

**Investigation into the circumstances surrounding the death
of a man at HMP Birmingham in December 2005**

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

July 2007

This is the report of an investigation into the circumstances of the death of a man at HMP Birmingham in December 2005. The man was found hanging in his cell in the High Dependency Unit. He had been in custody for almost five months at the time of his death.

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

The investigation was carried out by two of my colleagues. I would like to thank the Governor of Birmingham, and his staff for their help. I am sorry that it has taken longer than I would have liked to complete this report, but that reflects the seriousness of the matters raised by the man's death.

The man had suffered from depression and anxiety for many years and he was also agoraphobic. Due to these conditions he found it difficult to be in a standard prison wing. It was for this reason that he was located in the High Dependency Unit, where he seemed to settle quite well.

The man was treated by a number of different clinicians while in Birmingham. Among other professionals involved in his care, the man was seen by a consultant psychiatrist from the local mental health trust. The man twice told the psychiatrist that he had thoughts of suicide, but this information was not shared with anyone else involved in his care.

The independent clinical review, commissioned as part of this investigation, is extremely critical of the man's care and treatment. As well as criticising poor or absent communication, the review also draws attention to the erratic prescribing and supply of his medication.

Following the man's death, three letters were found in his cell addressed to his family, the prison Governor and police. In one of these letters, the man spoke bitterly about how he was affected by the delays and interruptions in the provision of his medication. He indicated clearly that it was this that led to him to decide to take his life.

This ranks amongst the most disturbing cases I have encountered in the two and a half years that I have held responsibility for the investigation of deaths in prison custody. I am much influenced by the findings of the clinical review which highlights significant deficiencies in the delivery of care to the man. And in retrospect, the conclusion seems inescapable that he should have benefited from the support and monitoring he would have received under the ACCT procedure.

I have made 18 recommendations. One is about how a family is told about a death in custody. The remaining 17 recommendations are all about healthcare provision.

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

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Prisons and Probation Ombudsman

July 2007

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SUMMARY

In July 2005, the man was received into HMP Birmingham having been convicted of several offences, including three counts of blackmail. He was sentenced to three years and nine months imprisonment later that month.

On arrival at Birmingham, the man had a standard healthcare assessment to explore his past medical history, his current health needs, his use of prescribed medication and whether he had any thoughts of self-harm. The man said that he was concerned about his mental health and that he had previously been treated for depression, anxiety and paranoia (several days later, the man also revealed that he suffered from agoraphobia). Among other prescribed medicines, the man said that he was receiving diazepam (for anxiety).

The man's condition of agoraphobia made it very difficult for him to settle in the standard prison wings – it was noted that he would not go on exercise, association or visits. Having spent six weeks in standard location, the man was moved to the High Dependency Unit (HDU) which offers accommodation and support to prisoners who have difficulty coping within the prison environment. All of the evidence shows that the man benefited from being in the HDU and he was able to associate with the prisoners there to some extent.

Another adverse effect resulting from the man's agoraphobia was that he was not able to receive visits in the prison's visiting hall. To help with this problem, arrangements were made for the man to receive several visits in the prison chaplaincy.

The overall delivery of healthcare to the man has been criticised strongly in the independent clinical review. National protocols advise that prolonged use of diazepam should be avoided and that abrupt withdrawal of that medicine should also be avoided. The doctors involved in the man's care planned from an early stage to reduce and then stop his diazepam, but the management of this plan was poor and the man often suffered delays and interruptions in receiving the drug.

As well as criticism of the prescribing and dispensing of medication, the clinical reviewers describe the man's healthcare delivery as being patchy and disorganised with no obvious long-term treatment plan. Comment is also made that no one person maintained an overview or took responsibility for his package of care. One of the reasons behind that comment was the lack of information sharing between the clinicians involved – such clinicians included GPs and locum GPs, prison nurses, the prison community mental health team and consultant psychiatrists from the local mental health trust. On two separate occasions, the man indicated to a consultant psychiatrist that he was thinking of taking his life, but this information was not passed on.

During roll check on the morning of 6 December, the man was found hanging in his cell. Healthcare staff attended as well as ambulance paramedics. Resuscitation was not attempted as it was clear he had died some time before he was discovered.

I have made 18 recommendations. One recommendation relates to notifying families about deaths in custody. The remaining 17 recommendations all concern healthcare provision.

