Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jai Singh, a prisoner at HMP Birmingham, on 27 January 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 Jai Singh died in hospital of hypoxic brain damage caused by multi-organ failure on 27 January 2022, having been found suffocating in his cell at HMP Birmingham earlier that day. He was 50 years old. I offer my condolences to Mr Singh's family and friends.

Mr Singh was a troubled man who appeared to struggle with his first time in prison. I am concerned that opportunities were missed to identify and consider his risk of suicide and self-harm properly, particularly in the last weeks of his life when significant concerns were raised about his mental ill-health.

At the same time, the support Mr Singh received from the mental health team at Birmingham did not meet his needs. I am particularly concerned that a psychiatrist's recommendation that Mr Singh should be admitted to the mental health inpatient unit was not instigated.

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. On 21 September 2021, Mr Singh was remanded in custody to HMP Birmingham. It was his first time in prison and he was charged with the murder of his wife.

2. On 4 November, a mental health nurse recommended that Mr Singh should be prescribed antidepressants. Later that month, prison staff started suicide and self-harm prevention procedures (known as ACCT) when Mr Singh said that he "wanted to kill himself" as he had not yet received medication. The ACCT procedures were closed a week later.

3. On 4 January, Mr Singh told a prison doctor that he had harmed himself by scratching his arms. Three days later, healthcare staff received a report from a psychiatrist who had assessed Mr Singh at the request of his solicitor. The psychiatrist recommended that Mr Singh should be admitted to a medium secure psychiatric hospital.

4. On 12 January, Mr Singh told a prison nurse that he heard voices of family members telling him that he was "going to die". He said that he thought that family members in the community and people in prison were trying to poison him. The nurse referred Mr Singh to the weekly multidisciplinary team meeting for allocation to a mental health key worker.

5. On 14 January, a prison psychiatrist assessed Mr Singh. He recommended that Mr Singh should be admitted to the prison's mental health inpatient unit. A nurse completed a referral that afternoon.

6. On 19 January, the multidisciplinary team meeting allocated Mr Singh to a mental health nurse. Due to his working pattern and training, the nurse was not able to see Mr Singh before his death. That day, the weekly regional resource meeting considered his referral to the mental health inpatient unit. They concluded that Mr Singh should be managed on a prison wing rather than the inpatient unit.

7. On 24 January, hospital staff contacted prison healthcare staff and told them that Mr Singh's referral did not follow the referral process and would be closed.

8. At 10.07am on 27 January, a prison officer found Mr Singh in his cell, with a plastic bag over his head. Prison staff removed the bag and began cardiopulmonary resuscitation. Paramedics took Mr Singh to City Hospital, Birmingham, where he died that night.

Findings

Identifying the risk of suicide and self-harm

9. We are concerned that there were some missed opportunities to identify Mr Singh as at risk of suicide and self-harm. There is no evidence that his significant risk factors were considered when he first arrived in prison. During a later court appearance, court staff completed a suicide and self-harm warning form which did

not prompt an interview when he returned from court and was not shared with the reception nurse. When a wider range of risk factors were revealed in January 2022, greater consideration should have been given to starting ACCT procedures.

10. When ACCT procedures were started in November 2021, mandatory support actions were not completed. The ACCT procedures were closed at a case review which was not multidisciplinary and before resolving all of the issues that had prompted their opening.

Clinical care

11. The clinical reviewer found that the mental health care that Mr Singh received in prison was not of the required standard or equivalent to that he would expect to receive in the community. It took too long for a mental health nurse to see him after he was recommended for allocation and the decision not to admit him to the mental health inpatient unit, contrary to the prison psychiatrist's recommendation, was made without contributions from staff who knew Mr Singh.

Translation services

12. Several members of staff, as well as Mr Singh's cellmate, told us that he struggled with English and preferred to speak in other languages. Some significant assessments and reviews were completed in a language not of his choosing and no one tried to use a formal interpretation service.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

  - ACCT support actions are completed with actions that are specific and meaningful and include all of the issues identified during the assessment interview and at case reviews;

  - healthcare staff are invited and contribute to all case reviews where their support is relevant; and

  - ACCT monitoring does not stop until all support actions have been completed and risk is no longer considered raised.

