

**Investigation into the circumstances surrounding the death
of a man
at HMP Birmingham in March 2007**

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

March 2008

This is the report of an investigation into the circumstances of the death of a man at HMP Birmingham in March 2007. His cause of death was a subarachnoid haemorrhage (a sudden bleed in the brain). He was 53 years old.

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

I would like to thank the Governor of Birmingham and his staff for their help and assistance during the course of this investigation.

The man died following an altercation with his cell-mate. The cell-mate was arrested and charged with murder but was acquitted at trial in July 2007.

Given the circumstances under which the man died, my investigation focussed on any risks that might have been associated with the two men sharing a cell. I have found no reason for either man to have been considered unsuitable to share a cell and no reason why they should not have shared together. The man's death occurred in extremely unfortunate circumstances that could not have been anticipated.

Whilst having no direct bearing on the man's death, I have asked the Governor to consider three housekeeping matters.

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Prisons and Probation Ombudsman

March 2008

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SUMMARY

The man was a 53 year-old remand prisoner at HMP Birmingham. He died in very unusual circumstances one early evening in March 2007. The man was in a shared cell. According to the cell-mate he and the man began to argue about the television. They had a physical tussle and the man collapsed to the floor. The cell-mate alerted staff who attempted to treat the man. Ambulance paramedics attended and they also provided treatment. Unfortunately, all efforts proved unsuccessful and the man was pronounced dead.

The cell-mate told staff what happened and this information was passed to the police. Police officers attended and the cell-mate was arrested and charged with murder.

At post mortem the man was found to have sustained a tear to his vertebral artery. The cause of death was given as traumatic subarachnoid haemorrhage due to a ruptured left ventricle artery.

In July 2007 the cell-mate was acquitted of all charges.

The investigation by my office was suspended pending the cell-mate's trial. When the trial was concluded, my investigation focussed on whether there was anything to suggest that the two men should not have shared a cell. The cell sharing risk assessment is the process used to help consider whether a prisoner might pose a risk to potential cell-mates. At the end of the assessment a prisoner will be deemed high, medium or low risk. Guidance about the cell sharing risk assessment makes clear that the process does not replace staff judgement. Nor does it rule out sharing by prisoners who pose a risk.

The evidence given by the cell-mate, and two prisoners who previously shared cells with the man, suggests that the man might have been a difficult person to share with. However, there is no evidence to suggest that the man posed any risk to cell-mates. Nor is there evidence to suggest that the cell-mate posed any risk.

THE INVESTIGATION PROCESS

The investigation was opened in mid March 2007 when one of my colleagues visited HMP Birmingham. He met a number of prison staff and a police detective. The detective told my investigator that the man's cell-mate had been charged with murder. He asked that the Ombudsman's investigation be suspended until after the cell-mate's trial. In the meantime, Birmingham displayed notices to prisoners and staff about the Ombudsman's interest.

In July 2007 the cell-mate appeared at court and was acquitted of all charges. My investigator was told by the police that he could proceed with his own investigation.

My investigator interviewed the cell-mate. He also interviewed three other prisoners who had given statements to the police. No additional prisoners came forward to give evidence in response to the published notices. Five members of staff were also interviewed.

One of my Family Liaison Officers contacted both the man's mother and his partner.

The man's mother said that her son was a gentle giant. She could not believe that he would have argued over a television remote control. She thought it was more in his nature to hand it over and avoid any confrontation. She was aware that her son had three previous cell-mates and her son had had no trouble or friction with any of these men. She had since found out that the final cell-mate was in custody for violent offences.

The man's partner questioned why two men with a history of violent behaviour were sharing a cell. She wanted to know whether any risk assessments were made before they were together. She felt her partner's death could have been avoided if there were better systems in place to assess potential risk. She said that when she spoke to her partner prior to his death, he had not mentioned any issues with his cell-mate.

The man's mother spoke about the funeral. She said the wake had been very well attended, to the point of over-flowing. She had received wonderful support from the community, including West Mercia police. Two members of staff from Birmingham attended on behalf of the prison.

HMP BIRMINGHAM

HMP Birmingham is a local prison built in 1849 for adult male prisoners. The prison can hold up to around 1,450 prisoners.

A-wing at Birmingham is the wing where the man was located. The wing has a total of 94 cells. Of these, 93 are double cells and only one is a single cell. A-wing mainly holds remand prisoners.

In February 2007, Birmingham received an announced inspection from Her Majesty's Chief Inspector of Prisons (HMCIP). In the introduction to the report, HMCIP 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 ...'

The cell sharing risk assessment

When a person first arrives in prison the standard reception process includes a cell sharing risk assessment. Prison Service Instruction (PSI) 32/2005 explains that the purpose of the risk assessment is to:

- draw together information about risk
- make best use of documentary evidence
- support staff judgement about allocation to cells and risk management
- record additional operational precautionary measures for a prisoner identified as a potential risk where cell sharing is unavoidable
- provide a record about risk of harm to others as a prisoner moves between wings/prisons
- to enable early identification of racist, homophobic or violent prisoners to ensure that other ... procedures to protect potential victims are followed.

PSI 32/2005 goes on to advise that the cell sharing risk assessment does not:

- replace staff judgement
- provide an actuarial risk score
- rule out cell sharing by prisoners who pose a risk.

Other guidance and instruction in PSI32/2005 includes:

A prisoner with a history of violence in custody (situational violence) presents a heightened risk ...

A risk minimisation plan must be in place to manage any high or medium risks identified. This must be agreed within 7 days and signed by the duty governor ...

Cell sharing risk assessment can aid identification and management of prisoners who show signs of racism ... Sharing with someone from a non-targeted group can be considered.

A register of prisoners designated as high or medium risk must be held centrally in each establishment to provide an audit trail of open and closed cases ...

Regular reviews will be required for those prisoners initially rated as high or medium risk ... [Reviews] should initially be after one month, then at least three monthly intervals ...

There are three levels of risk: high, medium and low. There are two parts to the assessment. The first part is completed by a reception officer. The second part is completed by a member of the healthcare team who makes his or her own separate assessment.

The cell sharing risk minimisation plan includes an interview with the prisoner to explore his attitude towards the risk he is perceived to pose to others.

Birmingham's Head of Safer Custody confirmed that the cell sharing risk assessment is a tool to try to ensure that a prisoner is safe to share with others. This applies both to them not posing a risk to others and not being at risk from others. The initial assessment is carried out by the reception senior officer. A nurse will then see the prisoner and make their own assessment. In Birmingham, the prisoner then goes to the first night centre where the senior officer will use the information obtained at reception to decide whether the prisoner should be allocated a single or double cell. The vast majority of the cells in the prison are double cells and, as Birmingham usually operates at full capacity, the expectation is that most prisoners have to share.

KEY EVENTS

Events leading up 12 March 2007

In December 2006, the man was arrested and charged with racially aggravated criminal damage. This was in connection with the clashes between the Black and Asian communities in the Handsworth area of Birmingham in October 2005. The man was taken to Birmingham Magistrates' Court where he was remanded into prison custody.

Due to overcrowding at HMP Birmingham, the man was initially remanded into HMP Shrewsbury. However, in early January 2007 he was transferred to Birmingham. On arrival, he was seen in reception by the Reception Senior Officer (SO). Among other things, the Reception SO completed sections 1 and 2 of the cell sharing risk assessment.

The Reception SO told my investigator that he had worked in reception for about two years. In assessing a prisoner's cell sharing risk he asks questions about their previous offences and whether they include offences such as manslaughter, grievous bodily harm or offences relating to race or homophobia. He asks prisoners about their temperament, for instance whether they are prone to outbursts of temper. He said that he also asks prisoners if they have any concerns about sharing with others. The Reception SO said that in making his assessment he takes into account both the prisoner's answers and his demeanour. He assessed the man's level of cell sharing risk as low.

