

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Nash a prisoner at HMP Birmingham on 16 June 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 we oversee can improve their work in the future.

Mr Kevin Nash was found hanged in his cell at HMP Birmingham on 16 June 2015. He was 33 years old. I offer my condolences to Mr Nash's family and friends.

Mr Nash had a number of factors which increased his risk of suicide, including that he had recently been recalled to prison, he had substance misuse problems, bereavement issues, relationship difficulties and a history of depression. These issues were noted in his records, but no one fully considered his vulnerability in the light of them, either when he arrived or subsequently when further information about his vulnerability was received. Instead, the staff appear to have relied too much on their assessment of his presentation.

While I recognise that it would have been difficult to predict or prevent Mr Nash's actions on 16 June, I am concerned that we identified similar issues about risk assessment after the self-inflicted deaths of two other recently recalled prisoners at Birmingham in 2013 and 2014. The Director needs to assure himself that lessons have now been learned and better procedures put in place.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2016

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Summary

Events

1. On 12 February 2015, Mr Kevin Nash was released on licence from prison. He had been released on licence and recalled twice before. He was arrested again for breach of licence on 31 May and arrived at HMP Birmingham on 1 June. He had a history of substance misuse, depression and relationship problems. In April, he had been treated in hospital for a suspected overdose, although he said he had not overdosed. During his sentence, he had twice been identified as at risk of suicide and self-harm and monitored under ACCT procedures.
2. Mr Nash told healthcare and other staff at the prison that he had no thoughts of suicide or self-harm. He was prescribed subutex (a heroin substitute) and completed an alcohol detoxification programme.
3. On 3 June, the National Offender Management Service sent Mr Nash's recall papers to the prison. The papers indicated that Mr Nash would be vulnerable if recalled to prison because of depression, anxiety and bereavement issues, which would need to be monitored. No one recorded any concerns about Mr Nash or reassessed his risk as a result.
4. There were very few entries about Mr Nash in his prison records. On 12 June, he was caught trying to conceal his subutex, but there is no record of whether this resulted in any action.
5. On the morning of 16 June, Mr Nash left two voice messages for his partner, in which he sounded low and upset. Around 11.50am, staff realised that Mr Nash had not collected his subutex. An officer went to his cell to check him and found him hanged from the window bars with a sheet around his neck. Prison staff and paramedics tried to resuscitate Mr Nash, but, sadly, he did not regain consciousness and was pronounced dead.

Findings

6. Mr Nash had a number of factors which increased his risk of suicide. Although these issues were noted in his record, no one fully took them into account when they assessed his risk. Staff relied too much on Mr Nash's presentation and his assurances that he had no thoughts of suicide or self-harm. We have raised similar concerns in two previous investigations into the self-inflicted deaths of recently recalled prisoners at Birmingham. At the time, the National Offender Management Service assured us that the prison had introduced processes to ensure that prisoners' risks were identified at reception, but we are not satisfied that this was the case when Mr Nash arrived. Nor was his risk reviewed when further information was received with his recall documents.
7. While it would have been difficult to predict or prevent Mr Nash's actions on 16 June, identifying his risk and managing him under ACCT suicide and self-harm prevention procedures should at least have helped ensure he received additional support to help reduce his risk.

Recommendation

- The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. This should ensure that staff, particularly reception and first night staff:
 - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from external sources, suicide and self-harm warning forms and PERs.
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed any suicidal intent.
 - Review risk whenever new information is received.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact them. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Nash's prison and medical records. HMP Dovegate, from where Mr Nash had been released before being recalled to Birmingham, could not find his records from when he was there.
10. An Assistant Ombudsman interviewed four members of staff and the investigator spoke to Mr Nash's offender manager (probation officer).
11. NHS England commissioned a clinical reviewer to review Mr Nash's clinical care at the prison.
12. We informed HM Coroner for Birmingham of the investigation and we sent her a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Nash's sister to explain the investigation. She had no specific additional matters for the investigation to consider.
14. Mr Nash's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Birmingham