- The Head of Healthcare should ensure that patients receive appropriate support from the mental health team that is equivalent to that which they could expect to receive in the community, including that:
  - medication requests from mental health nurses are considered and actioned as soon as possible;
  - patients are allocated a mental health key worker at the earliest opportunity and are assessed by the key worker within seven days, or earlier if urgent assessment is required;
  - an 'urgent' marker is added to the mental health inpatient unit's referral form;
  - relevant staff who know the patient are invited to contribute to the regional resource meeting, that meeting outcomes are documented in the medical record, and that prison psychiatrists are consulted if their recommendations for admission are not considered to meet the criteria for admission; and
  - if a patient's referral to a medium secure psychiatric hospital is refused, the hospital is contacted to establish the reasons and a further referral is considered when relevant.
- The Governor and Head of Healthcare should ensure that prisoners whose first language is not English are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

The Investigation Process

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

14. On 7 February 2022, the investigator visited Birmingham and interviewed Mr Singh's cellmate. He interviewed 12 members of staff at Birmingham from February to May.

15. NHS England commissioned a clinical reviewer to review Mr Singh's clinical care at the prison. The clinical reviewer joined the investigator for interviews with clinical staff.

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

17. The Ombudsman's family liaison officer contacted Mr Singh's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Singh's sister asked the following questions:

    - Was Mr Singh's mental health assessed at HMP Birmingham and what support did he receive for his mental health?
    - What medication was Mr Singh prescribed?
    - Where was Mr Singh located and was this suitable?

18. We shared the initial report with HM Prisons and Probation Service. They identified one factual inaccuracy, which we have amended in this final report. We have annexed their action plan to this report.

19. We also shared the initial report with Mr Singh's sister. She did not identify any factual inaccuracies.

Background Information

HMP Birmingham

20. HMP Birmingham is a local prison which holds up to 1,450 prisoners, although it is currently operating at a reduced capacity. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services. There are two inpatient units, one of which (Ward 2) is dedicated for patients with mental ill-health conditions.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Birmingham was a scrutiny visit in November 2020 and January 2021. Inspectors reported that levels of self-harm were higher than at similar prisons and that some incidents had not been reported correctly, which impacted on work to establish the causes of self-harm. Inspectors found that the quality of ACCT documents varied, with many ACCT documents containing insufficient actions on care maps and case reviews which were not multidisciplinary.

22. Inspectors also reported that mental health services were effectively led and waiting times to access services were not long.

Independent Monitoring Board

23. 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 incidents of self-harm had reduced and the introduction of self-harm fora meant that managers were now better aware of the reasons why prisoners harmed themselves.

Previous deaths at HMP Birmingham

24. Mr Singh was the eleventh prisoner to die at Birmingham since January 2020, and the second to take his own life. In our report into the self-inflicted death of a prisoner in January 2021, we found that the man received minimal therapeutic intervention for his mental ill-health and that his mental health care was not equivalent to that which he could have expected in the community.

Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

26. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

27. On 21 September 2021, Mr Jai Singh was remanded in custody to HMP Birmingham, charged with the murder of his wife. It was his first time in prison. Mr Singh had no recorded history of self-harm or treatment for mental ill-health in the community. On arrival at Birmingham, Mr Singh told reception staff that he had no history or thoughts of suicide or self-harm.

28. On 29 September, a mental health nurse assessed Mr Singh as his sister had contacted Birmingham to express concerns about his mental health. She recorded that Mr Singh said that he had heard voices and seen hallucinations but he would not elaborate on this. The nurse recorded that there was no evidence that Mr Singh was responding to unseen stimuli during the assessment, although his mood appeared low. Mr Singh said that he did not want to take any medication for low mood. The mental health nurse recorded that there was no evidence of acute mental illness and discharged Mr Singh from the mental health team's caseload.

29. On 13 October, Mr Singh's sister telephoned Birmingham, concerned about his wellbeing. A Custodial Manager (CM) subsequently spoke to Mr Singh. She recorded that he appeared to be in good spirits and did not raise any concerns.

November 2021

30. In early November, Mr Singh's family contacted Birmingham, concerned for his welfare. On 4 November, a nurse assessed Mr Singh and recorded that his sister said that he was "seeing things on television and saying bizarre things". The nurse recorded that Mr Singh said that he started hearing voices around two or three months previously, making comments such as, "You need to finish your life." Mr Singh also said that he had broken sleep and had experienced persistent headaches for three months. The nurse recorded that Mr Singh should start antidepressants for his low mood and altered sleep and sent a 'task' to a prison doctor to prescribe. He recorded that Mr Singh required no further input from the mental health team.

