

**Investigation into the circumstances surrounding the  
death of a prisoner  
at HMP Birmingham in August 2007**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**March 2009**

This is the report of an investigation into the death of a man who was found hanging in his cell in K wing at HMP Birmingham on 18 August 2007. He was 30 years old.

I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by one of my colleagues. Heart of Birmingham Teaching Primary Care Trust appointed a panel to carry out a review of the man's clinical care and treatment. I would like to thank the staff at Birmingham for their help.

The man had Irish nationality. He was serving a comparatively short sentence with a conditional release date in early December 2007. On completion of the sentence, he faced probable extradition back to Ireland where he would have been charged with certain other offences.

The man arrived in Birmingham less than 72 hours before his death, having been transferred there from HMP Wandsworth. His transfer arose from the currently endemic problem of overcrowding in the London prisons. He had already moved prisons on several occasions. After his arrival the man told a mental health nurse that he was felt depressed and he asked for sleeping tablets. The nurse did not consider that the man was displaying any symptoms of depression. Even so, he completed a referral for a follow-up consultation with a doctor.

Neither the nurse nor any other members of staff at Birmingham saw any signs to suggest that the man might have been at risk of self-harm. One officer described him as a 'larger than life' character which accorded with how the man described himself in a letter found after his death. The letter was among a number found at Wandsworth in which the man spoke of himself as a person who always laughed and joked, but only to mask his true feelings. The man also referred to taking his life. The man's mother has said though, that putting pen to paper was her son's way of dealing with problems so they should not be assumed to be suicide letters. She also pointed out that the letters were written some days before her son's death and he left behind no such letters at Birmingham.

Whether or not the enforced relocation from a prison in London to one in Birmingham played a part in the man's death cannot be known. However, transfer is an acknowledged risk factor, and my report shows that the man was uncertain why he moved and concerned that his family would be unable to visit him. I make five recommendations: two concerning arrangements for dealing with prisoners' property, the others to procedures in healthcare.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**March 2009**

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## SUMMARY

On 18 August 2007, the man was found hanging in his single cell in HMP Birmingham. He was 30 years of age and had previously been living in London with his partner and three young children.

The man had been arrested on 8 January 2007 in connection with two counts of burglary. He was initially remanded into HMP Blakenhurst (a prison in Redditch, to the south of Birmingham) before being transferred to HMP Pentonville. He was later transferred to HMP Wandsworth.

On 5 June, the man was convicted of burglary and theft and sentenced to one year and nine months imprisonment. His conditional release date was 3 December 2007.

The man was an Irish national wanted by the Irish authorities in connection with offences that occurred while he was living there. Consequently, extradition proceedings commenced and he attended Westminster Magistrates' Court on 14 August in connection with those measures. By the time the man's case was dealt with, all the London prisons were full and he spent that night in a police cell before being transferred to HMP Birmingham the following afternoon.

On arrival at Birmingham on 15 August the man was taken through the standard prison reception processes which included seeing a reception nurse. The man told the reception nurse that he had family problems and was also worried about his sentence. He asked her for sleeping tablets. The reception nurse noticed no signs that the man might be at risk of self-harm but she referred him to the mental health team because of the worries he reported about his family and his sentence.

Following the referral by the reception nurse, the man was seen that evening by a Registered Mental Nurse (RMN). The man told the RMN that he was 'severely depressed' because he had lost his partner and children and was having trouble sleeping. The RMN recorded what the man said, but he did not observe any signs of true clinical depression. In fact, he did not even think that the man was low in mood. The RMN was content, however, that the man should be prescribed tablets to help him sleep and he asked a doctor to write a prescription. The RMN also referred the man for a non-urgent follow-up consultation with a doctor.

The man was initially located into D wing, which is Birmingham's first night centre. Whilst there, he received a first night induction assessment during which he was given general information about prison life and about the prison. The man was asked about self-harm and he said that he had no such thoughts. He asked why he had been transferred to Birmingham and was told that it was probably because the London prisons were full.

The man received the second stage of his induction the following day and was again asked about self-harm. He again said that he had no such thoughts.

The man telephoned his partner later in the day. He told her that he was now in Birmingham and asked her to send him some money.

