

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr John Delahaye a prisoner at HMP Birmingham on 5 March 2018

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Delahaye was found dead on 5 March 2018 in his cell at HMP Birmingham after taking an overdose of insulin. Mr Delahaye was 46 years old. I offer my condolences to Mr Delahaye's family and friends.

Mr Delahaye was admitted to hospital following an insulin overdose on 31 December. We agree with the clinical reviewer that this was almost certainly deliberate.

I am concerned that when Mr Delahaye returned to Birmingham on 1 January following this overdose, there was no handover between hospital and prison healthcare staff and prison healthcare staff did not know he had returned to prison until the next day.

I am also concerned that suicide and self-harm monitoring procedures (known as ACCT) were not started until the day after he had returned to prison. In addition, I have concerns about the way the ACCT procedures were managed when they were started. Staff did not effectively investigate why Mr Delahaye had taken the overdose and healthcare staff were not involved. The ACCT was closed prematurely two weeks later, with little having been done to identify or mitigate Mr Delahaye's risk to himself. This was compounded by the fact that Mr Delahaye was discharged from mental health services after just one appointment. I am concerned to be repeating recommendations to Birmingham about suicide and self-harm prevention procedures.

It is very difficult to understand why Mr Delahaye was allowed to have his insulin back in his possession less than a month after his overdose. I am concerned that NHS guidelines were not followed when this decision was made.

I also have serious concerns about the way staff at Birmingham conducted roll checks and unlocks. When Mr Delahaye was found on the morning of 5 March, he had clearly been dead for some time and it seems possible that no member of staff had seen him for more than 13 hours. This needs to be rectified urgently.

Staff also failed to use an emergency code when they found Mr Delahaye unresponsive. Although this did not affect the outcome for Mr Delahaye, it could make a critical difference in other cases.

I have also made recommendations designed to improve staff support and family liaison.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**November 2018**

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# Summary

## Events

1. On 11 September 2017, Mr John Delahaye was remanded into custody, charged with offences of serious violence.
2. He had been diagnosed with type 1 diabetes in 2003 and was prescribed insulin on his arrival at HMP Birmingham. The following day, a doctor assessed him as being suitable to hold his medication in his possession.
3. On 31 December, staff found Mr Delahaye unresponsive in his cell. He had taken an insulin overdose. He was admitted to hospital and returned to the prison on the afternoon of 1 January. There was no handover from the hospital and healthcare staff were unaware of his return until the next day.
4. On 2 January, staff started suicide and self-harm procedures, known as ACCT. Mr Delahaye said he did not know if his insulin overdose had been accidental or intentional. A mental health nurse assessed him and discharged him back to the care of the GP. Mr Delahaye said he had no thoughts of suicide or self-harm.
5. On 17 January, staff stopped ACCT procedures. Mr Delahaye had consistently said that he had no thoughts of suicide and self-harm.
6. On 29 January, a GP assessed that Mr Delahaye was suitable to hold his medication in his possession once again. He was regularly issued self-administering insulin pens, the last occasion being on 4 March.
7. Staff locked Mr Delahaye into his cell around 5.00pm on 4 March. A Prison Custody Officer (PCO) completed roll checks at 9.15pm and 5.15am, but the officer could not be certain whether she had seen Mr Delahaye at these times as she said that if a prisoner had blocked his observation panel, she would not necessarily ensure she obtained a response.
8. On 5 March, around 7.30am, another PCO unlocked all the prisoners on Mr Delahaye's landing. He did not look into their cells. At 8.20am, an officer went to collect Mr Delahaye for an appointment. He found Mr Delahaye on the floor; rigor mortis had set in. He summoned assistance but resuscitation was not attempted as Mr Delahaye had clearly been dead for some time.

## Findings

### Management of ACCT

9. The clinical reviewer concluded – and we agree - that Mr Delahaye's overdose on 31 December was most likely to have been intentional. It would be impossible to deliver large quantities of insulin accidentally.
10. It is unacceptable that there was a day's delay in opening an ACCT after Mr Delahaye returned from hospital following this overdose.
11. When the ACCT was opened, the procedures, aimed at reducing Mr Delahaye's risk to himself, did not effectively investigate or challenge the reasons why he

had taken an overdose. This failing was exacerbated by the fact that no healthcare staff were involved. Caremap actions did not adequately address the triggers of Mr Delahaye's distress.

### **Clinical Care**

12. In the main, Mr Delahaye's diabetes was appropriately managed and treated. However, he missed several medical appointments, apparently because there were insufficient prison staff to accompany him, even to his annual diabetic check.
13. When Mr Delahaye returned to the prison from hospital after his overdose, healthcare staff did not know he had returned until the next day when they rang the hospital for an update.
14. Mr Delahaye should not have been allowed to have his insulin back in his possession so soon after his initial overdose. He should also have received more mental health support following this overdose.