31. On 7 November, Mr Singh's sister again contacted Birmingham, concerned about him. A CM spoke to Mr Singh and recorded that he said that he was struggling in prison. The CM recorded that he signposted Mr Singh to support channels such as the Samaritans. He noted that Mr Singh said that he had no thoughts of suicide or self-harm. The CM referred Mr Singh to the mental health team. He told us that he did not remember the conversation well but that Mr Singh "seemed okay" when they spoke.

32. In the early morning of 9 November, the night patrol officer found Mr Singh "screaming and in clear distress". Mr Singh said that he was struggling mentally and not sleeping. The night patrol officer completed a mental health referral. Later that day, a prison GP prescribed sleeping tablets.

33. On 12 November, a prison chaplain recorded that Mr Singh had told him that he was "constantly hearing negative voices" and that he "saw demons". Mr Singh said that he only slept for 30 minutes per day. He told the chaplain that he had told the

mental health team several weeks ago but had not been given anything to help. The chaplain recorded that this appeared to cause Mr Singh "extreme distress".

34. Later that day, a safer custody officer spoke to Mr Singh, who said that he was having trouble sleeping and was not feeling well. The safer custody officer advised him to apply for an appointment with a prison doctor. Mr Singh said that he had done this and had made an appointment for 17 November.

35. On 18 November, a CM spoke to Mr Singh and established that he had only applied for an appointment with the doctor on 15 November and was waiting for a date to be provided for the appointment. She recorded that Mr Singh was struggling to adjust to prison life.

36. On 19 November, a CM spoke to Mr Singh after his cellmate raised concerns about his welfare. Mr Singh said that he heard voices at night, which kept him awake. The CM referred him to the mental health team, and recorded his view that Mr Singh was struggling in prison.

37. On 22 November, Mr Singh told an officer that he "wanted to kill himself" and needed medication. The officer started ACCT procedures.

38. On 23 November, an officer interviewed Mr Singh for the ACCT procedures. He recorded that Mr Singh said that he was hearing voices often and wanted some medication "to help his head". Mr Singh said that he had never harmed himself and that his statement of intent to take his life was because "everything is finished". Mr Singh also said that his brother had taken his life around six or seven years ago "due to mental health issues".

39. A CM, who was the ACCT case co-ordinator, then led the first case review, with a nurse also present. He recorded that Mr Singh said that the voices he heard were telling him to kill himself but that he had no plans to do this. The CM recorded that Mr Singh had an appointment with a prison doctor on 29 November to discuss his headaches and lack of sleep. (The nurse recorded that the appointment was also to discuss prescribing antidepressants.) Mr Singh said that he was struggling to adjust to prison life and the CM recorded that he advised him to attend the gym or education to help with his wellbeing. The CM did not record any support actions in the care plan.

40. The CM told us that Mr Singh asked him whether the prison doctor could administer an injection to kill him. He said that Mr Singh appeared confused when he said this and that he did not interpret it as an indication that he wanted to die. The CM said that Mr Singh had not harmed himself and did not present as someone in crisis. He said that his impression was that Mr Singh was struggling to adjust to prison life. The CM said that Mr Singh could understand English if they spoke slowly to him.

41. The nurse recorded that Mr Singh had fleeting suicidal thoughts related to struggling to adjust in prison. He noted that Mr Singh said that he would "like to be injected with poison in his kidneys and die". The nurse concluded that the voices Mr Singh heard were reflective of his current distress and emotional state and likely his own thoughts rather than psychotic.

42. On 25 November, Mr Singh started sharing a cell. His cellmate told us that Mr Singh's struggled to settle in prison. He said that Mr Singh's behaviour was unusual in the first weeks that they shared a cell, including that he would sit in the corner of the cell, did not exercise, and when he left the cell he would wander on the landings and not speak to anyone. The cellmate said that Mr Singh often woke up in the early hours and stood in the dark. He said that Mr Singh described seeing ghosts. He said that Mr Singh struggled with English and had difficulty expressing the detail of his thoughts and feelings in English.

43. On 29 November, a prison GP reviewed Mr Singh. He recorded that Mr Singh reported headaches, poor sleep, and hearing voices telling him to harm himself. The prison GP recorded that Mr Singh said that he had no plans to harm himself. He prescribed mirtazapine (an antidepressant) and recorded that Mr Singh's symptoms appeared to be a reaction to his situation.