At about 2.00pm on 17 August, the man was transferred to K wing and he telephoned his solicitor's office just after his arrival. His solicitor was out of her office at the time but he spoke to one of her colleagues. The man said that one of his reasons for telephoning was about being transferred to Birmingham which meant that, having three young children, his partner would be unable to visit him.

The man was allocated a cell on the fourth landing on K wing. The cell had been left in a mess by the previous occupant and the man asked one of the landing officers if he could clean it. The officer noticed the man's Irish accent and told him that she was of Irish decent. They chatted about where their respective families came from and the man began singing the song 'It's a Long Way to Tipperary'. The officer told my investigator that the man seemed a jovial, larger than life, character.

Two other officers from K wing also recalled having contact with the man on 17 August including the officer who locked his cell door for the night. Both officers thought that the man seemed in a stable mood.

At just after 3.00am on 18 August, officers discovered that a prisoner in A wing had hanged himself. In response to that sad event, all the other cells in Birmingham were checked. Officers reached the man's cell at about 4.00am when they found him hanging from a ligature that had been wedged into the top of the cupboard door. Staff went into the cell but the man was already dead and so no attempts were made to resuscitate him.

When the man was transferred to Birmingham he went without his belongings which remained for the time being in Wandsworth. When the belongings were collected after the man's death they were found to include a number of unsent and undated letters to his mother and partner. In these letters the man spoke about his feelings. He indicated that he had nothing to live for and that he intended to end his life. The man's mother has said that it was her son's habit to put his thoughts on paper when he was feeling low. She has also emphasised that the letters were written some time before her son's death.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 22 August 2007 when my colleague visited HMP Birmingham. My investigator met Birmingham's Head of Safer Custody, and a trade union representative. My investigator informed them of the nature and scope of the investigation. Notices were issued informing staff and prisoners about the investigation. No members of the Independent Monitoring Board (IMB) were available that day. My investigator subsequently interviewed a number of the staff who had dealings with the man. No prisoners came forward in response to the notices.
2. A clinical review of the man's care and treatment was carried out by a panel appointed by the Heart of Birmingham Teaching Primary Care Trust.
3. One of my Family Liaison Officers telephoned the man's partner to explain the purpose of the investigation and to give her the opportunity to raise any concerns or questions she would like explored or addressed. The man's partner felt strongly that it was inappropriate to have transferred him to Birmingham given that it would be difficult for her to visit as she had three young children. She said that he had telephoned her several days before his death and had not sounded low in mood. She could not believe that he would take his life, especially without leaving a letter of explanation. The man's partner also questioned why he was located in a single cell given that he had previously harmed himself while in prison.
4. My family liaison officer also telephoned the man's mother. She said that her son was initially very concerned about being extradited back to Ireland. However, he had written to her towards the end of July to say that he had come to terms with the prospect. She said that his children were very important to him and she found it hard to believe that he would choose to leave them. The man's mother spoke about the letters that were subsequently found at Wandsworth in which her son spoke about ending his life. She said that it was his practice, when low, to put his thoughts on paper. She did not therefore consider the letters to be suicide letters.
5. The man's partner and mother both spoke about difficulties in contacting prison staff after the man's death when trying to determine who was the next-of-kin and in obtaining his belongings and making funeral arrangements. The man's partner said that she was never contacted directly by Birmingham, all contact was initiated by her. She was also told that she would be able to visit her partner's cell but this was not in fact arranged.
6. The solicitors acting for the man's partner subsequently wrote to my office raising some additional issues. They said that the man's partner understood that when the man went to court on 15 August he was told that his cell at Wandsworth was reserved for him and he would be able to return after his court appearance. She also said that the man had written to her complaining that he was being singled out by some of the staff at Wandsworth, in particular for being Irish. He wrote that he would be left until last to collect his food, by which time there would only be salads to eat.

7. When this report was issued in draft form to all interested parties, I received substantial responses both from the man's partner (through her legal advisers) and, directly, from the man's mother. The issues raised by each have been addressed either within this report, or within letters to the respective family members which have accompanied this final report.

