have been problematic. However, she considered that there should have been more professional curiosity about the reasons for the amitriptyline prescription so that it could have been properly risk assessed in line with the RCGP guidance. We recommend:

    The Head of Healthcare should review the processes for highlighting high-risk medication at medication reconciliation so it can be properly risk-assessed in accordance with the in-possession policy and Royal College of General Practitioners guidance.

51. Since Mr Mehmet's death, Birmingham have reviewed their in-possession policy. From 17 February 2022, amitriptyline is no longer an in-possession medication. The clinical reviewer has therefore made no recommendation.

Emergency response

52. There was a four-minute delay in calling the code blue, which was not called until the CM arrived. When the OSG saw that Mr Mehmet was on his cell floor, she should have tried to get a response from him and then called a code blue when he failed to respond. The delay made no difference in this case as Mr Mehmet was dead when found but in a future case, such a delay could be critical. We recommend:

    The Governor should ensure that staff radio a medical emergency code immediately when they find a prisoner unresponsive.

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