PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man at HMP Birmingham in June 2013

Our Vision

*‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’*

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Birmingham, on 15 June 2013. He was 23 years old. I offer my condolences to the man's family and friends.

An investigator was appointed and a clinical reviewer reviewed the man's clinical care at the prison. HMP Birmingham co-operated fully with the investigation. The investigation was suspended until a criminal investigation concluded and I regret the consequent delay in issuing this report.

The man had been released on licence from a prison sentence in February 2013, but was called to prison in April 2013, facing further charges for serious violent and sexual offences. At the time of his arrest, the man had held his ex-partner hostage, at knifepoint. While he was in police custody, the police constantly supervised him as he had tried to harm himself. Police flagged up his risk of suicide on his escort document but reception staff at Birmingham took no further action and did not consider his other risk factors for suicide. The prison missed further opportunities to identify the man's risk and support him, when his mother reported that he had threatened to kill himself and a member of staff listened to his recorded telephone calls.

Prison staff at Birmingham should have recognised that the man was at risk of suicide and self-harm when he first arrived at the prison and afterwards. As in many cases my office investigates, the staff relied too much on his personal presentation and his assurances that he did not intend to kill himself, rather than his evident risk factors, which should have been clear to them. I am very concerned that prison staff did not begin suicide and self-harm prevention procedures, as national instructions require, when the man's mother and telephone monitoring, alerted them that he had threatened to kill himself.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2015**

CONTENTS

Summary 5

Investigation process 6

HMP Birmingham 7

Key events 9

Issues 16

Recommendations 19

Action Plan 20

SUMMARY

1. The man left prison on a conditional licence in February 2013. On 25 April 2013, after the Ministry of Justice revoked his licence, the police arrested him and charged him with serious violent and sexual offences. At the time of his arrest, he had held his partner and one of his children hostage, at knife point. Police negotiators had persuaded him to surrender. He had recently attempted to take his own life and told one of the police doctors that he had suicidal thoughts. He spent two days in police custody, during which the police constantly observed him as a high risk of suicide.

2. The man arrived at HMP Birmingham on 27 April. His escort record indicated that he was at risk of suicide and self-harm. At a reception health screen, he said that he did not want to kill himself, but he was angry about being in custody and felt low. In spite of a number of clear indicators that he was at risk of suicide, reception staff did not begin Prison Service suicide and self-harm prevention procedures, known as ACCT.

3. On 10 May, the man's offender manager asked the prison to monitor his telephone calls, as she was concerned they might attempt to contact each other. In telephone conversations with his mother, the man had threatened to kill or harm himself. On 21 May, she telephoned the Offenders' Families Helpline, who informed the prison on her behalf, as she had not been able to get through. Staff noted the concern in the wing observation book, but did not begin any formal monitoring or support.

4. On 29 May, in response to the request by the man's offender manager, an administrator listened to recordings of the phone calls the man had made from 15 May. She heard him threaten to hang himself and immediately passed the information to safer custody, security and wing staff. When staff discussed this with him, the man said that he had been angry at the time and had no current thoughts of self-harm. They took no further action.

5. At 5.34am on 15 June, an officer discovered that the man had hanged himself from the window of his cell. As rigor mortis had set in, staff did not attempt resuscitation. Paramedics pronounced him dead at 5.49am.

6. We are concerned that, in spite of the man's history and evident range of risk factors, prison staff did not identify him as at risk of suicide and self-harm when he first arrived at Birmingham. They did not request his police medical records, which would have given more information. When the man's mother reported his threats to hang himself, prison staff did not comply with a mandatory requirement in national instructions, to begin suicide and self-harm prevention procedures. They missed a further opportunity later, when the administrator alerted operational staff to what he had said. Prison staff relied too much on the man's assurances that he would not kill himself, rather than his known risk factors.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Birmingham, informing them of the investigation and inviting them to contact him if they had relevant information. No one responded.

8. The investigator went to HMP Birmingham and met the Director and members of the safer custody team. He obtained copies of the man's prison and healthcare records.

9. The investigator informed HM Coroner for Birmingham of the investigation. We have sent the Coroner a copy of this report to her.

10. NHS England (Shropshire and Staffordshire Area) appointed a clinical reviewer to review the man's clinical care at HMP Birmingham.