INVESTIGATION PROCESS

1. The investigation was opened on 7 December 2005 when my colleagues visited HMP Birmingham. They met the head of safer custody and the duty governor on the day of the man's death. They also met two members of the Independent Monitoring Board (IMB) and a representative of the Prison Officers' Association (POA). One of my colleagues informed them of the nature and scope of the investigation. Notices were issued for staff and prisoners notifying them of the investigation. My colleagues subsequently interviewed a number of staff who had dealings with the man.
2. At the time of their visit, a community mental health team leader, was unavailable for interview. The mental health team leader, along with other clinicians involved in the man's care, was later interviewed for the purpose of the independent clinical review commissioned by Heart of Birmingham Teaching Primary Care Trust (PCT).
3. One of my family liaison officers contacted one of the man's sisters to inform her of the investigation. My investigator and family liaison officer visited the man's sister and her husband at their home.
4. The man's sister said that her brother suffered from agoraphobia and depression. Medication helped him deal with these conditions, although he still found it difficult to be in public places even to the extent of not feeling able to attend family gatherings and weddings. The man's sister received a letter from her brother about a week after he had gone into prison telling her that he was not receiving any medication. She telephoned the prison and spoke to a nurse who advised asking the man's GP to fax his prescription. When the man's sister spoke to the GP, she said she would send a letter to the prison with details of her brother's clinical condition. After a fortnight, the man said he was receiving some medication, but it was coming in 'drips and drabs'. He said he was finding this extremely difficult to deal with, as it was leading to him having dark thoughts and thoughts of suicide. The man's sister wrote to the Governor and she also contacted one of the chaplains about her concerns.
5. The man's sister said that the way she heard of her brother's death was difficult. She said that she was at work when she received a telephone call from the chaplain who said that he needed to speak to her, and asked her to come into the prison. She said that it would not be very convenient, so he asked her if they could meet at her home and if she could have a friend with her. The man's sister asked the chaplain if her brother was dead. He did not directly answer her question, but did say that she was making things very difficult for him. The chaplain and one of the prison governors then went to the house.
6. The man's sister told my investigator and family liaison officer, that she was horrified when she found out, after his death, that her brother had never been subject to special monitoring for those judged at risk of suicide.

HMP BIRMINGHAM

7. HMP Birmingham is a local prison built in 1849 for adult male prisoners. It serves the Crown and Magistrates' Courts of Birmingham, Stafford and Wolverhampton and the Magistrates' Courts of Burton, Cannock, Litchfield, Rugeley, Sutton Coldfield and Tamworth.

8. Birmingham has recently undergone a period of considerable change as a result of a multi-million pound investment programme, which has added new workshops, educational facilities, a new healthcare centre and gymnasium. The prison holds around 1,400 prisoners.

9. In May 2004, Birmingham received an unannounced inspection from Her Majesty's Chief Inspector of Prisons (HMCIP). The report issued by HMCIP following the inspection indicated the need for some development, but it also reported that:

‘... the overall picture is of a prison that has fundamentally changed for the better over the last four years ... Birmingham is an example of what can be done by a committed and determined Governor ...’

10. In June 2005, Birmingham started using the ACCT (Assessment, Care in Custody and Teamwork) process for the monitoring of prisoners judged to be at risk of self-harm or suicide. ACCT has been designed to replace the F2052SH process.

CARE FOR PEOPLE AT RISK OF SELF-HARM OR SUICIDE IN PRISON

11. It has long been recognised that being in custody can cause some people to think of harming or even killing themselves. Prison staff are trained in how to assist prisoners who are at risk of suicide or self-harm and all prisoners are asked whether they have any such thoughts when they first arrive in prison.

12. For many years, the system for supporting prisoners who were struggling to cope with their problems was managed through the 'Self-Harm At-Risk' Form – the F2052SH. Starting in 2005, the F2052SH began to be replaced with a new system to help identify and plan care for prisoners at risk of suicide or self-harm. The replacement is known as the ACCT Plan (Assessment, Care in Custody and Teamwork). ACCT encourages staff to work together to provide individual care to those prisoners judged to be at risk.

13. Prison Service Instruction (PSI) 18/2005 introduced ACCT and it contains both guidance notes and mandatory instructions. Among the mandatory instructions is the following:

'Prior to commencing use of ACCT in their establishment Governors ... must ensure they have complied with the actions listed at Appendix B.'

14. Among other actions listed in Appendix B to PSI 18/2005 is the following:

'... Governors ... must ensure that ... all staff in contact with prisoners ... (... not only residential/discipline staff, but other staff such as ... healthcare ... and mental health in-reach) are familiar with ACCT ...'

EVENTS LEADING UP TO THE MAN'S DEATH

15. The man was received into Birmingham in 22 July 2005. At that stage he had been convicted on a number of counts of blackmail and three lesser offences. He was still awaiting sentencing. As part of the standard prison reception process, the man received a First Reception Health Screen assessment. During that assessment, the man reported to the nurse that he was receiving several prescribed medications including diazepam. When asked whether he had any health concerns, the man said that he was concerned about his mental health and had received treatment for depression, anxiety and paranoia. He denied having any thoughts of self-harm.

