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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man  
at HMP Birmingham in April 2012**

## ***Our Vision***

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

This is a report of an investigation into the death of a man who died at HMP Birmingham in April 2012. The man hanged himself in his cell four days after he arrived at the prison. I offer my condolences to his family and friends.

My investigator undertook this investigation and a clinical reviewer carried out a review on the man's clinical care in prison. HMP Birmingham cooperated fully with the investigation. I apologise for the delay in completing this report.

When the man was arrested, he told police that he would kill himself as soon as he got to prison. This information was passed to the prison and suicide and self-harm prevention procedures were begun when he arrived. A mental health referral was made but an assessment had not taken place by the time of the man's death. In April, during a period when cells were unlocked on the wing for prisoners to associate with each other, the man went back to his cell, blocked the door lock with a piece of plastic cutlery and hanged himself using bed sheets. He left a note for his family telling them that he intended to take his own life. Because of the jammed door lock, it took prison staff 15 minutes to get into the cell. When they did, they attempted to resuscitate him but were unsuccessful.

The man was generally well supported by Birmingham's suicide and self-harm procedures and I am satisfied that prison staff did their best to get into the man's cell as quickly as they could. However, it is a concern that his mental health assessment was not prioritised and that he was left unsupervised during association. I am, therefore, pleased that the Director of Birmingham has already taken action to address these issues. I am also concerned that entries on the man's suicide and self-harm monitoring document, about when he was observed by staff, did not always reflect the time that these actually took place.

It is clear that the man was determined to take his own life and, ultimately, it appears unlikely that staff at Birmingham could have prevented this sad outcome.

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

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

**May 2013**

## **CONTENTS**

Summary

The investigation process

HMP Birmingham

Key events

Issues

Recommendation

## SUMMARY

1. The man was remanded to HMP Birmingham on 30 March 2012. This was not his first time in prison and he was on licence from a previous sentence when the alleged offences were committed. During a previous time in prison, the man had been subject to suicide and self-harm prevention procedures (known as ACCT) and had once attempted to hang himself. He had been homeless for some days before his imprisonment and said that he had attempted to take his own life three times during this period.
2. When the man was arrested, he said that he would kill himself as soon as he got to prison. He was monitored as at risk of suicide and self-harm and this information was passed to the prison.
3. At a health screen when he arrived at HMP Birmingham, the man maintained that he wanted to kill himself and an ACCT was opened. An action plan noted that a mental health assessment was needed, but this did not take place before his death. As part of the ACCT support arrangements, he was observed twice every hour, and prison staff, were required to have three “meaningful conversations” with him each day.
4. In April the man was socialising with other prisoners during a period when cells were unlocked in the afternoon. The officers on duty said that he seemed a bit brighter and more communicative and was interacting with other prisoners. Around 4.00pm when the prisoners were being locked back into their cells, officers noticed that the door to the man’s cell was closed and locked. The door observation panel had also been covered from the inside of the cell. A piece of plastic had been put into the lock mechanism and officers could not unlock the door. There was a small gap at the top and bottom of the cell door. Through the top of the door, prison staff saw bed sheets attached to the light fitting in the room and the top of the man’s head. An officer broke the observation panel and could see that he was hanging from the light fitting.
5. It took officers approximately 15 minutes before they were able to open the door and were able to try to resuscitate him. The man was taken to hospital but was pronounced dead at 5.04pm.
6. After the man’s death prisoners and staff received appropriate support.
7. The Director subsequently introduced two changes of policy and practice for managing prisoners subject to ACCT procedures during association periods and to ensure that prisoners at risk of suicide and self-harm receive prompt mental health assessments. We make a recommendation about correctly recording times of observations and entries in ACCT documents

## THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on the day of his death. The investigator visited the prison on 13 April and met the Director, the National Offender Management Service contract controllers and the prison family liaison officers. She visited the wing where the man had lived and spoke to his cell mate. She subsequently spoke to a member of the Independent Monitoring Board (IMB). The investigator obtained copies of the man's prison and clinical records.
9. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation inviting anyone who had relevant information to contact her. Only the man's cell mate came forward.
10. On 14 and 15 May, the investigator interviewed prison staff and the man's cell mate. After the interviews, the investigator gave the Director initial verbal feedback.
11. Heart of Birmingham Primary Care Trust (PCT) appointed a clinical reviewer to undertake a review of the clinical care the man received while he was at Birmingham. The clinical reviewer's report was not received till 11 December which contributed to the delay of this report. He had difficulty contacting staff at Birmingham because their email addresses had changed. The report was also delayed by sick absence in this office. We apologise for its late issue.
12. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation and a copy of this report has been sent to him.
13. One of our family liaison officers contacted the man's next of kin on 26 April to explain the investigation process and ask if the family had any matters they wished the investigation to consider. The man's family did not raise any specific issues, but said that the last time they had spoken to him, he had seemed very upset.
14. The man's family responded to the findings of the investigation. They raised concerns, including the recording of the time the man was seen and the problems staff had opening the cell door. The issues raised have been addressed in the accepted recommendation to this report.

## **HMP BIRMINGHAM**

15. HMP Birmingham is a large local prison, principally serving the West Midlands courts. It holds a maximum of 1450 men, both sentenced and unsentenced. The prison is the first public sector prison to have its management transferred to the private sector. Since 1 October 2011, it has been managed by G4S Care and Justice Services. Healthcare services are commissioned by NHS Birmingham and Solihull. The prison healthcare centre operates 24 hours a day.

### **Her Majesty's Inspectorate of Prisons**

16. HM Inspectorate of Prisons (HMIP) carried out an announced inspection of Birmingham in January 2012. Inspectors noted that the policy for reducing suicide and self-harm had been recently reviewed. HMIP found that care for prisoners at risk of suicide and self-harm was reasonable but could have been improved by systematically applying learning from previous incidents.

### **Independent Monitoring Board**

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community, who monitor standards to help ensure prisoners are treated fairly and decently. In their annual report for the period 2011-2012, the IMB were satisfied that ACCT procedures were carried out correctly and noted that the Safer Custody Team completed frequent checks of appropriate paperwork and reviews, and personally visited any prisoner causing particular concern.

### **Assessment Care in Custody and Teamwork**

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be regular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

### **Previous deaths at Birmingham.**

19. Forty prisoners have died at Birmingham since the Ombudsman took responsibility for investigating deaths in prison custody in 2004. Since 2010, there have been six apparently self-inflicted deaths before the man's. One of these prisoners also died within a week of arriving at Birmingham, but he had not been identified as at risk of suicide or self-harm.

## KEY EVENTS

20. The man was released on licence from HMP Stafford on 2 August 2011. The conditions of his licence required him to live at a specific address and abide by a curfew, but he left the address without permission. Shortly afterwards, on 28 March 2012, he was arrested and charged with serious sexual offences. Because he had expressed suicidal thoughts, he was assessed by a forensic psychiatric team in police custody who found no evidence of psychotic or depressive symptoms.
21. The man was taken to HMP Birmingham at 4.35pm on 30 March. During the journey, he told one of the escorting officers that as soon as he got to prison he was going to kill himself. Prison Custody Officer (PCO) A completed a suicide and self-harm warning form and ensured that the man was supervised during the journey. He passed the warning form to PCO B when the man arrived at the prison.
22. At a reception health screen, the man told Nurse A that he had been homeless after he left his licence address. He said he had attempted suicide by overdose three times in the previous week and had been taken to hospital but had then discharged himself. He said that he was still feeling suicidal and had been under the care of The Croft, a specialist mental health centre in Bilston. The nurse completed a concern and keep safe form to start the suicide and self harm procedures (known as ACCT) at 8.58pm. The man said that he was prescribed carbamazepine for epilepsy, salbutamol for asthma and an antidepressant, although he was unsure which.
23. PCO C and PCO D then interviewed the man to complete an ACCT Immediate Action Plan. It was agreed that he would live in a double cell with another prisoner for company and support and he would be observed hourly. Staff were required to have meaningful conversations with him three times a day. The officers explained to him how to use the prison telephone system and about the Listener scheme. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.) The man was prescribed the same medication he had been taking in the community, but was not allowed to keep his medication with him because of his previous attempts at overdose and his current state of mind. He was then taken to a cell in the first night centre. On 31 March, a caremap was completed as part of the ACCT procedure. The issues raised were that a referral should be made to mental health services and that he should move to G wing as soon as possible and be encouraged to mix with other prisoners for support.
24. The next day, 1 April, the man told PCO E that he had not expected to be remanded into custody and he was worried about returning to prison. He said that he would attempt to kill himself at any available opportunity. At 11.30am, PCO F carried out an ACCT assessment interview and the man told him that he had felt suicidal for months and had taken an overdose the Wednesday before his imprisonment. When he woke up in hospital after being treated he still wanted to die. He said that he felt hopeless and was

very concerned about the charges against him. PCO F told the investigator that the man was very quiet and withdrawn during the interview and it was very difficult to get information from him. The man was allowed a free two minute call to his family and PCO E said that he appeared upset after this. He spoke to him and the man said that he was okay and went back to his cell.

25. At 2.00pm, PCO E and PCO G reviewed the ACCT with the man. They noted that he seemed very low in mood and was tearful after his contact with his family. They increased his observations to two each hour and assessed him as a raised risk of self-harm and made a referral to the mental health team. The next ACCT review was arranged for 3 April.
26. On 2 April, the man attended healthcare for his second health screen and gave permission for the prison to obtain his community GP records, which were received the next day.
27. The First Night Centre manager and PCO H reviewed the man's ACCT on 3 April at 9.20am. The man told them that he still did not feel like he had anything to live for. He said that he was in contact with his family, but not with his son. He was refusing to eat, so it was agreed that he should be observed at meal times. He was going to be transferred to the Vulnerable Prisoners Unit (VPU) that day and said that he was happy about that because he had friends there. A further review was arranged for 10 April. The man moved to the VPU later that day. His cell mate said that the man was quiet and withdrawn and kept to himself.
28. On the day of the man's death, the cell bell call record indicates that the bell in the man's cell was used at least twice per hour. The prison investigation liaison officer explained that these indicated the checks on the man as part of his ACCT observations. At 9.55am, PCO I noted in the ACCT record that the man was not very talkative but said that he was okay and was settling in on the wing. At 11.50am, the man collected his lunch and was observed eating it and watching television in his cell. Another entry was made in the log at 1.45pm when PCO I observed that the man was in his cell watching television. At 2.00pm, the PCO unlocked the cell door for an association period, when prisoners can mix with each other, take showers and make telephone calls.
29. PCO I said that when he unlocked the cell, the man seemed a bit more talkative and went to play snooker with other prisoners. He saw him playing snooker and said he seemed brighter in his mood because he was interacting with others. He made two entries on the ACCT log, one at 3.00pm and another at 3.55pm. When the investigator asked the PCO if he actually saw the man at these times, he explained that he probably saw him 10 or 15 minutes before and the time on the record was the time that he made the written entry rather than the time he made the observation.
30. PCO I said that there were between 80 and 100 prisoners on the wing during the association period that day, of whom around four or five were on

ACCTs. The prisoners were supervised by four officers. He said that the prisoners could be on any of four landings, playing pool, showering or chatting. Some prisoners preferred to stay locked in their cells but would ring their cell bell if they wanted to come out. He also explained that if a prisoner was on an ACCT and he wanted to stay in his cell the bolt would be shot to prevent the door being locked and shut from inside. However, if someone who was on an ACCT wanted to stay in their cell with their cellmate it would be unlikely that the bolt would be shot. The man had left his cell and was associating with other prisoners on the wing. His cell mate was at work so the lock on his cell door was not shot.

31. At the end of association at 4.00pm, PCO I and PCO J started to lock the prisoners back in their cells. PCO J went down one side of landing two while PCO I locked the other side. PCO J said that there were a lot of prisoners returning to their cells at this time and he saw the man's cell mate, waiting by the cell door, which was closed. He said that when he went to open the door he noticed something white in the lock. At first he thought it was a piece of white paper and tried to pull it out with his fingers, but then he realised it was white plastic which had been jammed into the lock. He noted the observation panel had been covered from inside the cell with a piece of paper and immediately called PCO I, saying that there was a problem.
32. The cell card outside the door indicated that the cell contained a prisoner being monitored as a risk of suicide and self-harm so PCO J was immediately concerned. He radioed to ask for an ambulance to be called, for medical help and for the orderly officer, in charge of the prison's operations that day to attend. The call for an ambulance was received in the control room at 4.09pm and an emergency ambulance was called immediately.
33. PCO I went to assist PCO J and said that it looked like a plastic knife had been put in the lock and the end broken off so they were unable to pull it out. Through a small gap at the top of the cell door he saw a bed sheet hanging from the light fitting and the top of the man's head. PCO I tried to prise the plastic out of the lock using a different key while PCO J went to get Senior PCO A and a special ratchet for opening jammed cell doors. Other staff, including a manager and healthcare staff with emergency equipment, arrived at the cell shortly afterwards. Maintenance staff were called while the officers continued to try and get the door open. Two officers broke the glass observation panel with their batons. They could see that the man was suspended by bed sheets round his neck, which were attached to the light fitting. His feet were not touching the floor.
34. The manager had specialist training in entering cells and assessed the situation when he arrived. Other staff had used an anti-barricade ratchet to unscrew the lock from the outside of the cell but because the plastic was still in the lock barrel they were unable to open the lock. The manager had taken a door jack tool with him but when he examined the lock he realised that it would not be safe or useful to use it because the lock could not be

taken out. In his police statement he said he realised that the only way to get into the cell was to try and push the plastic back into the lock chute (a small hollow behind the lock but within the lock itself.)

35. The manager put the anti-barricade ratchet over the plastic knife, in the lock and asked another officer to kick the back of the ratchet. PCO K kicked the ratchet twice and then the door opened inwards. PCO I said that it had taken approximately 15 minutes to get the door open from when PCO J had first tried to unlock it.
36. As soon as the door was opened, the manager and PCO K went into the cell followed by PCO L. The man was hanging from the light fitting in the centre of the cell with his back towards the staff. There was no evident movement or noise. PCO K lifted the man and PCO L cut through the sheets using her anti-ligature knife which officers are required to carry. The manager, PCO K and PCO L then lowered the man to the floor and PCO L cut the sheets from his neck. As soon as this was done the healthcare staff, who had set up their emergency equipment ready to treat the man, went into the cell.
37. Nurse A, Nurse B and the Nurse Manager immediately started cardiopulmonary resuscitation (CPR). They attached a defibrillator to the man, to see if there was a shockable rhythm to restart the heart. The defibrillator advised them to continue with resuscitation and did not advise a shock at any time. A prison doctor arrived and supported the nurses. Paramedics arrived about 4.20pm and took over CPR, with the assistance of the nurses.
38. At 4.50pm, the man was taken to hospital by ambulance. Nurse A continued CPR in the ambulance. They arrived at City Hospital and the man was taken to the resuscitation room to be treated by hospital staff. At 5.04pm, he was pronounced dead.
39. The man had left a letter addressed to his sister in his cell, which indicated that he was going to take his life.
40. The prison family liaison officer was notified of the man's death while she was off duty. She got to the prison at 6.15pm, but it was not till 7.30pm that the police agreed that the man's family could be notified. She arrived at the home of the man's next of kin at 8.25pm. She provided ongoing support to the man's family and, in line with national guidance, the prison offered financial assistance with the funeral expenses.
41. At 5.40pm, a hot debrief was held where the staff who were involved in the response to the man's death were offered support. A number of concerns about the incident were raised and the Director issued two new instructions for staff on 19 April. The first instruction said that any prisoner on an ACCT in a shared cell should not be left alone in a locked cell at any time. If their cell mate left the cell, the prisoner should either be accompanied by another suitable prisoner or moved, and the cell door locked to prevent access.

42. The second instruction said that anyone regarded as at risk of suicide and self-harm identified as needing a mental health assessment at their health screen should be noted on the appointments ledger. The designated first night registered mental health nurse would then be required to assess the prisoner and ensure there was an agreed care plan in place to support them. If an assessment was not done by 9.00pm, a named registered mental health nurse should be identified to carry out the relevant assessment the next day.
  
43. After the man had been taken to hospital, staff on the wing notified the other prisoners of his death and reviewed all prisoners subject to suicide and self-harm procedures. On 12 April, staff interviewed 12 prisoners who were on the wing at the time the man was found in his cell. The prisoners were asked a number of questions about the incident and support after the event to help improve procedures.