### **Roll checks and unlock**

15. Roll checks on the night and morning before Mr Delahaye was found dead were not completed to a satisfactory standard. The officer could not guarantee that she had seen Mr Delahaye during either check and could not, therefore, confirm that he was alive at the time. This is not acceptable.
16. The officer who unlocked Mr Delahaye's cell on the morning of 5 March did not look into his cell to confirm his well-being, in contravention of Prison Service Instructions 75/2011. It is a further cause for concern that the Deputy Director was not aware of this instruction.

### **Emergency response**

17. The PCO who found Mr Delahaye unresponsive in his cell following his overdose on 31 December did not radio an emergency response code or even call for urgent medical assistance. This could have had serious consequences.
18. The PCOs who found Mr Delahaye unresponsive in his cell on 5 March, did not radio an emergency response code. As a result, there was a three minute delay before an ambulance was called. Although this did not affect the outcome in Mr Delahaye's case, it could make the difference between life and death in other circumstances.

### **Family liaison**

19. When Mr Delahaye was admitted to hospital following his overdose, his brother was not informed in line with Prison Service policy

### **Staff support**

20. Some staff said that they had not been adequately supported following Mr Delahaye's death.

## Recommendations

21. As the prison is currently being run by HM Prison and Probation Service (HMPPS), we have made our recommendations to the HMPPS Governor (and not to the Director).
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
    - ACCTs are opened immediately following any self-harm or potential suicide attempt;
    - a member of healthcare staff should attend all first case reviews and subsequent reviews where relevant;
    - all known risk factors are considered when determining the level of risk of suicide and self-harm; and
    - ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identifying who is responsible for him.
  - The Governor and Head of Healthcare should ensure that prisoners' medical appointments are facilitated appropriately and, in particular, if a prisoner misses a diabetic annual review, that it is rebooked.
  - The Head of Healthcare should ensure that prior to receiving medication in their possession, all prisoners should have an assessment completed using the NHS(E) template, taking into account all potential risk factors.
  - The Head of Healthcare should ensure that prisoners receive appropriate mental health care following an overdose.
  - The Governor and Head of Healthcare should ensure that there is a robust system for the handover of prisoners returning from hospital to prison, which considers their needs and any risk to themselves.
  - The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.
  - The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner.
  - The Governor should ensure that a prisoner's next of kin is informed if he becomes seriously ill.

- The Governor should ensure that staff receive adequate support following a death in custody.

## The Investigation Process

22. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded
23. The investigator visited Birmingham on 8 March 2018. She obtained copies of relevant extracts from Mr Delahaye's prison and medical records.
24. The investigator interviewed seven members of staff and two prisoners at Birmingham on 28 March. She subsequently interviewed one member of staff by telephone.
25. NHS England commissioned a clinical reviewer to review Mr Delahaye's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.
26. We informed HM Coroner for Birmingham and Solihull of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
27. One of the Ombudsman's family liaison officers, contacted Mr Delahaye's brother to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. Mr Delahaye's brother said that the prison had not informed him when Mr Delahaye was taken to hospital on 31 December. He wanted to know more details about this.
28. Mr Delahaye's brother also had several questions about Mr Delahaye's clinical care including whether his diabetes had been appropriately managed and whether he had been assessed by the mental health team. He also asked whether Mr Delahaye's telephone calls were being recorded or listened to, whether he had pressed his cell bell in the 24 hours before his death and why he was located in a single cell.
29. Mr Delahaye's brother's legal representative received a copy of the initial report. They did not make any comments.
30. The initial report was also shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

## Background Information

### HMP Birmingham

31. HMP Birmingham is a local prison, and holds up to 1,450 men. At the time of Mr Delahaye's death it was managed by G4S Care and Justice Services. From 20 August 2018, HM Prison and Probation Service (HMPPS) took over the running of the prison for a period of at least six months.
32. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour health services at the prison and sub-contracts Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit.

### HM Inspectorate of Prisons

33. An unannounced inspection of HMP Birmingham took place in July/August 2018. The inspection report has not yet been published. However, on 16 August, HM Chief Inspector of Prisons put the Justice Secretary publicly on notice that he must explain how conditions at Birmingham will be improved as a matter of urgency.
34. Inspectors found disturbingly high levels of violence and self-harm and a serious failure to tackle safety issues. Case management of prisoners at risk of suicide and self-harm was poor, the response to previous PPO recommendations had not been sustained and prisoners at risk of self-harm did not feel well cared for. Many staff lacked both confidence and competence in key prison skills. This was compounded by ineffective front-line management and leadership.

### Independent Monitoring Board

35. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2017, the IMB reported that ACCT documents and reviews were not always completed to the required standard. They also recognised the considerable efforts made by officers and prison management to provide a safe, positive environment for prisoners coming to Birmingham, often in difficult circumstances, including overcrowding and a significantly high turnover of prisoners.