11. One of the Ombudsman's family liaison officers and the investigator visited the man's family on 13 August 2013, to explain the investigation process. The man's family asked for the following issues to be considered during the investigation:

    - Was the man risk appropriately considered when he arrived at Birmingham?
    - Should staff have identified comments he made on the telephone about self-harm sooner and was appropriate action taken?
    - Was the man's location appropriate?
    - What medication was the man prescribed?
    - Had the man been placed on suicide and self-harm monitoring?

12. In line with the Ombudsman's terms of reference, we suspended our investigation while West Midlands Police conducted a criminal investigation into the circumstances of the man's death. The investigator met the police investigating his death to agree arrangements for information sharing and remained in contact with them throughout.

13. The police did not bring any criminal charges. After the conclusion of the Crown Prosecution Service (CPS) review, the police shared a number of documents, including all witness statements and the transcripts of interviews with staff and prisoners.

14. The man's family received a copy of the draft report. The family have made no comments.

15. The Prison Service responded on 19 December indicating no factual inaccuracies and accepting all recommendations. Their action plan is attached at page 20.

HMP BIRMINGHAM

16. HMP Birmingham is a large local prison, principally serving the West Midlands courts. It holds a maximum of 1450 remand and sentenced men. G4S Care and Justice Services has managed the prison since 1 October 2011. Birmingham and Solihull Mental Health Foundation Trust run healthcare services. The healthcare centre operates 24 hours a day.

Her Majesty's Inspectorate of Prisons

17. HM Inspectorate of Prisons' most recent inspection of Birmingham was in March 2014. Inspectors noted that high prisoner turnover and movements because of overcrowding meant that prisoners often arrived at reception late, putting first night and induction procedures under great strain. Despite this, inspectors found that first night staff were caring and generally did a good job keeping prisoners safe.

18. The number of incidents of self-harm was not high taking into account the size and complexity of the population and support for those at risk was good. However, the inspectors commented on the need for greater attention to identifying risk of suicide and self-harm for newly arrived prisoners.

19. Health services were generally very good and valued by most prisoners. Primary, in-reach and forensic mental health services were well integrated.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recent annual report, for 2012/13, the IMB reported that Birmingham's safer custody team continued to be pro-active but safer custody meetings were not well attended. They noted that during the reporting period there had been 354 incidents of self-harm compared with 276 the previous year. The number of ACCTs opened had decreased from 684 to 328.

Previous deaths

21. The man's death was one of three apparently self-inflicted deaths at Birmingham in 2013. In a previous investigation, we were concerned that prison staff did not appropriately consider and identify prisoners' risk of self-harm when they arrived and afterwards. We repeat a recommendation about this issue in this report

Assessment Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and managing prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to

supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how staff will meet them. There should be regular multidisciplinary reviews.

Vulnerable prisoners

23. Prisoners who are regarded as vulnerable can be held separately from other prisoners for their own interests under Prison Rule 45. There are a number of reasons why prisoners might be held separately in what are known as vulnerable prisoner units or wings. These include:

- Committing an offence of which other prisoners disapprove (for example, sexual offences or one involving a child);
- Accumulating debts to other prisoners they are unable to pay;
- Giving evidence to the prosecution or being regarded as an informer; or
- Susceptibility to bullying from other prisoners.

KEY EVENTS

24. On 2 November 2012, the man was sentenced to 15 months in prison. The next day, the man was very distressed that he was not allowed to contact his children. Staff at HMP Hewell opened ACCT suicide and self-harm prevention procedures but ended them the next day.

25. On 19 February 2013, the man left prison on conditional licence. His licence period would end on 21 April 2014. One of the conditions was that he was not to communicate with his ex-partner or his children, unless approved by Birmingham Children's Services. On 23 April 2013, after he had breached his licence three times (including assaulting his ex-partner at her home), his offender manager recalled the man to prison.

26. On 25 April, when the police went to the man's ex-partner's home to arrest him, he had barricaded the property. When they eventually got in, the man was holding his son in his arms and had two large knives. He was holding one of the knives against his ex-partner's throat. Police negotiators eventually persuaded him to surrender. Just before he was arrested he had tried to electrocute himself but blue a fuse. He had also tried to stab himself with one of the knifes.