44. On 30 November, a CM held an ACCT case review, with a second CM also present. He recorded that Mr Singh appeared more positive now that he had been prescribed medication. The CM noted that Mr Singh had not yet been to education but said he would attend. (There is no evidence that Mr Singh subsequently attended education.) He recorded that Mr Singh said that he had no plans to harm himself. The CM noted that he and the second CM ended ACCT monitoring because Mr Singh had not and did not plan to harm himself, he did not present as being in crisis and he had resolved his medication issue.

December 2021

45. On 3 December, a consultant forensic psychiatrist assessed Mr Singh on the instruction of his solicitor. In his report (dated 15 December and received at Birmingham on 7 January 2022), the forensic psychiatrist wrote that Mr Singh presented with symptoms including auditory hallucinations (hearing voices), low mood, tiredness and suicidal ideation. He concluded that Mr Singh satisfied the criteria for a psychotic disorder, probably schizophrenia, and that he required inpatient treatment and assessment in a psychiatric hospital. He noted that he had referred him to a medium secure hospital.

46. On 7 December, a CM held an ACCT post-closure review. He recorded that Mr Singh said that he was sleeping better and received help and support from his cellmate.

47. On 11 December, an officer completed a welfare check on Mr Singh, recording that his family had telephoned the prison and said that Mr Singh "was going to kill himself". He recorded that Mr Singh said that he had no thoughts of self-harm and was okay.

48. On 13 December, a prison GP reviewed Mr Singh. He recorded that Mr Singh said that he heard voices which spoke about loans he had taken, poisoned food or telling him to cut himself. Mr Singh said that he sometimes recognised the voices as his wife's family. He said that the mirtazapine helped a little. Mr Singh also said that he had experienced headaches for two years and was currently experiencing disturbed sleep. The prison GP recorded that most of Mr Singh's symptoms appeared "reactionary". He increased the dose of mirtazapine.

49. The prison GP told us that Mr Singh preferred to speak in Punjabi or Urdu and so their reviews were usually completed in these languages. He said that they also had conversations in English and Urdu. The prison GP said that Mr Singh would "struggle his way through English" but could have a very reasonable conversation in the language.

50. On 20 December, Mr Singh appeared in court and was remanded back to Birmingham to await his trial. A court officer completed a suicide and self-harm warning form, recording that he appeared very depressed and had told a court nurse that he would not be able to cope in prison. The court officer recorded that they had telephoned Birmingham and spoken to an officer in Reception.

51. No one at Birmingham recorded this information or that Mr Singh returned from court with a suicide and self-harm warning form. The officer told us that there was no formal interview in reception for prisoners returning from court, although if they had received a long sentence or court staff had raised concerns, the prisoner would be referred to the reception nurse.

52. A nurse assessed Mr Singh in reception. The nurse told us that he did not see the suicide and self-harm warning form and was not aware that one had been completed. He recorded that Mr Singh said that he was well but appeared low. The nurse telephoned L Wing and asked staff there to "keep an eye" on Mr Singh.

53. Mr Singh's cellmate told us that Mr Singh appeared a little better over the Christmas and New Year period. He said that Mr Singh began to talk and eat more than previously.

January 2022

54. On 4 January 2022, a prison GP reviewed Mr Singh. He recorded that Mr Singh had harmed himself by scratching his arms and legs and that he said that this was not an attempt to end his life. Mr Singh said that he had no current plans to end his life or harm himself further. Mr Singh also said that he had experienced side effects from mirtazapine so he agreed to reduce this prescription and to begin sertraline as an alternative. The prison GP told us that his understanding was that Mr Singh had scratched his arms due to "frustration" at his situation. He said that Mr Singh did not say how frequently he had scratched himself.

55. On 5 January, an officer completed a wellbeing check on Mr Singh when his family contacted the prison, concerned about his mental health. She recorded that Mr Singh said that he wanted to see the mental health team, and that she advised him to make an application and to ask staff or prisoners for assistance with this if he needed it.

56. On 12 January, a mental health nurse assessed Mr Singh following receipt of the consultant forensic psychiatrist report five days previously. She recorded that Mr Singh requested a Punjabi interpreter but there was not one available. The nurse told us that Mr Singh said that he had "very little understanding" of English. She said that Mr Singh understood what she said to him and was able to converse in "limited English" to the degree that she thought they both understood the conversation.