### Previous deaths at HMP Birmingham

36. Since 2013, there have been 28 deaths at Birmingham including that of Mr Delahaye. Eight of these were self-inflicted deaths, one was due to a drug overdose, one has yet to be classified and 18 were due to natural causes. There has also been one self-inflicted death and three due to natural causes since that of Mr Delahaye. We have previously made recommendations about considering all relevant factors when assessing a prisoner's risk to themselves, ACCT management, calling an ambulance immediately and contacting a prisoner's next of kin expediently. These are also issues relevant to this investigation.

## Assessment, Care in Custody and Teamwork (ACCT)

37. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

## In-possession medication risk assessment

38. On 14 December 2017, HMP Birmingham started using the new NHS (England) risk assessment template to determine whether prisoners are suitable to hold their medication in their own possession. All staff were trained and provided with user manuals. This is a thorough risk assessment comprising nine questions, and includes information about previous suicide attempts, self-harm and overdose.

## Key Events

39. Mr John Delahaye was remanded into custody at HMP Birmingham on 11 September 2017, charged with attempted murder, wounding with intent to do grievous bodily harm, possession of a knife and threats to kill. The alleged offences involved a knife attack on three people in a church.
40. This was not Mr Delahaye's first time in prison and he had previously served a lengthy prison sentence for another knife attack. Mr Delahaye had had various psychiatric referrals during previous prison sentences but had refused to engage with psychiatric specialists. He had a history of type 1 diabetes, diagnosed in 2003. He had attempted suicide by taking an overdose of insulin in the community in 2015.
41. When Mr Delahaye arrived at Birmingham, he was assessed as unsuitable to share a cell due to the nature of the charges, and was allocated a single cell. Dr A, prescribed him insulin to be administered with an injection pen in the morning and evening. Another GP also prescribed him metformin tablets to reduce his blood sugar levels.
42. On 12 September, Dr B, assessed Mr Delahaye as suitable to hold his medication in his possession. In his police statement, he noted that Mr Delahaye was not on an ACCT, there were no concerns about his behaviour and he had had his medication in his possession when in prison previously. The doctor also believed that Mr Delahaye would have better control of his blood glucose level if he was able to administer his own insulin. Mr Delahaye was given a machine to monitor his blood glucose levels and an extra sandwich every evening to help him moderate these levels.
43. On 2 October, Dr A prescribed Mr Delahaye glucose tablets to assist in maintaining his glucose levels. On 30 October, 4 December and 6 December, Mr Delahaye did not attend medical appointments. Prison Custody Officer (PCO) A was Mr Delahaye's personal officer. This meant that she was his first point of contact if he had any needs or concerns. She told the investigator that Mr Delahaye missed his medical appointments as there were insufficient staff to escort him. The PCO said that Mr Delahaye's mood changed over time in that he became quieter and withdrawn.
44. Mr Delahaye also told PCO A that he wanted to move to the old side of the prison, away from M wing where he was currently located. She told the investigator that she tried to arrange this and spoke to the movements officer but, because Mr Delahaye needed a single cell, he had to wait for a suitable space. She said that Mr Delahaye was unhappy about being unable to move. He told her that there was no specific reason for him wanting a move and that he did not have any issues with other prisoners.
45. From 8 December, Mr Delahaye began working in the prison laundry. On 31 December, PCO A went to Mr Delahaye's cell as she had not seen him during her shift. Mr Delahaye was lying on his bed and did not respond when she spoke to him. She said she could see that Mr Delahaye was breathing and was looking at her but he was not replying. She telephoned healthcare staff to ask them to attend the wing "*at their convenience*" (as recorded in Mr Delahaye's medical