16. Following his initial health screening, the man received a more detailed psychiatric assessment which was conducted by a registered mental health nurse (RMN). The man was asked whether he had any self-harm or suicidal ideas. The man said that he did have such thoughts, but had no concrete plans for following them through. The RMN noted on the screening form that the man should be referred to a psychiatrist.

17. For his first five days in Birmingham, the man remained in D-Wing, which acts as the prison's reception centre. Later in July, the man was transferred to M-Wing, which is a standard prison wing.

18. Two days later, the man was seen by a prison doctor. He reported that he suffered from agoraphobia (a fear of public places). The doctor noted that the man's GP had confirmed that he was receiving a number of prescribed medicines, including diazepam, and that he had been receiving these medicines for at least a year. The doctor noted that a referral should be made for the man to be seen by a psychiatrist.

19. In early August, the man asked to speak to the duty governor. The duty governor noted that the man's main concern was his mental health state and his anxiety about being in large crowds. The man mentioned taking his own life although he also said that he had never previously made any such attempt, nor ever harmed himself. The man asked to be placed on Prison Service Rule 45 for his own safety. At interview, the duty governor said that he thought he might have spent 10 or so minutes speaking with the man. Given the man's declaration that he had no history of self-harm or suicide attempts, the duty governor did not consider it appropriate to open an ACCT form. Instead, the duty governor thought that the most appropriate option was to arrange for the man to be reviewed by the mental health team within the next 24 hours.

20. Following on from the arrangement made by the duty governor, the man was seen the next day by the community mental health team leader.

21. Ten days later, the man was seen by a locum psychiatrist from Birmingham and Solihull Mental Health Trust. The psychiatrist made a lengthy note of her consultation with the man, which included him saying that:

'He feels he will not survive this sentence ...'

The psychiatrist noted that her plan was to seek the opinion of another psychiatrist.

22. In early September, the man transferred to Birmingham's High Dependency Unit (HDU). This unit was originally located in A-Wing before being relocated to C-Wing in early October 2005. The HDU holds up to 15 prisoners, all of whom find it difficult being in a standard prison wing. The reasoning behind the man's referral to the HDU was that he:

'Seems to have issues surrounding being around many people/large spaces. Won't go on exercise/association/visit due to amount of people.'

23. The referring officer's comment on why it was thought that the man would benefit from being in the unit was:

'Smaller space. Less people to attempt to interact with (staff and prisoners).'

24. A week later, Birmingham's Governor received a letter from the man's sister and another from his partner. The letter from the man's sister referred to a letter she had received from her brother in which he said that he was feeling suicidal. The man's sister spoke about her brother's depression and condition of agoraphobia, which she said was making his time in prison very difficult to cope with. The letter from his partner mentioned the same issues as his sister. On the same day that these letters were received, the community mental health team leader went to see the man and he made the following entry in the man's medical record:

'... Visit to explore the issues that the man is struggling with. All seems to revolve around his medication. He is asking for further diazepam despite having had reducing dose and then discontinuation of prescription. The man continues to receive setraline and propranolol.'

25. The community mental health team leader went back to see the man the next day when he made the following note:

'Return visit to ensure that the man received his medication last night ... all was ok ... for discussion [with] Prison GPs.'

26. Two days later, the psychiatrist made the following entry in the man's medical record:

'I had a discussion with the community mental health team leader ... today with regard to this patient. We discussed our concerns for his well-being and management. The prison has a policy regarding the reduction/cancellation of benzodiazepines due to the addictive potential. Unfortunately, this has been a major part of the man's maintenance for several years. He has disclosed his

disagreement with the planned reduction of diazepam. He already sees catastrophe resulting from this proposal ... [Plan]: ... To discuss (second opinion) with a doctor ... To follow-up next week.'

27. The man was seen by another psychiatrist in September, whose opinion included that the treating clinicians should continue reducing the dose of diazepam.

28. In line with her plan, the psychiatrist saw the man once more following the assessment made by the second psychiatrist. This consultation took place at the end of September, when this psychiatrist noted that the man had:

'... daily thoughts of suicide ...'

The psychiatrist's plan included for the man's diazepam to continue to be reduced and for him to have a further psychiatric review two weeks later.

29. An officer told the investigators that he started working in the HDU when it was first opened (this was around the end of 2003). The officer said that the process leading to a prisoner being located into the HDU started with wing staff recognising that one of their prisoners might gain from a transfer. The referral is followed up by an officer from HDU visiting the prisoner and explaining how the unit operates. It is then for the prisoner to decide whether or not he wishes to join the unit. The officer said that he had been the officer who visited the man at the time he was in M-Wing. The officer found the man to be a polite and well mannered individual. After moving to the HDU, the man said that he was glad to have moved to the unit because he found it difficult facing crowds of people. It suited him being in a unit with a smaller number of people.