After the man had been seen by the Reception SO, the Reception Nurse completed section 3 of the cell sharing risk form. She assessed the man as medium risk. The Reception Nurse no longer works at Birmingham so my investigator spoke instead to Birmingham's Lead Nurse in Reception. The Lead Nurse in Reception told my investigator that the Reception SO sees prisoners in a public space in front of many other prisoners. By contrast, the Reception Nurse will see prisoners in a private room. This difference can result in prisoners disclosing certain information to the nurse that they might withhold from the officer. One of the questions on the assessment form that the Reception Nurse had to answer was: '*... have you obtained any evidence that this prisoner may be at risk of harming others ...*' In answer, she ticked the option: '*Insufficient evidence to give opinion.*' The Lead Nurse in Reception speculated that the Reception Nurse had gone on to assess the man as medium risk for cell sharing as there was no evidence to conclude that he was either a low or a high risk.

Once the reception process had been completed, the man went to D-wing (the first night centre). On arrival, the locating officer completed section 4 of the man's cell sharing risk assessment. The locating officer deemed the man as suitable to share a cell.

Having spent the night of 4 January in D-wing, the man was transferred the next day to K-wing. The man remained there until 31 January when he was transferred to A-wing. His cell sharing risk assessment was reviewed that day. A note was made on

the form that the man had been involved in the Handsworth riots and his cell sharing risk was still judged to be medium.

On 7 January, the man saw a nurse for a 'Wellman' assessment. The nurse recorded that the man had a dislocated right finger and was complaining about painful bunions. The man also reported a history of an abdominal hernia. The man answered 'no' to a question about a history of serious illness in his family such as heart disease.

At Birmingham, prisoners are allocated personal officers. The allocation is determined by cell occupancy and two personal officers are allocated to each cell. The First and Second Officers were the personal officers for cell A2-003. My investigator asked the First Officer about an entry he made in the man's records on 4 February: *'Appears polite until you say no then [an] obvious change in him.'* (He made a similar entry on 18 February). The First Officer said that he had challenged the man because he was not wearing his footwear properly (which is a health and safety issue). The man became argumentative so the First Officer made a record of this. The man subsequently explained that he had a bunion on his foot and had to wear either soft shoes or, if wearing ordinary shoes, they had to be loose. Talking about the man in general, the First Officer described him as very tall and very loud. The man seemed comfortable in the prison and interacted well with other prisoners. The First Officer said that during association time the man would mix and chat with everybody.

A prisoner who shared a cell with the man from 31 January to 2 February told my investigator that the man was a difficult person to share with. He said that the man tended to switch television channels without asking. The man also had an irritating habit of banging down the toilet seat. This prisoner felt intimidated by the man so did not confront him about these issues. Nor did he say anything to staff.

On 7 February, the man began sharing with a new prisoner so his cell sharing risk was reviewed. The First Officer carried out the review. He told my investigator that he spoke to the man about the racial aspect of the Handsworth riots. The man said that he had been caught up in the riots, but not from a racial angle. Instead, he became involved because of the chance of stealing some property. Having spoken with the man, the First Officer was satisfied that he was not a racist and reduced his cell sharing risk from medium to low.

The prisoner who shared a cell with the man from 7 February to 25 February told my investigator that the man was very inconsiderate and would change television channels without consultation. This prisoner said that, although not scared by the man physically, he found him an overpowering personality and he did not feel able to challenge him. After one week of sharing with the man, this prisoner began asking staff for a cell move. He did not tell officers why he wanted a move and they did not ask. However, he said that the officers knew what the man was like and would have understood why he was asking. As Birmingham is a crowded prison it took the officers a few days to find this prisoner a new cell.

On 1 March, the man began sharing with the cell-mate who would later be involved in his death. The cell-mate had arrived in Birmingham on 12 February and was on

remand for common assault. As a result of his offence he was assessed as medium risk for cell sharing. In his interview with my investigator, the cell-mate said that the man behaved as if the cell belonged to him alone. For instance, he would leave newspapers strewn throughout the cell. The cell-mate said that he was neither scared of, nor intimidated by, the man. However, he tried to avoid arguing with him as he did not want a confrontation. The cell-mate said that, each time there was a vacant bed in the wing, he would ask officers if he could move but was always told that the bed had already been allocated. The cell-mate did not tell officers why he had asked to move and the officers never asked him for his reasons.

My investigator had agreed before his meeting with the cell-mate that they would not discuss the specific circumstances that resulted in the man's death as these had been dealt with at court. However, the cell-mate did mention that their argument commenced with the man changing the television channel without consultation. This was not something he had done before.

The First Officer said that he had little recollection of the cell-mate. He described him as an ordinary prisoner who kept his head down and who was just getting on with his time in the wing. The First Officer said that nothing was ever brought to his attention to suggest that the man and the cell-mate were having any problems sharing a cell. He said that prisoners will usually come forward if they are having problems and, in that case, officers will find out about the underlying problem. If the problem is significant, for instance a racial issue or potential violence, then action will be taken immediately. If appropriate, action will also be taken under the prison's anti-bullying policy. However, nothing was brought to staff's attention to suggest there was any bullying going on. If the problem between two prisoners is no more than they are not getting on together, a move might take a while to arrange. Any delay is because the wing is always at full capacity.

In his interview, the Second Officer (the other personal officer) initially described the man as intimidating if challenged. The Second Officer went on to say that it was not that the man was aggressive, but he was a large man with 'great presence'. Like the First Officer, the Second Officer also said that it was the issue about footwear that led to a confrontation with the man (noted in his records on 24 February). The man eventually explained the problem, but in the first instance he had flared up. Other than that, the man was not a problem and he seemed to mix well with others.

The Second Officer only had a vague recollection of the cell-mate. He said that he was unaware of there being any problems with the man and the cell-mate sharing a cell. Nor was he aware of any problems between the man and his previous cell-mates. The Second Officer said that swapping prisoners between cells to separate two prisoners not getting along was something that could probably be achieved within the same day. The Second Officer said that he was not on duty when the man died. He was shocked when he later heard what had happened.

Another prisoner who was a friend of the man told my investigator that the man had many friends who would visit him in his cell. This led to some of the cell-mate's tobacco going missing, resulting in an argument between the two. From then on the man and his cell-mate would have 'slanging matches' after lock-up. The man

thought he and the cell-mate might have a fight. The man knew that the cell-mate would come off best in a fight as he was younger and fitter.

My investigator asked the Head of Safer Custody about cell sharing risk minimisation plans as he could find no such plan in the cell-mate's records. This was despite the fact that the cell-mate remained at medium risk for the entire four weeks he was in Birmingham (a cell sharing risk minimisation plan should have been agreed within seven days of his initial assessment). The Head of Safer Custody was not sure whether risk minimisation plans were completed, but he agreed to remind staff that they should do so. Asked for his opinion on whether these two particular men should have been sharing a cell, the Head of Safer Custody said the fact that a prisoner has been judged medium or even high risk did not mean, for that reason alone, he is not suitable to share a cell. Similarly, two prisoners judged medium risk might also be able to share. He said that, although the man's records indicate that he could be difficult when opposed, the entries related to his attitude towards staff, not to prisoners. The Head of Safer Custody said he could see no reason from their records why the two men should not have shared a cell.

My investigator reported hearing that staff had been told to initially make all prisoners medium risk for cell sharing. The Head of Safer Prisons said this was not the case; this would cause a breakdown in the system. He agreed to issue an instruction correcting this misapprehension.

The early evening of 12 March 2007

At about 5.00pm the prisoners in A-wing collected their evening meals and returned to their cells to eat. The cell doors were locked.

In a statement taken by the police, the Third Officer wrote that that at about 6.05pm he heard a loud banging on the door of cell A2-003. The Third Officer looked through the cell observation hatch and saw the cell-mate pointing at the man who was lying on the floor motionless. The Third Officer shouted to other officers for help and unlocked cell A2-003. The Third Officer went into the cell. In his statement, he wrote that he did not notice the man's clothing being in disarray. Nor did he notice anything in the cell being out of place, nor anything to indicate there had been any kind of struggle. Other officers entered the cell and radioed for urgent medical assistance.

Three nurses responded promptly to the call for medical assistance. One thought they arrived within a minute of being called. The senior nurse of the three made the following record:

'[6.07pm] Arrival at scene. Prisoner found collapsed in cell lying on [left] side

...

'[6.10pm] ... [blood pressure] ¹¹⁵/₉₅. [pulse] 132 ...[Oxygen] given via face mask ...

'[6.12pm] [Emergency] ambulance requested ...

'[6.13pm] Prisoner turned over [onto back] to check condition. No respiratory effort noted ...

'[6.14pm] Defibrillator applied. No shock [instructed]. No circulation noted ... CPR (cardio pulmonary resuscitation) commenced. CPR continued continuously.

'[6.30pm] Paramedic crew arrived. Monitor attached. CPR continued. Pupils fixed and dilated. In [cardiac] arrest. CPR continued until removal to ambulance at [6.40pm]. Ambulance left site at [6.50pm].'

The Third Officer wrote in his police statement that he asked the cell-mate what had happened. The cell-mate said that he and the man had had a scuffle about the television. The man had banged his head and fallen to the floor. The Third Officer reported the conversation to the Principal Officer (who was the duty senior manager). The cell-mate was then moved into a single cell in the segregation unit.

In a written statement, the Principal Officer said that at about the time that the man was taken to hospital he telephoned the police to inform them what had happened. The Principal Officer's statement continued that at 7.12pm he was telephoned by an officer who had escorted the man to hospital who told him that the man had been pronounced dead. This news was passed on to the police.

Police officers arrived at the prison about 20 minutes later and interviewed staff and prisoners. The cell-mate was arrested and charged with murder.

Birmingham's care team gave support to staff and prisoners.

Due to the circumstances in which the man lost his life, it was the police who contacted his next of kin to break the news. Birmingham's Head of Safer Prisons spoke with the man's mother and his partner and gave them the opportunity to visit the prison and to see the man's cell. Birmingham paid the man's funeral expenses and two of the staff subsequently attended the funeral.

At post mortem, a Consultant Home Office Pathologist found haemorrhages in the man's neck muscles consistent with torn muscles fibres indicative of a forceful deflection of the head from left towards right. The Pathologist found no other obvious abnormality in the man's brain. The man's heart also appeared normal. The Pathologist gave the man's cause of death as:

- 1a) traumatic subarachnoid haemorrhage due to
- 1b) ruptured left ventricle artery.

At his murder trial in July 2007, the cell-mate was acquitted of the charges against him.

Ordinarily, deaths in prison custody are subject to a Coroner's inquest. Because the man's death was considered at Crown Court, I understand that the Coroner had decided that will be no inquest.

FINDINGS AND CONCLUSIONS

The man died in very unusual circumstances. His cell-mate was implicated, but at court he was cleared of the charges laid against him. The aim of my investigation was not to determine whether either the man or the cell-mate was to blame for the dispute or argument that ultimately resulted in the man's death. Instead, the purpose was to consider the circumstances of his death and whether it could have been prevented. I considered whether there was any reason that the two men should not have shared a cell. And if there was any such reason, whether the prison staff should have recognised it.

The investigation included interviews with prisoners, including the last three to share a cell with the man, including the cell-mate. In relating their evidence I am very conscious of the fact that the man has not been able to give his side of the story.

The cell sharing risk assessment is a tool used to help consider whether a prisoner might pose a risk to potential cell-mates. There are three levels of risk: high, medium or low. Before considering the cell sharing risk assessments made on the man and the cell-mate some context is needed. In recent years, the prison population in England and Wales has been running at or close to maximum capacity. At the time of the events of this case, Birmingham was taking overcrowding drafts of prisoners from London. To make room, Birmingham was displacing its own prisoners to Liverpool. Most cells in Birmingham are double cells and the general expectation is that the majority of prisoners will have to share. The cell sharing risk assessment does not rule out sharing by prisoners who pose a risk.

Turning then to the specific cell sharing risk assessments, the man arrived in Birmingham in early January 2007. The Reception Senior Officer judged the man as low risk for cell sharing. He was then seen by the Reception Nurse who judged him medium risk. Her reason for coming to that conclusion might simply have been that she felt she had insufficient information to do otherwise. The man's cell sharing risk was reviewed on 7 February when his risk was revised down to low. His risk assessment remained as low thereafter.