- record). Nurse A called the wing and was told that Mr Delahaye was unresponsive.
46. The nurse immediately went to see Mr Delahaye who was lying on his bed and did not respond to her. She noted that he appeared confused with staring eyes and tense arms and that he was peripherally cold. His oxygen saturation level was very low, as was his respiratory rate. The nurse asked an officer to collect the emergency bag. She injected Mr Delahaye with glucagon to increase his blood sugar level and he became more alert. He told her he was unsure how much insulin he had taken over the past few days. The nurse noted that he had been given an insulin pen the day before and all 250 units had been used. Each pen was supposed to last 28 days. The nurse asked staff to call an ambulance due to the amount of insulin Mr Delahaye had taken. Paramedics arrived and took Mr Delahaye to hospital. The nurse noted that it was unclear whether Mr Delahaye's insulin overdose was accidental or intentional. She completed a mental health referral on that basis.
  47. PCO B escorted Mr Delahaye to hospital. He said Mr Delahaye told hospital staff that he could not remember what had happened with his insulin. He was very quiet while at hospital and did not speak much to him.
  48. On 1 January 2018, at 2.45pm, Mr Delahaye returned to the prison. His return was not noted in his clinical or prison record. On 2 January, at 6.15am, Nurse A telephoned the hospital for an update on his condition but was told that Mr Delahaye was no longer there. The nurse telephoned the prison's control room who said Mr Delahaye had returned to Birmingham on 1 January between 7.00am and 7.30pm. The nurse noted that she would hand the information over to day staff to establish where in the prison Mr Delahaye was located, and to review him as necessary. She also referred Mr Delahaye to the mental health team.
  49. At 9.15am, Nurse B reviewed Mr Delahaye. He told her that he did not remember what had happened to his insulin. She offered him admission to the healthcare unit but he declined. The nurse checked his glucose level and administered his insulin as Mr Delahaye was no longer allowed to hold this medication in his own possession. The nurse started Prison Service suicide and self-harm prevention procedures, known as ACCT.
  50. At 11.30am, Nurse C and Community Psychiatric, Nurse D, assessed Mr Delahaye. He told them that he did not remember what had happened before being woken up by staff and did not know whether his insulin overdose was deliberate or accidental. He said he had no thoughts of suicide and self-harm. They noted that Mr Delahaye appeared "flat" in mood and "guarded" with his answers, but they concluded that he did not require any further mental health intervention and discharged him from their services.
  51. On 3 January, at 8.20am, PCO B completed Mr Delahaye's ACCT assessment. Mr Delahaye said he felt fine and was not distressed before he took the insulin overdose. He said he could not remember taking it. Mr Delahaye also said that he had attempted suicide in the community by taking an insulin overdose about two years earlier. Mr Delahaye said that he had no mental health issues but the PCO noted that he appeared to be "hiding something". Mr Delahaye said he had

no thoughts of suicide and self-harm. He told the PCO that he wanted to move from M wing to the older side of the prison.

52. At 8.40am, a first line manager (FLM), chaired the first ACCT case review with Mr Delahaye and PCO B. They noted that although Mr Delahaye engaged well, he seemed reluctant to disclose some information and they felt that there might be an issue he did not want to discuss. They increased his observations to five times per hour and planned to invite mental health staff to the next review. Actions on the caremap were to refer Mr Delahaye to the mental health team and relocate him to the older side of the prison. They immediately referred Mr Delahaye to the mental health team.
53. At 9.45am, a healthcare administrator, received this referral and recorded the information provided – namely that Mr Delahaye said he did not remember whether his insulin overdose had been intentional and that he appeared to be distant and withholding information.
54. At 9.55am, Mental Health Nurse E recorded that the mental health team had received a referral for Mr Delahaye from wing staff. However, as Mr Delahaye had been discharged by the mental health team the day before, the nurse did not consider that a further mental health assessment was necessary.
55. PCO A told the investigator that she had talked to Mr Delahaye after his overdose and completed some of the ACCT observations. She said that Mr Delahaye told her that she was the only person who would care if he died. The PCO said she told him to be careful how he took his insulin as she did not want him to hurt himself. Mr Delahaye told her that he would not deliberately take an insulin overdose. The PCO said that over the next few days, Mr Delahaye seemed to be interacting more with other prisoners and was livelier.
56. On 8 January, two other FLMs, chaired an ACCT review, attended by Mr Delahaye. Mr Delahaye again said he would like to move wings, had no thoughts of suicide and self-harm and would like to work in the kitchens (although he was still working in the laundry). Those present reduced his observations to twice per hour.
57. On 12 January, one of the FLMs chaired another ACCT review and reduced Mr Delahaye's observations to one per hour. On 17 January, staff closed Mr Delahaye's ACCT. He had consistently said he had no thoughts of suicide and self-harm. He still wanted to change employment and move to the other side of the prison but recognised this would take longer as he needed a single cell. The FLM told the investigator that Mr Delahaye seemed more settled and was not talking about moving wings as frequently. The post-closure review was set for 24 January.
58. On 24 January, the FLM completed Mr Delahaye's post-closure review. He said he had no thoughts of suicide and self-harm, was still unhappy at work and wanted his insulin back in his possession. He had no other issues. PCO A said she had no concerns about Mr Delahaye after the ACCT was closed.
59. On 29 January, Dr A assessed whether Mr Delahaye was suitable to have his medication in his possession. Mr Delahaye told the doctor that he had no

recollection of what had happened when he took an insulin overdose on 31 December and had no current thoughts of suicide and self-harm. Mr Delahaye said that he had previously taken an intentional overdose of insulin in the community in 2015, because he had no contact with his children. He said that his trial was to take place in a few weeks' time. He said he hoped to be found not guilty but was expecting a life sentence if found guilty. The doctor said that Mr Delahaye seemed calm, relaxed and positive. The doctor assessed that Mr Delahaye was now suitable to have his medication in his possession. He was issued with an insulin pen the next day.