30. The officer said that the man only had one close prisoner friend in the HDU. Although the man had no other close friends, he never had problems with any of the other prisoners. The officer said that he spoke a lot with the man – the comparatively small number of prisoners in the HDU compared to a standard wing meant that officers had more time to sit down to talk. The man would talk about ordinary things, such as about his family.

31. The officer said that, other than that the man was concerned about his agoraphobia, the only matters that seemed to concern him were relating to his medication. Each time the man complained about his medication the HDU staff would inform medical staff.

32. The officer said that the man's death had shocked him. The man had never said anything to make him think that he might have been at risk.

33. Another officer has also worked in the HDU since it first opened. He described the man as a quiet person, but one who did communicate with staff and had no difficulty in bringing to their attention any problems he was having. This officer said that the man fitted in well in the unit and seemed to have no problem mixing with the other prisoners.

The man tended to associate with just one or two other prisoners and this would mainly be with them visiting him in his cell. However, the man would come out onto the landing and would play the occasional game of pool. The man's dislike of crowds and public spaces made it difficult for him to receive visitors in the visiting area. To help the man with this, arrangements were made for him to receive some visits in the chaplaincy.

34. This officer also said that the man's main problem seemed to be his medication. The unit staff would usually contact the community mental health team leader and he would come to the unit to see the man.

35. This officer said that speaking from the staff's point of view, the man was a popular prisoner. Staff thought he was getting the best out of the unit. He went on to say that the man's death hit staff very hard as they felt they were offering him good care and that he was happy with it.

36. A third officer works in the HDU two days per week. On the other days, he works elsewhere in C-Wing. This officer gave similar evidence to the other two officers about how the man settled into the unit, about how he interacted with staff and other prisoners, and about how shocked all the staff were at the man's death.

37. The chaplain said that his first contact with the man had arisen after he received a telephone call from the man's sister. She told him that her brother was having problems with family visits. The chaplain went to see the man who explained that he had difficulty in dealing with situations where there were a lot of other people around. He found the visiting area difficult and even had problems walking along prison landings.

38. The chaplain arranged for the man to receive a family visit in the chaplaincy. The man's sister, the man's partner and a friend attended. At the end of the visit, the chaplain informed the man's sister that she should write to the prison Governor to ask for special dispensation for the man to continue receiving visits in the chaplaincy. The man had one more family visit in the chaplaincy, but he died before arrangements for a third visit had been completed. The chaplain had a number of conversations with the man's sister in connection with the arrangements for these visits.

39. The chaplain said that the man mentioned problems with his medication in every conversation they had. The chaplain made enquiries and was told that the man was receiving the right medication. In none of their conversations did the man make any threats that he would kill himself.

40. A prisoner in the HDU said that he worked as a cleaner in the unit. He made a point of befriending the man, who seemed reluctant to come out of his cell. As the man got used to the HDU and the people in the unit, he began to find it easier to come out of his cell. Other prisoners would visit the man in his cell. The man would say hello, but did not really bond with many people.

41. The prisoner said that the man had a lot of problems with his medication. His diazepam dose was lowered with a view to ending it, but the replacement medication he was given did not help and he was clearly not well.

42. The prisoner said that he and the man had had several conversations about death. The man was worried about his impending court case and mentioned that he had two houses which he thought were at risk of being re-possessed. The man had an idea that if he took his life the houses would be safe. On a separate occasion, the man had spoken about death and suicide but not in a way that made the prisoner think that the man was intending to take his life. The final occasion had been on the day before the man died. The man showed the prisoner a diagram he had drawn of a noose, but the man was joking with the staff that day and told the prisoner that he would deny having any suicidal thoughts if his friend were to report anything. In any case, the prisoner himself did not think that the man would do anything. The prisoner said that he noticed a decline in the man's mood in the final two weeks of his life. But he did not see a particular trigger point to suggest or indicate that the man would take his life.

43. The prisoner said that the staff in HDU put in a lot of time to support prisoners. They tried hard with the man and managed to get him to start using the gym. They also badgered healthcare to try to resolve the problems the man was having with his medication.

THE DISCOVERY OF THE MAN'S DEATH

44. An officer support grade (OSG) said that she started a night shift in C-Wing at 8.30pm in early December. The first thing she did was to count all the prisoners in the wing. Four or five of the prisoners were subject to special monitoring, as they were judged to be at risk of self-harm or suicide and the OSG had to check each of these prisoners five times per hour. In addition to carrying out these checks, the OSG also had to respond to any prisoners pressing their cell call bells. The man was not one of the prisoners who pressed their call bells.