The man's last three cell-mates all told my investigator that they disliked sharing with the man. Their evidence was that the man was rather untidy and inconsiderate. Two of them said that they asked staff for a cell move, although neither of them gave explanations to staff. One said that staff knew what the man was like and so they should have realised why he was asking for a move. If the evidence from these two prisoners is true then I am disappointed that officers did not try to explore what they were asking to move. Prison staff must be constantly alert to the potential of bullying by one prisoner against another. Staff should be aware that bullying does not have to be physical. It can also be verbal or psychological. Where there is evidence of bullying, the Prison Service has systems for managing such behaviour.

The First and Second Officers (the personal officers for prisoners occupying cell A2-003) both made entries in the man's records indicating that he could be argumentative. Both had spoken to him about his footwear being loose and therefore potentially dangerous. The man eventually explained that he had a bunion on his foot and that was why he could not tie his shoes properly.

Even if one accepts as true all the adverse comments made about the man, the most that could be said against him is that he might not have been the easiest person to share with. There is certainly no evidence to suggest that he posed a risk to potential cell-mates. I can find no reason for the man to have been rated as anything other than low risk for cell sharing.

Moving to the cell-mate, he arrived in Birmingham on 12 February. The cell-mate was on remand for assault. It seems that it was because of his offence that he was judged medium risk for cell sharing. The cell-mate remained at medium risk throughout his time at Birmingham. He appears to have been fully compliant with prison regulations and his records contain no adverse comments about his behaviour. The First Officer described the cell-mate as an ordinary prisoner who kept his head down. The Second Officer had very little recollection of him.

Guidance about the cell sharing risk assessment is contained in Prison Service Instruction 32/2005. It refers to prisoners with a history of violence as presenting a heightened risk, alluding very specifically to a history of violence in custody (that is, situational violence). In the cell-mate's case, there is nothing in his records to indicate any history of violence in custody.

Other guidance in the PSI relates to risk minimisation plans that must be put in place to manage any high or medium risk prisoners. The plan should be completed within seven days and in the cell-mate's case should have been in place by 19 February. However, his records contain no such plan. Birmingham's Head of Safer Custody was not sure whether risk minimisation plans were being completed at Birmingham. He agreed to remind staff about them.

PSI 32/2005 also sets out that regular reviews are required for those prisoners initially rated as high or medium risk. The first review should be after one month and, in the cell-mate's case, his review was due around the time of the man's death.

As the Head of Safer Prisons pointed out, the PSI does not expressly prevent a prisoner deemed at high risk from sharing a cell. However, it is self-evident that this should only happen exceptionally, if at all.

We can only now speculate about what would have happened in the cell-mate's case had there been a risk minimisation plan and cell sharing risk review. However, what we do know is that nothing occurred before the day of the man's death to suggest that he was a potential risk to other prisoner. The evidence would therefore suggest that the cell-mate might more appropriately have been assessed as low risk.

In conclusion, therefore, I can find no reason why the man and the cell-mate should not have shared a cell. Unfortunately, the man died as a result of a freakish accident that I do not believe could possibly have been anticipated.

RECOMMENDATIONS

I make no formal recommendations, but I make three housekeeping points:

- The Governor will wish to check that cell sharing risk minimisation plans are being completed for prisoners deemed medium or high risk (as required under PSI 32/2005).
- The Governor will wish to check that prisoners are not being routinely deemed medium risk for cell sharing purposes.
- The Governor will also wish to ensure that staff understand and are complying with anti-bullying policies.

RESPONSE TO DRAFT REPORT FROM THE MAN'S FAMILY

Before the final version of this report was issued, a version was sent in draft form to all relevant parties seeking their comments.

The man's mother reiterated her comments about her son's cell-mate being in custody for violent offences. She also reiterated her view that her son had had no problems with his previous cellmates. She said that she felt her son had been failed by the British judicial system.

The man's partner said that she accepted that HMP Birmingham had acted within their guidelines. However she thought there was a much bigger problem and that the prison system as a whole was at fault.