60. On 1 February, Mr Delahaye had blood tests to check his diabetes was being managed adequately. These showed that his blood sugar control could be improved, and healthcare staff recommended that Mr Delahaye should speak to a nurse.
61. On 5 February, Mr Delahaye lost his job in the laundry due to non-attendance. PCO A said that Mr Delahaye told her that he could not be bothered to go to work anymore and that he had 'had enough'.
62. All of Mr Delahaye's telephone calls were recorded although prison staff did not listen to them at the time. The investigator listened to those made from the end of January. Mr Delahaye called his brother on an almost daily basis. They mainly talked about Mr Delahaye's impending court case. Mr Delahaye said he was due attend court for trial on 12 March. He repeatedly asked his brother to assist by being a witness and with his legal representation. He was frustrated because he felt no one was telling the truth and he said he was "going to die in jail" because of it. He told his brother that he had been in hospital after being found unconscious in his cell and said that it was a pity that staff had found him as it would have been easier otherwise. Mr Delahaye said he wanted to move wings as he was on a wing "full of informers".
63. On 27 February, Mr Delahaye appeared at Birmingham Crown Court. PCO A was working in reception and took Mr Delahaye back to his cell when he returned to the prison. She told the investigator that he seemed fine.
64. Mr Delahaye telephoned his brother for the last time on 2 March. He had not called him for a week, which was unusual. They discussed his court case. Mr Delahaye said he would not be able to get a fair trial, he did not know why he was trying, he was wasting his time and no one was telling the truth. He was next due in court on 12 March for trial on the charges of threats to kill.
65. On 4 March, in the afternoon, Mr Delahaye was issued with a new insulin pen. A prisoner, told the investigator that he often spent his association time with Mr Delahaye. He said that Mr Delahaye never spoke to him about any concerns he had. He said he seemed his usual self when he saw him on 4 March just before they were both locked up for the night. Mr Delahaye said that he would see him in the morning. Another prisoner, also said that Mr Delahaye had seemed fine the last time he saw him that day.

66. Staff locked Mr Delahaye into his cell around 5.00pm. At 5.15pm, PCO C completed her roll check. She told police that she had looked through Mr Delahaye's observation panel. She said Mr Delahaye had seemed his usual self all day and she had no concerns about him.
67. Another said that he heard an officer talking to Mr Delahaye around 9.00pm. He could not hear what they were talking about but he was sure it was Mr Delahaye as his was the only cell located on that side of him. The investigator has not been able to verify this conversation. The prisoner also said he heard Mr Delahaye's chair scraping back and forth around 11.00pm. He did not hear anything else for the rest of the night. There is no CCTV on the wing.
68. PCO D started work at 9.00pm that evening. She was the only member of staff on M wing where Mr Delahaye was located. She started her roll check at 9.15pm. She told the investigator that, although she cannot specifically remember checking Mr Delahaye's cell, she must have done as she checked them all. The PCO said that when she did a roll check she checked that the cell door was secure and looked through the observation panel to confirm the prisoner was inside and was well. She said that a lot of prisoners at Birmingham blocked their observation panels. If this was the case, she tried to hear them in their cell or get a response from them by banging their door. If she did not get a response, she said she would only contact her manager to unlock the cell to check on a prisoner if a prisoner was subject to ACCT monitoring. The PCO could not recall whether Mr Delahaye's observation panel was blocked that night.

### Events of 5 March

69. Mr Delahaye did not ring his cell bell overnight. PCO D began her morning roll check at 5.15am. She took the same approach as the previous evening. She told the investigator that she could not remember specifically checking Mr Delahaye's cell but knew that she checked them all. She said there was nothing out of the ordinary that morning.
70. At around 7.30am, PCO B unlocked the prisoners on Mr Delahaye's landing. When he unlocked the doors, he did not look in each cell. A prisoner said that he went to see Mr Delahaye around 8.00am. However, as his door was unlocked and slightly ajar, rather than being open, he assumed that Mr Delahaye was still asleep and did not go into his cell.
71. PCO E went to collect Mr Delahaye at 8.20am for a videolink he had scheduled with his solicitor at 8.30am. When he got to Mr Delahaye's cell, the door was unlocked and slightly ajar. He went in and found Mr Delahaye lying on the floor on his back with a chair on top of him. He was paler than usual with vomit round his mouth. He shouted Mr Delahaye's name but got no response. He could see Mr Delahaye was not breathing and said that he appeared stiff with rigor mortis. The PCO said, from Mr Delahaye's appearance, he believed he had died. The PCO pulled the door closed, as other prisoners were nearby, stepped outside the cell and called to PCO F, who was nearby, to come to Mr Delahaye's cell. She went into the cell, came out and said she thought Mr Delahaye was dead. PCO E then radioed a request that all staff, the emergency response nurse, and a director should go to the landing immediately. It was 8.23am.