45. Before her shift ended on the following morning, the OSG was required to count the prisoners in C-Wing. She commenced this count sometime between about 5.50am (according to her interview with the investigator) and 6.10am (according to her contemporaneous written statement). When the OSG reached the man's cell, she found that he had placed paper over the observation panel in his door. The OSG banged on the door and called to the man to remove the paper. The man did not respond. The OSG was carrying a cell key, but this was contained in a sealed pouch which is only to be opened in the case of a clear emergency. The OSG interrupted her count of prisoners and went to tell a senior officer (SO) about the man's cell.

46. The SO was the assistant Night Orderly Officer for that night. At about 5.25am that morning, an emergency occurred in which a prisoner had allegedly taken his cell mate's drugs. From the prisoner's appearance, it seemed to the SO that he might well have taken an overdose. The nurse in attendance agreed and so arrangements were made to send the prisoner to outside hospital as quickly as possible. At about 6.15am, the OSG reported the problem with the man's cell. At this time the SO was in the midst of helping to take the other prisoner to a taxi to send him to hospital. The SO told the OSG that he would deal with the man once he had finished with the other prisoner.

47. Another officer who started work at 6.30am that morning began counting the prisoners. When he arrived at the man's cell, which was at around 6.50am, he found that the observation panel was covered. The officer unlocked the cell door and saw the man by the window suspended by a ligature. The officer blew his alarm whistle and then supported the man's weight as he began to untie the ligature. Other staff arrived at this point and, once the ligature was freed, the man was lowered to the floor. The officer said that the man's body was cold to the touch and rigor mortis had started to set in. The officer checked the man for presence of a pulse, but he found none. No attempts were made to try to resuscitate the man as it was clear that he was already dead. A nurse, who responded to the whistle alarm, described the man's body as being very cold.

48. Ambulance paramedics arrived at around 7.15am. Their report, following examination of the man's body, confirms that rigor mortis had set in.

DEALING WITH SIMULTANEOUS EMERGENCY INCIDENTS

49. As noted, on the night, the SO was the assistant Night Orderly Officer. (Because of its size, Birmingham employs both a Night Orderly Officer and an assistant.) The SO explained at interview that his responsibility was to supervise the main parts of the old prison containing A to J wings. Two further wings and the healthcare unit are based in the new part of the prison. But the assistant Night Orderly Officer can only gain access to that part of the prison after the Night Orderly Officer has released the double locks that, for security reasons, separate the two sections. The SO said that it was at about 6.15am that the OSG reported to him that the man had blocked the observation panel on his door. At that time in the morning, the Night Orderly Officer would have been disengaging the double locks around the prison ahead of the arrival of the day staff and the beginning of a new day.

50. Birmingham's head of operations, told the investigator that, at night time, the assistant Night Orderly Officer has to prioritise when simultaneous incidents arise. The head of operations said that, in the case of more than one obvious emergency, he would expect the assistant Night Orderly Officer to ask the Night Orderly Officer to help. In such circumstances, a duty such as disengaging the double locks can be postponed. The head of operations went on to say, however, that a blocked observation panel is not, in itself, an emergency. Although prisoners are told that they should not do this, it is common for them to do so to gain some privacy.

THE LETTERS FOUND IN THE MAN'S CELL

51. Following the man's death, three letters were found in his cell within which he discussed his decision to take his life. One letter was addressed to the prison Governor, the police and his family. A second letter was addressed to the man's mother and family. The third letter was addressed to his partner.

52. In the letter addressed to the prison Governor, the police and his family, the man spoke about his treatment in prison. He complained about having to wait two weeks before he started to receive any medication, and about constant delays in the issue of his medication once it had been prescribed. Sometimes these delays would be three or four days, once it was much longer than that. He also complained about the decision to wean him off one of his medicines – diazepam. He wrote that he was calmed by diazepam and that this drug stopped his mind from racing, helped him to avoid suicidal thoughts and helped him to sleep. It was, he wrote, the problems of medication that eventually led to him refusing medication and his decision to take his life. The man also claimed in this letter that, on about five occasions, he had told the community mental health team leader, the psychiatric nurse, that he would kill himself. The man also referred to the landing officers to whom he sent his thanks for helping when they could. He added that he had been careful to withhold from them anything that could have made them suspicious about his plans.

53. In the letters to his mother, family and partner, the man repeatedly spoke of the love he felt for them and apologised repeatedly for the action he was going to take.

AFTER THE MAN'S DEATH

54. The man's nominated next-of-kin was his sister. The news of the man's death was broken to her by one of the prison chaplains, who had had contact with her in connection with the man's family visits.

55. The chaplain, together with one of the prison governors went to the man's sisters home at around 10am, but they found that no-one was in.