## HMP BIRMINGHAM

8. HMP Birmingham is a local prison built in 1849 for adult male prisoners. The prison can hold around 1,450 prisoners.
9. In his brief time at Birmingham, the man was initially located in D wing, which is the first night centre. He then moved to K wing, which is for second stage induction and where prisoners remain for around a week before transfer to one of the main residential wings.
10. In February 2007, Birmingham received an announced inspection from Her Majesty's Chief Inspector of Prisons. In the introduction to her report the Chief Inspector wrote:

“This inspection took place at a time of renewed and acute population pressure ... During the inspection Birmingham was receiving overcrowding drafts (of prisoners) from London, and displacing the same number of its own prisoners to Liverpool ...”
11. In its annual report for the period 1 July 2006 to 30 June 2007, Birmingham's Independent Monitoring Board (IMB) commended the work carried out by each of the three units with which the man had contact – reception, the first night centre (D wing) and the second stage induction centre (K wing). The IMB spoke about how busy each unit had been, but said new receptions to the prison were being dealt with quickly, sensitively and with respect. The IMB also noted that there had been a great improvement in the caring and conscientious treatment of prisoners on induction during the past year.
12. The man's death was the 12<sup>th</sup> apparently self-inflicted death in Birmingham since I took on responsibility for the investigation of deaths in custody in April 2004.

## KEY FINDINGS

13. On 8 January 2007, the man was arrested at his home in London and charged with two offences of burglary that had occurred the previous November. He spent two days in police custody before being remanded into HMP Blakenhurst in Redditch, south of Birmingham on 10 January. The most likely reason for the man being taken to Blakenhurst is that all the London prisons were full. On 17 January, the man was transferred to HMP Pentonville.
14. The man was convicted of burglary and theft on 5 June 2007 for which he was sentenced to one year and nine months imprisonment. His conditional release date, taking account of time served on remand, was 3 December 2007.
15. At this time, the man was still wanted by the Irish authorities in connection with certain offences in which he was allegedly involved while living in Ireland. As a result, the man attended extradition proceedings at court on a number of occasions. Due to crowding in the London prisons, the man did not always return to a London prison following a court appearance. In the period 18 June to 19 July the man spent time in the following prisons: Pentonville, Edmunds Hill (in Suffolk), Wandsworth, Edmunds Hill again, and Wandsworth again.
16. The man had been continuously at Wandsworth for almost a month when he attended Westminster Magistrates' Court on 14 August. By the time his case was heard that day, all the London prisons were again full and he spent that night in a police cell. The following day he was transferred to HMP Birmingham.
17. On arrival at Birmingham on 15 August, the man was seen by a reception nurse for a standard prison reception health assessment. The nurse made the following entry in the man's electronic medical record:

“... not on any medication but requesting [sleeping tablets] due to family problems. No medical conditions ... refer to mental health. Worried about sentence. Self harmed once, four years ago<sup>1</sup> but hasn't done anything since. Doesn't feel that he will self-harm here. States doesn't want to share a cell.”
18. At interview, the reception nurse said that she had some recollection of the man and recalled him having some worries about his family and his sentence. However, she could not recall him elaborating on those problems. Nor did he elaborate about why he did not want to share a cell. He simply said that it was due to a previous experience that he did not wish to talk about. The reception nurse said that the man seemed a little down, but there was no sign of any mental health problems and no indication to her that he might have been at risk of self-harm. The nurse said that she would not have referred the man to the mental health team if he only requested sleeping tablets. She referred him because of all the problems he mentioned such as family worries and concern

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<sup>1</sup> The man reported at a previous prison that it was the news of his father's death that caused him to harm himself.

about his sentence. She added that prisoners referred to the mental health team on first reception are seen by the team the same day.

19. A Registered Mental Nurse (RMN) saw the man on the evening of 15 August following the referral from the reception nurse. In assessing the man, the RMN used a tick chart headed 'Brief Mental State Examination'. The majority of the RMN's assessments indicated that the man was mentally stable. For instance, he recorded that the man was well groomed, he was calm, his speech was normal and there was nothing to indicate that he had any thoughts of self-harm. However, the RMN also noted: "Says severely depressed. Lost house, children and wife/partner."
20. The RMN told my investigator that the expression 'severely depressed' came from the man. The RMN did not himself consider there was any evidence that the man was clinically depressed. In fact he did not even seem low in mood. However, for further investigations the RMN made a non-urgent referral for follow-up by a doctor (a non-urgent referral meant that the man would be seen several days later). The man also said that he had not slept well for several days and asked for sleeping tablets. The RMN was satisfied that this was a reasonable request, so spoke to the reception doctor who wrote a prescription.
21. The first night officer on D wing said that prisoners usually spend their first one or two nights on D wing where they receive an induction into prison life in general and information about Birmingham in particular. Prisoners are spoken to both individually and in groups. The first night officer saw the man on 15 August for a first night induction assessment. The officer told my investigator that the man said he did not understand why he had been transferred to Birmingham. The first night officer told him that he was not the only prisoner who had arrived from London that day so it seemed the London prisons were full. In answer to questions about self-harm, the man said that he had never attempted to harm himself and had no current thoughts of doing so. The officer said that the first night induction assessment usually takes between ten to 15 minutes to complete and the question about the reason for the transfer to Birmingham was the only significant matter they discussed. The officer said that the man was calm and polite throughout the interview. He thought that this was his only contact with the man.
22. On the morning of 16 August, the man had a brief telephone conversation with his partner. He told her that he was now in Birmingham and he gave her the address. He also asked her to send him some money.
23. An officer who works on D wing conducts second day interviews with prisoners. He saw the man on 16 August. This officer told my investigator that he had only a vague recollection of the man as he was one out of about six or seven prisoners transferred from London that week. The officer said that prisoners transferred from London usually ask why they have been transferred and how they can be transferred back again. The officer thought that the man asked these questions, but there was nothing unusual about him and he seemed resigned to what had happened. The man was again asked whether he felt at risk of self-harm and again replied that he had no such thoughts.

24. At just before 2.00pm that afternoon the man attempted to telephone his partner. She did not answer and the man began to leave a voicemail message. However the message ended after only a few words: "... this is ..."
25. At about 2.00pm on 17 August, the man was moved to K wing. K wing deals with the second stage of the induction process such as an introduction to the gym and information about education.
26. A Senior Officer (SO) told my investigator that just after arriving on K wing the man asked for a welfare telephone call<sup>2</sup>. He told the senior officer that he had been transferred from Wandsworth, had no money, and wanted to telephone his solicitor. The senior officer authorised the call. The senior officer said that their contact had been brief, but they shared a brief joke about regional accents and the man seemed fine.
27. My investigator obtained a copy of the telephone conversation that the man had with his solicitor's office on the early afternoon of 17 August. The man's solicitor was not in the office but a colleague offered to take a message. The man said that he was telephoning for two reasons. First, he was phoning about his appeal against his conviction. Second, he was phoning to report that he had been transferred to Birmingham. He said that with three young children it would not be possible for his partner to visit him.
28. An officer who works on the fourth landing on K wing where the man had been allocated a single cell. This officer told my investigator that the previous occupant had left the cell in a mess and the man asked her if he could clean it. He also asked her several questions about the wing. The officer noticed the man's Irish accent and told him that her family were from Ireland. She asked him where he was from. They chatted about their backgrounds. She thought that the man seemed quite jovial and he sang the song 'It's a Long Way to Tipperary'. The officer told my investigator that the man seemed a 'larger than life' character. The man asked the officer if he could telephone his partner, but when he dialled the number he got no reply. The man continued cleaning his cell, which he finished in about half-an-hour. The officer asked the man if he wanted to try again to contact his partner. He telephoned once more but again got no reply.
29. The man told this officer that he had three young children and asked about obtaining a transfer back to Wandsworth. She told him about the application process. The officer left the wing at about 6.00pm and the man remained in a good mood throughout the afternoon. She noticed him talking to the landing cleaners about general arrangements on the wing. That was the last time that she saw him.
30. The second officer on K wing's fourth landing told my investigator that her practice is always to introduce herself to prisoners when unlocking them in the morning. Despite the high throughput of prisoners on K wing, she remembered

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<sup>2</sup> A welfare telephone call is one made at the prison's expense.

meeting the man on 17 August because of his Irish accent. The second officer said that the man was very polite and seemed not to have any concerns or problems. The second officer recalled checking the man when carrying out a roll check at around 8.00pm that evening. She said that she looked into the cell and saw the man lying on his back on his bed, watching television. His feet were crossed and his hands were behind his head. The second officer said that the man seemed fine.

### **The discovery of the man's death**

31. At just after 3.00am on 18 August, a prisoner was found dead in his cell in A wing. As a result, the night patrol officers checked all the other cells. At just before 4.00am, a fourth officer began checking the cells on the fourth landing on K wing. When the officer looked into the man's cell he saw him suspended from a ligature made from a bed sheet that was wedged into the cupboard door. The officer called for assistance. Several staff responded without delay and entered the cell. Staff supported the man's body and cut the ligature. One of the staff responding was a nurse. She noted in the man's clinical records that his body was cold to the touch and cyanosed<sup>3</sup>. As it was obvious to staff that the man was dead, cardio pulmonary resuscitation was not attempted. Ambulance paramedics arrived at the prison at 4.08am and the man was officially pronounced dead at 4.13am.

### **After the man's death**

32. The man's partner lives in London. Birmingham contacted the prison closest to her home, HMP Wormwood Scrubs, and asked staff from that prison to visit to break the news in person. One of the prison's governors, together with a chaplain, visited that afternoon to tell his partner of the man's death.
33. The man's mother lives in Ireland. Birmingham contacted the police authorities in Ireland and an officer from a local station told her of her son's death. The man's body was subsequently returned to Ireland for his funeral. Birmingham arranged for the funeral directors to send their bill direct to the prison for settlement.
34. Birmingham's deputy governor was contacted at home shortly after the man's death and he attended the prison before 5.30am. He held a debriefing meeting before the night staff went off duty. Staff were offered support by the prison care team. An additional care team member was also placed on duty for the following night. Prison staff spoke to prisoners in the cells adjoining the man's to inform them about what had happened.
35. As the man's transfer from Wandsworth to Birmingham was unplanned, he had travelled direct from court to Birmingham without his belongings. Following the man's death his belongings at Wandsworth were collected together and sent to Birmingham. The belongings were found to contain a number of letters to his mother and his partner. Among other sentiments expressed, the man wrote that,

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<sup>3</sup> Cyanosis is when the body's extremities turn blue due to absence of oxygen.

although he always laughed and joked, he did so to prevent people seeing how much he was damaged. He explained that he felt he had nothing to live for and that it was his intention to kill himself. He also wrote that it was his decision and no one else was to blame.

## ISSUES

### The man's transfer to Birmingham

36. Before his arrest in January 2007, the man was living in London with his partner and three young children. Having been convicted and sentenced, and having moved prisons several times, the man was by 15 August in HMP Wandsworth. On that day he went to Westminster Magistrates' Court for a hearing on proceedings for his extradition to Ireland in connection with past offences there. By the time the man's case had been dealt with, the London prisons were full and so he was transferred to Birmingham. The man was confused about the reason for his transfer. He asked staff at Birmingham for an explanation and he also asked about obtaining a transfer back to London.
37. In her most recent inspection report on Birmingham, Her Majesty's Chief Inspector of Prisons referred to the acute prisoner population pressure. The effects have included the transfer of prisoners from London to Birmingham. The consequences for prisoners' family ties need no elucidation. The man's partner might well have been eligible for assistance with travelling expenses, but even so a visit would have been tiresome for her and the children.
38. The Chief Inspector issued her report in February 2007. By the time of the man's transfer to Birmingham, just six months later, the national prison population had risen by 1,000, and one year on from the man's death the population has risen by a further 3,000. The impact on individual prisoners is manifest in terms of disruption, uncertainty and continuity of care.
39. The man's partner had understood that his cell at Wandsworth had been reserved for him so he could return there after his court case. Prison Service Instruction 30/2006<sup>4</sup> includes direction on discharge to court. It sets out categories of prisoners who should always return from court to the discharging prison. Such prisoners include juveniles, category A (high risk) prisoners, vulnerable prisoners, those with mobility problems etc. The man did not fall into any of the listed categories. If anyone did tell the man that he would be returning to Wandsworth after his court appearance, they were incautious (and, as things turned out) incorrect to do so.

### Should staff have realised that the man was at risk?

40. The paperwork supplied to my investigator by Birmingham included nothing from the man's last period in Wandsworth (although papers from earlier periods of this particular sentence were included and must have reached Birmingham via Wandsworth). Because of the missing paperwork, it has not been possible to consider how the man was coping in Wandsworth in the weeks leading up to his unplanned transfer into Birmingham on 15 August. From information held centrally, however, Wandsworth have been able to confirm that the man was not subject to the special monitoring and support arrangements that are put in place

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<sup>4</sup> Advice, guidance and instruction to staff are contained in documents known as Prison Service Orders (PSOs) and Prison Service Instructions (PSIs).

for prisoners deemed to be at risk of self-harm. This investigation has therefore focussed on the man's time in Birmingham.

41. Upon his arrival in Birmingham the man was seen by the reception nurse for an initial healthcare assessment. She noted that the man reported harming himself once in the past, four years previously, but that he had no present thoughts of self-harm. The reception nurse noted that the man wanted sleeping tablets, which he said he needed due to family problems. She also recorded the man saying that he was worried about his sentence. (As he had only a few months remaining of his current sentence, his worry presumably related to his potential extradition.) The reception nurse told my investigator that she had no concerns that the man might be at risk of self-harm, but she referred him to the mental health team due to his request for sleeping tablets.
42. The Registered Mental Nurse (RMN) saw the man later that day. He noted the man as saying that he was severely depressed due to losing his partner and children. At interview, the RMN said that the words 'severely depressed' were the man's. As far as the RMN was concerned, the man was not displaying any signs of depression and did not even seem low in spirits. The RMN asked the reception doctor to prescribe sleeping tablets. He also wrote a referral for a non-urgent follow-up by a doctor for further investigations.
43. Even though the man had no more than brief contact with several staff at Birmingham, most of those who encountered him were able to recall him to mind. One officer described the man as a 'larger than life' character which seems to accord with the way in which he described himself in a letter to his mother. More specifically, this officer talked about the man chatting about Ireland and singing 'It's a Long Way to Tipperary' when she told him of her Irish roots.
44. Other staff who recalled the man from their brief contact with him were three other officers as well as the Senior Officer. None recognised any signs that the man might have been at risk, and he denied having any thoughts of self-harm when asked during the induction process at Birmingham.
45. We know that the man was confused about his transfer to Birmingham. He asked several staff about the reason for this and about transferring back to London. However, there is nothing to suggest that the man expressed concerns about being in Birmingham that should have alerted staff to the possibility he would harm himself. It should be borne in mind too, that during this fairly brief time in custody, the man had already been transferred between prisons on a number of occasions.
46. I conclude on this matter that there were no grounds for staff to have suspected that the man was at risk.

### **Should the man have been in a single cell?**

47. The man's partner has questioned the decision to place him in a single cell, given that he had previously harmed himself in prison. This investigation has shown that he was allocated a single cell after expressly requesting one when he arrived in Birmingham. He told the nurse on reception that his reason for making the request was a previous experience about which he did not wish to elaborate.
48. In deciding whether or not to place a prisoner in a single or a shared cell staff need to consider a variety of factors. They need to consider whether the prisoner might pose a risk to others, or indeed whether the prisoner might be at risk from others. In managing prisoners at risk of self-harm, it is recognised that cell sharing can be an important element of the support provided for the at-risk prisoner. However, responsibility for the care of an at-risk prisoner lies with management and staff, not with the at-risk prisoner's cell-mate.
49. As already mentioned, the man's one declared act of self-harm had been four years previously. On arrival in Birmingham he denied having any present thoughts of self-harm, and there seems to have been nothing about his demeanour to cause staff to think otherwise. Had staff considered the man to be at risk, they would have put in place an action plan to minimise the risk. That plan might have included putting him in a shared cell. But with no apparent reason to believe there was any risk, the decision to place the man in a single cell was reasonable.
50. I should add that the man's records include two other cell-sharing risk assessments indicating his reluctance to share a cell. One was from Edmunds Hill dated 18 June when the man said that he had concerns about sharing. He did, however, agree to give sharing a try. The second assessment was completed at Wandsworth on 5 July when the man declared that he would not share. The man's request for a single cell at Birmingham was not, therefore, an unusual or suspicious request for him to have made.

### **Missing paperwork from Wandsworth**

51. My investigator has made concerted efforts to try to locate the probable missing papers for the man's last period in Wandsworth. He was assured by Wandsworth that the documents would have been sent with the man when he went to Westminster Magistrates' Court on 14 August. He was told that this would be standard practice because of the possibility of the prisoner being transferred to a different prison following the hearing. However, despite repeated enquiries of Birmingham, no further papers for the man have been located.
52. It is not possible for me to say definitively where the missing papers might be but I am inclined to believe that they remain somewhere in Wandsworth. The only other explanation is that Birmingham received all of the papers, managed to secure most of them, but also managed to lose all those for the man's time at

Wandsworth from 19 July to 14 August. I think the former explanation is the more likely.

53. Without knowing what was recorded in the missing papers it is not possible to say whether their disappearance might have compromised the man's care in any way after his arrival in Birmingham. Most importantly, however, we at least know that the man had not been judged at risk of self-harm while at Wandsworth.
54. The man's partner has said that he wrote to her complaining about maltreatment by some of the staff at Wandsworth. Again, the lack of paperwork for the man's last spell in Wandsworth makes it difficult for me to comment conclusively on this matter. My investigator has been informed, however, that the man submitted no formal complaints at Wandsworth about his treatment during that period.

### **The man's referral for follow-up by a doctor**

55. On 20 August, two days after the man's death, the form completed by the RMN referring the man for a medical follow-up was found in a uniform jacket that was hanging on a chair. Birmingham investigated the circumstances that resulted in the form being misplaced. The investigation discovered that that an Operational Support Grade officer collected the referral form and put it in his jacket pocket. His intention was to deliver the form to the primary care team but he forgot to do so.
56. This referral had been for a non-urgent follow-up, meaning that the man would probably not have been seen until after that weekend. As a consequence, the fact that the referral form went missing for a short period of time would have had no impact on the man's care.

### **The response when the man was found**

57. The man was discovered at 4.00am when it was decided that all cells should be checked following the discovery of the death of another prisoner earlier that night. Under normal circumstances, a full roll check would not have been started until around 5.30am. When the man was discovered, staff responded quickly to cut away the ligature and to check for signs of life. Examinations carried out by a nurse clearly indicate that the man was already deceased. I consider that the decision not to attempt resuscitation was reasonable.

### **Contact with the man's family**

58. The man had named his partner as his next-of-kin and had named his mother as another person who should be notified in the event of an emergency. I was pleased to learn that Birmingham arranged for both family members to be notified promptly and in person of the man's death. Birmingham also liaised appropriately with regard to the man's funeral arrangements.
59. Much less well handled have been the arrangements for other contact with the man's family. When I issued my report in draft form, I commented on two aspects of the family liaison arrangements. The first aspect related to the man's

property. My understanding at that time was that some of the property was still held at the prison despite several requests for its return from the man's partner's solicitors. I referred then to the guidance supplementary to chapter four of Prison Service Order (PSO) 2710 which contains advice on deciding who is legally entitled to the property, and on what to do in the case of a dispute within the family as to this entitlement. I expressed the opinion that this was a matter that should have been resolved long before. I then went on to recommend that the prison should arrange for the man's property to be returned to his family without further delay. The Prison Service's response was to accept my recommendation and to say that:

"The man's partner's solicitors have requested that the prison keep the man's property for the time being whilst they try to ascertain how the man's partner would like to receive it (whether she will collect it in person or would prefer to have it sent by post)."

60. In preparing this final version of the report, my investigator asked Birmingham whether the property had at last been returned to the man's partner. My investigator was told that the property had not been returned to the man's partner but had instead been posted to his mother in Ireland<sup>5</sup>. I was dismayed to hear of this. Having indicated in response to the draft report that the property would be returned, correctly in my view, to the man's partner (and the mother of his children), I can see no logic to a reversal of that decision. I fear that this news may only serve to add further to the man's partner's distress.