## ISSUES

### Healthcare

44. When the man was arrested and in police custody, he said he had been homeless for the previous two weeks. It is not known whether he had taken his medication during that time. The police arranged a mental health assessment and doctors said that there was no evidence of psychotic or depressive illness. However, as the man had previously tried to take his own life a number of times in the past and three times in the previous week, he was closely observed during his time in police custody. The information about his high risk of self-harm was passed appropriately to the prison.
45. Nurse A completed the man's health screen when he arrived at Birmingham and started the suicide and self-harm procedures because he continued to say that he would kill himself. The clinical reviewer said that the man received a level of healthcare consistent with NHS provision to the wider population in terms of the treatment of his depression. Although it would have been preferable for the man to have had a mental health assessment as a matter of priority (discussed below) we consider that overall, the man had a satisfactory standard of clinical care at the prison.

### ACCT

46. The ACCT was started appropriately, when the man first arrived at Birmingham. The information about his suicidal thoughts was passed on properly, from the police and escort services. The information contained in the ACCT is comprehensive and the risks he posed were reviewed as necessary. The immediate action plan and caremap were clear and aimed at reducing the man's risk of self-harm. The clinical reviewer also comments that the ACCT "is comprehensive and thorough and indicates a good degree of engagement with the man." We are satisfied that the ACCT was generally well managed, although we have some concern about timings of entries during association. (See below.)

### ACCT monitoring during association

47. The man was regarded as a risk of suicide on 4 April and had been allocated a shared cell as a protective factor. However, he was able to go back to his cell unobserved during an association period when his cell mate was at work. He locked the cell door from inside the cell and jammed the lock to hinder prison staff from getting into the cell to save his life. The Director has taken action to help prevent a prisoner being monitored as at risk of suicide and self-harm, doing the same thing during association in future. We therefore make no recommendation about this aspect of the man's monitoring during association.
48. However, we are concerned that the ACCT observation entries did not give an accurate account of when the man was seen. PCO I made two entries in

the ACCT log during the association period, one at 3.00pm and another at 3.55pm. He told us that, although these were the times the entries were made, it was likely that he had seen The man as long as 15 minutes before. We consider it important that timings of ACCT entries give an accurate account of when the prisoner was observed. If the timings do not reflect the observation it is difficult to be sure that officers are complying with the required level of observation or that the timings of events is accurate. In this case an entry was made at 3.55pm suggesting the man was seen on the wing at that time, but this appears unlikely as he was found locked in his cell at 4.00pm. Ideally entries should be made at the time of the observation, but we accept that this might sometime be difficult, such as during a busy association period. When that happens the officer should make a note of the time of the observation, and the entry in the ACCT should record that time, as well as the time the ACCT entry was made. We make the following recommendation.

**The Director should ensure that, where these are different, entries in ACCT records accurately record the time an observation was made as well as the time of the entry.**

### **Mental health assessments**

49. The man had an ACCT careplan objective to have a mental health assessment and a referral for an assessment was made on 31 March. At the ACCT review on 3 April, it was noted that the man had not yet been assessed and this was chased up by the First Night Centre manager. No assessment took place that day or the next, before the man died.
50. The Director issued an operational instruction on 19 April, requiring any prisoner on an ACCT and needing a mental health assessment to have one completed either the same day or the day after. As the man had been assessed when he was in police custody a few days previously there is little to indicate that an earlier mental health assessment at the prison would have affected the outcome in the man's case. Nevertheless, we welcome the commitment to ensure that, in future, prisoners at risk of suicide and self-harm receive prompt mental health assessments. We therefore do not make a recommendation about this matter.

### **Emergency response**

51. While staff were trying to open the cell door, an ambulance was called. The response by the prison staff to the emergency was swift and appropriate. Nurses arrived quickly and had emergency equipment prepared and ready to use as soon as they were able to get into the cell. The resuscitation attempts by the clinical staff were appropriate and comprehensive.

## Recommendation

1. The Director should ensure that, where these are different, entries in ACCT records accurately record the time an observation was made as well as the time of the entry.

**This recommendation has been accepted by the prison.** They said, “An operational order has been published to all staff, detailing that when making entries in the ACCT book, the comments should clearly state what time the comment was entered into the document and what time the observation and/or conversations referred to was made if different.”