57. The nurse recorded that Mr Singh said that he heard the voices of his wife's family members telling him that he was "going to die". Mr Singh said that he thought family members in the community and people in prison were trying to poison him. Mr Singh also said that he had previously scratched his arms and that his hallucinations sometimes made him think about harming himself but he did not want to do this as he wanted to be "strong for his children" as he was "fearful they will be harmed by family members". The nurse recorded that Mr Singh would be assessed by the prison psychiatrist and discussed at the weekly multidisciplinary team meeting in order to be allocated to the mental health team's caseload. She also asked a prison doctor to prescribe medication to help Mr Singh sleep, which was done later that day. (The multidisciplinary team meeting is held every Wednesday so Mr Singh was listed for discussion at the next meeting on 19 January.)

58. On 14 January, a prison psychiatrist assessed Mr Singh, with a nurse also present. He told us that Mr Singh could not speak English and his understanding of the language was "very bad". They held the review in Hindi. The prison psychiatrist recorded that Mr Singh was low and tearful and said that his life was "not worth living anymore". He recorded that Mr Singh said that he had cut his arm and leg recently and had thoughts of harming himself but no current plans to do so. The prison psychiatrist told us that Mr Singh said that his children were a protective factor. He recorded that Mr Singh said that he heard the voices of family members threatening to kill him and telling him that his food was poisoned. Mr Singh also told the prison psychiatrist that he sometimes saw family members on the wing and believed that they may kill him. The prison psychiatrist recorded that he considered Mr Singh's likely diagnosis to be depression with psychotic symptoms. He noted that he was not convinced about the psychotic symptoms and that this required further exploration and, as a result, he would not yet prescribe antipsychotic medication. The prison psychiatrist also noted that the consultant forensic psychiatrist, had recommended hospital admission and recorded that Mr Singh should move to Ward 2 (the healthcare inpatient unit for prisoners with mental ill health conditions).

59. In the afternoon, the nurse completed a referral form for Ward 2 and sent this by email to the relevant inbox. The nurse told us that he thought he marked the referral as 'urgent' but this was not the case.

60. On 15 January, the deputy Ward 2 manager and the mental health team manager, discussed the referral. The deputy Ward 2 manager recorded that the referral did not appear to be urgent as one of the reasons for admission was for treatment whereas Mr Singh was currently compliant with his medication. She recorded that they agreed that the referral could be discussed at the weekly regional resource meeting on 19 January. (The regional resource meeting is held every Wednesday and mental health professionals from prisons in the West Midlands attend to discuss referrals made from those prisons to the mental health inpatient unit at Birmingham.) The deputy Ward 2 manager told us that she discussed the referral with colleagues in the mental health team and agreed that there were no "red flags" that meant Mr Singh required immediate admission to the inpatient unit.

61. On 19 January, the multidisciplinary team discussed Mr Singh's assessment at their weekly meeting. They allocated him to a nurse's caseload. The nurse told us that because he worked part-time and had to attend a training course, he was not able

to see Mr Singh until 27 January. (The nurse arrived on L Wing to see Mr Singh when the emergency response was ongoing.)

62. That day, the regional resource meeting discussed Mr Singh's referral to Ward 2. They concluded that he should be managed on the wing, with support from the mental health team and prison doctor. This outcome was not recorded in Mr Singh's medical record.

63. On 24 January, the medium secure psychiatric hospital emailed the mental health team at Birmingham and wrote that consultant forensic psychiatrist's referral had been closed. They wrote that there were no plans for hospital admission or assessment. The mental health team manager told us that the hospital did not accept the referral because it did not follow the correct process as they do not accept referrals from court reports.

64. On 25 January, a prison GP reviewed Mr Singh. He recorded that Mr Singh was keen to move to Ward 2. The prison GP recorded that Mr Singh's memory and concentration were poor and he appeared dejected, although Mr Singh said that his sleeping tablets had helped. The prison GP noted that he would increase the dose of sertraline and chase the Ward 2 admission. He told us that he was unaware (as it had not been recorded in the medical record) that the regional resource meeting had chosen not to admit Mr Singh to Ward 2.