27. At the police station, police constantly monitored the man, as they were concerned about his risk of suicide and self-harm. He told doctors who reviewed him that he was an alcoholic and used recreational drugs. He initially appeared intoxicated. He said that he had been diagnosed with depression, felt low and wanted to harm or kill someone. Four doctors assessed him while he was in police custody and recorded that the man was tearful, had poor eye contact, thoughts of self-harm and strong intentions to harm others. Doctors prescribed diazepam (a sedative) to relieve symptoms of withdrawal from alcohol and zopiclone (a sleeping tablet).

28. On Saturday 27 April, the man appeared at Birmingham Magistrates' Court, charged with two counts of rape, common assault, threats to kill and unlawful imprisonment against his ex-partner. The court remanded him to HMP Birmingham. The police had noted on the man's Person Escort Record (PER) that he was at risk of suicide. Escort staff did not have the medical records completed in police custody so they were not available to staff at Birmingham.

HMP Birmingham

29. When they arrived at Birmingham, escort staff passed the PER to reception staff. A first line manager, carried out reception procedures. This included a cell sharing risk assessment (CSRA) to assess the man's suitability to share a cell.

30. The reception manager recorded:

> 'PER - SELF HARM / SUICIDE MARKER. [The man] states he has no current thoughts of self-harm/suicide, but he did try to hurt himself the

other night, but states he done this as he was annoyed and felt set up but is fine now…'

31. The reception manager noted that the man did not want to be allocated to the wing for vulnerable prisoners. In a police interview, the reception manager said that he had concluded the man was a standard risk of violence to others and therefore suitable to share a cell. He had no other concerns about his well-being. He was aware that the man had tried to harm himself before he had been remanded to prison, but, after their conversation, the reception manager felt that there were no immediate issues and it was unnecessary to start ACCT procedures.

32. A nurse completed the medical section of the CSRA form, and a health assessment. The nurse recorded that the man had said he had no thoughts of suicide or self-harm but said he felt low in mood. She referred him to the prison GP. The nurse recorded the following comments:

    '… Reception health screen – Laceration and bruising to his back. Tried to stab himself a few nights ago. Refer to GP reference substance use. History of opiate use, last used five days ago. History of cannabis use, last used four days ago. Spends around £140.00 per week on drugs. Drinks 1 bottle of spirits and 8 cans per day ...'

    In the medical section of the CSRA, the nurse noted that she did not consider the man at increased risk of violence to another prisoner. The man signed the consent form for access to his previous medical records but said that he was no longer registered with a GP.

33. A locum GP, reviewed the nurse's assessment. He did not see the man personally or any of the documents that had arrived with him. He noted that the man had been referred for therapy for drug addiction and alcohol detoxification. He completed a medication risk assessment and prescribed standard medication for alcohol detoxification, including paracetomol, diazepam (to be taken supervised) and vitamins. The GP also recorded that the man had no history of self-harm and no current ACCT plan.

34. A prison custody officer spoke to the man to complete a first night assessment. The man told him that he had expected to come to prison. He said that he used drugs recreationally, was an alcoholic and that he was experiencing withdrawal symptoms. He said that he had self-harmed within the last month, but had no current thoughts of suicide or self-harm. The officer recorded that the man was quiet but cheerful and had no concerns about being in prison. There is no record that the officer or any of the reception staff considered the man's risk factors, such as the fact that he had been recalled to prison, his alleged violent offence against family members and that he was withdrawing from alcohol.

35. The officer ticked the form to indicate that the man had other worries or concerns but did not list any details, as the assessment form requires. When interviewed, the officer explained that he might have ticked 'yes' in error, or that

he had forgotten to complete the details. He said he would have started ACCT procedures if the man had mentioned anything to concern him. He could not recall seeing anything significant in his reception or other documents.

36. On Monday 29 April, the man moved to a cell in A wing, on a landing reserved for prisoners at risk due to their offence. At a secondary health screen and an appointment with a doctor the same day, the man repeated that, although he had tried to stab himself the previous week, he had no current thoughts of suicide or self-harm. He told the doctor that he had 'mad thoughts' like knocking doors down and harming someone. The doctor referred the man to the primary care mental health team to consider whether he needed medication to relieve his symptoms. To inform the mental health team of the priority, he completed a Threshold Assessment Grid score, which is used to determine a patient's perceived level of mental health problems. The man scored eight, indicating mild symptoms.

37. On 1 May, another prison probation officer, told the man that the courts had imposed a restraining order forbidding him from contacting his ex-partner and that they considered he was a risk to his children. She warned him that his telephone calls would be recorded and could be monitored.

38. On Thursday 2 May, in a telephone conversation with his sister, the man spoke about an attempt to electrocute himself on the night of his arrest. He said that the only person he was trying to harm was himself, that he felt like doing it" and could not deal with things anymore.

39. The next day, the man told his mother that he would 'string up' if he got a long sentence and was not allowed to see his children. His mother asked him to explain what he meant and he said that he would hang himself. He asked his mother to tell his ex-partner what he had said, but she refused. The man repeated that he would hang himself, and said that there was more than one way to do it prison, whether staff watched him or not.

40. On 10 May, the man attended a preliminary hearing at Birmingham Crown Court. The same day, the offender manager, emailed the probation officer and asked the prison to monitor his telephone calls as she was concerned that the man and his ex-partner might be trying to contact each other.

41. The probation officer told the man on 15 May, that in view of the charges he was facing, the probation and children and families services would not support an application for him to have contact with his children. She noted that the man became verbally aggressive, but vented his anger at the agencies involved. (The next day, the probation officer submitted two security information reports (SIRs) describing the man's reaction during their conversation and passing on the offender manager's request for his telephone calls to be monitored.)

42. During the early evening of 15 May, the man telephoned his mother. (The telephone call was recorded but not monitored at the time.) The man told her that he had been in tears and had been thinking about things and was getting close to 'doing it'. His mother said that he was being unfair and should not say

things like that, but he said he was only telling the truth. His mother then handed the telephone to her husband. The man told him that he was 'not good at the moment' and had thoughts of doing things to himself, as he could no longer cope with the stress.

43. On 17 May, in another telephone conversation with his mother, the man said that he intended to ask to see the mental health team for antidepressants. He said that his 'head was all over the place' and that he was 'stressing over things', such as the lack of contact with his children. He said that he felt he had been treated as if he were guilty.

44. On Tuesday 21 May, the man told his mother that he had not seen a doctor since the last time they had spoken. He believed it was because doctors did not go to the vulnerable prisoners' wings. He asked his mother to contact the prison to arrange this and she advised him to tell his solicitor, who was due to visit him on Friday. The man was concerned that he might receive an indeterminate sentence and implied that, if so, he would kill himself.

45. At 5.22pm, the man's mother telephoned the Offenders' Families Helpline as she had been able to get through to anyone at the prison. She told the co-ordinator, that she was concerned about her son as he had threatened to take his life and that she had been unable to contact the prison. The co-ordinator said that he had telephoned Birmingham at 5.59pm, on behalf of the man's mother, and spoken to a first line manager. The line manager had agreed to check the man and monitor the situation. The co-ordinator reported this back to the man's mother.

46. The line manager recorded in the wing observation book, 'from the family this prisoner states he is low in mood, staff be aware please'. He also noted that he had spoken to an officer and a first line manager, who both knew the man.

47. The manager said he had no recollection of the conversation with the other line manager, but thought that the man had been coping all right in prison. The officer said that he recalled a conversation with the line manager on 21 May. He had told him that the man's family were concerned about him being in a low mood. The officer had agreed to have a chat and keep an eye on him. He said that the man had not been very open with him, but he appeared fine. His demeanour, behaviour and attitude had not changed, so he had no concerns about him.

48. The next day, 22 May, the man's mother asked him whether anyone had been to see him the previous day, as she had been told that the prison would arrange a doctor to see him. The man said that no one had been to see him and he had had no reply to his application to see a GP. The man's mother said that she had been told that he was on 'suicide watch' and a doctor would see him.

49. On 29 May, an administrator, listened to the man' recorded telephone calls, as a result of the probation officer' request. She subsequently listened to all his calls, which amounted to 53 in total, between 15 May and 14 June 2013. The

probation officer had emailed her the previous day to ask about any relevant telephone calls, for a review of his case on 30 May. The administrator identified two telephone calls to the man's mother, on 15 May and 21 May, in which the man had spoken about taking his own life. She completed a security information report for the security team, and emailed the probation officer and the safer custody team. The administrator also telephoned a first line manager on A wing, about her concerns.

50. In a statement, the A wing manager said that she had advised the administrator to inform the safer custody team who would log the concerns and raise a suicide warning form. (This form was delivered to A wing later that day for the A wing manager to record the action she had taken.) The A wing manager said she had spoken to The man about what he had said to his mother. She said that he told her that he had been angry about some family issues, but he did not feel low and had no thoughts of suicide or self-harm.

51. The A wing manager said that after she had spoken to the man, she did not consider he was at heightened risk of harming himself. In her view, his anger about his situation and his family issues did not increase his risk, as this was a normal emotion for most prisoners. The A wing manager said that the telephone call with his mother had been two weeks earlier and, since then, the man had shown no unusual behaviour. His mood had appeared normal and there had been no acts or statements of intentions to self-harm. She was satisfied that there was no need to take any further action such as beginning ACCT monitoring. He had said he did not want to speak to a Listener. (Listeners are prisoners trained by the Samaritans to provide confidential support to other prisoners in distress.)

52. On 30 May, at an appointment with the GP, the man said that he had felt stressed and anxious as he was innocent of the charges he was facing. He was also concerned that other prisoners would find about his alleged offences and he did not want to move to G wing (the main wing for vulnerable prisoners at Birmingham, which houses men charged with, or convicted of, sexual offences). The man said that he had tried to electrocute himself just before his arrest. Since returning to prison, he had had fleeting thoughts of suicide but no plan to act on his thoughts. The GP said that he did not consider that the man was a high risk of suicide or self-harm, but thought he would benefit from a review in a week's time. In the meantime, he prescribed a short course of sleeping tablets.

53. The same day, the probation officer went to see the man before she attend a Multi-Agency Public Protection Arrangements (MAPPA) meeting about his case. The probation officer said that he had apologised for his outburst on 15 May and they discussed the reasons why he was not allowed to have contact with his children. He seemed to understand the procedures and asked what he could do in the meantime to be able to see them again. The man told the probation officer that he had enrolled on an alcohol and drugs course, which he could complete in his cell. He also intended to complete a parenting skills course. He said that he wanted to see his children and had too much to live for to consider harming himself. The probation officer said that she had never had

any concerns that he was at risk of suicide or self-harm and that he had never mentioned such thoughts to her.

54. At a follow-up appointment with the GP on 6 June, the man appeared much brighter in mood and said that he had received some positive news about his case. He said he had no thoughts of suicide or self-harm. The GP felt that the man was positive about his situation and seemed calm and settled, but said that the sleeping tablets had not helped. The GP prescribed antidepressants and planned to see him again in two weeks.

Events on 14/15 June

55. On the afternoon of 14 June, during a telephone call with his mother, the man said that, his head was 'frazzled' and that he had been trying to write some letters, but nothing was coming to him. He did not mention any intentions to harm himself.

56. A friend of the man, who lived in the cell next to him, said that they had spoken during the day and the man had been his usual talkative self and 'quite hyper'. The man's friend said that the man had never seemed depressed or mentioned thoughts of harming himself. He said that at around 7.30pm, just before prisoners were locked up for the evening, the man had asked whether he had any tobacco, sugar or magazines and said that he would chat to him through the walls or window. However, he did not hear anything from the man after they went back to their cells. The man's friend said that he took medication to help him sleep, but was awake at around 2.00 – 3.00am, when he heard a loud thump. He could not pinpoint where the noise had come from.

57. On the night of 14/15 June, an officer was on night duty on A wing. The Officer began his shift at 9.00pm, and shortly afterwards, he checked that each prisoner was present on the wing. In a statement, he said that during the night there had been no reported problems and he had no cause to visit the man's cell. At around 5.30am, he carried out another check, ready to hand over to the day staff. The Officer said that at approximately 5.34am, he looked through the observation panel of the man's cell and realised that he was hanging from the window. He immediately radioed a code blue, indicating a medical emergency. He said that he did not go into the cell as he was on his own.

58. The officer said that he ran downstairs to the office to tell a first line manager, that he needed help. The manager and an operational support grade (OSG), then went to the cell. On the way, the manager radioed to ask other staff, including nurses, to attend the emergency.

59. The OSG said that they arrived outside the cell at 5.35am and, after checking through the observation panel, the manager went in. Two officers also responded to the emergency call and arrived on A4 landing just as the manager went into the cell. The manager cut the ligature made of torn bedding from around the man's neck. He said that as he did so, he had been unable to hold his weight, and the man fell to the floor. All the staff said that there were clear signs of rigor mortis and it was evident that the man was dead.

60. A nurse arrived and examined the man. His arms were stiff and frozen in the air and his pupils were fixed and dilated. As rigor mortis was present, she did not attempt cardiopulmonary resuscitation.

61. A paramedic with the West Midlands Ambulance Service, said that they received an emergency call from the prison, at around 5.30am on 15 June. An ambulance was already in the area and got to the prison within five minutes. A second ambulance arrived shortly afterwards. The paramedic examined the man and agreed that the presence of rigor mortis meant that they should not try to resuscitate him. An electrocardiograph established that the man's heart had stopped and that there was no electrical activity. The paramedic confirmed the man's death at 5.49am.

Events after the man's death

62. While the paramedics were assessing the man, prison staff discovered two letters, one addressed to the man's ex-partner and the other to his mother in which he apologised for his actions.

63. The manager and the duty governor, debriefed the staff involved in the emergency response and offered them support. At around 10.30am, the duty governor and family liaison officer went to see the man's mother and informed her that her son had died. They told her about the investigation procedures and the financial assistance available to assist with the funeral.

64. A post-mortem examination carried out on 17 June, gave the cause of the man's death as hanging.

ISSUES

Clinical care

65. The clinical reviewer noted that the man had no chronic physical or mental health problems and that healthcare staff had prescribed appropriate medication for his difficulty sleeping. The clinical reviewer considered that, in general, there was good communication within the healthcare department and they kept adequate clinical notes. He noted that the man's alcohol misuse had been identified and treated appropriately using standard alcohol detoxification treatment.

66. The clinical reviewer concluded that healthcare staff managed the man's healthcare appropriately. However, he was concerned that staff did not request a copy of the man's medical records for the time he had spent in the community before he was recalled to prison, and did not obtain the police forensic medical examiner's clinical notes for the period between his arrest and return to prison. Although there is no evidence that the absence of the man's GP records resulted in any specific harm, there might have been useful medical information in the notes to help healthcare staff make correct clinical decisions. We are concerned that healthcare staff could have used his medical records, particularly from his time in police custody, to assess his risk of suicide more effectively. (We discuss this below). We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff request prisoners' community medical records, and police medical records, when a prisoner has spent time in police custody immediately before arriving in prison.

Assessment of the man's risk of suicide and self-harm

67. The police arrested the man on 25 April and he spent two days in police custody. He told the police that at the time of his arrest he had attempted to electrocute himself shortly before his arrest. At the police station, he was constantly supervised as the police believed that he was at high risk of suicide and self-harm. They recorded this risk on the man's escort record.

68. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011, about early days in custody, both list a number of risk factors and potential triggers for suicide and self-harm. The man had a number of factors that were significant indicators of risk of suicide, including recall to prison; early days in custody; previous self-harm; depression; drug/alcohol dependency; violent and sexual offences, particularly against family members; relationship instability; and he was subject to child protection/harassment measures. Staff interview newly-arrived prisoners specifically to assess their risk of suicide and self-harm and all staff are expected to be alert to the increased risk of suicide and self-harm posed by prisoners with known risk factors and act appropriately to address any concerns. We are concerned that no one appears to have considered these risk factors, either when he first arrived at the prison or subsequently.

69. The reception officer, the reception manager and nurse saw the escort record on which the man's suicide risk had been recorded. The nurse was aware of recent self-harm as she noted in the cell sharing risk assessment, that he had tried to stab himself a few nights before (at the time of his arrest.) He told both staff that, although he felt low, he had no current thoughts of suicide and self-harm. The staff relied on what he told them and took no action on the warning. There is no evidence that either of them considered the man's other known risks, including his recall to prison, his charges of violent offences against his family, or his withdrawal from alcohol when making their decision. The first night officer, who interviewed him later, was also aware that the man had recently tried to take his own life, but did not note any other risk factors. The officer appears to have been reassured by the man saying he had no thoughts of suicide or self-harm.

70. The information about his risk from the escort record, although apparently discounted, should not have been the only prompt for considering whether the man was at risk of suicide. The man's background and the circumstances of his arrest should have alerted staff that he was at high risk. The staff took insufficient account of all the man's known risk factors and should at least have considered beginning ACCT procedures when he first arrived at Birmingham on 27 April. They missed a further opportunity to consider this at a full health assessment on 29 April, when the man's again reported his recent attempt to stab himself. Again, the staff appeared to have relied on what the man said, without any consideration of his range of risk factors.