61. In my draft report I made a second recommendation relating to property:

**I also recommend that the Governor ensures that staff dealing with families following deaths in custody are reminded of the guidance set out in PSO 2710 concerning prisoner property.**

62. The Prison Service's response to that recommendation was to say (rather complacently) that:

"Staff dealing with deaths in custody are aware of the guidance set out in PSO 2710 concerning prisoner property."

63. The circumstances concerning the handling of the man's property, as I have just related, suggest most strongly that staff awareness may need reinforcement through training. I draw this to the Governor's attention.

64. In my draft report, I also referred to the man's partner's complaint about on-going contact with Birmingham. She had said that she was not contacted directly by Birmingham, and that all contact was initiated by her. Nor were arrangements made for her to view the man's cell. In its response, the Prison Service said that arrangements had been made on two occasions for the man's partner to visit the prison to view the cell but she did not attend on either occasion.

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<sup>5</sup> Please refer to the Annex to this report.



### **The letters found at Wandsworth**

65. After the man's death, letters were found among his belongings at Wandsworth which could be considered as suicide letters. They were undated and the man's mother told my Family Liaison Officer that she did not think they should be assumed to be suicide letters. She said the letters were written at Wandsworth so were obviously completed some time before her son's death. She said that it was her son's practice to put his thoughts and feelings down on paper when he was feeling low. The man's mother also said that, if her son intended the letters to be suicide letters, he would have written them in Birmingham.
66. Whether or not the man intended to take his life will be a matter for consideration at the Coroner's Inquest.

### **Main findings from the clinical review**

67. The clinical review found that the man received care comparable to that he could have expected to have received in the community. However, the reviewers comment that the man's frequent moves between different prisons would suggest that none of the staff were able to get to know him. (I agree.) The reviewers found some deficiencies in record keeping and have made three recommendations which relate to communication and record keeping. I endorse their recommendations.

### **Independence of the clinical review**

68. In the case of public sector prisons such as Birmingham, I am required to approach the commissioning Primary Care Trust to obtain a clinical review of the prisoner's care and treatment. In order to achieve independence, I would expect the review to be undertaken by individuals with no direct contractual links to the prison. However, recent practice following deaths in Birmingham has been for the clinical review to be conducted by senior healthcare staff employed in the prison. That is what has happened in the man's case. I expressed my concern in a recent investigation report about the potential conflict of interest and apparent lack of independence that results from with this practice. In that report, I urged the Heart of Birmingham Teaching PCT to consider my concerns when appointing reviewers in future investigations.

## RECOMMENDATIONS

The following recommendations were made in the draft version of this report. The Prison Service's responses appear in italics following each recommendation. Despite the Prison Service's acceptance of the first recommendation, the man's property was subsequently returned to his mother rather than his partner (this is discussed in paragraphs 59 and 60). The Prison Service's response to the second recommendation is discussed in paragraphs 62 to 63.

1. The Governor should arrange for the man's property to be returned to his family without further delay.

*Recommendation accepted: The man's partner's solicitors have requested that the prison keep the man's property for the time being whilst they try to ascertain how the man's partner would like to receive it (whether she will collect it in person or would prefer to have it sent by post).*

2. I also recommend that the Governor ensures that staff dealing with families following deaths in custody are reminded of the guidance set out in PSO 2710 concerning prisoner property.

*Recommendation accepted: Staff dealing with deaths in custody are aware of the guidance set out in PSO 2710 concerning prisoner property.*

I also endorse the following three recommendations made by the clinical review panel:

3. All consultations should be recorded contemporaneously in the electronic medical record.

*Recommendation accepted: Consultations are being recorded contemporaneously in the prisoners' electronic medical records.*

4. A clear protocol should be written for onward referral and communicated to all staff.

*Recommendation accepted: Pathway is in place. This will be re-issued and audited. Target for completion is end November 2008*

5. All prescribed medication should be entered into the electronic medical record.

*Recommendation accepted: In place and audited by head of pharmacy.*

## **ANNEX**

Following the issue of the final report of this investigation, Birmingham confirmed that the man's property had not in fact been posted to his mother in Ireland but was still held at the prison. The property was then, correctly, sent to the man's partner.