72. When she heard the radio transmission, one of the FLMs went straight to Mr Delahaye's cell. When she got there (she estimated within 30 seconds), there were three officers standing outside his cell. (PCO B had also arrived.) She immediately went into the cell and saw Mr Delahaye lying on the floor with a chair on him. The PCO said Mr Delahaye looked rigid. She radioed a code blue, asked for an ambulance to be requested and for any director to attend the landing, and instructed staff to lock other prisoners away. (A code blue emergency indicates circumstances where a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically.) It was 8.26am. The control room immediately requested an ambulance. Because of Mr Delahaye's condition, the PCO did not attempt to resuscitate him.
73. Nurse F was the emergency response nurse. She heard PCO E request for her to attend the landing and she immediately went to M wing, along with Nurse G. As they were entering the wing, they heard the code blue emergency call. On their way to the cell, Nurse F requested the assistance of Nurse H who was in the medication hatch. They went straight to Mr Delahaye's cell while Nurse G went to get the emergency bag. PCO B turned on his body-worn camera as the two nurses arrived at Mr Delahaye's cell.
74. Nurse F said that Mr Delahaye was lying on his back on the floor, with his head closest to the window and his legs slightly under his bed with his feet crossed. His arms were bent at the elbows and resting on his chest. There was a chair upside down over his body and vomit around his mouth. The nurses moved the chair and assessed for signs of life. They noted that Mr Delahaye was cold, rigor mortis had set in and there was evidence of blood pooling around Mr Delahaye's shoulders. Due to obvious signs that Mr Delahaye had died, the nurses deemed that CPR would be futile and undignified and did not attempt to resuscitate him.
75. Nurse F noted that there was an insulin pen beside Mr Delahaye which had been given to him the day before and was empty. The nurse also noted from Mr Delahaye's monitor that he had checked his blood glucose level at 6.15pm the night before and it was within the normal range. Paramedics arrived, agreed that attempting resuscitation would be futile and, at 8.51am, pronounced Mr Delahaye dead.

### **Contact with Mr Delahaye's family**

76. A family liaison officer, a FLM, and the Director, went to Mr Delahaye's brother's house at 12.30pm. They told him that his brother had died and offered their condolences. The family liaison officer remained in contact with Mr Delahaye's brother and offered a contribution to Mr Delahaye's funeral expenses in line with prison service instructions.

### **Support for prisoners and staff**

77. After Mr Delahaye's death, the Intelligence Director, debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. PCO A told the investigator that she had not been asked how she was by

management or the care team. PCO E said that his colleagues had been very supportive but he did not feel sufficiently supported by managers.

78. The prison posted notices informing other prisoners of Mr Delahaye's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Delahaye's death.

### **Post-mortem report**

79. The post-mortem report indicated that Mr Delahaye's cause of death was an insulin overdose.

# Findings

## Management of ACCT

80. Mr Delahaye was not subject to ACCT monitoring at Birmingham until after he took an insulin overdose on 31 December 2017. We consider that this was reasonable in the circumstances.
81. After his overdose, Mr Delahaye returned to Birmingham on 1 January, at 2.45pm. There are no details of this in his medical or prison record, nor was there any record of a handover from the hospital to prison healthcare staff. (This is discussed further, below.) A nurse opened an ACCT on 2 January once she realised that Mr Delahaye had returned to the prison. An ACCT should have been opened on 31 December when Mr Delahaye was hospitalised and the ACCT assessment should have been undertaken as soon as he returned to the prison.
82. Prison Service Instruction (PSI) 64/2011 states that healthcare staff should attend the first ACCT review. This was particularly relevant for Mr Delahaye given his recent overdose. No healthcare staff were present at any of Mr Delahaye's four ACCT reviews, which included the initial case review and the closure of the ACCT. At the second review, the case manager recorded that she would invite mental health staff to the next review. There is no evidence that this occurred.
83. Mr Delahaye was not effectively challenged about his earlier overdose. The clinical reviewer concluded – and we agree - that it was most likely to have been intentional. It would be impossible to deliver large quantities of insulin accidentally. A maximum of 60 units of insulin can be administered in one injection and to empty the 300-unit pen Mr Delahaye would have had to select the dose and inject himself multiple times. Even if prison staff did not understand this, the presence of healthcare at reviews could have assisted, or staff could have consulted nurses. Mental health staff also did not effectively challenge Mr Delahaye on this point (discussed further below).
84. In addition, staff believed that Mr Delahaye was distant and appeared to be withholding information, raising further cause for concern. The date of the overdose – New Year's Eve – may have been significant and Mr Delahaye had an upcoming trial at which he expected to receive a long sentence. Given all these factors, we do not consider that Mr Delahaye's risk was adequately assessed or that he received effective support while subject to ACCT procedures. The ACCT was closed prematurely, two weeks later, with no understanding of Mr Delahaye's reasons for taking the overdose.
85. PSI 64/2011 also states that caremap actions should be detailed and time-bound, and aimed at reducing the risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress. Mr Delahaye's caremap actions were for him to be moved to the older side of the prison and to be referred to the mental health team. Mr Delahaye was assessed by the mental health team but he had not moved cells when his ACCT was closed. He recognised this would take longer

as he required a single cell. Staff did not adequately assess or address the triggers of Mr Delahaye's distress.