71. Staff judgement is fundamental to assessing risk and relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. All risk factors must be recorded, collated and considered to ensure that a prisoner's level of risk is holistically judged. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk.

72. It seems that in assessing the man's risk of suicide or self-harm, the staff relied heavily on his statement that he had no such thoughts at that time. The man had a number of significant risk factors which should have been considered carefully in the context of suicide and self-harm. We are concerned that the staff who assessed him did not give enough weight to these risk factors and did not consider whether he needed additional support.

Handling of concerns by the man's family about his risk of self-harm

73. In May, during three telephone calls with his mother, the man's indicated that he might kill himself. The Offenders' Families Helpline service reported this to the prison on behalf of his mother on 21 May. An officer recorded the initial concerns in the wing observation book. No one took any further significant action. An officer said he had appeared fine, but there is no evidence of a fully considered assessment of his risk as a result of the worrying information about

his state of mind. Again, the staff relied on what the man said to them, yet prisoners who intend to kill themselves rarely tell staff.

74. PSI 64/2011 sets out a mandatory requirement that when staff receive information from a concerned family member which indicates an increase in a prisoner's risk, they should begin ACCT procedures to support the prisoner. The prison did not comply with this.

75. A prison administrator listened to the man's calls, retrospectively, on 29 May. She notified the security and safer custody teams, the man's probation officer and the wing of two telephone calls to his mother in which he had spoken about taking his own life. Staff spoke to him about this but, despite clear evidence that he had expressed an intention to harm himself, discounted the risk, as the calls had been two weeks earlier and the man now said he had no thoughts of suicide or self-harm. Again, the staff do not appear to have considered the context of the calls and his other risk factors and they placed too much reliance on what the man said. In other recent investigations into deaths at the prison, we have identified the need for staff at Birmingham to take account of all risk factors when assessing prisoners' risk of suicide and self-harm. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed, or expressed suicidal intent, or if they receive information from family members which indicates a risk of suicide or self-harm.**

Emergency response

83. When the officer found the man hanging, he correctly radioed a code blue emergency. He did not go straight into the cell using the emergency key, which staff carry at night, but went to get help from a nearby manager. This led to a short delay before a member of staff cut the ligature from around the man's neck and assessed him. This did not affect the outcome as it was clear that the man had been dead for some time. The clinical reviewer was satisfied that as there were clear signs of death, the decision not to attempt resuscitation was correct and we agree.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff request prisoners' community medical records, and police medical records, when a prisoner has spent time in police custody immediately before arriving in prison.

2. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that staff:

   - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
   - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
   - Open an ACCT plan when a prisoner has recently self-harmed, or expressed suicidal intent, or if they receive information from family members which indicates a risk of suicide or self-harm.

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Head of Healthcare should ensure that healthcare staff request prisoners' community medical records, and police medical records, when a prisoner has spent time in police custody immediately before arriving in prison	Accepted	An agreed process is in place which ensures medical notes are requested when a prisoner is received into HMP Birmingham. Although police medical records are not routinely requested, a Person Escort Record (PER) form which contains medical information received from the police is available to the nurses completing the initial reception screening. This identifies any concerns raised from the police station regarding a prisoner. A Standard Operating Procedure has been in place since January 2013 and a reminder was issued to staff to ensure the standard operating procedure is followed at all times as directed.	complete	
2	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that staff: • Have a clear understanding of responsibilities and the need to share all relevant information about risk. • Consider and record all the known risk factors of a newly-	Accepted	The local Safer Custody Policy issued in August 2013 reinforces the national policy with regard to the identification and support for prisoners at risk of self-harm. All prisoner facing staff and partner agencies have been reminded through the issuing of a local Operational Order of their responsibility to share relevant self-harm risk information. The Reception and First Night Centre screening processes ensure	Complete Head of Safer Custody	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. • Open an ACCT plan when a prisoner has recently self-harmed, or expressed suicidal intent, or if they receive information from family members which indicates a risk of suicide or self-harm.		consideration is given to all known risk factors identified in suicide and self-harm warning forms and PERS, which are recorded on a number of systems including NOMIS, SystmOne (the electronic medical records), First Night Centre, induction document, and the ACCT documentation where deemed appropriate. All staff have been reminded through the publication of a local Operational Order for the need to open an ACCT document following an incident of self-harm, or when a prisoner expresses suicidal intent, or self-harm risk information is received from family members.		