65. On 26 January, Mr Singh spoke to a nurse at the medication hatch. Mr Singh said that he did not think he was receiving the correct medication and was beginning to hear voices. The nurse recorded that Mr Singh was alert and oriented. He told Mr Singh that he would send a 'task' to the mental health team to review him.

Events of 27 January 2022

66. On 27 January, Mr Singh's cellmate attended court. Mr Singh was therefore alone in the cell from around 7.50am. At around 8.10am, he was unlocked and spent time walking around the landings and collecting medication. At around 8.30am, Mr Singh returned to his cell and, at around 8.40am, an officer locked the cell.

67. At 10.07am, the officer went to Mr Singh's cell as part of a stand fast roll check (where prison staff are asked to conduct a count of prisoners outside of the usual times that this would take place). She told us that through the cell door observation panel, she could see Mr Singh sitting on the end of his bed with his legs and chest in view, but not his head. The officer said that this did not seem right, and when she tried to open the door (which she did two seconds after arriving at the cell), she found that Mr Singh had created a barricade. (Mr Singh had used a crutch, which his cellmate had brought into prison due to a leg injury, to make the barricade.) The officer shouted to colleagues for assistance.

68. A CM responded and recorded that, from the observation panel, she could see a plastic bag over Mr Singh's head. With assistance from wing staff, the door was opened (25 seconds after the officer had first arrived at the cell). The CM radioed a code blue medical emergency, indicating a life-threatening situation. The control room operator telephoned for an ambulance.

69. The CM and an officer removed the bag and began cardiopulmonary resuscitation under the direction of a nurse who arrived shortly afterwards. The nurse applied a defibrillator, which advised to continue resuscitation. Other prison staff took over cardiopulmonary resuscitation until paramedics arrived at 10.23am and took charge of the resuscitation.

70. At 11.00am, paramedics transferred Mr Singh to an ambulance and took him to City Hospital, Birmingham. At 11.40pm, Mr Singh died.

Contact with Mr Singh's family

71. When the ambulance left to take Mr Singh to hospital, an operational manager telephoned his sister and told her what had happened. Mr Singh's sister and other family members visited him in hospital later that morning and met a prison family liaison officer.

72. When he died, an operational manager telephoned Mr Singh's family to inform them.

Support for prisoners and staff

73. After Mr Singh's death, an operational 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.

74. An operational manager spoke to Mr Singh's cellmate when he returned to the prison in the early evening of 27 January and signposted him to support services.

Post-mortem report

75. A post-mortem examination established the cause of death as hypoxic-ischaemic brain damage caused by multi-organ failure.

Findings

Identifying the risk of suicide and self-harm

76. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Birmingham should have recognised Mr Singh as at risk and begun ACCT procedures to support him.

Reception and first night

77. Mr Singh had some significant risk factors for suicide and self-harm when he arrived at Birmingham. It was his first time in prison. He was charged with the murder of his wife and likely to be sentenced to life in prison if found guilty. The nature of his offence meant that there might be barriers to maintaining a relationship with his children and other family members. There is no evidence that reception or first night staff considered that Mr Singh's risk factors might have meant that he was at increased risk of suicide and self-harm, or considered starting ACCT procedures.

ACCT procedures

78. Prison staff appropriately started ACCT procedures when Mr Singh said that he wanted to end his life. However, some of the ACCT procedures were poorly managed and not in line with national guidance.

First case review

79. PSI 64/2011 states that support actions must be set at the first case review to mitigate and lower risk for all prisoners subject to ACCT monitoring. These should be completed as part of a care plan in the ACCT document, identifying action points required to reduce risk, who is responsible for completing these actions points and when they should be completed.

80. There were no support actions completed in Mr Singh's ACCT document. A CM who was the case co-ordinator, told us that he did not record any support actions because he thought that all of Mr Singh's issues had been resolved. He said that Mr Singh's medication had been "sorted" and he had a doctor's appointment arranged. The CM said that he has since been told by the Head of Safety that he should have set these as support actions. However, we note that Mr Singh had not yet seen the doctor and had not yet been prescribed medication. These action points were therefore still outstanding and were not resolved. Mr Singh also said that he was struggling to adjust to prison life and, while the CM recorded in the case review that he advised Mr Singh to attend the gym or education, these should have been recorded as support actions to ensure they were achieved before the ACCT was closed.

Closing case review

81. PSI 64/2011 states that the ACCT case co-ordinator must ensure that healthcare staff are always invited to attend (or provide a written contribution if attendance is not possible) any case reviews where they are relevant to supporting the prisoner.

82. There were no healthcare staff at Mr Singh's closing case review. Two of his key issues were seeing the doctor and getting medication. He had also recently been assessed by the mental health team. Our view is that it would have been appropriate for a healthcare member of staff to attend the case review to provide input on these issues.

83. PSI 64/2011 also states that ACCT procedures can be closed when the risk of harm has reduced to a level where it is no longer considered raised, and all support actions have been completed with their intended outcome achieved.

84. When Mr Singh's ACCT procedures were closed, he had not yet seen a doctor or been prescribed any medication. There was not therefore an opportunity for the case review team to discuss the outcome of his appointment with Mr Singh. He had also not begun any purposeful activity and continued to spend most of the day in his cell.

85. It is apparent that the issues identified at the assessment and first case review had not yet been resolved and our view is that the ACCT procedures should not have been closed at this stage. It is possible that not completing an appropriate care plan, and not holding a multidisciplinary case review with healthcare input, contributed to the decision to close the ACCT procedures while there were still outstanding issues.

Return from court on 20 December 2021

86. On 20 December 2021, a court officer completed a suicide and self-harm warning form, which returned to Birmingham with Mr Singh, and telephoned reception staff with their concerns.

87. No one at Birmingham made a record of this telephone conversation or that Mr Singh returned with a suicide and self-harm warning form. There is no evidence that reception staff interviewed him on his return. A reception officer told us that prisoners returning from court would usually only receive a brief informal conversation but would be sent to the reception nurse if they had received a long sentence that day. Although Mr Singh was referred to the reception nurse for review, the nurse told us that he did not see and was not aware of the suicide and self-harm warning form.

88. Communication between agencies is important in identifying the risk of suicide and self-harm. When court staff identified a potential increase in Mr Singh's risk, this should have prompted reception staff to interview him on his return, consider staring ACCT procedures, and record their findings.

Events of January 2022

89. A much wider range of significant risk factors were revealed in the weeks before Mr Singh died. He began to harm himself by scratching his arms and said that his life was no longer worth living. As previously, Mr Singh spoke of hearing voices or seeing delusions and sometimes now said that these were of family members who intended him harm. Healthcare staff now knew that an independent psychiatrist had recommended Mr Singh's admission to a medium secure psychiatric hospital. As in previous months, Mr Singh's family contacted the prison with concerns for his wellbeing.

90. We are concerned that many of these events were treated in isolation. Too much weight was given to Mr Singh's comments that he did not wish to end his life or that his children – with whom he had not had any contact – were protective factors. Wing staff told us that they were not aware that Mr Singh had been recommended for psychiatric hospital admission or to the healthcare inpatient unit.

91. We are concerned that no one appeared to consider Mr Singh's significant risk factors holistically or that together they might increase his risk of suicide and self-harm, and ACCT procedures were not started. If staff had started ACCT procedures, it would have allowed them to identify and address Mr Singh's issues and triggers, and work together to reduce the impact of these, while at the same time allowing more frequent monitoring of his wellbeing. While we cannot say that this would have led to a different outcome, it would have given prison staff more chance of preventing his death. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **ACCT support actions are completed with actions that are specific and meaningful and include all of the issues identified during the assessment interview and at case reviews;**
- **healthcare staff are invited and contribute to all case reviews where their support is relevant; and**
- **ACCT monitoring does not stop until all support actions have been completed and risk is no longer considered raised.**

Clinical care

92. The clinical reviewer identified several omissions in Mr Singh's clinical management at Birmingham.

Prescribing medication

93. On 4 November 2021, a mental health nurse recommended that Mr Singh should start antidepressants and sent a 'task' to prison doctors to prescribe them. The medication was not commenced until 29 November, over three weeks later. Mr Singh's concerns about access to medication was a significant factor when ACCT procedures were started over two weeks after the task was sent. The clinical reviewer noted that it is unclear why the delay to prescribing occurred.

Allocation of mental health keyworker

94. On 7 January 2022, healthcare staff received the consultant forensic psychiatrist's report, recommending Mr Singh's admission to a medium secure psychiatric hospital. He was reviewed five days later, and it was noted that he would be allocated a mental health key worker at the next team meeting, which was now a week away. When Mr Singh was subsequently allocated to a mental health nurse on 19 January, the nurse's working pattern meant that he was not able to attempt to see Mr Singh until 27 January. The mental health team manager told us that patients should be seen by their key worker within seven days of allocation.

95. Mr Singh was not seen by a mental health key worker within seven days of allocation, and the clinical reviewer notes that it was over two weeks since he was recommended for allocation and nearly three weeks since receipt of the consultant forensic psychiatrist's report. This is too long for a patient who had been recommended for hospital admission.

Admission to mental health inpatient unit

96. On 14 January, a prison psychiatrist recorded that Mr Singh should move to Birmingham's mental health inpatient unit. A nurse sent a referral form later that afternoon. The deputy ward manager told us that referrals marked as urgent are admitted immediately and standard referrals are considered at the regional resource meeting held on Wednesdays. Mr Singh's referral was not marked as urgent. The deputy ward manager said that patients who have been referred for admission to a medium secure psychiatric hospital would not necessarily require urgent admission to the mental health inpatient unit. She said that there is no section on the referral form to indicate urgency and decisions are made by discussion with colleagues in the mental health team.

97. The clinical reviewer found that the referral form should indicate urgency in order to prevent potential delays to admission. She identified that the mental health inpatient unit had empty beds when Mr Singh's referral was received and so he could have been admitted immediately.

98. Mr Singh's potential admission was subsequently discussed at the regional resource meeting on 19 January. The panel concluded that his admission was not required and that he could be managed on a prison wing instead. The refusal of admission was not recorded in Mr Singh's medical record and prison psychiatrists were not consulted or informed. The clinical reviewer noted that those who attended the meeting had not previously worked with Mr Singh and did not know his history.

99. The clinical reviewer found that Mr Singh should have been admitted to the mental health inpatient unit following the recommendation of the prison psychiatrist. She found that this was a missed opportunity to observe Mr Singh in a controlled environment which would have aided future decisions about care and medication. The clinical reviewer also found that the failure to record and communicate the decision and reasons not to admit Mr Singh meant that professionals, including a prison doctor who assessed him the following week, did not have full information and thought that he was still waiting for a place on the inpatient unit.

Admission to medium secure psychiatric hospital

100. On 24 January, staff at the medium secure psychiatric hospital informed prison healthcare staff that the consultant forensic psychiatrist's referral was closed. The mental health team manager told us that the hospital did not accept the referral because it did not follow the correct referral procedure. The clinical reviewer found that no one in the mental health team at Birmingham sought to commence a further referral following the correct procedure and there is no evidence that anyone sought to discuss the referral process with the hospital.

101. The clinical reviewer concluded that the mental health care that Mr Singh received was not of the required standard and not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that patients receive appropriate support from the mental health team that is equivalent to that which they could expect to receive in the community, including that:

- **medication requests from mental health nurses are considered and actioned as soon as possible;**
- **patients are allocated a mental health key worker at the earliest opportunity and are assessed by the key worker within seven days, or earlier if urgent assessment is required;**
- **an 'urgent' marker is added to the mental health inpatient unit referral form;**
- **relevant staff who know the patient are invited to contribute to the regional resource meeting, that meeting outcomes are documented in the medical record, and that prison psychiatrists are consulted if their recommendations for admission are not considered to meet the criteria for admission; and**
- **If a patient's referral to a medium secure psychiatric hospital is refused, the hospital is contacted to establish the reasons and a further referral is considered when relevant.**

Translation services

102. PSI 64/2011 states that all members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk or during the risk management

process. Further Prison Service guidance states that staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them.

103. Prison and healthcare staff gave us different accounts of the level of Mr Singh's English. Some told us that Mr Singh's English was sufficient to understand what they said to him and for them to understand his meaning. Some healthcare staff told us that Mr Singh's English was limited and that they spoke to him in his preferred languages. On one occasion, Mr Singh requested an interpreter, but none was available. Mr Singh's cellmate told us that Mr Singh struggled with English and with expressing his thoughts and feelings in the language.

104. As with all prisons, Birmingham has a contract with a professional telephone interpreting service. This service was not used for Mr Singh. There is also no evidence that anyone considered referring Mr Singh to an English as a second language course. A failure to communicate effectively with prisoners can make it harder to identify risk factors or properly assess mental ill-health. We make the following recommendation:

The Governor and Head of Healthcare should that prisoners whose first language is not English are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

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