86. On 5 February, a month before his death, Mr Delahaye lost his job because of poor attendance and told PCO A, his personal officer, that he could not be bothered to go to work any more and that he had 'had enough'. Given his previous overdose, we would have expected the PCO to have considered opening an ACCT when Mr Delahaye said this, particularly as he had just attended court and was due to face trial (when he might have expected to receive a life sentence) in a week's time.
87. The Head of Safer Custody, told the investigator that she had improved ACCT management since Mr Delahaye's death. She said she had issued guidance, including posters and case manager reminder cards, and held meetings to improve healthcare's attendance at ACCT case reviews, particularly the first case review. She said that this had resulted in a significant improvement in healthcare staff attending case reviews. She said that ACCTs are now reviewed every morning in a multidisciplinary management meeting so that all departments are aware of the reviews that are due.
88. We welcome these actions and recognise that the issues we identified in Mr Delahaye's ACCT management have already begun to be addressed. Nevertheless, Birmingham has not acted sufficiently robustly in response to previous recommendations we have made in this regard and we therefore make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:**

- **ACCTs are opened immediately following any self-harm or potential suicide attempt;**
- **a member of healthcare staff should attend all first case reviews and subsequent reviews where relevant;**
- **all known risk factors are considered when determining the level of risk of suicide and self-harm; and**
- **ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identifying who is responsible for him.**

## Clinical Care

### *Diabetic care*

89. The clinical reviewer noted that blood tests were undertaken to check Mr Delahaye's diabetic control and that he received extra food to assist him with this. Mr Delahaye was also given a blood sugar testing machine and prescribed dextrose tablets in case his blood sugar level had fallen. He was prescribed appropriate medication. Mr Delahaye was also invited for an annual diabetes health check soon after his arrival at the prison, which was good medical practice. However, Mr Delahaye did not attend this appointment. The clinical reviewer considered that a diabetes-trained nurse should have visited Mr Delahaye on the

wing following this missed appointment. Mr Delahaye also missed several medical appointments which his personal officer said was due to there being insufficient staff to escort him. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners' medical appointments are facilitated appropriately and, in particular, if a prisoner misses a diabetic annual review, it is rebooked.**

### *In-possession medication*

90. Mr Delahaye was prescribed medication in his possession from the day after he arrived at Birmingham. The clinical reviewer considered that it would have been more appropriate to assess Mr Delahaye over seven days before he was assessed as suitable for in-possession medication. She noted that the initial in-possession medication risk assessment was incomplete.
91. Mr Delahaye took an insulin overdose on 31 December 2017. The clinical reviewer considered that a new risk assessment should have been completed following his return to prison on 1 January and that Mr Delahaye should have formally been assessed as not suitable for in-possession medication. (His medication was not held in his possession until 29 January but this was a result of communication failure between team members rather than a formal assessment.)
92. On 29 January, Dr A assessed Mr Delahaye as suitable to hold his medication in his possession. The clinical reviewer noted that the doctor did not use the NHS(E) assessment template which asks whether a prisoner has self-harmed or attempted suicide or overdosed on medication in the last 12 months, and considers the seriousness of a prisoner's offence. If these questions had been addressed, Mr Delahaye would have been considered a high for in-possession medication.
93. Given Mr Delahaye's recent overdose and earlier overdose in the community, as well as the seriousness of his offence, the clinical reviewer concluded that he should not have been given in-possession medication so soon without a period of further monitoring and engagement with a diabetes nurse and primary mental health teams. We make the following recommendation:

**The Head of Healthcare should ensure that prior to receiving medication in their possession, all prisoners should have an assessment completed using the NHS(E) template, taking into account all potential risk factors.**

### *Mental healthcare*

94. Mr Delahaye was referred for a mental health assessment following his insulin overdose on 31 December. He was assessed by a mental health nurse on 2 January and discharged from mental health services. Mr Delahaye's assertion that he could not recall whether the overdose was accidental or intentional was not effectively challenged at this assessment. The nurse noted that Mr Delahaye seemed to be "guarded" in his answers and was "flat" in mood. The clinical reviewer concluded that he should not have been discharged from the mental health team so quickly and that they should have challenged him about how and why he took an overdose. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners receive appropriate mental health care following an overdose.**