15. HMP Birmingham is a local prison, principally serving the West Midlands courts, which holds up to 1,450 men. G4S Care and Justice Services manage the prison. Birmingham and Solihull Mental Health Foundation Trust provide 24-hour health services at the prison. Birmingham Community Healthcare NHS Trust are subcontracted to provide primary care services

HM Inspectorate of Prisons

16. The most recent inspection of HMP Birmingham was in February and March 2014. Inspectors noted that prisoners often arrived late in the evening, which put first night and induction procedures under strain and meant some important actions were missed. They reported that most prisoners felt safe on their first night, that levels of self-harm were low and support for those at risk of suicide and self-harm was good. Inspectors found that a common feature of the four self-inflicted deaths since its last inspection was that the prisoners had only recently arrived at Birmingham and the safety of newly arrived prisoners was a significant risk that required attention. Healthcare provision, substance misuse support services, and mental health support were good.

Independent Monitoring Board

17. 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 2015, the IMB reported concerns about new prisoners arriving late in the evening and not receiving the full first night process. The Board was generally positive about healthcare services.

Previous deaths at HMP Birmingham

18. Mr Nash's death was the fifth self-inflicted death at Birmingham since April 2013. Our investigations into two of these deaths in April 2013 and December 2013 found failure to use an emergency response code immediately as a common factor. In two of the four deaths (in June 2013 and April 2014), the prisoners had been recalled to prison after release on licence and we were concerned that staff had not fully considered their risks factors for suicide.

Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support and monitor prisoners assessed as being at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

20. On 10 September 2012, Mr Kevin Nash was convicted of burglary and sentenced to 42 months in prison. He had been in prison before and had a history of substance misuse. Mr Nash served his sentence at HMP Dovegate, where he was twice monitored under ACCT suicide and self-harm prevention procedures. Dovegate was unable to find the records covering Mr Nash's time there, so we do not know why.
21. In June 2014, Mr Nash was released on licence, but he breached his licence conditions and was recalled to prison. On 7 July, he was released again. In January 2015, Mr Nash was recalled again for 28 days, after his partner said he had assaulted her. On 12 February 2015, he was released on licence once more.
22. Mr Nash's offender manager (probation officer) said that he saw Mr Nash every week. For a short while after his release in February 2015, Mr Nash had lived in supported accommodation managed by a charity working with people with mild to moderate mental health problems, but he was not happy there. Mr Nash said he sometimes felt low in mood and depressed but did not say that he had thought about suicide.
23. In April, Mr Nash was charged with burglary, vehicle theft and motoring offences, which breached his licence conditions. On 7 May, his offender manager recommended he should be recalled to prison. In the recall report, he wrote that Mr Nash was finding it difficult to cope with the recent breakdown of his relationship and was low in mood.
24. In February 2015, Mr Nash's community GP prescribed him sertraline (an antidepressant) when Mr Nash complained of anxiety and depression. On 28 April, Mr Nash was admitted to hospital after an overdose. (There is no further information about the overdose in Mr Nash's records.) He was discharged after a few hours. The GP said that he saw Mr Nash on 7 May and discussed his risk of suicide. Mr Nash told the GP he had not taken an overdose and said he had no thoughts of suicide.
25. On 31 May, Mr Nash was arrested and held in police custody overnight. At 9.45pm, a doctor assessed Mr Nash and recorded that he was epileptic and was prescribed pregabalin (an anticonvulsant). The doctor also noted that Mr Nash was prescribed subutex (a heroin replacement medication), which he had not taken that day. Mr Nash reported no other mental or physical health problems and said that he felt fine, had no history of self-harm and no thoughts of suicide or self-harm. The doctor prescribed dihydrocodeine (an opioid pain relief medication), zopiclone to help Mr Nash sleep, and pregabalin. Mr Nash said that he was not dependent on alcohol and had not had drunk alcohol in the previous 24 hours.
26. On 1 June, Mr Nash appeared in court and was recalled to HMP Birmingham. His Person Escort Record (PER - which accompanied him from police custody to court and then to prison) noted that he used subutex and was epileptic. Mr Nash arrived at HMP Birmingham just before 8.00pm. He told a prison nurse in reception that he had been prescribed quetiapine (an antipsychotic sometimes used for bipolar depression) but had not taken it as prescribed. Mr Nash said

that he had drunk a large amount of alcohol in the last week, but had not used any drugs. The nurse recorded that Mr Nash had no history of self-harm and he said that he had no thoughts of suicide or self-harm. Nurse Schneider wrote that he seemed stable in mood and that she had no concerns about him.

27. The nurse recorded that Mr Nash suffered from anxiety, asthma, and sciatica (back pain). She noted that the PER indicated that Mr Nash was epileptic. Mr Nash said that he was prescribed pregabalin (which can also be prescribed to treat neuropathic pain), an inhaler for asthma and subutex. The nurse referred Mr Nash to the prison's drug and alcohol recovery team.
28. At 8.45pm, a prison GP assessed Mr Nash and recorded that he had drug and alcohol problems. The GP noted that Mr Nash had self-harmed more than five years ago, but recorded no other details. He prescribed prochlorperazine, thiamine, and vitamin B to alleviate the symptoms of alcohol withdrawal, diazepam (to reduce the chance of an alcohol withdrawal related seizure) and ibuprofen.
29. A prison manager assessed Mr Nash as suitable to share a cell and the nurse agreed that there was no medical reason for him not to share. Mr Nash was given a cell in the prison's first night centre.
30. Because he had arrived at the prison late, an officer did not see him for a "first night interview" until the next day, 2 June. Mr Nash said that he was not worried about being in prison. He said that he used subutex, was an alcoholic, and was suffering withdrawal symptoms. Mr Nash said that he had never self-harmed and did not currently feel like harming himself. A prison officer recorded that Mr Nash said that he had never been treated for depression. Mr Nash told the officer that his parents and grandparents had recently died.
31. The first night interview pro-forma notes, in bold font, that prisoners who have been recalled to prison for breaching their licence are at high risk of suicide and self-harm. The officer recorded that Mr Nash had been recalled, but that the officer's only real concerns about Mr Nash was about his alcohol and drug withdrawal. The officer indicated that Mr Nash was polite and cooperative, and that he had no other concerns about him. The officer was absent from the prison due to sickness during the investigation and we could not interview him.
32. At 10.00am, the prison GP saw Mr Nash again and recorded more details about his substance misuse. Mr Nash said that he had been working with his community drugs team for eight years and had been prescribed 16mg of subutex. He said that he had gone on the run when he learnt he was being recalled to prison and had been buying the same dose of subutex from dealers. Mr Nash said that he had not received any subutex since his arrest. Mr Nash said that he drank six cans of super strength beer and half a bottle of vodka every day and reported suffering a seizure every few weeks. The GP thought that Mr Nash's seizures were probably symptoms of alcohol withdrawal, rather than epilepsy. The GP noted that Mr Nash had been prescribed pregabalin in the community, to treat sciatica, anxiety and seizures. He did not continue the prescription.
33. The GP took Mr Nash's baseline clinical observations and noted that he was not showing any signs of alcohol withdrawal and said he did not feel anxious. Mr

Nash tested positive for subutex and the GP noted that he would prescribe subutex again, once Mr Nash's community subutex prescription had been confirmed. Later that day, Mr Nash's community GP faxed a summary of his medical notes to Birmingham. The notes referred to his admission to hospital in April and that he had said he had not taken an overdose. The GP prescribed subutex later that day.

34. On 3 June, the Offender Management and Public Protection Group of the National Offender Management Service sent Mr Nash's recall papers to Birmingham. The recall letter detailed that Mr Nash was extremely low in mood because of the recall to prison and the recent breakdown of his relationship. During his last two probation appointments, he had been very emotional and said he was struggling to control his feelings. Although Mr Nash had not disclosed any thoughts of suicide or self-harm, the letter highlighted that he would be vulnerable if recalled to prison because of his emotional state, which would need to be monitored. It also noted that two of his close family members had died in the last two years, while he had been in prison.
35. On 4 June, Mr Nash told a prison nurse that he had not been prescribed pregabalin. The next day, a prison GP reviewed Mr Nash's medical record and noted that he was not convinced that Mr Nash needed pregabalin. However, he prescribed a lower dose than Mr Nash had said he had been prescribed in the community and recorded that, if they were not able to confirm a medical need for pregabalin, they would reduce and then stop the prescription.
36. On 5 June an offender supervisor delivered the recall papers to Mr Nash who signed that he understood what they meant. The offender supervisor was absent from the prison on sick leave for the duration of the investigation and we were unable to interview him. The Head of Safer Custody told the investigator that she would have expected the offender supervisor to discuss the information in the recall letter with Mr Nash and, if he had had any concerns about Mr Nash, to take appropriate action. The offender supervisor did not record any concerns.
37. On 6 June, Mr Nash finished his five-day alcohol detoxification. Prisoners receiving controlled medication, such as subutex, are normally allocated to B Wing but, when it is full, they go to C Wing. Mr Nash moved to C Wing where he shared a cell. Mr Nash's was allocated a personal officer on C Wing, but the officer said that she had never met Mr Nash. The manager of C Wing said that personal officers were expected to make one entry a week in the prisoner's records. There were no personal officer entries in Mr Nash's record.
38. At 3.30pm on 7 June, Mr Nash saw a nurse from the Integrated Drug Treatment Service (IDTS). Mr Nash told the nurse that he had been prescribed 24mg of subutex in the community and said that he was currently being prescribed 8mg, which was not enough. Mr Nash asked to continue the alcohol detoxification programme, but the nurse recorded that Mr Nash looked generally well and had no apparent drug or alcohol withdrawal symptoms, but did not record that he had used any clinical tools to assess Mr Nash's drug or alcohol withdrawal symptoms. Mr Nash said that he was not sleeping well and the nurse noted that he had given Mr Nash advice about this. He advised Mr Nash to speak to the detoxification nurses on B3 landing if he continued to have problems. Mr Nash's

subutex dose remained unchanged at 8mg. According to his medical record, Mr Nash did not complain of withdrawal symptoms or insomnia again.

39. On 10 June, Mr Nash told a prison GP that he had been prescribed pregabalin to treat sciatica caused by a car accident in 2014. Mr Nash then said he had been prescribed it to treat his anxiety. He said that he had lost both of his parents recently and his partner had had a stillborn baby. Mr Nash told the GP that he had been bullied for the medication at Dovegate. The GP remained unconvinced that Mr Nash needed to be prescribed pregabalin and noted that he would talk to Mr Nash's community GP and consider stopping the prescription, which Mr Nash seemed to accept. The GP prescribed two weeks supply of amitriptyline (an antidepressant medication also sometimes prescribed to treat neuropathic pain) and another week's course of diazepam to reduce the risk of alcohol withdrawal seizures.
40. Later that day, the GP recorded that he had spoken to Mr Nash's community GP and had decided to stop prescribing pregabalin because there was no medical need for it.
41. Nurses continued to observe Mr Nash when he took his subutex, but, on 12 June, an officer caught him trying to conceal the medication (possibly to sell or pass to another prisoner). There is no record that anyone discussed this with Mr Nash or took any further action. A healthcare manager told the investigator that, in such situations, staff were expected to refer the prisoner to the doctor for a medication review, but there is no evidence that this happened. (We are aware from a previous investigation at that prison that this usually happens and this does not appear to have had any bearing on Mr Nash's death.)
42. On 15 June, Mr Nash phoned his partner three times from the telephone in his cell. At 3.36pm, the conversation sounded calm and friendly. However, at 10.25pm, he left a message for her, asking what he had done wrong and, five minutes later at 10.30pm, he left another message saying that she left his "head in tatters all the time."

16 June 2015

43. The prisoner in the cell next door to Mr Nash, told the police that, at about 7.35am on 16 June, he and Mr Nash had a drink and a cigarette together. The prisoner said that they talked for about 15 minutes and that Mr Nash had seemed upbeat and in good spirits. He said that they talked about their partners and that Mr Nash had said it was hard to be away from his. Mr Nash told the prisoner that he thought he was due in court that day. The prisoner told the police that he had no concerns about Mr Nash that morning. At about 8.30am, prisoners on C Wing were unlocked to allow them some time in the open air on the exercise yard. The prisoner said that, as he left the landing, he saw Mr Nash leaning against the banisters outside his cell. This was the last time anyone remembered seeing Mr Nash alive.
44. At 7.54am, Mr Nash phoned his partner and left a message asking what he had done wrong as she was not answering his calls. He sounded low and upset. At 7.59am, he spoke to his father for almost three minutes and they talked about his father visiting and bringing him some clothes. Mr Nash said that he thought he

was appearing in court that day. There is no record that he was due in court on 16 June.

45. That morning, two officers were working on Mr Nash's landing and locked all the prisoners in their cells, after the hour-long exercise period. At about 9.45am, most prisoners (except those who were ill or on the lowest level of privileges) were unlocked for an association period, (when prisoners can mix with each other on the wing). The association period finished at about 11.00am, and all of the prisoners were locked in their cells again. Neither officer could recall locking or unlocking Mr Nash's cell, or seeing him that morning. Both officers said that their usual practice when unlocking cell doors was to look through the observation panel first.
46. C Wing prisoners who are prescribed subutex normally collect their medication from a nurse on the wing between 10.00am and 11.00am each day. At around 11.50am, prisoners are unlocked to collect their lunch and at about this time, officers noticed that Mr Nash had not collected his subutex. An officer told the investigator that she went to the wing office to see if Mr Nash had left the wing for any reason, and found that he had not. The officer noted that, according to information in the office, Mr Nash shared a cell so she went to the cell, intending to ask his cellmate where Mr Nash was. (In fact, his cellmate had moved to another prison four days earlier and Mr Nash was on his own in the cell. His cellmate was released from prison before we were able to interview him, and did not leave any contact details.)
47. The officer looked through the observation panel in the cell door and saw a pair of shoes behind the privacy curtain at the back of the cell. She unlocked the door and called to the prisoner. When he did not respond she pulled back the curtain and found that Mr Nash had hanged himself by a sheet attached to the window bars.
48. According to the prison's log of radio messages, at 11.49am, the officer radioed that she needed help on Landing 4. She told the investigator that she knew she should have radioed a 'code blue' message (which indicates circumstances such as when a prisoner is unconscious and should alert other staff to attend with emergency equipment and the control room to call an ambulance immediately) but was in shock at the time. A minute later, the officer radioed that she needed nurses to attend.
49. Another officer told the investigator he was standing only about a metre away from Mr Nash's cell when the officer ran out of the cell and told him to get help. He said that he looked quickly into the cell and then shouted to staff on the landing below that they needed help. He then went into Mr Nash's cell and he and the officer cut the sheet from around Mr Nash's neck. They checked for a pulse, but could not find one.
50. About 11.30am, a prison manager said that he returned to the wing from meetings and started supervising lunch on Landing 2. He said that, at about 11.50am, he realised that something was happening on Landing 4 and then a prisoner directed him to Mr Nash's cell. When he got to the cell, he saw Mr Nash lying on the cell floor and the officer's kneeling next to him. One of the officers told him that he could not find a pulse. At 11.50am, the manager radioed a code

blue and the control room called for an ambulance. The officer had already begun cardiopulmonary resuscitation. At 11.51am, someone pressed the general alarm.

51. The manager said that a nurse and a student nurse arrived at the cell at about 11.52am, with some medical equipment. The nurse told the investigator that she had not heard a code blue message but had responded to the general alarm. She said that someone else, she did not know who, collected the emergency response bag, containing oxygen and a defibrillator, from the central office. The nurse said that Mr Nash was blue and cold and his jaw was stiff. The defibrillator found no shockable heart rhythm and the staff continued with cardiopulmonary resuscitation. Two prison GP's arrived at Mr Nash's cell just after midday and supervised the resuscitation efforts.
52. The first ambulance arrived at Birmingham at 11.56am, with another arriving at 12.10pm, and the paramedics took over emergency treatment. Sadly, Mr Nash did not regain consciousness and, at 12.56pm, the paramedics recorded that he was dead.

Contact with the family.

53. At 4.05pm, the Prison Director, the Head of Safer Custody the prison's family liaison officer, arrived at Mr Nash's sister's house and broke the news of his death. The family liaison officer and a colleague went to Mr Nash's funeral. The prison offered a financial contribution towards the cost of Mr Nash's funeral, in line with national Prison Service instructions.

Support for prisoners and staff

54. After Mr Nash's death, the Director debriefed the 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.
55. The prison posted notices informing other prisoners of Mr Nash's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Nash's death.

Post-mortem report

56. At the time this report was issued, the coroner had not received the results of Mr Nash's post-mortem examination. Toxicology tests revealed the presence of subutex and diazepam, at levels consistent with his prescribed medication. No other illicit drugs or alcohol were found (although the toxicology analysis did not test for synthetic cannabinoids (new psychoactive substances), such as 'spice' or 'mamba' which are increasingly used in prisons).

Findings

Assessment of risk of suicide or self harm

57. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self harm. Mr Nash had a number of these risks. He had been at Birmingham for just over two weeks, after being recalled for breaching his licence. He was dependent on drugs and alcohol and was prescribed medication to help manage the symptoms of alcohol withdrawal. His licence recall paperwork highlighted that he had been having problems with his partner, had bereavement issues, was vulnerable, and low in mood. Although Mr Nash said that he had never tried to harm himself or attempt suicide, he had been admitted to hospital in April 2015, with a suspected overdose and he had been monitored under ACCT procedures in the past.
58. All of this information was available to staff at Birmingham, but there is no evidence that anyone fully considered or noted his risk factors when he arrived. The licence recall letter indicated that that Mr Nash's emotional state would need monitoring if recalled to prison because he was vulnerable, but there is no evidence that anyone reassessed his risk in the light of the information in the letter or discussed this with Mr Nash.
59. Staff judgement is fundamental to the ACCT system, but we are concerned that staff relied so heavily on Mr Nash's presentation, when he had a number of known risk factors when he arrived at the prison. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged.
60. While we accept that it would have been difficult to predict Mr Nash's actions on 16 June, this emphasises the need not to rely on how a prisoner appears and what he says at a particular moment. It is possible that a full consideration of all the risk factors, when Mr Nash first arrived, would still have reached the conclusion that he did not need additional monitoring and support. However, the lack of any evidence that staff considered the range of risk factors indicates a need for the prison to improve its assessment of risk for all new prisoners and to review the risk when further information is received. We made a recommendation about this in an investigation into a self-inflicted death at Birmingham in 2014. The prison indicated that they had introduced processes to ensure that risks were properly identified and recorded when prisoners arrived at Birmingham. We are not satisfied that all Mr Nash's risks were fully recorded or considered. We make a similar recommendation to the one we made in 2014:

The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. This should ensure that staff, particularly reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from external sources, suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed any suicidal intent.**
- **Review risk whenever new information is received.**

Clinical care

61. The clinical reviewer had no concerns about the clinical care Mr Nash received at Birmingham, including the management of his subutex prescription and alcohol detoxification.

Emergency Response

62. Prison Service Instruction (PSI) 03/2013, about emergency medical response procedures, requires Governors and Directors to have an emergency protocol based on the PSI, which ensures that staff use appropriate medical emergency response codes to alert others to the nature of the emergency and that an ambulance is called automatically in a life-threatening situation. Birmingham has an Operational Order 149/2013 about code red and code blue emergency procedures. It states that staff must use code red or code blue over the radio net or telephone when discovering a potentially life-threatening health related emergency. The communication room will then immediately dial 999 and request an emergency ambulance.
63. At 11.49am, an officer radioed for help. Other staff attended quickly and a manager called a code blue message at 11.50am. The control room immediately called an ambulance. Staff and paramedics gave appropriate emergency treatment but, sadly, Mr Nash did not respond. While, ideally, the officer should have called a code blue immediately, we recognise that she was in shock and are satisfied that there was very little delay as the code blue was called within a minute. The emergency response was appropriate and timely.

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