56. The chaplain and the governor then returned to the prison and the chaplain telephoned the man's sister at her place of work. He asked her to visit the prison and, when she said it was not convenient for her to leave work at that time, he asked her to return to her home. The man's sister realised that the news was bad and asked him directly if her brother was dead. However, the chaplain did not want to tell her of her brother's death by telephone and so made arrangements to go back to her house to tell her in person.

57. The man's family took up an offer for them to visit the prison to see the man's cell and they met some of the staff in the HDU. The family was told that Birmingham would pay the funeral costs.

58. The staff involved in finding the man were offered the opportunity to speak with members of Birmingham's care team. The same opportunity was offered to the staff and prisoners in the HDU unit.

ISSUES FROM THE CLINICAL REVIEW AND ITS CONCLUSIONS

59. Following the man's death, Heart of Birmingham Teaching PCT commissioned an independent investigation into his care and treatment from an ex-Director of Public Health and an ex-NHS manager. Their review, which appears at annex A, is extremely detailed and contains significant criticism of many aspects of the man's care and treatment. In their chronology of events, the reviewers itemise around 20 separate occasions when there were failures or omissions in the delivery of care to the man. The most frequently occurring omission related to delays and interruptions in the prescribing and administration of medicines to the man. Poor communication between the different clinical teams responsible for the man's care and treatment is also subject to severe criticism.

60. The reviewers reached the following conclusions:

The man had a history of mental disorder and frequently expressed suicidal ideas. His family warned the prison of his vulnerability and of his need for family support. His history and his obvious distress should have triggered the ACCT process, leading to a multidisciplinary review and a management plan (CAREMAP). Unfortunately, nobody saw fit to invoke the ACCT process so there was no overall management plan.

The man's healthcare was patchy and disorganised with no one person maintaining an overview or taking responsibility for his package of care. His health needs were mainly to do with his mental health problems but because there was no formal contract or service level agreement between the Primary Care Trust and the Mental Health Trust nobody took overall responsibility. He was seen on an ad-hoc basis by a number of mental health professionals but there was no obvious long-term plan for his treatment and communication with the primary care team was poor or absent.

His primary care was equally patchy and he saw a bewildering number of nurses, GPs and locum GPs. Communication between the various health professionals was hindered by the frequent absence of the Inmate Medical Record and medication charts and the general disorganisation of the medical records system.

The system for prescribing and dispensing medicines was also disorganised. Prescriptions went missing and there were frequent gaps between prescriptions. Although there is no formal policy on the prescribing of diazepam within the prison, doctors were actively discouraged from prescribing it (this is discussed further in the main body of the clinical review). Eventually, following a period of erratic and variable supply, a decision was made to wean the man off the drug even though he had been taking it for about 18 months and he was psychologically reliant on it.

We may never know the reasons why the man committed suicide but the disorganised healthcare, the confusing array of health encounters and the chaotic treatment regime must be considered as possible contributory factors.

FINDINGS AND CONCLUSIONS

61. When the man arrived in HMP Birmingham in July, he received a health screen interview during which he denied having any thoughts of self-harm. However, he reported having concerns about his mental health, said that he had received treatment for depression in the past, and reported that, among other prescribed medicines, he was receiving diazepam. When the man was seen by a prison GP one week later, he reported that he suffered from agoraphobia.

62. The man spent the first six weeks of his time at Birmingham in standard prison locations. It was noticed during this time that he was finding it difficult being with so many other people and that he would not go on exercise or association. After an assessment to gauge his suitability, the man was transferred to the High Dependency Unit (HDU).

63. All of the evidence – from staff, from a prisoner friend of the man’s, and from his letters to his family and others – indicates that he settled well in the HDU. He clearly remained reserved, but he kept his door open to allow other prisoners to visit him in his cell. He also played the occasional game of pool, and was described as observing the goings-on in the wing while standing at the doorway of his cell. In one of his final letters, the man said that the landing staff had done their best to help him and that he withheld from them anything that could have made them suspect that he was planning to take his life.

64. Besides its impact on the man’s involvement in activities on the wing, another effect of the man’s agoraphobia was that he found it difficult to receive visits in the visits hall. To help with this, one of the chaplains, arranged for the man to receive some visits in the chaplaincy.

65. In contrast to the complimentary remarks in his letter about the landing officers, the man was highly critical of his clinical care and treatment. Within the man’s medical records there is an entry about him saying that he was pessimistic about his chances of surviving his prison sentence. Another entry reports him saying that he was having daily thoughts of suicide. On this point, the clinical review concludes that both the man’s own comments and those made in writing to the prison by his family should have triggered the opening of an ACCT document. Had an ACCT document been opened, one of the outcomes would have been improved sharing of information between the clinical and non-clinical staff responsible for the man’s welfare. This would have resulted in landing officers being made aware of comments the man had made about having thoughts of suicide.

66. The fact that no ACCT form was opened has led the clinical reviewers to question how effectively ACCT training and awareness has been rolled out through the prison. It is the responsibility of the Governor to ensure that all those who have contact with prisoners, including those such as visiting psychiatrists, are aware of ACCT. Recommendations on this issue are made in this report.

67. Another conclusion made in the clinical review is that the man's healthcare was patchy and disorganised. The clinical reviewers point out that nobody took overall responsibility for his care and that there was no obvious long-term plan for his treatment.

68. Beyond his repeated apologies to his family for the action he was about to take, and his expressions of love for them, the strongest theme emerging from the letters the man left after his death was the problem he was having with receipt of medication. The clinical reviewers confirm that the prescribing and dispensing of medication for the man was indeed disorganised, with frequent gaps between prescriptions. The reviewers point out that the man was psychologically dependent on one of his medicines, namely diazepam, but the supply of that medicine was also erratic before the decision was then made to wean him off it. (The clinical review includes two recommendations about policy and practice in prescribing diazepam.)

69. The clinical reviewers' final conclusion is that the man's disorganised healthcare provision must be considered as a possible contributory factor leading to his decision to take his own life. The content of his final letters supports that conclusion.

70. The man's death was discovered when the officer went into his cell at 6.50am. However, over half an hour earlier the OSG found that the man had covered his cell door observation panel. She reported this to the SO, the assistant Night Orderly Officer. He told her that he would deal with the matter after dealing with the problem he was facing at that moment. The problem of the moment was a prisoner who it seemed had taken an overdose and who needed to be transferred to outside hospital urgently. Birmingham's head of operations has explained that it is common for prisoners to cover their observation panels, so finding an obscured panel does not, in itself, constitute an emergency. I agree that it was entirely appropriate for the SO to have prioritised the two problems in the way he did. In any case, descriptions of the man's body when found indicate that he had died some hours earlier.

71. Upon the man's death, the chaplain and one of the governors went to the man's sister's home to break the sad news to her in person. As it was a weekday, and as both the man's sister and her husband are employed, no-one was at home. The chaplain then telephoned the man's sister at work and asked her to visit the prison – although he did not tell her why he was asking her to do so. When the man's sister said that it was not particularly convenient for her to leave work at that particular time, the chaplain then asked her to return to her own home, to ensure that she was in company with a friend, and that he would visit her there. Unsurprisingly, the man's sister guessed that her brother was dead and she asked the chaplain if that was the case. She says he replied that she was making things difficult, and could she return to her home as he had asked.

72. Bearing the responsibility for breaking the news of a death in prison custody is not an easy or an enviable duty. Help and advice for those asked to carry out this task is contained in the guidance supplementary to Prison Service Order 2710. It was

entirely appropriate, and in line with the guidance, for the chaplain and the governor to have visited the man's sister's home to break the news in person. Unfortunately, the guidance is silent on the approach to take in the case that no family members are found to be at home when the visit is made. It was with the very best of intentions that the chaplain then telephoned the man's sister at her place of work, but from the words exchanged in their conversation it was hardly surprising that she guessed what had happened. In this case, the chaplain had established a relationship with the man's sister through his involvement in arranging family visits for her brother. Given the existence of such a relationship, a better approach when the chaplain telephoned the man's sister might have been for him to have been candid about why he was contacting her. He could then have arranged a follow-up visit to her home in person.

I recommend that the Governor arranges a review of Birmingham's contingency plans for notifying families about deaths in custody – in particular to consider alternative approaches when the initial visit to the family home proves unsuccessful.

RECOMMENDATIONS

The following recommendations were made in the draft version of this report. The Prison Service's response is included in italics following each recommendation:

1. I recommend that the Governor arranges a review of Birmingham's contingency plans for notifying families about deaths in custody – in particular to consider alternative approaches when the initial visit to the family home proves unsuccessful.

Recommendation accepted: The establishment will look at alternative approaches when the initial visit to the family home proves unsuccessful, breaking the news by telephone would always be used as a last resort.

2. The records management system should be overhauled and improved so that the Inmate Medical Record is always available for every healthcare interaction. Ideally, a computerised medical record should be introduced, consistent with that used in the rest of the NHS.

Recommendation accepted: Filing clerk appointed. A new policy has been implemented to improve the management of medical records.

3. A summary of the previous primary care medical record should be obtained as a matter of routine for all prisoners entering HMP Birmingham. If, at reception screening, a prisoner is identified as having ongoing care from his GP, the transfer of records should be expedited (by fax or e-mail).

Recommendation partially accepted: Logistically difficult for all records. Arrangements are in place to access primary care records for prisoners who are receiving on going care from their GP. This is expedited by fax with a hard copy to follow.

4. If a prisoner has received specialist care for an ongoing condition, the details of that care should be obtained from the relevant specialist.

Recommendation accepted: Policy developed and implemented for both Primary Care and Mental Health Services to obtain information regarding the patients management from the relevant specialist.

5. All healthcare staff, including visiting specialists, should be trained in record keeping.

Recommendation accepted: Record keeping training forms part of an annual rolling programme.

6. The quality of record keeping should be regularly audited.

Recommendation accepted: The quality of all clinical records is subject to regular audit.

7. There should be a clear policy on the use of diazepam and other similar drugs within the prison. The policy should take into account the security implications of such drugs but should also be 'patient centred' and allow individual clinicians some discretion.

Recommendation accepted: Policy has been developed in line with BNF guidance. This policy is being expanded to manage the specific issues of benzodiazepines in substance misuse. Clinicians have the discretion to deviate from the guidance should a clinical need dictate. Target for completion is January 2007.

8. If a doctor decides to prescribe a reducing dose of diazepam, the regime, should be in line with good prescribing practice e.g. as described in the British National Formulary.

Recommendation accepted: As above. Target for completion is January 2007.

9. A 'repeat prescribing' system should be established so that prisoners with chronic conditions who are receiving long-term medication can obtain their medicines easily and with no gaps.

Recommendation accepted: Prisoners with a chronic condition have all medication recorded in their individual patient medication record which is held as a computerised record in pharmacy. The dates that the medication is next due is highlighted as the current prescription is dispensed to ensure later doses are not missed.

10. Whenever a prisoner does not receive his supervised medication the reason should be investigated and appropriate action taken.

Recommendation accepted: The nurses who administer supervised medication will note when prisoners do not attend at the hatch for their medication and inform pharmacy who will then inform the GP. If a prisoner refuses more than three doses the above protocol is followed.

11. The Primary Care Trust and the Mental Health Trust should agree a detailed contract/service level agreement for the provision of mental health services within the prison. The contract should set out the expectations and responsibilities of each party. It should clearly state the criteria for receiving continuing specialist mental health treatment and make provision for the provision of primary mental health care to those who do not meet these criteria.

Recommendation accepted: Service level agreement signed. Discussions with the commissioner regarding development of primary mental health services commenced and funding identified. Development of agreed pathways and full implementation of the care programme approach by March 2007.

12. The PCT and the Mental Health Trust should make every effort to provide continuity of care within the prison.

Recommendation accepted: Agreement at the Prison Partnership board for the appointment of a single Director for Prison Health who will have overall managerial responsibility and accountability for Prison Health. Appointment is out to advert. Target for completion is March 2007.

13. Communication between the primary care team and the mental health team should be improved. It might be helpful to hold joint meetings/case conferences to allow the teams to discuss the joint management of individual patients.

Recommendation accepted: Appointment of the Consultant Psychiatrist who hold weekly multidisciplinary case conferences. GPs hold a daily ward round.

14. All healthcare staff, including visiting specialists should be trained in the use of the ACCT system.

Recommendation accepted: A proportion of the staff have already received training a rolling program is being implemented to ensure that new staff are trained and there is an annual update for all staff. Target for completion is March 2007.

15. Trigger criteria for initiating ACCT should be agreed and applied consistently throughout the prison.

Recommendation accepted: Integral aspect of the ACCT document.

16. Whenever a healthcare worker sees a prisoner who reports suicidal feelings this should be documented and an ACCT plan considered. If the decision is made not to initiate ACCT, the reasons for this should be recorded. Even if an ACCT plan is not opened, the healthcare worker should consider whether or not to inform a prison officer.

Recommendation accepted: As above. Record keeping training program developed. Standard of clinical records subject to regular audit.

17. All primary healthcare staff should be trained in resuscitation techniques. This training should be updated regularly and a register of training maintained by the Healthcare Manager.

Recommendation accepted: This is an integral aspect of training and is subject to regular audit by the Nurse Manager. Central electronic data base held of all training need and delivery.

18. A full set of emergency equipment, including resuscitation equipment, should be carried when responding to emergency alert calls.

Recommendation accepted: A full set of emergency equipment is located on every wing and checked on a regular basis.

FAMILY RESPONSE TO REPORT

In response to the Ombudsman's draft report the man's family wished to add their own recommendations. These were:

1. That there should be monitoring by an independent person of any prisoner who has expressed suicidal thoughts and/or where concerns have arisen.

(It is felt that were such an independent monitor in place, this tragedy would have been avoided)

2. An Advocacy Service should be established for use by prisoners in such a vulnerable position.

(Again, it is felt that if such a service was available in a case like this to address the concerns that were clearly being expressed in the lead-up to the death, the death could have been avoided)

3. There should be a minimum level of information made available to prisoners as to who to turn to when he or she is getting nowhere in progressing issues of concern.

(It is felt that the deceased clearly felt that he had no-one to turn to)