*Return from hospital*

95. Mr Delahaye returned to the prison on 1 January. There is no entry to indicate this in either his medical or prison record. The clinical reviewer noted that there was no handover between hospital staff and healthcare staff at the prison, as there should have been. In addition, Mr Delahaye's ACCT was not opened until the next morning. As he had just returned from hospital, following an overdose, this was a serious omission. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that there is a robust system for the handover of prisoners returning from hospital to prison, which considers their needs and any risk to themselves.**

*Emergency response codes*

96. PSI 03/2013, on medical emergency response codes, requires prisons to have a protocol on communicating the nature of a medical emergency, the type of equipment to take to the incident and to ensure that there are no delays in calling an ambulance. It states that if a medical emergency code is radioed, an ambulance must be called immediately.
97. Birmingham's local policy requires that the use of the medical emergency codes complies with PSI 03/2013. This requires that staff should radio a code blue emergency when a prisoner has difficulty breathing or is unconscious, and ensure that an emergency ambulance is called automatically.
98. When PCO A found Mr Delahaye unresponsive in his cell on 31 December, she telephoned healthcare and asked them to attend the wing "at their convenience". Fortunately, a nurse telephoned the wing immediately and went there straightaway when she realised the gravity of the situation. As a result, there was very little delay before Mr Delahaye received treatment. However, this might not have been the case and the PCO should have radioed a code blue emergency when she found Mr Delahaye unresponsive.
99. On 5 March, when PCO E discovered Mr Delahaye in his cell, he immediately thought he was dead because of his appearance. He shouted to a colleague nearby who also attended and thought the same thing. The PCO then radioed for staff to attend immediately. The PCO said that he knew they had an emergency code system at Birmingham but that he forgot to radio a code blue emergency due to the shock of what he had seen. He was concerned with getting staff assistance to the cell as soon as possible. Although staff did attend immediately and there was no delay to Mr Delahaye's treatment, the failure to call a code blue meant that there was a three-minute delay in telephoning an ambulance.
100. The failure to radio a code blue on 31 December and 5 March did not compromise the care Mr Delahaye received or affect the outcome on 5 March. However, in another emergency, it could do so. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.**

## **Roll check and unlock procedures**

### ***Roll checks***

101. A roll check is primarily a security check to count prisoners to ensure that they are present in their cells, but it is also an opportunity for any concerns about prisoners' safety to be identified and addressed.
102. PCO D said that she completed roll checks overnight from 4-5 March at 9.15pm and 5.15am. Although she said she was certain that she had checked every cell, she also said that a lot of prisoners blocked their observation panels, and that, if she did not get a response in those circumstances, she would only consider unlocking a cell if the prisoner was subject to ACCT monitoring. She could not remember whether Mr Delahaye had covered his observation panel.
103. It is a cause for serious concern that an officer tasked to complete a roll check is not ensuring that all the prisoners are in their cells. Unless that is done, the roll check is meaningless.

### ***Unlock***

104. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual says, "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."
105. Prison Service Instruction 75/2011 'Residential Services' says:

"Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable..."

"[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."
106. Officer B unlocked the prisoners on Mr Delahaye's landing at 7.30am on 5 March. He said that he did not look into prisoners' cells at unlock and he was not expected to do so. The Deputy Director, told the investigator that he did not think there was an instruction to look into a prisoner's cell when they were unlocked,

although he thought this was best practice. It is a concern that he was not aware of PSI 75/2011.

107. We know that Mr Delahaye was alive at 6.15pm on 4 March when he checked his blood sugar levels. We are concerned that staff may not have seen him after that until he was found dead, lying on the floor with a chair on top of him, at 8.20am the following morning. We note that Mr Delahaye had been dead for some time by then. If effective roll checks and an unlock check had been carried out, he might have been found sooner. We cannot say whether this would have changed the outcome for Mr Delahaye, but it might have done.
108. We make the following recommendation:

**The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.**

### Family Liaison

109. Mr Delahaye was not informed when his brother took an insulin overdose on 31 December and was admitted to hospital. PSI 64/2011 states that prison staff should inform a prisoner's next of kin if a prisoner is taken seriously ill. Mr Delahaye was initially unresponsive and his condition was serious enough to warrant hospital admission. Birmingham should have informed his brother of this. We therefore make the following recommendation:

**The Governor should ensure that a prisoner's next of kin is informed if he becomes seriously ill.**

### Staff support

110. PCO E said that he had felt supported by his colleagues but had not received any formal support from management or the care team. PCO A said that no one had asked after her welfare after Mr Delahaye died. She was his personal officer and seemed to know him best from the staff we interviewed. We would have expected some formal support to have been offered to her. We therefore make the following recommendation:

**The Governor should ensure that staff receive adequate support following a death in custody.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations