Report of an Independent Investigation into the Case of Mr Adakite commissioned by the Secretary of State for Justice in accordance with Article 2 of the European Convention on Human Rights

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Glossary

ACCT	Assessment, Care in Custody and Teamwork: Care planning system used to identify and care for prisoners at risk of suicide or self-harm
Adjudication	Disciplinary system for dealing with alleged breaches of prison discipline
Association	Prisoners' recreation period / time out of cell
Brent	Secure telefax facility
CARAT	Counselling, Assessment, Referral, Advice and Throughcare
CASU	Care and Separation Unit. A dedicated wing within a prison where prisoners may be segregated in order to maintain order or discipline; to protect the safety of persons living, working or visiting the establishment; for their own protection; pending adjudication or as a punishment of cellular confinement following adjudication
Category B	The category of prisoners for whom the highest conditions of security are not necessary but for whom escape must be made very difficult.
Category C	The category of prisoners that cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt

CC	Cellular Confinement
CNA	Certified Normal Accommodation (Uncrowded capacity is the Prison Service's own measure of accommodation). CNA represents the good, decent standard of accommodation that the Service aspires to provide all prisoners
Constant Supervision	Where a prisoner is supervised by a designated member of staff on a one to one basis, remaining within eyesight at all times and within a suitable distance to be able to intervene quickly. The term Constant Observation or Watch is also used
CPN	Community Psychiatric Nurse
CSRA	Cell Sharing Risk Assessment
Depot injection	A special preparation of medication, including anti-psychotic medication, which is given by injection
Developing Nominal	A prisoner who, because of their current or increasing level of activity, must be monitored and intelligence gathered on them to establish the degree of threat that they pose to the security objectives and priorities of the prison
DIRF	Discrimination Incident Report Form
ECHR	European Convention on Human Rights

F2050	Prisoner’s personal record
F2050A	Information of special importance in a Prisoner’s Record
F213	Report of Injury to a Prisoner
F213SH	Report of Injury to a Prisoner following self-harm
G4S Care and Justice Services	Provider of custodial and escort services
GCS	Glasgow Coma Scale is a neurological scale which aims to give a reliable and objective way of recording the conscious state of a person for initial as well as subsequent assessment.
HMCIP	Her Majesty’s Chief Inspector of Prisons
HMPPS	Her Majesty’s Prison and Probation Service
HCO	Health Care Officer
HCSO	Health Care Senior Officer
Hotel	The radio call sign for a Healthcare Officer or Nurse
Gödel airway	A medical device used to maintain or open a patient’s airway
IEP	Incentive and Earned Privileges

IMB	Independent Monitoring Board. A group of members of the public who monitor the day-to-day life in their local prison or removal centre and ensure that proper standards of care and decency are maintained. IMB members are independent and unpaid
IMR	Inmate Medical Record
In-reach Team	Staff responsible for healthcare of prisoners suffering from mental health problems. This forms secondary mental healthcare in which prisoners are treated by specialists referred by primary care providers
IDTS	Integrated Drug Treatment Service. A joint service of the Home Office, Department of Health, Ministry of Justice and the National Offender Management Service, which includes clinical interventions, such as opiate substitute maintenance prescribing, detoxification, structured CARAT intervention and strengthened links to Community Services
Listener	A prisoner trained by the Samaritans to offer support to prisoners at risk of self-harm or in distress
NOMS	National Offender Management Service, an executive agency responsible for making sure that people serve the order handed out by the courts, both in prisons and the community. (On

	1 April 2017 NOMS was replaced by HM Prison and Probation Service)
OASys	Offender Assessment System
Offender Manager	Probation Officer responsible for the management of individual offenders from pre-sentence, through custody and during the licence period
Operational Capacity	The total number of prisoners that an establishment can hold taking into account control, security and the proper operation of the planned regime
PCT	Primary Care Trust
PER	Person Escort Record. A form for ensuring that information about the risks posed by prisoners on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody
PGA	Prison Governors' Association
PNC	Police National Computer
POA	Prison Officers' Association (Trade Union)
Prison-NOMIS	Prison National Offender Management Information System, abbreviated to P-NOMIS. An operational database containing offenders'

	personal details, offences and case history, et cetera
Prominent Nominal	A prisoner who poses a high risk to the security objectives and priorities of the prison
Recess	Communal shower and bath area
Rule 45	The Prison Rule under which a prisoner may be segregated or removed from Association for reasons of maintaining good order or discipline or in the prisoner's own interest
SARU	Separation and Reintegration Unit (see CASU)
SIR	Security Information Report. A form for describing what they have seen, heard, found etc. This was either placed in a box or, if urgent, taken by hand to security or a senior manager in the prison. The SIR would be evaluated and appropriate action directed/taken
Smokers' pack	an emergency allocation of tobacco
SO	Senior Officer
SystmOne	A clinical software brand supporting the 'one patient, one record' model of healthcare
Triage	The action of sorting patients according to priority

Quantum	The integrated network of computers used by Public Sector Prisons
Unannounced inspection	Prison inspection carried out without notice to a prison following up the recommendations of a full announced inspection
VR	Violence Reduction

Executive Summary

On 7 June 2011, Mr Adakite arrived at HMP Birmingham having been recalled to prison as a result of breaches of his post-release licence conditions, which had been in place since his release from prison on 18 April 2011.

On 9 June, Mr Adakite was moved to the Health Care unit owing to concerns about his mental health and risk of self-harm. Mr Adakite had served a number of prison sentences in the past, had a history of poor mental and physical health and of self-harm. He also had a history of alcohol and drug misuse.

Mr Adakite was originally located on Ward One of the Health Care unit in order for him to be observed, he was then moved to Ward Two which catered for prisoners with mental health problems.

While he was in HMP Birmingham, Mr Adakite was dealt with properly on reception and concerns about his risk of self-harm were taken seriously at all times. Efforts were also made to address his mental health needs during the short time he was in the care of HMP Birmingham.

On the morning of 16 June at approximately 10:45, while he was in the shower recess of the ward, Mr Adakite was attacked by another prisoner, Mr Lamproite, and suffered life-threatening injuries to his head.

When Mr Adakite was discovered in the shower recess area with serious head injuries, staff were quick to take action, gave immediate first aid and an emergency ambulance was called and arrived promptly. Paramedics then took over treatment and Mr Adakite was taken to hospital.

Mr Lamproite was a remand prisoner who was transferred to HMP Birmingham from HMP Nottingham on 3 May 2011. Mr Lamproite had a history of mental illness and there were reports that he had been violent during his time in Nottingham. On reception into HMP Birmingham, the Cell Sharing Risk

Assessment was inadequate as it failed to take into account factors that may have indicated that Mr Lamproite was a significant risk to other prisoners and staff. Much of this information was available on the computerised case management system which all prisons use. This was not checked properly. Mr Lamproite was placed in a shared cell. However, if all the information had been taken into account, a decision to place him in a single cell would have been a correct outcome.

Much of the detail of Mr Lamproite's behaviour, including his alleged violence towards other prisoners at Nottingham, was contained in his security file. This file was not received at HMP Birmingham until 16 May. This was an unacceptable delay and breached the prescribed national standards for the completion and transfer of such information, which specifies that such information should be available as soon as the transferred prisoner is received at a new prison. When the information was eventually received, the staff at HMP Birmingham noted it but did little to modify their management of Mr Lamproite. Although the records state that he would be monitored and managed robustly, there was no evidence of such actions taking place. Most crucially, no reassessment of Mr Lamproite's cell-sharing risk took place despite the evidence of his propensity to be violent towards other prisoners.

On 4 June, Mr Lamproite seriously assaulted his cellmate and although there was no formal internal investigation, a police investigation took place. Following the assault, Mr Lamproite was taken to the Close Supervision and Segregation Unit. On 7 June 2011, following concerns about his deteriorating mental health, Mr Lamproite was moved to Ward Two of the Health Care unit in order for his mental health to be monitored and assessed.

At the time of the incident, a policy was in place that set out the arrangements for the safe supervision of prisoners who were in-patients in the Health Care unit. The policy set out two levels of supervision: Level A, the highest, and Level B, where supervision levels, particularly the number of staff required to unlock a prisoner from his cell, were lower. Mr Lamproite was correctly identified as a

Level A prisoner on 7 June 2011 and plans were set in motion to address his mental health issues.

The safe supervision policy required daily reviews of a prisoner. This did not happen and there was nothing recorded until 16 June, when at a ward meeting, it was decided to reduce Mr Lamproite's supervision to Level B. This meant that the number of staff required to unlock him was reduced and he would have some opportunity to associate with other prisoners, albeit with restrictions. The justification for the change in supervision level was not made explicit in the review meeting documentation and not all staff present agreed with the decision.

Mr Lamproite was told about the changed arrangements, including a requirement not to go into other prisoners' cells because staff could not see him in such situations. Soon after, he was seen to go into another prisoner's cell and was warned by a member of staff.

Mr Lamproite was overseen by staff on the ward and he was allowed to go for a shower with other prisoners. The shower recess was kept under observation by two staff. A window looked on to the recess, which was covered by a 'modesty curtain' which could be pulled aside in order for staff to observe what was happening. This meant that the observation was frequent but not continuous. It was during the time that Mr Lamproite was not observed that he assaulted Mr Adakite.

The assault was unprovoked and the motivation is not clear, although it is likely that Mr Lamproite thought that Mr Adakite was a sex offender, a type of offender he disliked. Mr Adakite was not a sex offender. After assaulting Mr Adakite, Mr Lamproite walked out of the shower recess and when staff discovered Mr Adakite in a pool of blood, Mr Lamproite was immediately taken back to his cell. Mr Adakite was given emergency first aid, an ambulance was called promptly and he was then taken to hospital after treatment by paramedics. The police were also informed and started a criminal investigation given the severity of the assault.

Mr Adakite remained in hospital until he was transferred to a Medium Secure psychiatric unit in December 2011. The assault had a long term impact on him in terms of his physical and mental health. On 11 September 2013, Mr Adakite sadly died as a result of a long-standing health problem unconnected to the assault.

Mr Lamproite was transferred to a special hospital in November 2011. In June 2012, he was made the subject of a Hospital Order to run without time limit.

In this report of our investigation, we make a total of 31 findings and 18 recommendations.

List of Findings

Finding 1

We conclude that the procedures in PSI 52/2010 and PSO 3050 (applicable to early days in custody and to continuity of health care respectively) were followed to a good standard in relation to Mr Adakite. Staff monitored Mr Adakite's safety and well-being throughout the first night in prison, and action was taken to address his immediate health issues.

Finding 2

The overall health care Mr Adakite received whilst a serving prisoner at HMP Birmingham was equivalent to that he could have expected in the community.

Finding 3

In relation to Mr Adakite, the standard of note-keeping in the SystmOne clinical record was to an acceptable standard and the majority of the clinical entries were accurate, detailed and commented on further plans for follow-up. Care planning was evident; especially with follow-up depot injections, dressing reviews and Assessment, Care in Custody and Teamwork reviews, as well as both general nursing and mental health reviews.

Finding 4

We conclude that there were shortcomings with the health-screening process carried out when Mr Adakite arrived at HMP Birmingham, as it relied on questions being answered truthfully and did not include sufficient scrutiny of existing records.

Finding 5

We conclude that the decision to locate Mr Adakite to Ward One was a sensible precaution because he was at risk of further self-harm and that it was appropriate to move him to Ward Two because that was the location for patients with mental health conditions.

Finding 6

From our investigations we conclude that the Assessment, Care in Custody and Teamwork process was managed appropriately with effective planning and regular reviews. However, in the absence of the Assessment, Care in Custody and Teamwork document, it was not possible to assess whether the quantity of interactions was in-line with the plan and whether there was quality interaction with Mr Adakite.

Finding 7

We conclude that staff responded well following the assault on Mr Adakite and that he received a good standard of care until paramedics arrived.

Finding 8

We conclude that non-clinical staff acted appropriately to ensure that the paramedics could access the scene promptly, to preserve evidence at the crime scene and to support those affected by the incident.

Finding 9

We conclude that the Reception Officer at HMP Birmingham failed to properly complete the Cell Sharing Risk Assessment on Mr Lamproite as no reasons were given for the indicators being circled on the operational assessment of the Cell Sharing Risk Assessment.

Finding 10

The violence identified on the Person Escort Record form relating to Mr Lamproite was not explored. We also conclude that the Prison National Offender Management Information System record relating to Mr Lamproite was not examined in order to check whether there was any reason why Mr Lamproite could not share a cell.

Finding 11

We conclude that the nurse completing the Cell Sharing Risk Assessment on Mr Lamproite did not adequately check the previous entries in the clinical record.

Finding 12

We conclude that security information about Mr Lamproite was processed ineffectively at HMP Nottingham and that there was an unacceptable delay in passing information to HMP Birmingham following Mr Lamproite's transfer via court.

Finding 13

We conclude that staff at HMP Birmingham failed to act on the information that was supplied about Mr Lamproite properly. In particular, no review of Mr Lamproite's Cell Sharing Risk Assessment took place and this contributed directly to the assault on Mr Lamproite's cellmate on 4 June 2011.

Finding 14

We conclude that there was no investigation of the factors leading to the assault by Mr Lamproite on his cellmate on 4 June 2011, which may have identified shortfalls in the earlier Cell Sharing Risk Assessment process at HMP Birmingham.

Finding 15

There was little evidence that staff actively managed Mr Lamproite in a way that would reduce his risk of violence towards other prisoners before he committed an assault on 4 June 2011.

Finding 16

We conclude that although there is no evidence that being segregated contributed to a deterioration in Mr Lamproite's mental health, the physical environment might have had a detrimental impact.

Finding 17

We conclude that the supervision level for Mr Lamproite was set at the appropriate level on arrival in Health Care.

Finding 18

We conclude that there was good communication with Mr Lamproite about his mental health and that it was a positive development that healthcare staff encouraged him to consider taking anti-psychotic medication.

Finding 19

We found that in relation to Mr Lamproite, there was appropriate care-planning by healthcare staff.

Finding 20

We conclude that when recommending that Mr Lamproite should not be left alone with female staff, that there should also have been consideration of how to reduce the potential risk to prisoners who Mr Lamproite may have identified as sex offenders.

Finding 21

We conclude that failure to document concerns about Mr Lamproite led to the review on 16 June 2011, having insufficient evidence to properly evaluate whether his level of supervision should be changed.

Finding 22

We conclude that there were no formal and recorded daily reviews of Mr Lamproite as stipulated in the Safe Supervision of Prisoners (in-patients) policy.

Finding 23

We conclude that failure to obtain medical history about Mr Lamproite from his previous prison or from the medium secure psychiatric hospital contributed to poor decision-making at the review meeting on 16 June 2011.

Finding 24

We recognise that managers were seeking to provide an environment to better assess Mr Lamproite, to improve his regime level and indirectly those of others, who had previously been locked up when Mr Lamproite was allowed out of his cell. However, we conclude that inadequate safeguards were in place because Mr Lamproite was allowed to go out of sight into the recess.

Finding 25

We conclude that insufficient weight was given to Mr Lamproite's recent assaults on other prisoners and his propensity to target those who he suspected were sex offenders or held racist views and that the inadequate review on the morning of 16 June 2011 directly led to Mr Lamproite being able to assault Mr Adakite.

Finding 26

We conclude that due to the difficulty and sensitivity of supervising the recess, it would have been more appropriate to allow Mr Lamproite to use the recess separately.

Finding 27

We conclude that poor supervision of the recess directly led to Mr Lamproite being able to assault Mr Adakite.

Finding 28

We found no evidence that the decision to reduce the number of staff required to unlock Mr Lamproite from his cell was driven by financial considerations.

Finding 29

We agree with the family of Mr Adakite that the decision to change the level of supervision of Mr Lamproite was flawed and that the supervision of the shower area was inadequate.

Finding 30

Vulnerable and violent prisoners were in close proximity as Ward Two held prisoners with mental health problems, which were disparate in nature with varying symptoms and behaviour. We conclude that co-location was not unreasonable, provided adequate control and supervision arrangements were in place.

Finding 31

We examined the bed watch logs, assessments and reviews, which were available and the clinical reviewer studied the SystmOne medical record entries. We take the view that although the documentation we have seen in relation to Mr Adakite's time in hospital is incomplete, there was no evidence to indicate that the terms of reference for this investigation should be extended beyond the date of the original commission.

LIST OF RECOMMENDATIONS

Recommendations to HM Prison and Probation Service

Recommendation 2

Cell Sharing Risk Assessments should be quality-assured to ensure that they are properly evidenced and, in particular, that the relevant Prison National Offender Management Information System transfer record has been checked prior to a particular prisoner being located in a shared cell.

Recommendation 6

When a prison security department receives critical security information from a sending establishment outside the prescribed timescales, this should be communicated to the Governor at the sending prison so that remedial action is taken to rectify any system failures.

Recommendation 15

Recess areas should be added to the list of examples of locations where a prisoner with a high-risk cell-sharing risk assessment should be prevented from using with other prisoners.

Recommendation 16

Good practice guidelines should be published on the supervision of recess areas to cover standard risk and high-risk prisoners.

Recommendation 17

All relevant documentation relating to a prisoner following an incident that may result in an investigation under Article 2 should be promptly secured.

Recommendation 18

The list of documents to be retained as set out in PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults where an independent investigation will be necessary should mirror that in PSI 64/2011,

Management of Prisoners at risk of harm to self, to others and from others (Safer Custody).

Recommendations to the Director of HMP Birmingham

Recommendation 3

Managers at HMP Birmingham should ensure that all staff involved in the initial assessment of prisoners on reception receive appropriate training.

Recommendation 4

Managers at HMP Birmingham should remind staff of the factors that can lead to an increased likelihood that a prisoner will harm his cellmate.

Recommendation 5

Managers at HMP Birmingham should remind staff completing Cell Sharing Risk Assessment forms and reviews that Prison National Offender Management Information System holds previous Cell Sharing Risk Assessments and review decisions as well as adjudication histories (current and previous sentences) and notes on prisoner behaviour.

Recommendation 7

Staff at HMP Birmingham should receive refresher training on the completion of Cell Sharing Risk Assessment reviews following the receipt of new information.

Recommendation 8

Managers at HMP Birmingham should ensure that the violence reduction strategy is applied to prisoners who have displayed recent violent behaviour in previous prisons as well as in HMP Birmingham. This should include:

i. applying a multi-disciplinary approach and identifying factors which trigger their violent behaviour; and
ii. developing a management plan, which aims to reduce risk and change behaviour.

Recommendation 9

The Safe Supervision of Prisoners (in-patients) policy should be reviewed in consultation with Birmingham and Solihull Mental Health NHS Foundation Trust and further guidance should be included on managing patients with particularly challenging behaviour.

Recommendation 11

Managers at HMP Birmingham should remind prison staff in contact with prisoners of the importance of documenting events in a prisoner's Prison National Offender Management Information System record.

Recommendation 13

Prisoners on Level A of the Safe Supervision of Prisoners (in-patients) policy should be reviewed on a daily basis in accordance with that policy and these reviews should be documented.

Recommendation 14

Greater priority should be given to seeking back records from previous establishments, particularly for those prisoners with complex needs or challenging behaviour, where assessments from a previous sentence may be particularly useful.

Recommendations to Birmingham and Solihull Mental Health NHS Foundation Trust

Recommendation 1

A brief review of the available SystmOne medical record should be made by staff prior to performing initial health-screening to validate the answers made to the template-driven questions.

Recommendation 10

There should be an effective system for following up requests for medical records if these fail to arrive.

Recommendation 12

Staff employed by Birmingham and Solihull Mental Health NHS Foundation Trust should be reminded of the specific requirements in PSI 73/2011, P-NOMIS to add case notes about behavioural issues or which detail specific issues that might help the care of the offender by staff generally.

Part 1. The Investigation

1.1 How we conducted the investigation

Andy Smith, former Assistant Chief Inspector of Probation, assisted by Louise Taylor, a retired Governor from the Prison Service, conducted the investigation. Dr Peter Billingsley, who conducted the clinical reviews, is an independent General Practitioner who provides general practitioner services to a prison and is also the author of a number of independent reviews.

The investigation was commissioned on 7 October 2015 by Mark Taylor of the National Offender Management Service (NOMS) who represented the Secretary of State for Justice in this matter. During the investigation Gordon Davison took over as the commissioning authority for independent investigations into incidents of serious self-harm or serious assaults as this area of work moved from the Equality, Rights and Decency Group to the Safer Custody and Public Protection Group.

It should also be noted that at the time of the incident the National Offender Management Service was the executive agency responsible for prison and probation services in England and Wales. On 1 April 2017 Her Majesty's Prison and Probation Service (HMPPS) replaced NOMS as the executive agency responsible for delivering prison and probation services.

The Terms of Reference were:

- to examine the management of Mr Adakite by HMP Birmingham from his reception on 7 June 2011 until the incident on 16 June 2011 and any relevant intelligence, and in the light of the policies and procedures applicable to Mr Adakite at the relevant time;

- to examine the management of Mr Lamproite by HMP Birmingham from his reception on 3 May 2011 until the incident on 16 June 2011 and any relevant intelligence;

- to examine relevant health issues during the period that Mr Adakite spent in custody at HMP Birmingham, including mental health assessments, and his clinical care up to the point of the incident on 16 June 2011;

- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- to provide a draft and final report of your findings including the relevant supporting documents as annexes;

- to provide your views, as part of the draft report, on what you consider to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State will take your views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.[1]

On 19 May 2016, I requested that my Terms of Reference were extended.[2] On 2 June 2016, the commissioning authority extended them to include:

- to examine relevant health issues during the period that Mr Lamproite spent in custody at HMP Birmingham, including mental health

[1] Commissioning letter from Mark Taylor, NOMS, to Andy Smith, dated 7 October 2015

[2] Letter from Andy Smith to Mark Taylor, NOMS, dated 19 May 2016

assessments and his clinical care from his reception on 3 May 2011 until the incident on 16 June 2011.[3]

Louise Taylor and I conducted a detailed examination of the records that were initially disclosed to us appertaining to both Mr Adakite and Mr Lamproite. This included the security file of Mr Lamproite containing Security Information Reports from both HMP Nottingham and HMP Birmingham. We were also able to read a copy of the Prison Service Investigation that was commissioned by the West Midlands Deputy Director of Custody and completed by the Governor of another prison.

We received documentation from the Solicitors' representing the family of Mr Adakite. These included the medical records from Mr Adakite's stays in hospitals, although this period fell outside our terms of reference.

Dr Peter Billingsley conducted a clinical review based on the medical records on Mr Adakite and Mr Lamproite. His findings and conclusions have been incorporated into this report.

We met with the mother and aunt of Mr Adakite and noted their views and concerns and visited the prison, including walking the route that the ambulance would have taken and examining the layout of the Health Care centre.

A chronology of the events leading up to the assault on Mr Adakite was prepared[4], which included information about the submission of security information on Mr Lamproite at the time of his transfer from HMP Nottingham and his reception at HMP Birmingham.

We were advised that Mr Adakite has now sadly died and that Mr Lamproite is currently located in the Special Hospital system.

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[3] Commissioning amendment letter from Mark Taylor, NOMS to Andy Smith, dated 2 June 2016

[4] Chronology as at 17 August 2016

At an early stage, letters explaining the nature of the investigation and our Terms of Reference were sent to the Independent Monitoring Board (IMB), Prison Governors' Association (PGA) and Prison Officers' Association (POA) at HMP Birmingham. However, the interviews with individuals involved in the care and management of Mr Adakite and Mr Lamproite were delayed in order to allow the clinical reviewer to complete his reports.

We subsequently interviewed six staff over two days at HMP Birmingham and carried out telephone interviews with three present or former members of staff and had a telephone conversation with a further member of staff.

We were provided with a number of police witness statements by West Midlands Police, which related to the assault and an earlier incident. Where relevant, we have made reference to some of these statements in the report.

We also received information from Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham Community Healthcare Trust, which operated the healthcare provision at HMP Birmingham.

I wrote to the perpetrator of the assault, Mr Lamproite, asking if he would be willing to be interviewed, but he declined.

The Chair of the IMB at HMP Birmingham also provided us with a report.[5]

1.2 HM Prison Birmingham

HMP Birmingham holds adult male prisoners, both convicted and unconvicted, who are Category B and Category C; there is also a small population of retained Category D prisoners. It is a Victorian local prison with modern additions. In 2004, it underwent considerable modification with the addition of 450 prisoner

[5] Evidence regarding Article 2 Investigation, Chair Independent Monitoring Board, HMP Birmingham, dated 6 February 2016

places, new workshops, educational facilities, a new Health Care centre and gymnasium, as well as extensions and improvements to existing facilities.

The management of HMP Birmingham was transferred from the public sector (NOMS) to G4S Care and Justice Services. It was the first public sector prison to transfer to the private sector and the fifth prison to be operated by the company in the UK. G4S Care and Justice Services' 15-year contract started in October 2011.

The assault on Mr Adakite occurred during the six-month transition process following the announcement about the transfer by the then Justice Secretary, Kenneth Clarke, in March 2011. The prison was operated by the public sector on the date of the assault on Mr Adakite, 16 June 2011.

At the time of the incident the Certified Normal Accommodation (CNA) was 1111 and the operational capacity 1450[6].

The Healthcare In-patient Unit is split over two levels, both with broadly similar layouts. The lower level is used for prisoners with medical needs that require nursing support, whilst the upper level is used for prisoners with complex mental health needs. Both levels have a nursing station in the centre of one wall with cells located on the opposite wall. Behind the nurses' station is a recess containing urinals, a toilet, a bath and a shower area. The layout within the recess is that, as one enters, the showers are on the left and opposite them are sinks and the toilet. At the back of the shower is one bath, which is separated from the rest of the shower area by a curtain. In the nurses' station there is a small window looking into the shower area and this has a modesty curtain across it.

[6] Cell Certificate Schedule Summary Sheet, Birmingham dated 30 September 2011

1.3 HM Chief Inspector of Prisons

HM Chief Inspector of Prisons (HMCIP), Nick Hardwick, published an inspection report on HMP Birmingham in March 2012, following an unannounced inspection in January 2012 (six months after the incident). The Chief Inspector concluded that:

> 'For most prisoners, HMP Birmingham was reasonably safe. Prisoners' perception of their current safety had improved since the last inspection although the proportion who had felt unsafe at some point was worse than at other local prisons……Strategies for addressing bullying were weak and if a prisoner needed to be moved, it tended to be the victim rather than the bully.'[7]

In addition, inspectors found that whilst data was collected there was little scrutiny and analysis of incidents to establish the underlying reasons and develop strategies to tackle violence. Investigations of unexplained injuries were good but those into allegations of bullying were superficial. The anti-bullying process was not effective in challenging unacceptable behaviour, and new procedures were being devised.[8]

Most initial assessments and care plans for those identified as at risk of suicide and self-harm were reasonably good but disappointingly there was little continuity of case management, and few reviews were multidisciplinary.[9]

Inspectors took the view that there was a good range of community-equivalent clinical services, but prisoners' views about the quality of health services were relatively poor. Clinical staff were well qualified and primary care services were delivered professionally. Pharmacy services were generally good but night medication was issued very early. Inpatient facilities were impressive and

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[7] Report of an announced inspection of HMP Birmingham by HM Chief Inspector of Prisons, 9 – 13 January 2012, page 3

[8] Report of an announced inspection of HMP Birmingham by HM Chief Inspector of Prisons, 9 – 13 January 2012, page 22

[9] Report of an announced inspection of HMP Birmingham by HM Chief Inspector of Prisons, 9 – 13 January 2012, page 18

backed up by good quality care. Mental health services were generally good, but prisoner transfers to secure hospitals took too long.[10]

A further inspection took place in 2014 and the Chief Inspector reported some progress:

> 'Overall and in the context of the risks and challenges faced by this prison, this is an encouraging report. Birmingham is well led and we found a much improved staff culture.'

> 'The prison was calm and ordered and most prisoners generally felt safe. The number of violent incidents was not high and while some violence reduction initiatives required more rigour, the safer custody team was well motivated, proactive and known around the prison.' [11]

The inspection raised concerns about the bleak segregation unit, with a featureless exercise yard and very little natural light. Whilst relationships between staff and prisoners were good, record keeping was poor and did not reflect the progressive work that inspectors saw.[12]

1.4 Annual Report of the Independent Monitoring Board to the Secretary of State for Justice 2011 (1 July 2010 - 30 June 2011)

The annual report of HMP Birmingham, Independent Monitoring Board (IMB) for the relevant period under investigation made a number of observations about the prison.

There were concerns about the transfer of Assessment, Care in Custody and Teamwork (ACCT) documents from other prisons.

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[10] Report of an announced inspection of HMP Birmingham by HM Chief Inspector of Prisons, 9 – 13 January 2012, page 13

[11] Report of an unannounced inspection of HMP Birmingham, by HM Chief Inspector of Prisons, 24 February – 7 March 2014, page 6

[12] Report of an unannounced inspection of HMP Birmingham, by HM Chief Inspector of Prisons, 24 February – 7 March 2014, page 28

> ‘HMP Birmingham still finds they are receiving prisoners on ACCT documents without prior notification from the sending Prison. The IMB requested that the Prison Service re-iterates to all Prisons the importance of notification to sending Prisons as per PSO 2700.’[13]

The prison held a significant number of prisoners with challenging mental health needs, yet provided a good level of health care.

> ‘There are many prisoners with severe and enduring mental health issues and assessments for potential moves to medium and high secure hospitals continue to be protracted.’[14]

> ‘Health Care - In general the IMB has observed a good level of care being provided by staff towards a sometimes very difficult group of prisoners.’[15]

The Chair of HMP Birmingham IMB also provided a brief report for this investigation and commented:

> ‘I have looked through our rota records and record of Applications and Request & Complaints received. I have also discussed the incident with …the other member of the Board who was operational at the time. Neither of us have any memory of either prisoner prior to the incident, or that there was a particularly difficult atmosphere at the prison during that time.’[16]

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[13] HMP Birmingham, Annual Report of the Independent Monitoring Board to the Secretary of State for Justice 2011, paragraph 4.3 iv

[14] HMP Birmingham, Annual Report of the Independent Monitoring Board to the Secretary of State for Justice 2011, paragraph 5.4 ii

[15] HMP Birmingham, Annual Report of the Independent Monitoring Board to the Secretary of State for Justice 2011, paragraph 5.4 vii

[16] Evidence regarding Article 2 Investigation into the case of Mr Adakite, Chair Independent Monitoring Board, HMP Birmingham, dated 6 February 2016, page 1

Part 2. The Events in detail

2.1 Background: Mr Adakite

Mr Adakite was born and brought up in Belfast and subsequently moved to Birmingham with his mother, where he completed his secondary education. He moved to North Wales when he was 16. A Pre-Sentence report completed in June 2009 reported that he had difficulty reading and writing and had little work history. He had begun a plumbing course but was unable to complete this due to chaotic drug use. Prior to his remand in custody, he had claimed benefits made up of Income Support and Disability Living Allowance.

Mr Adakite had a long history of offending, mostly for acquisitive crime, including theft, burglary, taking a conveyance, handling stolen goods and obtaining property by deception. He also had conviction for possession of Class A and Class B drugs, affray, possession of a bladed article, resisting or obstructing a constable and actual bodily harm. He had a history of failing to comply and breaching trust by failing to surrender or breaching bail in the past. His most serious conviction was for an offence of robbery on a vulnerable man, from whom he demanded money and made a credible threat to stab.

He also had a long history of mental health problems. In his interview for his Pre-Sentence Report, he stated that he had been sectioned under the Mental Health Act on many occasions, had been diagnosed with schizophrenia and had been prescribed medication for this.

Mr Adakite's most recent conviction related to an offence which occurred whilst he was an inpatient at a Mental Health Unit in North Wales. He travelled to Llandudno, where he bought and drank a bottle of vodka and slept rough for the night. On the following day he began to beg for money to travel back to the Unit. When he was unsuccessful, he saw an elderly couple and, through distraction, snatched the handbag that was between the couple. On 13 April 2009, he was arrested and remanded in custody at HMP Altcourse. In July 2009, he was

sentenced to four years at Caernarvon Crown Court on for attempted robbery.[17] HMP Altcourse assessed and categorised him as a Category C prisoner and identified him as suitable for allocation to HMP Risley.

On 24 July 2009, Mr Adakite was found guilty under Rule 51, paragraph 9, of the Prison Rules of having opiates in his urine and as a result, ten additional days were added to his earliest date of release. On 4 August 2009, he was found guilty of attempting to assault a Prison Custody Officer by attempting to throw a punch at him. He received a punishment of 14 days no canteen, facilities to purchase and use of private cash, together with 14 days no association.

On 26 August 2009, Mr Adakite was transferred to HMP Risley. He was identified on reception as having a history of self-harm and was quickly identified as being vulnerable. He had poor coping skills and was seen as being at risk of self-harm. He was employed as the wing painter and assisted the servery orderly.

Mr Adakite's behaviour was good and he applied for remission of added days on 12 May 2010, stating that he had remained drug-free (as demonstrated by negative mandatory and voluntary drug tests), had no other behavioural problems and had not received any Incentive and Earned Privileges (IEP) warnings. He added that he had worked hard. Staff reports confirmed that he worked well as the wing painter and was observed to be respectful and getting on well with other prisoners. As a result, five of the days that had been added were restored to him on 13 June 2010.

The Offender Assessment System (OASys) Risk of Self-Harm Analysis also noted that Mr Adakite displayed vulnerability during his sentence. The ACCT plan is a multidisciplinary approach to reduce self-harm in prison by being supportive of all prisoners, identifying and caring for those at risk by producing a plan of observations, interactions and actions by staff and prisoners to reduce self-harm. Mr Adakite was supported via the ACCT process in October 2009,

[17] Order for four years imprisonment, dated 10 July 2009

January 2010, and in January / February 2011.

Mr Adakite was also identified as being targeted by others in the past and during his most recent sentence. In April and October 2010, he was reviewed for re-categorisation. It was noted that no offence-focused work had been completed due to mental health issues and that he was not able to cope on normal location. As a result he was not found suitable for open conditions. The resettlement checklist completed in March 2011 noted that, although two referrals had been made to the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team, on both occasions he had declined to work with them. His record contains one undated referral outcome form in which Mr Adakite is recorded as stating that he does not need to work with CARATs as he had not used drugs for six years and had given them up prior to custody. He had worked with the Community Psychiatric Nurse (CPN) at HMP Risley and had regular counselling.

On 18 April 2011, Mr Adakite was released from HMP Risley on licence. He was given additional licence conditions to comply with testing for controlled Class A drugs, to reside at a specialist hostel for offenders with mental health problems and to attend all appointments arranged for him with a psychiatrist, psychologist and medical practitioner and comply with any care or treatment they recommend.[18]

Mr Adakite initially engaged quite well, but on 1 June he tested positive for cocaine and would have been issued with a formal warning during the following week. However, during the weekend of 4/5 June, he was overheard by a member of hostel staff using threatening and abusive language on the telephone to his mother. When the staff member ended the call, Mr Adakite directed the abuse at the staff member. There was a further positive drug test result for cocaine and opiates on 5 June. Mr Adakite was also reported as associating with other drug-using residents and there were concerns about 'his frivolous spending of his benefit money', lending and borrowing money and property to and from other

[18] License, Criminal Justice Act 2003, HMP Risley dated 18 April 2011

residents, which had led to animosity between them. His licence was revoked on 7 June, when it was reported that his behaviour had deteriorated.[19]

2.2 The Arrival of Mr Adakite at HMP Birmingham 7 June 2011

The Person Escort Record (PER) shows that Mr Adakite was collected from Stechford Police Station in Birmingham at 16:45 on 7 June. There were notes on the form to identify that there was a self-harm risk as Mr Adakite had previously tried to cut his own throat in 2001. He was also identified as a heroin user.[20]

Mr Adakite arrived at HMP Birmingham at 17:25. A Staff Nurse saw him at 18:51 and completed a health-screening at which Mr Adakite disclosed that he had received treatment from a psychiatrist outside prison and reported that he does not feel like self-harming or suicide, although he had tried to kill himself years ago. He denied using drugs or alcohol in the previous month.[21] A referral was made to the doctor and for a mental health assessment. He was seen by the doctor at 19:26 and prescribed medication.[22]

At 19:31, he was seen in the First Night Centre by a Mental Health Nurse (MHN) and reported that he was not depressed but was unsure of why he had been recalled, although admitted to telling his Probation Officer that he had been using crack cocaine. At the time of the assessment, he did not show any signs or symptoms of relapsing. Follow-up action was noted to contact the hostel about Mr Adakite's treatment plan and diagnosis.[23]

[19] Licence Revocation, dated 7 June 2011

[20] Person Escort Record Form, dated 7 June 2011

[21] Clinical Record Mr Adakite dated 7 June 2011

[22] Clinical RecordMr Adakite dated 7 June 2011

[23] Clinical Record Mr Adakite dated 7 June 2011

It was identified that Mr Adakite had previously been at HMP Risley. Back records and the sentence calculation sheet were requested from Risley during the morning following reception.

2.3 Mr Adakite in First Night Centre 7- 9 June 2011

Mr Adakite was located in the First Night Centre and on the following day was seen by the locum General Practitioner (GP), who reviewed his drug use, medical history and medication. The review noted that he had resumed taking three to four bags of heroin a day. The locum GP also noted that Mr Adakite had tested positive for methadone in his urine and that there was an existing referral to hospital for Hepatitis C treatment.[24] He was then seen by the Staff Nurse who undertook a further assessment and took vital signs. The Staff Nurse also noted that Mr Adakite had sustained a human bite[25] and the GP correctly prescribed an antibiotic.[26]

On 9 June, a Staff Nurse saw Mr Adakite as a result of him self-harming and making cuts to his arm with a razor. The nurse performed first aid and dressed his wounds, but was unable to apply Steri Strips (adhesive strips that help close the edges of a small wound) to them due to persistent bleeding.[27] The nurse returned later to reassess, clean, apply Steri Strips and dress the wound.[28] A Report of Injury to Prisoner following Self-harm (F213SH) should have been completed and filed with his clinical record, but we were not given a copy. The ACCT process was actioned, which included opening an ACCT document and placing Mr Adakite on five times per hour observations. Whilst, there is no doubt from the clinical record that an ACCT form was opened, the prison could not supply us with the document because it could not be located.

[24] Clinical Record Mr Adakite dated 8 June 2011

[25] Clinical Record Mr Adakite dated 8 June 2011

[26] Clinical Record Mr Adakite dated 8 June 2011

[27] Clinical Record Mr Adakite dated 9 June 2011

[28] Clinical Record Mr Adakite dated 9 June 2011

Initially, Mr Adakite was relocated to the first floor landing of D Wing (the First Night Centre) and the entry by Staff Nurse 1 in the Clinical Record reported that Mr Adakite said that he was frightened at being back in prison because he could not cope, but also that he did not like being at the hostel due to the level of drug-taking. He also said he had been hearing a voice since he was 16 years old. The entry also stated that the voice told him that, 'he would leave him alone once he was (in) a single cell. Mr Adakite said he gets beat up when placed in a double cell due to responding to voices'.[29] The cell certificate shows that of the 12 cells on the ground floor of D Wing, ten were double cells.[30] The ACCT document should have recorded Mr Adakite's cell number, but in the absence of this document, we were unable to ascertain where he was located and whether or not this was a double or single cell.

The Clinical Record reports that Developing Prison Service Manager 2 approached Staff Nurse 1 and discussed the case. A residential Officer had been told that the voice was telling him to tie a television to his neck and drop it. As a result, Mr Adakite was placed under constant supervision to reduce the risk of further self-harm.[31]

2.4 Mr Adakite in the Health Care Unit 9 - 16 June 2011

As a result of being placed on constant supervision, Mr Adakite was relocated to the Health Care Centre. Due to all constant supervision cells being used on Ward Two, he was placed on Ward One. Ward One was normally used for patients with a physical illness and Ward Two for patients with mental health problems.

On 10 June, Mr Adakite had a mental health review, where he reported that on a daily basis he was hearing a voice, which told him that he could not cope with two years' imprisonment and told him not to eat food as people were trying to poison him. He had not eaten since Tuesday (7 June) and reported that when

[29] Clinical Record Mr Adakite dated 9 June 2011

[30] Cell Certificate Schedule, HMP Birmingham, D1 Landing, undated

[31] Clinical Record Mr Adakite dated 9 June 2011

he had eaten, he had made himself sick due to discomfort, which he attributed to the voices telling him about being poisoned. Mr Adakite said that the self-harm was in response to the voice and also the stress of his situation. He felt better having cut himself and denied any further thoughts or plans of self-harm. He described his mood as being low, one out of ten.

Mr Adakite was subsequently seen by Mental Health Nurse 3 who administered a depot injection.

Dr Peter Billingsley, the clinical reviewer for this investigation, noted that, 'Oral medication was prescribed under supervised consumption. Dr 4 also saw him and again documented the current auditory hallucination problem and historic admissions, both informal and formal under mental health section. A current prescription for methadone was documented. He declared that he would self-harm further, but that he did not want to die when he self-harmed.'

On 10 June, Mental Health Nurse 3 saw Mr Adakite again and summarised current events in bullet points on his record. These included that Mr Adakite had received depot medication, had not used crack cocaine for six days and was on a 14-day methadone detoxification programme. The 28-day recall was explained to him. As he had no tobacco, a tobacco pack was authorised by one of the Governors. He was also given telephone credit, so he could call his family. The Clinical Record notes that Mr Adakite stated 'that he had feelings of suicide – thoughts are command in nature and can tend to be impulsive' but it was also noted that 'his mood has elevated' and he had 'no thoughts of deliberate self-harm at this time'. He promised to try to eat over the coming weekend.[32] The record appeared contradictory in that it stated that Mr Adakite had feelings of suicide, but not thoughts of self-harm. We have assumed that the reference to 'had feelings of suicide' was intended to be in the past tense, whilst the reference to 'no thoughts of deliberate self-harm' was clearly his state of mind at the time of interview.

[32] Clinical Record Mr Adakite dated 10 June 2011

Follow-up with the Mental Health In-reach Team (MHIRT) was planned for the 13 June. Mr Adakite was booked for further depot injection on 21 June.[33]

The constant supervision was removed as part of the review in the afternoon of 10 June as he had no plans of deliberate self-harm and his mood had elevated as the day had gone on. The ACCT was modified and observations reduced to four times per hour at night and three times per hour during the day. Other action points were for the CPN to contact the Probation Service and the hostel regarding the incident that led to the recall of Mr Adakite. The next review of his ACCT was set for 13 June. Following his depot injection, Mr Adakite was assessed as calm in the evening.

On 11 June, he spent most of the day in his cell because of a clinical incident on the ward, but was observed to have slept and eaten well. No physical concerns were raised and he denied having any idea of self-harm.[34]

At approximately 15:30 on 12 June, Mr Adakite was transferred to Ward Two, following discussions with the team, and appeared to be settled on the ward with no issues relating to on-going self-harm ideation recorded. He was located in cell H3-04.[35]

Mr Adakite's ACCT was reviewed on 13 June, and he stated that he had no thoughts of self-harm or suicide. The level of monitoring did not change because it was planned to relocate him to P Wing in the near future. He stated he did get thoughts of self-harm and usually cuts to obtain relief, but did not feel like self-harming at that time. He felt that others picked on him and he said that on the Sunday prior to coming into prison he was beaten up and had a fit. He stated that another resident at the hostel had threatened to kill him and had intimidated him. He showed staff a large bruise and other marks. He was not happy about

[33] Clinical Record Mr Adakite dated 10 June 2011

[34] Clinical Record Mr Adakite dated 11 June 2011

[35] Clinical Record Mr Adakite dated 12 June 2011

the prospect of going onto normal location but was worried about going on Rule 45 as he thought other prisoners might think he was a sex offender. He was also worried about being bullied by others. Mr Adakite also disclosed feelings of paranoia, insecurity and hearing a voice that told him to do things.[36]

On 13 June, members of staff from the CARAT team and a mental health officer also saw Mr Adakite as planned. He was low in mood and a little vacant; his methadone dosage was maintained at 15 mg per day and further follow-up was planned for once he returned to normal location.[37]

Mr Adakite was also seen later by Dr 5, consultant psychiatrist, who reviewed his recent history and commented on his mental status. Dr 5 found that he was physically slow with slow speech, was unduly apologetic and considered that the recent relapse with drugs had induced acute worsening of chronic psychosis. Medication for his mental health was reviewed and changes made.[38]

Mental Health Nurse 6 reviewed Mr Adakite later that evening and also commented on the commanding voices that Mr Adakite was reporting.[39]

On the morning of the 14th June, Mental Health Nurse 7 recorded that Mr Adakite had been agitated on the previous evening and that he was abusive when he was told that it was not possible to see the Governor for the purposes of being issued a 'smoker's pack.' Mr Adakite later apologised for his behaviour. ACCT observations were continued. In the evening Mental Health Nurse 6 reported that he spent a lot of time lying on his bed watching television and smoking and that he had taken meals. He remained low in mood and discussed access to phone calls and again to a smoker's pack.[40]

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[36] Clinical Record Mr Adakite dated 13 June 2011

[37] Clinical Record Mr Adakite dated 13 June 2011

[38] Clinical Record Mr Adakite dated 13 June 2011

[39] Clinical Record Mr Adakite dated 13 June 2011

[40] Clinical Record Mr Adakite dated 14 June 2011

On the morning of the 15 June, Mental Health Nurse 7 recorded the overnight summary and documented that ACCT observations were maintained, that Mr Adakite was compliant with medication and there were appropriate interactions.[41] The following day Staff Nurse 1 documented retrospectively that he had accepted his medication, lunch and discussed his apprehension about the upcoming video link later in the day with his Offender Manager 8, when the behaviour that led to his recall would be discussed.[42]

2.5 The day of the assault, 16 June 2011

Mr Adakite had been settled overnight and the report from the night staff was that he had been watching TV, had slept well and had made appropriate requests for hot drinks. His ACCT observations were maintained at four times per day.[43] He was due to have another ACCT review on 16 June.

That evening, a mental health nurse retrospectively documented that Mr Adakite had accepted morning medication, which included 15mg of methadone and then had a bath. Later, he had a shave and then handed back his razor to staff.[44]

Officer 9 said in his interview with us, "I had more contact with him actually on the day that the incident happened than any other, to be honest, because he, he was having a visit from his mother in the afternoon and he wanted a shave, but he wasn't very good at it. So, he asked me if – you know, I mean, in private – if I could give him a shave. So, I took him into his cell and was chatting away, and I actually shaved him and tidied him up for the visit in the afternoon."[45]

[41] Clinical Record Mr Adakite dated 15 June 2011

[42] Clinical Record Mr Adakite dated 16 June 2011

[43] Clinical Record Mr Adakite dated 16 June 2011

[44] Clinical Record Mr Adakite dated 16 June 2011

[45] Transcript of Interview with Officer 9 on 19 July 2016, page 3

Officer 9's recollection of giving Mr Adakite a shave that morning because he was having a visit from his mother conflicts with the police witness statement of Mr Adakite's mother,[46] as it is apparent that she had no plans to visit.

Shortly after on the morning of 16 June, Mr Adakite entered the shower recess on Ward Two. The Incident Statement indicates that Mr Adakite was found lying in a deep pool of his own blood around his head.[47] Immediate first aid was given and paramedics attended. Mr Adakite was then taken by ambulance to hospital.

2.6 Management of Mr Adakite following the incident on 16 June 2011

As Mr Adakite had been recalled to custody whilst serving his sentence in the community, he was sent a recall pack. A licence revocation order had been sent to Birmingham Prison from Public Protection Casework Section on 13 June. Mr Adakite was sent a letter giving the reason for revocation of his licence on 20 June, four days after the assault. Due to his physical condition, he was unable to confirm disclosure of the recall dossier or make any representations against recall.

The Parole Board reviewed his case at a Panel Hearing on 20 July. The panel made no recommendation about his release. In making this decision, the panel of the Parole Board weighed the possible benefits of further supervision against the risks of reoffending during the licence period. The panel also considered if supervision had broken down to the extent that further compliance with licence conditions would be unlikely. There were no written representations from either Mr Adakite or his legal advisor.

The panel accepted the reports that Mr Adakite presented a high risk of serious harm to the public and a medium risk to family members and staff. They also noted that there had been deterioration in his mental health, which when linked to his relapse into drug misuse, resulted in his aggressive behaviour to others

[46] Police Witness statement of Mr Adakite's mother dated 30 June 2011, page 1

[47] Incident Statement completed by Senior Officer 24, incorrectly dated 27 April 2011

and a heightened risk of harm to himself. His psychological well-being was identified as a significant risk factor as he had been diagnosed as suffering from schizophrenia, together with substance misuse both drugs and alcohol.

An outline risk management plan was submitted, including accommodation at a hostel, but there was no confirmed place and doubt about his ability to comply with the rules of the hostel. The panel also recorded the uncertainty around Mr Adakite's physical health and took into account that his Offender Manager was not supporting his re-release as there was work that he needed to undertake in prison regarding his drugs misuse and relapse prevention.

The panel concluded that his risk of reoffending could not be managed in the community, but as his sentence expiry date was 12 April 2013, it was likely that his case could be reviewed again. However, there was no further review.

Mr Adakite remained in hospital until December 2011 until he was transferred under a mental health section to a medium secure facility, which specialised in accommodating patients with brain injury. The assault had a long-term impact on Mr Adakite in terms of his physical and mental health. On 11 September 2013, he sadly died as a result of a long standing health problem unconnected to the assault.

2.7 Background of Mr Lamproite

According to the Pre-Sentence Report and the associated OASys assessment prepared for Crown Court in September 2009, Mr Lamproite was brought up in the Midlands and had supportive and caring parents who continued to support him despite his offending. He was expelled from school but did pass a number of examinations and went on to study media at college although he did not complete the course. He eventually left home and lived in rented accommodation. The report confirms that Mr Lamproite has never had full-time employment, but had experience of door-to-door sales work, telephone sales and part-time work in a fast food outlet. He was also involved in church activities. He was assessed as presenting a medium risk of harm to others.

Mr Lamproite had three previous convictions of a violent nature. According to an OASys assessment completed in 2007, he received a custodial sentence in a Young Offender Institution for an offence of grievous bodily harm in 2005. During this sentence, he was transferred under a Mental Health Act Section to a medium secure psychiatric hospital on 24 January 2006 after an apparent psychotic breakdown in HMYOI Glen Parva.

He was given treatment and returned to custody on 29 June 2006; he did not cope well, was disruptive and went back to the medium secure psychiatric hospital. The breakdown appears to be related to his conversion to Christianity in December 2005. Mr Lamproite engaged with to a limited extent with mental health staff, but was on the whole reluctant. In April 2007, a Mental Health Review Tribunal lifted the Section and he was released from hospital on licence on 23 April 2007.

At the time the licence supervision finished in July 2007, there were still concerns about his reluctance to share information, his rigid views and his inability to understand the perspective of others.

In June 2009, Mr Lamproite committed a robbery in the early hours of the morning and less than week later assault and theft offences in a nightclub. The apparent motivation was financial but the record acknowledges that he was also probably 'confused'. At a Crown Court in October 2009 Mr Lamproite was given an 18-month prison sentence for these offences.

In prison, it was alleged that Mr Lamproite was involved in a number of incidents of disruptive behaviour and was eventually transferred to HM Prison Stocken on 10 December 2009. There was a mental health review prior to this release and, although there were some concerns, he was not considered to be psychotic. He was released from HMP Stocken on licence on 13 April 2010 and went back to live in Nottingham. The licence contained a condition to: 'Comply with any requirements specified by your supervising officer, by cooperating with mental

health services as required'. The licence expired on 13 September 2010 and he was subsequently charged with further offences and remanded in custody.

On 3 December 2010, he was received at HMP Birmingham as an unconvicted remand from Magistrates' Court. At that time he was identified as standard risk on a Cell Sharing Risk Assessment (CSRA).[48] He was transferred from HMP Birmingham via court to HMP Nottingham on 4 January 2011

2.8 Mr Lamproite transfer from HMP Nottingham and reception into HMP Birmingham on 3 May 2011

The terms of reference for this investigation exclude detailed consideration of the period Mr Lamproite was in HMP Nottingham. However, during his time in Nottingham there were a number of alleged incidents that caused concern and are relevant to subsequent decisions taken by staff in HMP Birmingham. These incidents are set out below.

On 8 January, P-NOMIS records that a VR investigation was completed following the assault of his cellmate. He was placed on VR stage 2 monitoring. There was no national definition of the different levels of monitoring under the Violence Reduction strategy, but generally increasing the level resulted in closer supervision and sometimes reduced privileges. His cell-sharing risk assessment was increased to high. We were not supplied with the CSRA documentation although the review was recorded on NOMIS.[49] No Security Incident Report (SIR) was completed about this incident.

On 29 January, a Violence Reduction (VR) 21-day review was completed, resulting in his return to standard IEP (Incentives and Earned Privileges). Future behaviour targets were set to be respectful to others, to be non-violent, refrain from aggressive or threatening and to attend activities as required.

[48] CSRA for initial reception in HMP Birmingham dated 3 December 2010

[49] NOMIS Transfer Report for Mr Lamproite page 17 of 22

Two SIRs were submitted on 30 January and 5 February relating to prison indiscipline of a possible pass of an item during a visit and blown electrics in cell respectively. (Blown electrics in a cell are considered suspicious because they may relate to charging of a mobile telephone.)

Of greater relevance to this investigation are the two SIRs submitted on 24 February, which related to an exchange of blows with another prisoner in the Health Care waiting room. A VR investigation was requested.

Subsequently, three SIRs were submitted relating to an assault on the same prisoner on 7 March using a piece of a mug. P-NOMIS also states that the assault on prisoner resulted in him sustaining a ten-inch laceration to the right side of his face as a result of use of the ceramic mug. Mr Lamproite was identified as aggressor in this fight, transferred to the Segregation Unit and he was placed on report.

It is reported that his behaviour further deteriorated and whilst attending a video link on 8 March, he repeatedly punched and kneed another prisoner. A P-NOMIS record on 18 March states that Mr Lamproite had made a sustained and vicious assault punching and kneeing the prisoner repeatedly around the head and face. The attack only ceased when staff entered the holding room. He told staff that he did it because the prisoner had swastika tattoos on his hand. An SIR submitted on 8 March also reported the assault and this was also recorded in a further SIR submitted on 1 April that reported that Mr Lamproite had assaulted a prisoner who had a swastika tattoo. Mr Lamproite was located in the Segregation Unit and placed on report.

He was segregated under Rule 45 on 8 March for the reason of good order or discipline (GOoD) as a result of assaults on other prisoners. He was also on stage 3 of the Violence Reduction Policy at that time. He behaved well on the unit and engaged with the CPN.

On 18 March, an SIR was submitted about a threat of assault. At that time, Mr Lamproite was in the process of receiving a mental health assessment. Mr Lamproite is reported to have stated to the In-reach worker that he was 'receiving instruction to kill another prisoner' and had been told to rip off the head of another prisoner.

On 5 April, an SIR was submitted and stated that that staff observed Mr Lamproite bullying another prisoner on 1 April. Another SIR reported on 10 April that he had asked inappropriate questions to a member of staff and on 12 April, a further SIR indicated that he appeared to be intimidating a prisoner who he thought was a sex offender.

On 22 April, an SIR was submitted about an assault, in which Mr Lamproite used fragments of a ceramic mug on another prisoner, who retaliated with a pen. Both prisoners used weapons and one member of staff was stabbed in the thigh whilst another sustained an injury to his right hand. Both prisoners were placed on report. On 23 April 2011, another SIR also reported this. Mr Lamproite later told staff that he knew that the prisoner was a rapist and "just needed 5 minutes alone with him".

On 23 April, an SIR reported threats to prisoners who Mr Lamproite believed were either sex offenders or racists. This was collated / evaluated and entries made by the security manager and Governor on 26 April, but not actioned until 5 May, two days after Mr Lamproite was transferred to Birmingham.

On 27 April, a P-NOMIS entry reported that he was involved in an incident with another prisoner, located to the Separation and Reintegration Unit pending adjudication and placed on VR2 Basic.

On 30 April, an SIR reported inappropriate behaviour towards a female member of staff. The collator/evaluator, security manager and Governor processed the SIR on 4 May, but the security office actions were not completed until 10 May.

As a result of the considerable number of SIRs, Mr Lamproite was identified as a Prominent Nominal, which means that he was subject to increased monitoring by the Security Department.[50]

On 2 May, Mr Lamproite received 21 days' cellular confinement at HMP Nottingham, but he left Nottingham the following morning at 08:20, because he was remanded to Birmingham Crown Court. Information about the adjudication and his security file was not sent with the escort and was subsequently received at HMP Birmingham on 16 May.

The PER form completed at Nottingham and transferred with him stated the details of the current and relevant risks. These were listed as having a history of self-harm in custody, as having a violent nature including C-NOMIS alerts and as being a risk to females and a serious risk of harm to others.

The PER Form also recorded that documents transferred with Mr Lamproite were his F2050 Core record, his Property Card, his remand time calculation, confidential medical documents and one warrant. The PER form does not list the CSRA form as being transferred with him.[51]

More detailed information would also have been available to view via P-NOMIS. The NOMIS transfer report disclosed to us shows a number of offences of violence and volatility, including a comment about the alleged assault on his cellmate on 8 January.[52]

Records of the outcome of three previous CSRAs[53] were entered in summary on P-NOMIS in accordance with PSI 73/2011.[54] On reception on 3 December, P-NOMIS shows that Mr Lamproite's calculated result was assessed as low risk.

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[50] HMP Nottingham, Security Department Prominent Nominals Chart for Mr Lamproite

[51] Person Escort Form for Mr Lamproite dated 3 May 2011

[52] NOMIS Transfer Report for Mr Lamproite, page 11 of 22

[53] NOMIS Transfer Report for Mr Lamproite, page 17 of 22

[54] PSI 73/2011 Prison-NOMIS, paragraph 4.18

On review on 4 January, Mr Lamproite's calculated result was assessed as high risk. This timing of this review accords with the entry on P-NOMIS dated 8 January 2011, which states that a VR investigation was completed following the assault on his cellmate in their shared cell at Nottingham.[55]

The list of CSRAs on P-NOMIS shows a further CSRA review on 3 May, where the result was high because of his previous history with an additional comment given as 'after serious alleged assault on cell mate'.[56] This was the date of Mr Lamproite's transfer to HMP Birmingham when the documentation described below shows that he was identified as low risk.

In addition, a P-NOMIS record completed at Birmingham on 26 January stated that no monitoring restrictions were required but it was noted that Mr Lamproite had, 'Serious violence on his record including GBH in 2004. Alerts on Nomis relate to risk of harm to staff. Has previous battery conviction against prison officer (2005) and concerns regarding risk of harm to female staff'.[57]

Mr Lamproite was received by court staff at 10:20, prior to his court appearance. He was then transferred by the escort contractor and received at Birmingham at 16.35.

A CSRA was completed at Birmingham, which identified Mr Lamproite as having no issues or concerns. However, the officer completing the form identified contraindications to Mr Lamproite being suitable for location in a shared cell. These were indicated by three boxes having been ticked on the form. One area of concern identified was 'officer's observations', but the officer did not specify what had caused his or her concern. Also identified as a contraindication to cell-sharing were the warrant (current charge or offence) and the information provided on the PER form (violent behaviour in police, court, PECS [Prisoner Escort Contractor Services] custody. Similarly, there is no further explanation for the

[55] NOMIS Transfer Report for Mr Lamproite, page 11 of 22

[56] NOMIS Transfer Report for Mr Lamproite, page 17 of 22

[57] NOMIS Transfer Report for Mr Lamproite page 11 of 22

ticks on the form. The healthcare assessment identified that there were no indications from available records or their own observations that would indicate that there was immediate risk that Mr Lamproite might assault his cellmate.[58]

The Reception Officer recorded that the sources of evidence confirmed as searched were: Mr Lamproite's warrant and the PER. No checks were confirmed as being made on the Police National Computer (PNC) for previous convictions, on P-NOMIS for current and historical adjudication history or any other source. The Reception Officer completing the CSRA appeared from the signature on the forms to be the same person who completed the CSRA at HMP Birmingham at his first reception in December 2010.

[58] Cell Sharing Risk Assessment dated 3 May 2011

2.9 Mr Lamproite in HMP Birmingham 3 May – 7 June 2011

Mr Lamproite was placed on normal location in a shared cell on B Wing.

On 16 May, 13 days after transfer, HMP Birmingham received details of Mr Lamproite's adjudications about previous violence in the post from HMP Nottingham. An SIR was completed at Birmingham stating that Mr Lamproite 'had received 21 days cc [cellular confinement] for two serious assaults on prisoners at Nottingham on 2 May. He is also on a Violence Reduction book and on basic regime, we have also received a further adjudication for fighting using weapons. We were not notified before his arrival'. The writer stated that he had passed the information onto the duty Governor that day and notified wing staff. We have been unable to ascertain who the duty Governor was on that day or the precise information that was received. The information was noted and files updated. The security manager was tasked to contact his counterpart at Nottingham to enquire why this information was not received initially.

On 17 May, a fax was sent by an OSG (Operational Support Grade) in the Security Department at HMP Nottingham, attaching the intelligence card for Mr Lamproite.[59]

On 18 May, a P-NOMIS record entry was made by Governor 10, which stated, 'I have spoken to HMP Nottingham Safer Custody team who are unable to give me any further information on Mr Lamproite, at this point. It is apparent from his P-NOMIS history sheet entries that he may become a serious risk to other prisoners on the wing. Since being in Birmingham these (sic) no evidence of anti-social behaviour but staff have been informed of his past and staff are to be made aware of what he is capable of. Due to the Duty Manager's decision to maintain his current status, he will remain on normal location on a standard IEP regime but will be monitored and managed robustly to prevent any further violent

[59] Fax dated 17 May 2011 Birmingham Security Department attaching 3 page Intelligence Card

outbursts'.[60] It was not clear how this monitoring should occur or how it was intended to manage Mr Lamproite robustly. There is no evidence that any further monitoring took place prior to the assault described below.

At approximately 02:05 on 4 June, the member of staff patrolling B Wing heard banging and on further investigation went to landing 4 where he saw the cell bell from cell B4-34 flashing. On investigation, he could see Mr Lamproite pinning down his cellmate. The patrol officer radioed for assistance and ordered Mr Lamproite to step back, which he refused to do. The response team arrived and Mr Lamproite was located in the Care and Supervision Unit (CASU). His cellmate required hospitalisation due to receiving a serious injury to his left forearm, requiring an operation.[61] The cellmate subsequently made a statement to the police that two days before he was assaulted, he had asked the VR officer if he could move out of the cell that he shared with Mr Lamproite because he did not feel safe sharing a cell with Mr Lamproite because he was constantly talking about stabbing prisoners who were sexual offenders.[62]

The Segregation log for 4 June shows that Mr Lamproite was received into the CASU at 02:15 and located in cell S1-22. He went to hospital at 04:00 for treatment on his hand, returning at 09:05 and was then located in cell S1-03.[63] He was placed on Prison Rule 53/4, which allows a prisoner to be segregated pending investigation. Health Care completed the segregation algorithm and confirmed that Mr Lamproite was fit for continued segregation.[64] Due to mental health concerns, he was allowed to retain an in-cell television.

Staff Nurse 11 documented that Mr Lamproite engaged with the assessment and denied any history of hearing voices, had no paranoid ideation, no thoughts of self-harm or suicide and that he had never taken prescribed medication for

[60] NOMIS Transfer Report for Mr Lamproite page 4 of 22

[61] Report of Injury to a Prisoner, dated 4 June 2011

[62] Witness Statement of cell mate assaulted by Mr Lamproite on 4 June 2011 taken on 17 July 2011, page 1

[63] HMP Birmingham Segregation Unit Log dated 4 June 2011

[64] Initial Segregation Health Screen incorrectly dated 4 May 2011

mental health. He claimed that he had never been admitted to hospital, although this was untrue as Mr Lamproite had been admitted to a medium secure unit in July 2006. Mr Lamproite also claimed that the injuries sustained resulted from self-defense. Staff Nurse 11 commented that he appeared to be having anger issues but no mental health issues were noted during the assessment.[65]

Mr Lamproite's core record contained an undated assessment that was produced at some time following the assault on Mr Lamproite's cellmate on 4 June. The author is unknown but the assessment states that a broken ceramic mug was used in the assault and that Mr Lamproite asked other prisoners what their offence was and if they were not able to prove that they were not a sex offender then he assaulted them. It identified that although 'healthcare may be a more suitable place for him', it cautioned against placing Mr Lamproite in healthcare due to the high number of sex offenders held there and the less regimented regime.[66]

On 5 June, an SIR was submitted indicating that a prisoner had witnessed Mr Lamproite showing off a homemade weapon from a tin lid in his cell. The weapon was retrieved and bagged as evidence, but was identified as not having been used in the assault on the previous day.

On 6 June, both Mr Lamproite and Mr Lamproite's cellmate were charged with fighting under Prison Rule 51, paragraph 4. The adjudications for both prisoners were opened by a Governor and adjourned for police enquiries. Although both prisoners were placed on report, Mr Lamproites cellmate was not segregated as a result of the fight.[67] Following adjudication, Mr Lamproite was placed on Rule 45 in the interest of Good Order or Discipline (GOoD). The assessment for GOoD stated that Mr Lamproite would be segregated for 'a period of assessment following a serious assault/fight where significant injuries were sustained'.[68]

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[65] Clinical Record Mr Lamproite dated 4 June 2011

[66] Undated and unsigned assessment of Mr Lamproite

[67] HMP Birmingham, Segregation Log, 6 June 2011

[68] Segregation under Rule 45/ YOI Rule 49, Authority of Initial Segregation dated 6 June 2011

His cell-sharing risk assessment was changed to high as a result of the assault on another prisoner, whose injuries were serious, required hospitalisation and were considered life-threatening.[69] This factor alone makes a prisoner a mandatory high risk. There were also positive markers for previous cell assaults in other establishments or in previous custody and for more than two incidents of violence to other prisoners or staff.

Staff made an entry in the Prisoner Personal Record System on 6 June that Mr Lamproite displays 'behaviour that he is unsure/unaware of various things'.[70] As he did not give any information about the assault on his cellmate and denied any mental health issues, it was decided to monitor him with a view to a possible admission to Health Care. He was seen by a member of the In-Reach team who wrote, 'No evidence of Mental Health (sic) Monitor by segregation/health. Will re-assess if deterioration in mental health'.[71] In all other respects, his time in the Segregation Unit was uneventful with only routine conversations and interactions being recorded.

No entries were made in the Prisoner Personal Record System after 15:15 on 7 June, until after the assault on Mr Adakite. A multi-disciplinary team meeting took place on 7 June and it was decided to admit Mr Lamproite to Ward Two in Health Care and that the forensic team should review him on 9 June and liaise with HMP Nottingham Mental Health In-reach team to obtain information, although no further information was forthcoming.

[69] Cell Sharing Risk Review Record, dated 5 June 2011

[70] Prisoner Personal Record System (PPRS) 2052A, entry dated 6 June 2011 at 12:00

[71] Prisoner Personal Record System (PPRS) 2052A, entry dated 6 June 2011 at 14:00

2.10 Mr Lamproite in the Health Care Unit 7-16 June 2011

On Tuesday 7 June at 18:50, Mr Lamproite was admitted to the Health Care Centre for an observation of his mental health in line with decisions made at the multi-disciplinary meeting.

An undated document headed overview of patients on Ward 2 provided the following information, 'Mr Lamproite was admitted onto the ward from the segregation unit on 07/06/11 following concerns from the in-reach team. He stabbed his cellmate for reasons unknown and has previous history of violence towards his cellmates. Current offence is for attempted robbery and firearm offence. History of mental illness. Known to [a medium secure psychiatric hospital] and another hospital in Nottingham. Plan – Notes to be requested from [medium secure psychiatric hospital], Continue with in-patient assessment'.[72]

The Health Care Unit at HMP Birmingham had a Safe Supervision of Prisoners (In-patients) policy. The aim of this document was stated as being 'to provide a clear and robust system for managing the regime of patients residing on the In-Patients department at HMP Birmingham to ensure a safe and controlled, yet purposeful regime'. Level A is defined under the strategy as, 'Prisoner is violent and unpredictable. He has committed recent assaults on staff or there is confirmed intelligence to suggest he will assault staff or other prisoners in the future'. Level B is for when a prisoner 'can be unpredictable and disruptive on occasions. May not necessarily be violent but behaviour out of cell may be such that he will need increased supervision e.g. frequently refuses to return to his cell.'[73] The document stated that routine reviews should be carried out daily by a multi-disciplinary team consisting of at least a prison manager (SO/PO/Governor), a Senior Nurse and at least one member of healthcare staff (Nurse or Officer) and that each review must record the decision with the reasons, the names of those involved and the date.

[72] Overview of Patients on Ward 2, undated

[73] Safe Supervision of Prisoners (in-patients) agreed between Clinical Services Manager, Birmingham and Solihull Mental Health Trust and Governor of HMP Winson Green dated August 2004, paragraphs 1 – 3

Mr Lamproite was assessed as falling into level A under, 'Safe Supervision of Prisoners' (In-patients) policy on arrival in Health Care. The in-patient risk assessment recorded on 7 June shows the following behavioural concerns: assaults/violence, abusive, hostage risk and issues with certain groups e.g. women. Other observations noted included that Mr Lamproite had been 'admitted to healthcare due to serious assaults to cell mates x 3'.[74]

On the night following 7 June, the Clinical Record reports that Mr Lamproite was observed responding to voices and talking and laughing inappropriately. The clinical reviewer for this Article 2 investigation noted that, 'When confronted by staff, he denied any auditory hallucination'.

On 8 June, during the ward round, Mr Lamproite said that he had been arguing with his cellmate and it got out of hand. It was recorded in the clinical notes that he 'appeared slightly suspicious at times and gazed around the room before answering'.[75]

On 9 June, Dr 12 identified Mr Lamproite's psychiatric history and medication and requested medical records from the medium secure psychiatric hospital to confirm this. She commented that Mr Lamproite did not accept the diagnosis of schizophrenia, although he did confirm that the argument and fight with his cellmate had been the result of hearing command auditory hallucinations. Mr Lamproite denied hearing voices since the incident or having any paranoid thoughts and was 'very vague about his symptoms'.[76]

On 9 June, Staff Nurse 11 documented that Mr Lamproite had been compliant with his medication, had his finger re-dressed and specifically that he was unlocked from his cell to allow him to collect his lunchtime meal and had taken his meal. Staff Nurse 11 also documented that following his discharge from the

[74] HMP Birmingham In-patients Behaviour Risk Assessment relating to Mr Lamproite dated 7 June 2011, page 1

[75] Clinical Record Mr Lamproite dated 08 June 2011

[76] Clinical Record Mr Lamproite dated 09 June 2011

medium secure psychiatric hospital, Mr Lamproite was eligible for follow-up from the Forensic Community Mental Health Team and that he would be seen the following week by the Forensic Team to assess his level of need for medium or secure services.[77] A care plan was also created around the dressings required to his finger.

A Management of Aggression Care Plan was created by Staff Nurse 13 and documented in the clinical notes. This care plan identified Mr Lamproite's risk, specifically towards paedophile's and female staff.[78] A psychosis care plan was also created with the aim to monitor his behaviour, record the nature of the auditory hallucinations and encourage him to take anti-psychotic medication when prescribed. The care plan was due to be reviewed on 16 June. There was concern that Mr Lamproite appeared to be developing psychosis.[79]

On 10 June, the clinical notes recorded that he presented as very stable, able to mask symptoms and presenting a high risk to females. Ward Manager 14 noted on the clinical notes that Mr Lamproite had been admitted to psychiatric hospitals with a diagnosis of schizophrenia and had history of serious assaults (including against staff) and that he appears very stable and able to mask his symptoms. In particular, Ward Manager 14 documented that he 'presents a high risk to others and it appears his ideas he forms about others being sex offenders are delusional in nature'. [80] It was noted that Mr Lamproite should not to be left alone with females. A high priority reminder was made on the front page of SystmOne record stating: 'PSYCHIATRIC HISTORY – HISTORY OF SERIOUS ASSAULTS ON OTHERS'.[81]

[77] Clinical Record Mr Lamproite dated 09 June 2011

[78] Clinical Record Mr Lamproite dated 09 June 2011

[79] Clinical Record Mr Lamproite dated 09 June 2011

[80] Clinical Record Mr Lamproite dated 10 June 2011

[81] Clinical Record Mr Lamproite dated 10 June 2011

During the next two days, Mr Lamproite was compliant, well behaved and discussed taking anti-psychotic medication.[82] On 12 June, a note was made in Mr Lamproite's clinical record that he, 'appears settled in mood and mental states, kept a low profile, he spent some time watching TV in bed'.[83]

On 14 June, he complained to Healthcare Senior Officer 15 that he did not have as much association time as others, but failed to acknowledge his motivation to assault others.[84] On 15 June, whilst on the exercise yard, Mr Lamproite expressed a wish to be taken off Level A unlock.[85] He also said the same to another member of staff.

The Safe Supervision of Prisoners (in patients) policy builds in regular reviews, including daily reviews of prisoners on level A, although there are no recorded earlier reviews of Mr Lamproite on the in-patient risk assessment form. Officer 16 told us that reviews of all in-patients took place at the morning meeting of managers, uniformed and healthcare staff on Ward Two prior to unlocking prisoners. He said that records of this meeting may have been entered in the clinical records of individual prisoners, but as a uniformed member of staff, he would not have had access to this. Staff Nurse 1 confirmed that a nurse occasionally would make an entry to this effect in clinical notes, but this was not done routinely as the risk assessment process was a discipline rather than a healthcare process.[86]

In his police witness statement about the events of 16 June 2016, Ward Manager 14 said, 'That morning, as normal, we had a full handover where we look at all prisoners on the ward and any ongoing issues so that all staff are made aware'.[87] In his police witness statement, Healthcare Senior Officer 15 said that a review

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82 Clinical record Mr Lamproite dated 11 June 2011, Clinical record Mr Lamproite dated 12 June 2011

83 Clinical Record Mr Lamproite dated 12 June 2011

84 Clinical record Mr Lamproite dated 14 June 2011

85 Clinical record Mr Lamproite dated 15 June 2011

86 Transcript of Interview with Staff Nurse 1 on 18 July 2016, page 4/5

87 Witness Statement of Ward Manager 14 on 14 July 2011, page 1

of Mr Lamproite had taken place on the previous day[88] (although there was no record of this) and that on the day of the assault, they had discussed that Mr Lamproite had a history of assaults on other prisoners and that he had previously assaulted nursing staff, but it was not specified whether this was in prison or at an external hospital. However, at HMP Birmingham, he had not presented with any overt symptoms of mental illness, although it was recognised that his history indicated that he was a risk. A discussion took place that his behaviour and conversation had been appropriate with staff. If supervision was reduced then it was conditional that when he was out of his cell with others that he would remain in public areas and not go into anyone else's cell and that only specially selected prisoners would be unlocked rather than all the patients on the ward.

Officer 16, Officer 9 and Staff Nurse 1 reported that at Mr Lamproite's review, they expressed the view that Mr Lamproite should remain on level A, because he was yet to be fully assessed and was not well known to the staff. Officer 9 described Mr Lamproite as, "cold, calculating". Officer 9 felt strongly that Mr Lamproite was constantly evaluating to identify weaknesses.[89] They said that it was the managers' view that Mr Lamproite's supervision level should be reduced to B. Officer 9 and Officer 16 felt strongly that managers had enforced their view on the Officers and had not given adequate reason for downgrading Mr Lamproite's supervision level.[90] Healthcare Senior Officer 15 acknowledged that there had been disagreement at the decision to reduce Mr Lamproite's supervision level to B, but he could not remember who had expressed the disagreement. Deputy Ward Manager 17 said that he could not remember any disagreement at the meeting. Healthcare Senior Officer 15 said that he felt that Mr Lamproite should have been allowed to associate alongside other prisoners in order to demonstrate that he was able to mix with others. It was not appropriate to keep somebody for a long period on a very restricted regime as this was not in their best interests and it also reduced the opportunity for others to be unlocked

[88] Witness Statement of Healthcare Senior Officer 15 on 14 July 2011, page 1

[89] Transcript of Interview with Officer 9 on 19 July 2016, page 2

[90] Transcript of Interview with Officer 9 on 19 July 2016, page 4; Transcript of Interview with Officer 16 on 18 July 2016, page 4/5; Transcript of Interview with Staff Nurse 1 on 18 July 2016, page 2/3

due to the time taken to meet the needs of an individual prisoner on level A, such as for showers, cell cleaning and other time out of cell.[91]

The documentation records that prior to unlock on June 16, Mr Lamproite's level of supervision under the Safe Supervision of Prisoners (In-patients) policy was changed to level B. This review included the level of regime activity allowed. For example, Mr Lamproite was allowed to exercise and dine in association with others, but was not allowed to share a cell. The detail of the review was that Mr Lamproite was, 'to be allowed to mix with others but is to remain in public areas and not to enter others' cells'. No reason was given on this form for the change in regime level. Those present at the review were listed as Healthcare Senior Officer 15, Officer 9, Officer 16, Ward Manager 14, Deputy Ward Manager 17 and Staff Nurse 1[92], although Officer 9 said that he did not think that Staff Nurse 1 was there and Officer 16 did not mention Staff Nurse 1 as being present.[93] However, Staff Nurse 1 reported that she had been present, at least at the beginning[94] and this was confirmed in her police statement.[95] In his police statement, Officer 16 said that Staff Nurse 1 was there and also mentioned an Officer 18 being present.[96]

In his police witness statement, Ward Manager 14 explained the reason for reducing the level of supervision on Mr Lamproite as, 'he showed no alert (sic) signs of mental illness, no aggression towards staff when unlocked and no signs of mood disorder and hadn't breached any prison rules'.[97] In the Clinical Record he also wrote, 'During the morning handover a discussion was held about Mr Lamproite's unlock status, it was felt that Mr Lamproite had presented as stable, no overt evidence of psychosis had been noted, his interactions with staff had

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[91] Transcript of Interview with Healthcare Senior Officer 15 on 18 July 2016, page 3

[92] HMP Birmingham In-patients Behaviour Risk Assessment relating to Mr Lamproite dated 7 June 2011, page 2

[93] Transcript of Interview with Officer 9 on 19 July 2016, page 4 and Transcript of Interview with Officer 16 on 18 July 2016, page 3

[94] Transcript of Interview with Staff Nurse 1 on 18 July 2016, page 4

[95] Witness Statement of Staff Nurse 1 on 17 July 2011, page 1

[96] Witness Statement of Officer 16 on 16 July 2011, page 1

[97] Witness Statement of Ward Manager 14 on 14 July 2011, page 2

been appropriate and there had been no evidence of aggression displayed…Due to the fact that Mr Lamproite has been on a level A unlock we felt to assist us with his assessment it was decided to allow him to have a limited unlock with a limited number of other prisoners it was decided that he would be told that he had to remain in the main body of ward 2 and for staff to monitor and be aware of his whereabouts at all times.'[98] The police statement of Healthcare Senior Officer 15 is consistent with this.[99]

Deputy Ward Manager 17 also wrote that, 'Mr Lamproite was discussed in the morning handover and it was decided by all present that his unlock status should be relaxed to a level B due to there being no incident of aggression or assaults noted since his arrival onto healthcare.'[100]

Both the above entries were made after the assault, although they recorded events prior to the assault. The clinical reviewer advised us that they are still considered to be contemporaneous.[101]

The regime required at level B was that, 'prisoners should not be unlocked unless there are at least three staff trained in C&R (Control and Restraint) level 2 present on the ward, two of which must be a prison officer grades (sic). They should not necessarily be excluded from being unlocked at the same time as other prisoners but caution should be exercised and an assessment made before unlocking about which Level B prisoners may be unlocked together. This assessment should be based on the information provided on each patient's risk assessment. Similarly the decision whether the patient may dine in association will be based on his individual risk assessment.'[102]

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[98] Clinical Record Mr Lamproite dated 16 June 2011

[99] Witness Statement of Healthcare Senior Officer 15 on 14 July 2011, page 1

[100] Clinical Record Mr Lamproite dated 16 June 2011

[101] Clinical Review on Mr Lamproite whilst a serving prisoner at HMP Birmingham carried out by Dr Peter Billingsley, dated 22 August 2016

[102] Safe Supervision of Prisoners (in-patients) agreed between Clinical Services Manager, Birmingham and Solihull Mental Health Trust and Governor of HMP Winson Green dated August 2004, paragraph 7

2.11 The events leading up to the assault on 16 June 2011

Healthcare Senior Officer 15 and Officer 16 communicated the decision of the review meeting to Mr Lamproite. When they did so, Healthcare Senior Officer 15 described him as appropriate and compliant with what was proposed and agreeing to the terms of integrating with other patients. At one point, Healthcare Senior Officer 15 saw him entering the cell of another prisoner and called him out and reminded him to stay in the public area. He complied without any problem or complaint.

Officer 16 reported that he only thought that he and Officer 9 were on Ward 2 at the time of the incident, although Healthcare Senior Officer 15 said that he had based himself next to the pool table. Officer 9 was adamant that only Officer 16 was with him on the landing. When he submitted the transcript of his interview, he added that there was a witness that would confirm that Healthcare Senior Officer 15 was not there. As a result, I telephoned him and he told me that an Officer supervising a constant supervision (of a prisoner in a cell) had told him that he could see the pool table and that Healthcare Senior Officer 15 was not there. I contacted this Officer and spoke to him. He confirmed that whilst he was carrying out a constant supervision he had the pool table in his line of sight and that he did not see Healthcare Senior Officer 15.

Officer 9 recalled that he thought there were insufficient staff to lock up Mr Lamproite because there were only two of them on the ward and he was worried that they would not be able to cope if Mr Lamproite became agitated. He was disappointed that after the managers had decided to unlock Mr Lamproite with others, that none of them had remained on the landing in support. However, in Officer 16's police statement, he only specifically mentioned that Ward Manager 14 left the ward for duties elsewhere and the statement implies that both Healthcare Senior Officer 15 and Deputy Ward Manager 17 were on the ward because they responded immediately when Officer 16 raised the alarm.

At approximately 10:45 on 16 June, two members of staff, Officer 16 and Officer 9, were supervising the Ward two recess containing showers and bath. Mr Adakite was already present in the recess when Officer 16 gave Mr Lamproite a razor and Mr Lamproite entered the recess to shower. In his police statement Officer 16 wrote, 'I can't say for definite how long Mr Lamproite was in the shower, but he had time enough for a good wash. When he came out he handed me the razor and mirror back'.[103]

Officer 16 said he only took his eye off recess for 10 seconds. Healthcare Senior Officer 15 said that the level of observation was not known. He said that it would normally be every 20 minutes for normal prisoners but more frequently when a prisoner like Mr Lamproite was present. Both Officer 9 and Officer 16 reported that they had kept almost constant visual observation of Mr Lamproite whilst he was in the shower. In Mr Lamproite's clinical notes, Ward Manager 14 wrote that staff were observing 'on a regular basis approximately every two minutes'[104]. The assault happened during a period when something else happened on the ward to distract them and although neither Officer 16 or Officer 9 could remember what that was, they both recalled that it was only approximately 15 seconds when Mr Lamproite was not being watched when the assault happened. Officer 9 believed that Mr Lamproite had noticed that he was not being observed and took the opportunity to assault Mr Adakite.

A prisoner said that he was in the middle shower between Mr Adakite and Mr Lamproite and made a statement to the police. He stated that Mr Lamproite asked Mr Adakite about his offence and that Mr Adakite responded that he had been involved in a robbery, where a young Asian boy threatened him with a knife. He stated that he heard Mr Adakite say that he and his Asian friend stabbed the young boy and he then saw Mr Lamproite punch Mr Adakite in the face and when Mr Adakite fell down on his face, he saw Mr Lamproite punch and kick Mr Adakite around his body, whilst also stamping on his head. He then left the shower and

[103] Witness Statement of Officer 16 on 16 July 2011, page 2

[104] Clinical Record Mr Lamproite dated 16 June 2011

about five minutes later overheard Mr Lamproite, who had also left the shower area, say that he had assaulted another prisoner. He stated that he went to the shower area to have a look and saw Mr Adakite lying flat on his face with blood everywhere and described him as being positioned near the bath area. He went back to his cell and heard staff raise the alarm.[105]

This accords with the police statement of Officer 16, who saw Mr Lamproite leave the shower and took his razor and mirror, checked the former to ensure it was intact and amend the records, before then re-checking the recess.[106]

A SIR completed on 23 June, recorded that just prior to Mr Adakite being discovered by Officer 16, Mr Lamproite was heard to say, "I've just banged out a nonce in the recess". In his police statement, Healthcare Senior Officer 15 clarified this by saying that Mr Lamproite had made this statement to another prisoner who had also told him that as soon as Mr Lamproite had finished talking to him, he heard Officer 16 raise the alarm about Mr Adakite.[107]

2.12 Staff management of the incident following discovery of Mr Adakite

At approximately 10:45 on 16 June, Officer 16 looked into Ward 2 recess and observed Mr Adakite lying in a pool of blood around his head and immediately called for assistance and ambulance. The Control Room called for an ambulance at 10:47. Immediate medical attention was given. At no time did anyone hear a cry for help. According to the Report of Injury to Prisoner, Mr Adakite was 'semi-conscious with serious head injury'. A Gödel airway was used and physical observations were taken.[108]

Although Officer 16's police statement said that Deputy Ward Manager 17 and Healthcare Senior Officer 15 responded immediately, in Ward Manager 14's

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[105] Witness Statement of Prisoner who claimed to have seen the assault taken on 3 August 2011, pages 1 - 2

[106] Witness Statement of Officer 16 on 16 July 2011, page 2

[107] Witness Statement of Officer 16 on 14 July 2011, page 3

[108] Report of Injury to Prisoner relating to Mr Adakine dated 16 June 2011

statement, he states that he was in the Primary Mental Healthcare Team's office and was approached by Deputy Ward Manager 17 and informed that there was an emergency on the ward.[109]

Officer 9 wrote in the Occurrence book on the date of the assault that, 'After supervising Mr Lamproite in the shower area he came out and returned the razor and mirror that had been issued. He started to walk back to his cell. Officer 16 checked the shower area and noticed Mr Adakite lying on the floor in a pool of blood and raised the alarm. I escorted Mr Lamproite back to his cell and stated to Mr Lamproite that he had done it to which he shrugged his shoulders and walked into his cell and I secured it. All necessary parties were informed and eventually Mr Adakite was taken to hospital and Mr Lamproite to the segregation unit'.[110]

Healthcare Senior Officer 15 said he was alerted to an incident in the shower when Officer 16 called out. Healthcare Senior Officer 15 then went into the shower area and saw Mr Adakite on the floor lying on his right side with a large pool of blood under his head, spreading into the bathroom. He asked for an ambulance to be called immediately, medically trained staff were to be called urgently and for all prisoners to be returned to their cells. The orderly officer should be called to manage the scene and security attend to ensure that evidence was preserved. Officer 16 and Officer 9 described a prisoner who was also in the shower as appearing absolutely petrified.

Healthcare Senior Officer 15's police statement described Mr Adakite as, 'conscious but unresponsive to speech, he was moving around the floor but uncoordinated'.

Healthcare Senior Officer 15 supported his head as he was in danger of hitting it against the doorframe leading to the bathroom and then maintained him in that

[109] Witness Statement of Ward Manager 14 on 17 August 2011, page 1

[110] Extract from Occurrence Book, dated 16 June 2011

position so that his blood loss drained away from his airway. He noticed that his mouth and nose were bleeding heavily and there was bleeding from a head wound, but he was unable to assess his injuries because of the amount of blood present and his priority to maintain his airway. He then handed over to more qualified and appropriately trained staff.[111]

The clinical reviewer has noted that, Dr 19 documented at 11:42 that he attended an emergency call on Ward 2 and noted an emergency ambulance had already been called and staff were in attendance. He documented that Mr Adakite was lying on the floor of the bathroom, he was agitated, his breathing was obstructed, there was blood around and a large laceration in the right temporal region. Dr 19 realised that his level of consciousness was reduced, GCS [Glasgow Coma Scale] 9 (out of 15). His eyes were open, he was making incomprehensible sounds and that he responded to painful stimuli only.

Dr 19 considered post seizure, or assault the most likely scenario - as supported from comments by staff. Shortly after, Staff Nurse 20, who also responded to the Hotel 2 call, joined him and she noted Dr 19, Healthcare Senior Officer 15 and another Healthcare officer already in attendance. Further examination confirmed pupils dilated and a rapid pulse of 100 per minute. Because he was so agitated, an initial blood pressure was unable to be taken, but an elevated reading of 163/98mmHg was subsequently recorded. Because of low oxygen saturations between 83-90%, immediate first aid included inserting an opharyngeal airway (a medical device used to maintain or open a patient's airway), which he tolerated and giving high flow oxygen. His cervical spine was stabilized, to prevent further injury to the head and neck, and pressure was applied to stop bleeding.

Duty Governor 21 arrived on the scene at 10:55 and having observed that medical assistance to Mr Adakite was being provided, he instructed Senior Officer 24 'to secure the doorway of the shower area, treat as a possible crime scene and restrict access to people other than the clinical staff and act as log

[111] Witness Statement of Healthcare Senior Officer 15 on 14 July 2011, page 2

keeper'[112]

The ambulance arrived at 10:58 and arrived at the scene at 11:00 and at 11:29 the ambulance was escorted to the back gate. At 11:37 Mr Adakite left for hospital with an escort chain attached.[113]

The assailant, Mr Lamproite was secured in his cell and kept under observation.

At 11:15, the police were contacted and crime reference number allocated.

At 11:40, the clothing of the prisoner, who was also in the shower at the time of the incident was bagged and tagged.

At 11:57, he was moved to the CASU.

At 14:00, there was an attempt to contact Mr Adakite's next of kin (mother), but they were unable to make contact until 15:48. Mr Adakite's mother, in her police witness statement, stated that the time of contact was 'approximately 16:30'.[114]

At 16:00, the Family Liaison Officer was dispatched to hospital.

Officer 9 told us that he was present when security staff entered Mr Lamproite's cell to remove his clothing as part of the preservation of evidence. Officer 9 noticed that the clothing given was not the clothing that Mr Lamproite was wearing when he left the shower. As a result, security staff and Officer 9 entered the cell and retrieved blood-stained clothes and shoes from behind Mr Lamproite's bed.[115] This does not accord with Officer 22's police statement dated 14 July 2011, in which he states that he entered Mr Lamproite's cell with Officer

[112] Witness Statement of Duty Governor 21 on 15 July 2011, page 1

[113] Extract from Gatekeeper's Daily Occurrence Book, dated 16 June 2011

[114] Witness Statement of mother of Mr Adakine on 30 June 2011, page 1

[115] Transcript of Interview with Officer 9 on 19 July 2016, page 6

23 and seized and bagged clothes and shoes and then moved Mr Lamproite to another cell whilst they searched it and did not retrieve any other items.[116]

The crime scene was secured and a log kept by Senior Officer 24, of those entering the scene.[117] The Control Room maintained a separate log.[118]

Duty Governor 21 said that he would have expected 'the people who saw the initial incident or were involved in the initial incident' to put in statements, but the police formally interviewed staff quickly and therefore there was no need for a separate statement from individual members of staff.[119] We noted that with the exception of Officer 16, who was interviewed on the day of the incident, police statements were not taken until 14 July 2011 or later in some cases. The original prison service internal investigating officer had access to police statements, but we were not given copies until after our interviews of staff. An incident checklist was produced which lists documents and actions required.[120] Although there was space on the form to indicate if statements from witnesses were supplied, none were indicated as having been produced.

Senior Officer 24 completed an incident statement identifying the prisoners involved, the staff at the scene and a précis of the actions taken[121]. It was dated and timed '20.10.27.04.2011'; Senior Officer 24 explained when interviewed that he had dated the form incorrectly because he had used a template from an earlier incident.[122] A report was generated on the Incident Reporting System at 15:43.[123]

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[116] Witness Statement of Officer 22 on 14 July 2011, pages 1-2

[117] Crime Scene Log completed on an ACCT Daily Supervision and Support Record

[118] HMP Birmingham Control Room Incident Log, incorrectly dated as 1 May 2011

[119] Transcript of Interview with Duty Governor 21 on 18 July 2016, pages 6 - 7

[120] Incident Checklist Index

[121] Incident Statement completed by Senior Officer 24, incorrectly dated 27 April 2011

[122] Transcript of telephone call with Senior Officer 24 on 26 July 2016, page 2

[123] Reportable Incidents Distribution Report, report generated 16 June 2011 at 15:43

Senior Officer 24 confirmed that a 'hot debrief' did take place[124] and this is also documented in his incident statement[125]. Duty Governor 21 also recalled that a hot debrief took place[126]. No minutes were taken of the debrief as this is not required under incident management procedures, but we would have expected the hot debrief to have checked on the welfare of staff attending the incident, offered support and encouragement to staff and to offer access to the Care Team. Officer 9 told us that he and Officer 16 felt unsupported as no one spoke to them following the incident or thanked them for managing it initially, stating, "No-one had come up to us and said, "How are you? Are you all right?" "Well done", you know what I mean? "You did well there." Nothing. No-one even said anything to us. And just left us. And then we just carried on with the shift as, as per normal."[127] However, an undated and unsigned log of events that occurred between 10:45 and 16:00 on 16 June records that at 11:40 there was a hot debrief where all staff including the care team were in attendance.[128] We were not able to ascertain when this record of events was produced.

The ward occurrence also records that Ward Manager 14 asked staff to ensure that all patients on ward two were given access to a listener.[129]

During his telephone interview, Ward Manager 14 recalled some sort of debrief meeting following the incident, but was unsure when it had taken place. He did recall that after the event he was involved in reviewing policies and procedures aimed at preventing a reoccurrence.

[124] Transcript of telephone call with Senior Officer 24 on 26 July 2016, page 2

[125] Incident Statement completed by Senior Officer 24, incorrectly dated 27 April 2011

[126] Email Prison Liaison Point 2 to Andy Smith and others dated 29 June 2016

[127] Transcript of Interview with Officer 9 on 19 July 2016, page 11

[128] Untitled and Undated Log of events

[129] Extract from Occurrence Book dated 16 June 2011

2.13 Management of Mr Lamproite following the incident on 16 June 2011

Mr Lamproite was located in the CASU at midday on 16 June 2011. He was assessed as requiring a three-Officer unlock.[130] Dr 12 performed a forensic assessment in the unit when Mr Lamproite claimed to have no knowledge of what happened. He was then taken into police custody for interview at 20:40.[131] Mr Lamproite returned to the CASU from police custody at approximately 13:30 on 18 June. He was re-admitted to healthcare at 16:15 on 3 August.[132]

On 2 November 2011, Mr Lamproite was transferred to the High Security Hospital system. In June 2012, Mr Lamproite appeared at Crown Court having been charged with a number of offences including the two assaults committed in Birmingham prison. For the offence of Wounding with intent to do Grievous Bodily Harm which had taken place on 4 June 2011 a Hospital Order was made with a section 41 Restriction order. In relation to the assault on Mr Adakite (Causing Grievous Bodily Harm with intent) no evidence was offered by the prosecution and he was therefore found not guilty. [133]

[130] Segregation Case Review dated 16 June 2011

[131] HMP Birmingham Segregation Unit Log dated 16 June 2011

[132] Clinical Record Mr Lamproite dated 3 August 2011

[133] Email dated 23 August 2016 from Safer Custody Caseworker to Andy Smith

Part 3. Issues examined in the investigation

3.1 How well were Mr Adakite's mental and physical health needs assessed and treated?

PSI 52/2010 required that the PER form and any other available documentation must be examined on reception into prison to identify any immediate needs and risks already recorded. The prisoner must also be interviewed, in private if possible, to discover and record any further immediate needs and risks, and any other information about the prisoner that may be relevant, particularly during their first night in custody.[134] All incoming prisoners must be medically examined, in private if possible, by a qualified member of the Healthcare team, or a competent and trained Health Care Assistant, who has been trained in ACCT procedures, to determine whether they have any short or long term physical or mental health needs, including disability, drugs or alcohol issues, and ensure that any follow-up action is taken, that anyone who needs to know about individual prisoners' ongoing healthcare requirements is informed, and that actions taken are recorded in the appropriate record.[135]

Similarly, Standard 22 Health Services for Prisoners requires that a health screen, using the revised F2169, takes place before the prisoner's first night to primarily detect immediate physical health problems, immediate mental health problems, significant drug or alcohol abuse and risk of suicide or self-harm.[136]

In reception, Mr Adakite was seen by a staff nurse[137] and then by the doctor who prescribed medication.[138] He also saw a mental health nurse.[139]

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[134] PSI 52/2010, paragraph 2.14

[135] PSI 52/2010, paragraph 2.35

[136] Standard 22 Health Services for Prisoners, paragraph 18

[137] Clinical Record Mr Adakine dated 7 June 2011

[138] Clinical Record Mr Adakine dated 7 June 2011

[139] Clinical Record Mr Adakine dated 7 June 2011

Where immediate health needs are detected, a prisoner must be referred to an appropriate healthcare worker or specialist team. All prisoners not identified with immediate health needs are offered a general health assessment to take place in the week following reception.[140] On reception, the standard template driven initial health screen was used to assess Mr Adakite's physical and mental state. Mr Adakite failed to disclose his use of intravenous drugs or the drug abuse that had been largely responsible for his recall. His schizophrenia history was identified, but not his history of self-harm. There are obvious limitations in the accuracy of a template that relies on questions being answered truthfully. However, questioning identified his recent stay at HMP Risley, epilepsy diagnosis and current medication. Although there were limitations in the initial assessment, half an hour later, there was a further evaluation that identified that he had been using crack cocaine prior to his recall. The mental health nurse completing this review noted that he was receiving antipsychotic medication and correctly identified the need for liaison with the hostel where he had been living prior to his arrest regarding his treatment plan.

Despite these interviews, the clinical reviewer has identified that, 'although he reported no current visual or auditory hallucinations, he did suffer these symptoms and a review of his existing medical record would have identified this'.

Birmingham had a dedicated first night centre where Mr Adakite remained for two days and subsequently he was admitted to Health Care and, given his chronic, physical and mental health problems, this was the most appropriate location for him.

PSO 3050 Continuity of Healthcare for Prisoners emphasised the importance of continuity of healthcare received by prisoners, particularly after reception and transfer. It was evident from the clinical record that it was quickly identified that it would be appropriate to contact the hostel about Mr Adakite's treatment plan and diagnosis. They were also aware of an existing referral for Hepatitis C

[140] Standard 22 Health Services for Prisoners, paragraph 19-20

treatment. As part of the ACCT review on 10 June, the CPN was identified to contact the Probation Service and mental health would contact the hostel to identify the fellow resident who had been involved in an incident with Mr Adakite and had been recalled to prison.[141]

PSI 45/2010 Integrated Drug Treatment Services (IDTS) states that, 'Local prisons must be able to offer immediate access to clinical services as described in the Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006) whenever there is a clinical need. This means that all drug or alcohol dependent prisoners arriving in Reception must always be offered immediate admission to a stabilisation unit.'[142] Mr Adakite did not admit to problem with opiate abuse on reception, although a urine test on 8 June showed that he tested positive for methadone and the notes from his review on the 10 June showed that he was on a 14-day methadone detoxification process. However, HMP Birmingham confirmed that Mr Adakite was not on IDTS.

The clinical reviewer has commented as follows: 'He had a diagnosis of Hepatitis C, a blood-borne viral infection associated with intravenous drug use, which causes chronic liver damage. He suffered from epilepsy and was taking anti-epileptic medication to prevent seizures. During the period of the review no seizures were reported, but on the day of the assault, it may well have been that he suffered a seizure after the head injury. He suffered from a chronic enduring mental health problem, for which he was taking both oral and injected antipsychotic medication. A diagnosis of schizophrenia was recorded in the clinical record and on 13th June 2011, Dr 5 considered that he was suffering from a drug or stimulant induced acute worsening of his chronic, possibly depressive psychosis. For this reason, he was treated with a combination of both antipsychotic and antidepressant medication.'

[141] Clinical Record Mr Adakine dated 10 June 2011

[142] PSI 45/2010 Integrated Drug Treatment Services paragraph 5.6

The clinical reviewer identified that Mr Adakite was a problematic drug user and was dependent on heroin and crack cocaine. The use of drugs exacerbated his mental health problems and also led to physical health problems. He was also nicotine dependent and on the 10 June, with the Governor's discretion, he was issued with a tobacco pack.

Finding 1

We conclude that the procedures in PSI 52/2010 and PSO 3050 (applicable to early days in custody and to continuity of health care respectively) were followed to a good standard in relation to Mr Adakite. Staff monitored Mr Adakite's safety and well-being throughout the first night in prison, and action was taken to address his immediate health issues.

Finding 2

The overall health care Mr Adakite received whilst a serving prisoner at HMP Birmingham was equivalent to that he could have expected in the community.

Finding 3

In relation to Mr Adakite, the standard of note-keeping in the SystmOne clinical record was to an acceptable standard and the majority of the clinical entries were accurate, detailed and commented on further plans for follow-up. Care planning was evident; especially with follow-up depot injections, dressing reviews and Assessment, Care in Custody and Teamwork reviews, as well as both general nursing and mental health reviews.

Finding 4

We conclude that there were shortcomings with the health-screening process carried out when Mr Adakite arrived at HMP Birmingham as it relied on questions being answered truthfully and did not include sufficient scrutiny of existing records.

Recommendation 1 to Birmingham and Solihull Mental Health NHS Foundation Trust

A brief review of the available SystmOne medical record should be made by staff prior to performing initial health screening to validate the answers made to the template driven questions.

3.2 How was the ACCT process managed?

PSI 52/2010 requires that if a prisoner is identified as being at risk of suicide or self-harm an ACCT must be opened.[143]

It is recognised that first night in custody is one of the most stressful times for prisoners, because family and community links have been broken and the future is uncertain. Many self-inflicted deaths and self-harm incidents occur within the first 24 hours, the first week, and the first month, so extra emphasis must be placed on tackling safer custody issues during the first 24 hours and beyond.

Although new guidance was issued in 2011, PSO 2700 (Suicide Prevention and Self-harm Management) was in force at the time of Mr Adakite's reception. It also required that special care was afforded to newly received prisoners. In particular, for prisoners recalled to custody, as Mr Adakite had been, the PSO required that checks for risk to self were undertaken.[144] Documentation demonstrates that it was established that he had previously tried to kill himself and it was also documented that back records were requested from HMP Risley. Appropriate care was given to Mr Adakite on his first two days in custody and in the absence of any thoughts of self-harm, it would not have been appropriate to place him on under the ACCT process at that time.

However, following self-harm on 9 June, in accordance with PSO 2700,[145] an ACCT document was opened. He was relocated to the first floor of D Wing, the

[143] PSI 52/2010, paragraph 2.33

[144] PSO 2700 Suicide Prevention and Self-harm Management paragraph 4.8.4

[145] PSO 2700 Suicide Prevention and Self-harm Management paragraph 13.3.1

First Night Centre, which would be appropriate to allow closer observation by staff and the level of supervision was set in accordance with PSO 2700.[146] In the absence of the ACCT form, which would have recorded Mr Adakite's location, it is not clear whether or not the cell was a shared cell. However, Staff Nurse 1 told us that cells on the ground floor were double cells, although the cell certificate showed that 10 out of the 12 cells on the ground floor were shared cells. A shared cell would have been most appropriate in these circumstances as there does not appear to be any contraindications to cell-sharing in the assessment of Mr Adakite. Cell-sharing is known to help reduce feelings of loneliness and provide both with someone to talk to. Cellmates can also inform staff if they are particularly worried about their companion.

Staff Nurse 1 told us that she did not think it was necessary to place Mr Adakite in the Healthcare centre, but a governor overrode this decision and as a result Mr Adakite was placed under constant supervision. Constant supervision is where a prisoner is supervised by a designated member of staff on a one-to-one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly. Due to all constant supervision cells being used on Ward Two, he was placed on Ward One. Ward One is normally used for patients with a physical illness and Ward Two for patients with mental health problems. In normal circumstances, Ward Two would have been more suitable; but, given that the other constant supervision cells were occupied, Ward One was the next most suitable location. This was also in accordance with PSI 52/2010 which required that, 'Where appropriate, following medical assessment, new prisoners may be located in Healthcare or a detoxification unit, or, if appropriate, a vulnerable prisoners unit or segregation unit'[147] and that 'when allocating prisoners to their accommodation for their first night in the establishment, and subsequently, staff must take account of the requirement to manage any risk of harm to or from others, and any risk of suicide or self-harm.[148]

[146] Clinical Record Mr Adakine dated 9 June 2011

[147] PSI 52/2010, paragraph 3.11

[148] PSI 52/2010, paragraph 3.12

Without the ACCT document, it is also not possible to know whether conversations and observations were completed at the required intervals, whether all events relevant to the care of Mr Adakite were appropriately noted in his ACCT, the quality, frequency and attendance at case reviews and whether there was ongoing quality check of the form. However, the quality and quantity of entries made in the clinical record were detailed and timely and included actions to reduce the risk of self-harm, identify support and deal with his mental health problems. The decision to remove the constant supervision was appropriate given Mr Adakite's improvement in mood.

Finding 5

We conclude that the decision to locate Mr Adakite to Ward One was a sensible precaution because he was at risk of further self-harm and that it was appropriate to move him to Ward Two because that was the location for patients with mental health conditions.

Finding 6

From our investigations we conclude that the Assessment, Care in Custody and Teamwork process was managed appropriately with effective planning and regular reviews. However, in the absence of the Assessment, Care in Custody and Teamwork document, it was not possible to assess whether the quantity of interactions was in-line with the plan and whether there was quality interaction with Mr Adakite.

3.3 How well did staff respond to the assault on 16 June 2011?

Officer 16 responded appropriately when he discovered Mr Adakite in the shower area by calling for assistance and an ambulance. Other staff also responded quickly to the emergency. Officer 9 gave priority to securing Mr Lamproite in his cell and staff also ensured other prisoners were locked up. The ambulance was allowed into the prison and escorted to the scene in a timely manner.

The Clinical Reviewer has identified that, 'The First Aid response to the assault on the 16th June 2011 was appropriate. Staff arrived timely and the correct

equipment was used. An emergency ambulance was called at 1047 (within 2 minutes of the incident) and arrived at HMP Birmingham at 1058. This is outside of the community target 8-minute response for Red 1 Ambulance emergencies, but the triage of the dispatch to the paramedic responders is not known. Staff appropriately secured his airway and administered high flow oxygen whilst waiting for the paramedic responders, who took over his management at 1100.'

It is also clear that non-clinical staff made appropriate decisions in identifying that the recess area was a potential crime scene. The scene was secured and a log was maintained of those entering and leaving the area. Clothing of both Mr Lamproite and the other prisoner in the shower was removed and treated as evidence. A hot debrief took place and support was offered to prisoners on Ward 2. Attempts were made to contact Mr Adakite's next of kin and, when contact was made, a Family Liaison Officer was dispatched to the hospital. The Control Room kept a log and the incident was correctly reported to Prison Service Headquarters using the incident reporting system.

We were unable to assure whether or not staff involved received adequate support. It is clear from Officer 9's interview that he felt unsupported and there is only one reference to the involvement of the Care Team and this is in an undated and unsigned document.[149]

[149] Transcript of Interview with Officer 9 on 19 July 2016, page 6

Finding 7

We conclude that staff responded well following the assault on Mr Adakite and that he received a good standard of care until paramedics arrived.

Finding 8

We conclude that non-clinical staff acted appropriately to ensure that the paramedics could access the scene promptly, to preserve evidence at the crime scene and to support those affected by the incident.

3.4 How well was Mr Lamproite managed on first reception into HMP Birmingham on 3 May 2011?

On initial reception, a CSRA was completed in accordance with PS1 9/2011, which had implemented a new CSRA form on 4 April 2011. A CSRA is an essential tool in the identification of prisoners at risk of seriously assaulting or killing a cell-mate in a locked cell and other locations when space may be shared, such as unsupervised holding areas. PSI 9/2011 is explicit about the factors that have historically been shown to heighten the risk that a prisoner may murder or seriously assault another prisoner in a cell. These include repeated violence in custody.[150]

The PSI required that 'every time a prisoner is transferred to another establishment, the sending prison must ensure an up to date CSRA form accompanies the prisoner as part of the transfer documentation. The CSRA will be up to date unless it has been superseded by a further CSRA form or a CSRA review. These must be read before location decisions are made by receiving closed prisons where there is an option other than single cell occupancy. The current assessment is also recorded on NOMIS.'[151]

On transfer to Birmingham, the staff should have referred to the most recent cell-sharing risk assessment review, which had been completed at Nottingham on 8

[150] PSI 9/2011 Paragraph 1.14

[151] PSI 09/2011 paragraph 6.1

January after Mr Lamproite assaulted his cellmate. It should have been read before Mr Lamproite was located in Birmingham. This review was summarised on the NOMIS transfer report but the CSRA review documentation was not supplied to the internal investigation, nor was it supplied with the documentation received from HMP Birmingham. We conclude that it did not travel with Mr Lamproite's core record. However, the P-NOMIS entry should have alerted staff that Mr Lamproite should not be located in a shared cell.

A new CSRA was completed but this identified that there were no issues or concerns. However, three boxes were ticked on the form: officer's observations warrant (current charge or offence), PER (violent behaviour in police, court, PECS custody). The officer should have specified on the form the reason for ticking the box next to Officer's observations. For example, if he had concerns about Mr Lamproite's body language or demeanour, he should have given this as the reason for ticking the box. We believe that the Officer completing the assessment was the same member of staff that assessed Mr Lamproite on first reception into HMP Birmingham on 3 December 2010. It may be that when he saw his previous assessment, but not the subsequent review in Mr Lamproite's record, he made the assumption that there had been no increase in risk since first reception and the review of other information was therefore cursory.

Detailed guidance for completing the CSRA form was given in PSI 9/2011 and additionally training should have been delivered for staff involved in the reception/first day assessment.[152] The training plan for the prison should have included this requirement.

The healthcare assessment on the CSRA identified that there were no indications from available records or their own observations that would indicate that there was immediate risk that Mr Lamproite might assault his cellmate.[153] Echoing similar concerns about a failure to fully check records we noted in relation to Mr

[152] PSI 9/2011 paragraph 1.4

[153] PSI 9/2011 paragraph 2.8

Adakite, the clinical record did in fact include a comment dated 27 April 2011 by a Community Psychiatric Nurse at HMP Nottingham, regarding his fitness to plead in the upcoming court case and that he had assaulted another inmate.

We noted that the recent inquiry into the homicide of a child by a recently discharged prisoner from HMP Birmingham contained a recommendation that, 'HMP Birmingham (Healthcare) should ensure that prisoner self-disclosure of their past physical and/or mental health history is not the only resource of information utilised upon their reception to the Prison when other records are/could be available'[154].

PSI 9/2011 specifically mandates that, 'All information relevant to cell sharing risk held in NOMIS must be used to carry out initial assessments and reviews'[155]. However, the reception officer completing the CSRA only ticked the boxes to indicate that he had checked the warrant and the PER rather than also P-NOMIS or any other source of information. A check on P-NOMIS would have alerted staff to a significant history of violence because P-NOMIS includes notes on prisoner behaviour.

Failure to check P-NOMIS is particularly disappointing as there was a P-NOMIS violence alert on the PER form.

P-NOMIS records should have been used to inform the risk assessment and if the entries by the officer were considered insufficient to have made Mr Lamproite a high risk on a Cell Sharing Risk Assessment, then his previous history certainly would have done. In addition, we have been unable to establish the reason for Mr Lamproite's P-NOMIS record containing an entry recording the CSRA dated 3 May 2011 as high.[156] This entry does not agree with the paper CSRA which recorded Mr Lamproite's assessment as standard.

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[154] Homicide Investigation Report into the Death of a Child chaired by Dr Alison Reed, page 87 (September 2014) STEIS Reference 2013/7122

[155] PSI 9/2011 Paragraph 10.1

[156] P-NOMIS Transfer Report for Mr Lamproite page 17 of 22

Finding 9

We conclude that the Reception Officer at HMP Birmingham failed to properly complete the Cell Sharing Risk Assessment on Mr Lamproite as no reasons were given for the indicators being circled on the operational assessment of the Cell Sharing Risk Assessment.

Finding 10

The violence identified on the Person Escort Record form relating to Mr Lamproite was not explored. We also conclude that the Prison National Offender Management Information System record relating to Mr Lamproite was not examined in order to check whether there was any reason why Mr Lamproite could not share a cell.

Finding 11

We conclude that the nurse completing the Cell Sharing Risk Assessment on Mr Lamproite did not adequately check the previous entries in the clinical record.

Recommendation 2 to HM Prison and Probation Service

Cell Sharing Risk Assessments should be quality-assured to ensure that they are properly evidenced and, in particular, that the relevant Prison National Offender Management Information System transfer record has been checked prior to a particular prisoner being located in a shared cell.

Recommendation 3 to the Director of HMP Birmingham

Managers at HMP Birmingham should ensure that all staff involved in the initial assessment of prisoners on reception receive appropriate training.

Recommendation 4 to the Director of HMP Birmingham

Managers at HMP Birmingham should remind staff of the factors that can lead to an increased likelihood that a prisoner will harm his cellmate.

Recommendation 5 to the Director of HMP Birmingham

Managers at HMP Birmingham should remind staff completing Cell Sharing Risk Assessment forms and reviews that Prison National Offender Management Information System holds previous Cell Sharing Risk Assessments and review decisions as well as adjudication histories (current and previous sentences) and notes on prisoner behaviour.

3.5 Was information about the risk posed by Mr Lamproite supplied to HMP Birmingham staff in a timely manner?

There is considerable evidence to show that SIRs were processed ineffectively at Nottingham. For example, on 23 April 2011, an SIR was submitted alleging that Mr Lamproite was targeting prisoners who he believed were sex offenders or had racist views. This SIR was not completed until 5 May, two days after Mr Lamproite was transferred from Nottingham to Birmingham. In addition a further SIR about Mr Lamproite's propensity to assault those of racist views or wife abusers was initiated on 18 March but not completed until 30 March. This is well outside the required timescale to process SIRs within the maximum timescale of 72 hours.[157]

Information concerning an adjudication on Mr Lamproite, relating to an assaults on two other prisoners, was not received at HMP Birmingham until the 16 May via post. This adjudication had taken place on the 2 May. We tried to establish the reason for the delay in sending documentation from Nottingham. However, due to the time that had elapsed since the transfer took place it was not possible to establish the reason.

[157] Material from the National Security Framework

This information would have been critical in enabling an accurate assessment of Mr Lamproite on arrival at Birmingham and, if provided, is likely to have changed his initial assessment on his CSRA from standard to high. The failure to forward the security file is particularly disappointing given that Mr Lamproite was identified as a Prominent Nominal and was subject to increased monitoring by the Security Department.

The relevant section of the National Security Framework that was in place at the time of the assault specified that the security file should be double enveloped and sent with the escort on transfer. This may not have been possible in the case of Mr Lamproite, because the transfer to HMP Birmingham occurred following a court appearance. In this instance, the security file should have been sent urgently and securely by post to an authorised person in Birmingham's security department. Additionally, there should have been communication by Brent of any essential information within the Security file that Birmingham's Security Department needed to know about Mr Lamproite to counteract the threat of violence.[158]

Finding 12

We conclude that security information about Mr Lamproite was processed ineffectively at HMP Nottingham and that there was an unacceptable delay in passing information to HMP Birmingham following Mr Lamproite's transfer via court.

Recommendation 6 to HM Prison and Probation Service

When a prison security department receives critical security information from a sending establishment outside the prescribed timescales, this should be communicated to the Governor at the sending prison so that remedial action is taken to rectify any system failures.

[158] Email from Central Intelligence Bureau Manager (NOMS) dated 12 January 2010 – The Security File Accompanying the Escort

3.6 Did staff act on the information supplied about Mr Lamproite properly?

When information was received at Birmingham, P-NOMIS records indicate that the Duty Governor and wing staff were informed. Despite this, there is very little documented about Mr Lamproite's behaviour between his arrival at Birmingham and the assault on his cellmate on 4 June 2011. Disappointingly, although a P-NOMIS entry was made that Mr Lamproite would be monitored and managed robustly to prevent any further violent outbursts, there is no evidence that any monitoring or robust management took place. There is no evidence of residential staff or the violence reduction coordinator speaking to Mr Lamproite to make him aware that any repetition of the behaviour that he displayed at Nottingham would not be tolerated and that sanctions would be imposed. Neither was Mr Lamproite encouraged to address the causes of his violent behaviour.

There was no documented review of his CSRA or consideration of whether his level on the Incentive and Earned Privileges scheme (IEP) should be reduced or whether he should be placed on the Violence Reduction Strategy There is no documentation to take into account the weight given to the information received about Mr Lamproite's VR and IEP status and adjudication history compared to his behaviour in the two weeks that he had been at HMP Birmingham.

There are no entries on the record of follow-up action by discipline staff or healthcare until the assault took place on Mr Lamproite's cellmate on 4 June. He remained standard on CSRA, and was allowed to share a cell and consequently was able to assault his cellmate.

This is contrary to PSI 09/2011, which states, 'It will be necessary to review all high risk assessments, either when risk factors change or when offender management reviews take place. The timing for these reviews is determined by the nature of the risk. It will also be necessary to review standard risk

assessments where new or additional information becomes known which indicates increased risk.'[159]

Further guidance states that, 'However, because risk factors can be identified at any time, there must be a local policy to enable a rapid referral where an immediate decision is required; Where urgent concerns are raised that a standard risk prisoner should be increased to high risk, a decision can be taken by the duty governor (or any manager authorised by the Governor / Director) at any time. Having authorised an increase to high risk, the case would need to be reviewed and agreed at the next multi-disciplinary team meeting'.[160]

Whilst PSI 09/2011 required that when new information is received that was not available on reception that an immediate decision on the CSRA level can be taken by the Duty Governor / manager, but will need to be reviewed by the multi-disciplinary team when it next meets[161], there is no action identified in the PSI about what should follow if the Duty Governor (or other manager) deems that the prisoner should remain standard risk.

Due to lack of documentation, it is not possible to know for certain whether there was a failure to review Mr Lamproite's cell-sharing risk assessment or whether there was a review and a decision made to keep Mr Lamproite's CSRA as standard. In the absence of any review on the CSRA form and given the significant recent history of assaults, a decision to keep Mr Lamproite as standard would have been perverse. As a result, we conclude that no review of the CSRA took place. Failing to change Mr Lamproite's CSRA to high resulted in Mr Lamproite being able to share a cell and gave him an opportunity to assault his cellmate on 4 June. As a result of that assault, he was located in the Care and Separation Unit, his mental health deteriorated and he was subsequently moved to Healthcare, which in turn placed him in contact with Mr Adakite.

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[159] PSI 09/2011 Cell Sharing Risk Assessments paragraph 7.1

[160] PSI 09/2011 Cell Sharing Risk Assessment Appendix 4 Paragraph 1.8

[161] PSI 09/2011 Cell Sharing Risk Assessment Appendix 4 – 1.11

Following the assault on his cellmate, Mr Lamproite would have been categorised as a mandatory high risk because prisoners who have severely assaulted cellmates must be categorised as mandatory high risk because of the on-going, static nature of the risk they pose. We requested a copy of the investigation into the assault on Mr Lamproite's cellmate, but were informed that although a police investigation had taken place, no internal investigation had been commissioned.[162]

Finding 13

We conclude that staff at HMP Birmingham failed to act on the information that was supplied about Mr Lamproite properly. In particular, no review of Mr Lamproite's Cell Sharing Risk Assessment took place and this contributed directly to the assault on Mr Lamproite's cellmate on 4 June 2011.

Finding 14

We conclude that there was no investigation of the factors leading to the assault by Mr Lamproite on his cellmate on 4 June 2011, which may have identified shortfalls in the earlier Cell Sharing Risk Assessment process at HMP Birmingham.

Finding 15

There was little evidence that staff actively managed Mr Lamproite in a way that would reduce his risk of violence towards other prisoners before he committed an assault on 4 June 2011.

Recommendation 7 to the Director of HMP Birmingham

Staff at HMP Birmingham should receive refresher training on the completion of Cell Sharing Risk Assessment reviews following the receipt of new information.

[162] Email from Prison Liaison Point 1 to Andy Smith 22 August 2016

Recommendation 8 to the Director of HMP Birmingham

Managers at HMP Birmingham should ensure that the violence reduction strategy is applied to prisoners who have displayed recent violent behaviour in previous prisons as well as in HMP Birmingham. This should include:

i. applying a multi-disciplinary approach and identifying factors which trigger their violent behaviour; and
ii. developing a management plan, which aims to reduce risk and change behaviour.

3.7 How well was Mr Lamproite managed in the Care and Separation Unit between 4 - 7 June 2011?

Following the injury sustained as a result of the assault on his cellmate on 4 June, Mr Lamproite received appropriate treatment, including being sent to outside hospital and because the nurse identified his history of assaults and strange behaviour, including hearing voices, a referral was made to mental health.

As Mr Lamproite had been located in the CASU, the Initial Segregation Health Screen was completed to determine whether there were any apparent clinical reasons to advise against the use of segregation.[163] The clinical reviewer noted that the nurse recorded that Mr Lamproite engaged with the assessment and 'denied any history of hearing voices, no paranoid ideation, no thoughts of self-harm or suicide and that he had never taken prescribed medication for mental health, nor had he been admitted to hospital – which was not correct as he had been admitted to a medium secure unit in July 2006, and this could have been ascertained through scrutiny of the available SystmOne medical record.'

PSI 17/2006 required that the doctor must visit each prisoner in segregation as often as their individual health needs dictate and at least every three days. A registered nurse or healthcare officer must make the assessment on all other

[163] Initial Segregation Health Screen, incorrectly dated 4 May 2011

days, so that a member of healthcare staff visits the prisoner on a daily basis. Healthcare staff must assess the physical, emotional and mental well-being of the prisoner and whether there are any apparent clinical reasons to advise against the continuation of segregation (including cellular confinement). If healthcare staff have any concerns about a particular prisoner, guidance may be sought from other healthcare colleagues or the Head of Healthcare. It might be necessary to have a multi-disciplinary case conference to consider all the issues. A note of each visit (by a member of healthcare staff) must be made in the prisoner's clinical record.[164]

According to the CASU log either a doctor or a registered nurse visited Mr Lamproite daily in the CASU, but the visit on 5 June was not documented in the clinical notes.

Additionally, PSO 1700 on segregation required that a greater emphasis was made on maintaining the safety of prisoners in segregated environments. Positive regimes and activities were encouraged to act as a diversion to the boredom and loneliness of segregation. The segregation unit records show that there was minimal meaningful engagement with Mr Lamproite. He had access to an in-cell television as his mental health was a concern and he was also offered time in the fresh air and a shower. It should be noted however, that the HM Inspectorate of Prisons inspection in 2014 commented that the segregation unit was bleak and the exercise yard was featureless.[165]

He was reviewed again on 6 June and again denied any mental health issue. The nurse decided to continue to monitor him. A multi-disciplinary team meeting took place and it was decided to admit Mr Lamproite to Ward Two in Health Care and that the forensic team should review him on 9 June. It was also decided to liaise with HMP Nottingham Mental Health In-reach team to obtain information, although no further information was forthcoming.

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[164] PSI 17/2006 Annex A, paragraphs 4 - 6

[165] Report of an unannounced inspection of HMP Birmingham, by HM Chief Inspector of Prisons, 24 February – 7 March 2014, page 28, paragraph 1.71

It is clear that there was a degree of doubt about the state of Mr Lamproite's mental health. During his interview, Dr 19 explained:

"I think it can be quite perplexing to a lot of people when patients are admitted to Ward 2, the mental health ward, and sometimes when patients aren't. 'Cause sometimes you'll often have officers who are concerned about a patient, and the, the staff who assess him feel he isn't appropriate for Ward 2. Sometimes, they can simply be moved there for a period of assessment, and they can be discharged with no diagnosis of mental health problems at all. What we often had – I don't know if it was at that point – is patients who remained in Seg for a long time would often go to Ward 2 for a period of assessment, not particularly because there was a definite concern about mental health problems; but I don't know if that was what went on at that time – that was some time ago, now again. I don't remember what his indication would've been to go to Ward 2; but I certainly remember there was concerns about him generally – whether it was a personality issue, or more than that. But, yeah, it's always, it's always tricky ..."[166]

Finding 16

We conclude that although there is no evidence that being segregated contributed to a deterioration in Mr Lamproite's mental health, the physical environment might have had a detrimental impact.

3.8 Was Mr Lamproite's supervision level set appropriately on arrival in the Health Care Unit on 7 June 2011?

When he arrived in the Health Care unit, he was correctly assessed as Level A under the Healthcare Safe Supervision of Prisoners (in-patients) policy.

The initial review appropriately identified that Mr Lamproite had assaulted others, and as a result, he was placed on level A to ensure that the risk of harm to staff

[166] Transcript of Interview with Dr 19 on 18 July 2016, page 10 - 11

and other prisoners was minimised. Given the comments that had been made in the overview document of patients on Ward Two about his history of serious assault and doubt about his mental health, this was entirely appropriate.

The Safe Supervision of Prisoners (in-patients) document partially met the requirement in Standard 22 Health Services for Prisoners[167] to produce guidelines for the management, care and treatment of patients exhibiting challenging behaviour, including guidance on the rare use of seclusion in the Healthcare centre for managing prisoners exhibiting challenging behaviour as a result of their mental illness and maintenance of a register of use.

However, there was an absence of detail to assist staff in managing prisoners exhibiting challenging behaviour. In particular, the ongoing assessment specified the frequency of reviews but not the information to be considered.

Finding 17
We conclude that the supervision level for Mr Lamproite was set at the appropriate level on arrival in healthcare.

Recommendation 9 to the Director of HMP Birmingham
The Safe Supervision of Prisoners (in-patients) policy should be reviewed in consultation with Birmingham and Solihull Mental Health NHS Foundation Trust and further guidance should be included on managing patients with particularly challenging behaviour.

3.9 How well were Mr Lamproite's mental health needs assessed and treated while in the Health Care Unit between 7-16 June 2011?

PSO 3050 Continuity of Healthcare for Prisoners required that information is sought from the prisoner's GP or other relevant service he/she has recently been in contact with. The prisoner's explicit consent should be obtained before doing this, although in exceptional circumstances information may be requested and

[167] Standard 22 Health Services for Prisoners paragraph 23.2

disclosed without consent. Sources of information identified include medical records from previous periods in custody.[168]

When Mr Lamproite's back record was obtained from HMP Stocken for the purposes of this investigation, it contained Mr Lamproite's medical record, so it is evident that this source of information was not sought or received from Stocken.

Mr Lamproite was located in the Healthcare centre for little over a week, so there was limited time to complete assessments and begin treatment options. His physical health was taken care of through continuation of his prescribed medication and regular dressing of his finger injury. A care plan had been created around the dressings required to his finger.

His mental health was more complex because of his denial of his condition. For example, during the night following admission on 7 June, the clinical record reported that Mr Lamproite was observed responding to voices and talking and laughing inappropriately, but he denied any auditory hallucinations.[169]

On 9 June, Dr 12 correctly requested Mr Lamproite's medical records from the medium secure psychiatric hospital. However, we were concerned that there was no evidence that these records were obtained.

Although Mr Lamproite did not accept the diagnosis of schizophrenia, he did confirm that the argument and fight with his cellmate had been the result of hearing command auditory hallucinations. It was documented that following his discharge from the medium secure psychiatric hospital, he had not engaged with the Forensic Community Mental Health Team, but an appointment was made for him to see the Forensic Team to assess his level of need for medium or secure services.

[168] PSO 3050 Continuity of Healthcare for Prisoners paragraph 2.1

[169] Mr Lamproite Clinical Record 8 June 2011

His risk towards paedophiles and female staff had been quickly identified in a Management of Aggression Care Plan. It was also planned to monitor his behaviour, record the nature of the auditory hallucinations and encourage him to take anti-psychotic medication, when prescribed. The care plan was due to be reviewed on 16 June 2011. There was concern that he appeared to be developing psychosis. It is commendable that staff had encouraged Mr Lamproite to consider taking anti-psychotic medication.

Staff also became aware that Mr Lamproite had been admitted to psychiatric hospitals and had a diagnosis of schizophrenia. It was correct to create a high priority reminder on the front page of SystmOne record about his psychiatric history and history of assault on others. Staff expressed concern that although he appeared stable that he was able to mask his symptoms. Ward Manager 14 documented that he presented a high risk to others and it appeared that the ideas he formed about others being sex offenders were delusional in nature.[170] However, it is disappointing that the conclusion that Mr Lamproite should not to be left alone with females was not also applied to those for whom there was a risk that Mr Lamproite might believe were sex offenders.

Finding 18

We conclude that there was good communication with Mr Lamproite about his mental health and that it was a positive development that healthcare staff encouraged him to consider taking anti-psychotic medication.

Finding 19

We found that in relation to Mr Lamproite, there was appropriate care-planning by healthcare staff.

Finding 20

We conclude that when recommending that Mr Lamproite should not be left alone with female staff, that there should also have been consideration of how to reduce

[170] Mr Lamproite Clinical Record 10 June 2011

the potential risk to prisoners who Mr Lamproite may have identified as sex offenders.

Recommendation 10 to Birmingham and Solihull Mental Health NHS Foundation Trust

There should be an effective system for following up requests for medical records if these fail to arrive.

3.10 How effective were the evaluations of Mr Lamproite's behaviour?

The Safe Supervision of Prisoners (In-patients) policy requires daily reviews of prisoners on level A, but the risk assessment form for Mr Lamproite shows no evidence of any reviews between 7 June and 16 June. Of greater concern is that the review that took place on 16 June was inadequate in almost all respects. The review fails to justify the reason for changing the level to B.

For example, the review did not take into account that only five days previously that although Mr Lamproite presented as very stable, he was able to mask symptoms and presented a high risk to females. Although he had not presented with any overt symptoms of mental illness, it was recognised that his history indicated that he was a risk. Whilst appreciating that it was difficult to assess Mr Lamproite when he spent considerable time locked up and that is not in their best interests to keep a prisoner for a long period on a very restricted regime, it had been only nine days since Mr Lamproite had been located in healthcare. His prison medical record had not been retrieved from his last prison and contact had yet to be established with the medium secure psychiatric hospital where he had been previously held. Staff Nurse 1 could not remember the reasons for reducing the supervision level on Mr Lamproite[171], but Officer 16 said that managers felt that Mr Lamproite had been settled for a week and was complying with the

[171] Transcript of Interview with Staff Nurse 1 on 18 July 2016, page 4

regime.[172] Officer 9 said that the managers wanted Mr Lamproite out of his cell for a medical assessment.[173]

Neither Ward Manager 14 nor Deputy Ward Manager 17 could remember the review meeting[174], although the later had written after the assault that, 'it was decided by that his unlock status should be relaxed to level B'.[175] Officer 9, Officer 16 and Staff Nurse 1 were clear that their view had been that level A should be maintained. However, Healthcare Senior Officer 15 stated that, "if you want to review and assess somebody you've got to have an opportunity to do it, and because the time allowed out onto Level A is so limited, it's difficult to get a clear impression and idea of, of how he is. And so, at some point, you have to try and assess people. You know, yes, we were aware of his history but we have to try and manage risk, and I've worked in prison … I did work in prisons for, in one role or another for, for 30 years and you, you try and manage risk and the outcome isn't always what you predict."[176] We felt that the managers' view at the review may have been partially influenced by Mr Lamproite's complaints that he did not have as much association time as others and wanted to be taken off Level A unlock.

We were told that reviews of all in-patients took place at morning meetings of managers, uniformed and healthcare staff on Ward Two, but that these were not documented so it was not possible to monitor any concern, deterioration or improvement in Mr Lamproite's attitude and behaviour over time. Uniformed and healthcare Staff both believed that it was the others responsibility to enter the information. This is contrary to the requirements of NOMIS, which exists to give all staff access to relevant information.

[172] Transcript of Interview with Officer 16 on 18 July 2016, page 4

[173] Transcript of Interview with Officer 9 on 19 July 2016, page 4

[174] Transcript of telephone call with Ward Manager 14 dated 17 August 2016, page 2 and Deputy Ward Manager 17 dated 26 July 2016, page 1

[175] Clinical Record Mr Lamproite dated 16 June 2011

[176] Transcript of interview with Healthcare Senior Officer 15 on 18 July 2016 page 3

At interview, Officers identified reasons why they felt uncomfortable in Mr Lamproite's presence but no specific incidences were documented on Mr Lamproite's NOMIS record. PSI 73/2011 P-NOMIS states that 'staff from all areas of an establishment who have contact with an offender and who have access to P-NOMIS are able to enter comments into case notes. Comments are immediately available to all staff who have access to an offender's record'.[177] The PSI gives further guidance on healthcare comments, namely that Health and Mental Health staff who regularly engage with particular offenders should also add case notes but that these entries must not detail the private medical issues of offenders but should focus on behavioural issues or detail specific issues that might help the care of the offender by staff generally.[178]

Further, the restrictions that Mr Lamproite would remain in public areas and not go into anyone else's cell were unspecific as they failed to define a public area. Arguably, the recess is a public place, although the stall within it would be a private place. The staff on duty did not challenge Mr Lamproite when he attempted to enter the recess, although they recognised its vulnerability as an area where assaults take place.

Although his supervision level had been reduced, Mr Lamproite was still high risk on his CSRA. This covers not only cells, but also other shared space, including unsupervised holding rooms. Although recess areas are not specifically mentioned in PSI 9/2011, it is not unreasonable to expect that a recess area, which is not heavily supervised, would fall under the same criteria.

Finding 21

We conclude that failure to document concerns about Mr Lamproite led to the review on 16 June 2011 having insufficient evidence to properly evaluate whether his level of supervision should be changed.

[177] PSI 73/2011 paragraph 4.3

[178] PSI 73/2011 paragraph 4.23

Finding 22

We conclude that there were no formal and recorded daily reviews of Mr Lamproite as stipulated in the Safe Supervision of Prisoners (in-patients) policy.

Finding 23

We conclude that failure to obtain medical history about Mr Lamproite from his previous prison or from the medium secure psychiatric hospital contributed to poor decision-making at the review meeting on 16 June 2011.

Finding 24

We recognise that managers were seeking to provide an environment to better assess Mr Lamproite, to improve his regime level and indirectly those of others, who had previously been locked up when Mr Lamproite was allowed out of his cell. However, we conclude that inadequate safeguards were in place because Mr Lamproite was allowed to go out of sight into the recess.

Finding 25

We conclude that insufficient weight was given to Mr Lamproite's recent assaults on other prisoners and his propensity to target those who he suspected were sex offenders or held racist views and that the inadequate review on the morning of 16 June 2011 directly led to Mr Lamproite being able to assault Mr Adakite.

Recommendation 11 to the Director of HMP Birmingham

Managers at HMP Birmingham should remind prison staff in contact with prisoners of the importance of documenting events in a prisoner's Prison National Offender Management Information System record.

Recommendation 12 to Birmingham and Solihull Mental Health NHS Foundation Trust

Staff employed by Birmingham and Solihull Mental Health NHS Foundation Trust should be reminded of the specific requirements in PSI 73/2011, P-NOMIS to add

case notes about behavioural issues or which detail specific issues that might help the care of the offender by staff generally.

Recommendation 13 to the Director of HMP Birmingham

Prisoners on level A of the Safe Supervision of Prisoners (in-patients) policy should be reviewed on a daily basis in accordance with that policy and that these reviews should be documented.

Recommendation 14 to the Director of HMP Birmingham

Greater priority should be given to seeking back records from previous establishments, particularly for those prisoners with complex needs or challenging behaviour, where assessments from a previous sentence may be particularly useful.

3.11 How effective was supervision on the morning of the assault?

It is difficult to know whether the number of staff available during the morning of 16 June met the requirement in the local policy that 'prisoners should not be unlocked unless there are at least three staff trained in C&R level 2 present on the ward'. Both Officer 16 and Officer 9 were definitely on Ward Two. It would appear from the police statement of Officer 9, Ward Manager 14, and Healthcare Senior Officer 15, that Healthcare Senior Officer 15 was present on Ward Two and was in a position to quickly respond, but Officer 9 was adamant that Healthcare Senior Officer 15 was not present. A further witness, who was observing a prisoner on constant supervision supported Officer 9's comment that he could see the pool table where Healthcare Senior Officer 15 had said he was located but that he was not there. We were not able to conclude whether or not there were adequate staff on the ward immediately prior to the assault.

Despite being informed of the ground rules after his review, Mr Lamproite entered the cell of another prisoner on at least one occasion and had to be told not to. This should have alerted staff that he had not grasped or was not willing to abide by the instructions that he had been given and at the very least ensured that staff maintained a proactive supervision of his movements.

Mr Lamproite was then allowed to enter the recess whilst other prisoners were using the facility. Whilst there is a small window between the nursing station on the ward and the recess, it is appropriately covered by a modesty curtain, which makes observation difficult.

Officer 16 and Officer 9 both stated that they maintained almost constant observation of Mr Lamproite even when he was in the shower area and that when they were distracted, it was for no more than 20 seconds. Given the scale of the assault on Mr Adakite and the level of injury sustained, it is likely that the assault itself took more than the 15 to 20 seconds that they stated that Mr Lamproite was not observed. Furthermore, a prisoner alleged that he witnessed the start of the assault, and then there was sufficient time for him to walk out of the shower and for approximately five minutes to pass, before he went back into the shower and saw Mr Adakite lying on the floor. This description of Mr Adakite's condition and location is consistent with staff statements and as such it is compelling. However, his description of Mr Adakite's offence as a knife attack was inaccurate and there is no apparent reason why Mr Adakite would have lied about that. Additionally, no other member of staff identified this prisoner as being in the shower prior to the assault.

On balance, the evidence indicates that the supervision of the recess was inadequate and given the concerns raised by both Officer 16 and Officer 9, we would have expected that the frequency of checking the recess whilst Mr Lamproite was located there should have been higher or that Mr Lamproite should have been advised to shower when others were not in the recess.

Finding 26

We conclude that due to the difficulty and sensitivity of supervising the recess, it would have been more appropriate to allow Mr Lamproite to use the recess separately.

Finding 27

We conclude that poor supervision of the recess directly led to Mr Lamproite being able to assault Mr Adakite.

Recommendation 15 to HM Prison and Probation Service

Recess areas should be added to the list of examples of locations where a prisoner with a high-risk cell-sharing risk assessment should be prevented from using with other prisoners.

Recommendation 16 to HM Prison and Probation Service

Good practice guidelines should be published on the supervision of recess areas to cover standard risk and high-risk prisoners.

Part 4. Concerns raised by the family about the treatment of Mr Adakite before and after the incident

4.1 Issues Raised

At the beginning of the investigation, we met with Mr Adakite's mother and aunt to ascertain their views about the incident.[179] The family informed us that they had been told by various officers that Mr Lamproite had been on a three-officer unlock. The "girl in charge of security" had decided that they could not afford to keep three officers supervising him, so they took him off the three-officer unlock. The family wanted to know if she had been brought to account or punished for this decision.

The family were concerned that the prison knew about Mr Lamproite's background of assaults, but did not take this into account or give it adequate weight when making the decision to allow him access to other prisoners. One of the officers apparently said that, "[Mr Adakite] was in the wrong place at the wrong time". Mr Adakite's aunt said that they should have checked that the shower was empty before they let Mr Lamproite go in there. The family were also concerned that vulnerable prisoners were mixed with violent ones.

The family were also concerned about the restraints applied while Mr Adakite was in hospital. For example, they said that they thought that Mr Adakite should not have been restrained when he was in a coma. They were also unhappy about the behaviour of some members of staff and said that when Mr Adakite came out of the coma, he wanted to have a cigarette. They alleged that staff refused to take him out so that he could have a cigarette and that subsequently others refused to push him in his wheelchair down the corridor to say goodbye to his family after they visited. However, they felt that most members of staff were helpful and acted properly.

[179] Note of a Meeting with the family of Mr Adakite dated 5 January 2016

Finally, the family were disappointed that no one had apologised for what had happened.

4.2 Response to Issues Raised

As a result of the concerns raised by the family about the management of Mr Adakite after the incident, a formal request was made to the commissioning authority to broaden the terms of reference to cover the period until Mr Adakite's transfer to another hospital on 1 December 2011. This was declined in a letter from the commissioner on 15 March 2016[180], which stated that whilst he understood the family's desire for me to address these issues as part of the investigation, that it was not necessary or proportionate to expand the terms of reference. However, we were advised that this did not prevent us reviewing the issues raised by the family in order to ascertain whether the actions of prison staff whilst Mr Adakite was in hospital could be relevant to the assault on Mr Adakite that took place in HMP Birmingham on 16 June 2011. If we concluded that there was evidence of a link between the actions of escorting staff and Mr Adakite's health (i.e. that their actions impeded medical treatment), then it would be appropriate for the terms of reference for the investigation to be extended.

While in hospital, Mr Adakite was still serving his sentence and prison officers were deployed to the hospital. As was normal procedure, a log was kept by prison staff detailing what was happening to Mr Adakite and the level of restraint applied to prevent Mr Adakite absconding. Decisions about the level of restraint were approved by a governor who visited him daily. We were provided with some bed watch logs, reviews and assessments but the prison was unable to locate all of them. As a result, we received no information about his behaviour or the level of restraints that applied between 07:36 on 18 August 2011 and 06:05 on 16 October 2011.

[180] Letter from Mark Taylor to Andy Smith dated 15 March 2016

Finding 28

We found no evidence that the decision to reduce the number of staff required to unlock Mr Lamproite from his cell was driven by financial considerations.

Finding 29

We agree with the family of Mr Adakite that the decision to change the level of supervision of Mr Lamproite was flawed and that the supervision of the shower area was inadequate.

Finding 30

Vulnerable and violent prisoners were in close proximity as Ward Two held prisoners with mental health problems, which were disparate in nature with varying symptoms and behaviour. We conclude that co-location was not unreasonable, provided adequate control and supervision arrangements were in place.

Finding 31

We examined the bed watch logs, assessments and reviews, which were available and the clinical reviewer studied the SystmOne medical record entries. We take the view that although the documentation we have seen in relation to Mr Adakite's time in hospital is incomplete, there was no evidence to indicate that the terms of reference for this investigation should be extended beyond the date of the original commission.

Part 5. The Inquiry Process

5.1 Other Investigations

Internal Investigation

The Deputy Director of Custody (West Midlands) commissioned a governor from another prison, to investigate the circumstances surrounding the assault upon prisoner Mr Adakite, by prisoner Mr Lamproite on Thursday, 16 June 2011 in the Healthcare Centre at HMP Birmingham. In particular: -

- Whether the flow of information concerning Mr Lamproite from prison to prison and within HMP Birmingham was appropriate
- Whether the decision-making process regarding Mr Lamproite's location within HMP Birmingham and his cell-sharing risk status was appropriate.
- Whether the procedure for placing Mr Lamproite as a 3-officer unlock and any subsequent change to this status was appropriate.
- How Mr Lamproite came to be in a position to carry out the level of assault inflicted upon Mr Adakite.[181]

The conclusions of the investigating officer were similar to our own, namely that:

'The time taken to process SIR's within HMP Nottingham is not effective and the delays present as a security risk which could cause serious risk of harm.

The time taken for SIR's to be received at HMP Birmingham from HMP Nottingham was inappropriate given the availability of technology, however, the time delays above were a contributory factor.

The time taken for Mr Lamproite's adjudication records to be received at HMP Birmingham was inappropriate however these are available electronically on P-

[181] Investigation Report, dated 21 June 2011, page 2

NOMIS and should have been reviewed.

There was a failure at HMP Nottingham to carry out the correct procedures following the assault on a prisoner in a holding cell. The CSRA and the Discrimination Incident Reporting Form (DIRF) should have been completed and an investigation carried out.

There was a failure to follow up known issues identified on P-NOMIS history sheets as noted by Governor 10 on 18 May, however his segregation record shows that he was seen by a Mental Health In-reach team who stated that there was no evidence of mental health. Later reports on 9 June contradict this. It is unclear whether information was being shared.

The decision making process at HMP Birmingham regarding Mr Lamproite's location and Cell Sharing Risk Assessment status was based on inaccurate information and there was a lack of scrutiny of the NOMIS transfer report.

The procedures for placing Mr Lamproite, on Level A and the requirement to carry out daily reviews were not adhered to at HMP Birmingham.

The changes regarding Mr Lamproite's supervision level were not clearly communicated to all staff.

The observation of the shower area was ineffective.'[182]

We agree with all of the conclusions reached by the Internal Investigation.

When we asked why we could find no evidence of a response to this investigation from managers at HMP Birmingham, the Director responded that he had received no formal documentation about the report at the time it was produced[183]. The

[182] Investigation Report dated 21 June 2011, page 5

[183] Email Prison Liaison Point 3 to Andy Smith dated 13 December 2016

Deputy Director of Custody was unable to find any evidence that the report was sent to HMP Birmingham, but found it difficult to understand why the Director did not raise it with him if this had been the case[184]. This was disappointing because it meant opportunities to learn lessons from the incident were lost.

Safer Custody Report

We made enquiries of NOMS about whether there was a visit from the Safer Custody Advisor. Neither the person who was the national safer custody manager for Birmingham at the time of the incident nor the person in the policy team with safer custody knowledge had any records to suggest that a visit to Birmingham to review safer custody related matters was arranged following the assault on Mr Adakite. This type of visit would usually be organised at the request of either the regional manager or the Director of Public Sector prisons, but we cannot find any evidence of such a request being made.[185]

Birmingham and Solihull Mental Health NHS Foundation Trust

When serious incidents occur, the NHS has a responsibility to ensure that an appropriate investigation takes place in order to review what led to the incident, identify root causes and highlight where improvements can be made. Birmingham and Solihull Mental Health NHS Foundation Trust completed an Untoward Incident Document dated 20 June 2011, [186] a Serious Incident Management Report[187] and a Serious Incident Root Cause Analysis Report dated 19 April 2012[188].

The Untoward Incident Report described the circumstances leading to the assault, immediate actions taken by staff in stabilising Mr Adakite and that the

[184] Email Deputy Director of Custody, West Midlands to Andy Smith dated 19 December 2016

[185] Email Safer Custody Caseworker to Andy Smith dated 11 July 2016

[186] Birmingham and Solihull Mental Health Trust Untoward Incident Report

[187] Birmingham and Solihull Mental Health Trust Serious Incident Management Report

[188] Birmingham and Solihull Mental Health Trust Serious Incident Root Cause Analysis

likely cause was an assault. It identified that, 'the possible assailant had been reduced from a 3 man unlock earlier in the day and was being observed as to his interactions with others. Whilst a risk assessment had been undertaken it transpires that there is no formal step down process for individuals subject to a 3 man Unlock. The ward team, in conjunction with prison staff will develop this protocol over the next 2 weeks'. Both the Serious Incident Management Report and a Serious Incident Root Cause Analysis Report dated 19 April 2012 reached the same conclusion.

We largely agree with the reviews by Birmingham and Solihull Mental Health NHS Foundation Trust, although we believe that it was more accurate to say that the procedure in place was not followed rather than there was an absence of a 'step down process'. Although the action identified to develop a protocol was appropriate there should also have been a mechanism to ensure that the policy met the requirements of Healthcare Standard 22, in particular, the addition of detail to assist staff in managing prisoners exhibiting challenging behaviour and the information to be considered.

5.2 The Independent Article 2 Investigation

The Secretary of State for Justice commissioned the present investigation under the State's obligation under Article 2 of the European Convention on Human Rights in October 2015.

The disclosure process has proved cumbersome, particularly with regard to police statements. We sought access to these in the early stages of our investigation to help us frame questions to staff. However, although they had been supplied to the original prison service internal investigating Officer, they were not supplied to us until after we had concluded our interviews with staff.

It took a considerable time to gain access to Mr Lamproite's medical record and to appoint a clinical reviewer.

We were disappointed that certain records were not available that might have assisted us. The most important of these was Mr Adakite's ACCT document from HMP Birmingham.

Some of the national and local policies in place at the time of the assault had been superseded. We were able to access current policies via the Internet or were provided with the PSOs and PSIs that were relevant, but this was not the case with local strategies on security or safer custody. Consequently, we were not always able to ascertain whether the failings were due to the local policy not adhering to national standards or whether the local policy was not implemented correctly. However, there was no requirement for prisons to retain superseded policy documents. This issue was particularly problematic at HMP Birmingham because during the transfer from the public sector to G4S, electronic copies of policies in place at the time of the transfer were lost when Quantum PCs were removed from the prison.

PSI 64/2011 specifies that in the event of a death in custody, the prison must retain, and securely store in a locked cabinet with signed access only, all documentation (except for the clinical records) relating to the deceased prisoner for investigations by the police, the PPO and the coroner's inquest – see details below on retention of documents. Additionally, staff directly involved in the incident, particularly those who were first on scene, must complete Incident Report Forms as soon as is practicable.

Documentation retained should include:

- Copies of the F2050
- ACCT documentation
- Observation books
- Staff detail documents
- Local policies and protocols in operation at the time of the incident, in particular policies on suicide prevention, IEP and segregation
- Contracts with the local PCT [Primary Care Trust]
- Any evidential CCTV footage, pin phone records and cell bell logs

- Clinical records (to include all the health records such as Care Plans and dental records) must be retained by healthcare staff.[189]

PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults specifies that, 'all documentation relating to the prisoner(s) involved in the incident (for example the core record medical record, and ACCT and CSRA forms) must be retained'.[190] The difficulty that we incurred with the retrieval of documentation is likely to be avoided if the list in PSI 15/2014 mirrored that in PSI 64/2011. We do recognise however that it may not be apparent at an early stage that an Article 2 investigation will be necessary.

In retrospect, there are aspects of this investigation that we would have done differently, but there appears no mechanism that enables newly appointed investigators to learn from the experience of others. We are certain that we needlessly repeated some of other investigators' mistakes.

Whilst recognising that it is a matter for each investigator to decide how to conduct their investigation, we felt that there could be a saving in official time and money, if some good practice guidelines in the conduct of Article 2 investigations were made available.

Recommendation 17 to HM Prison and Probation Service

All relevant documentation relating to a prisoner following an incident that may result in an investigation under Article 2 should be promptly secured.

Recommendation 18 to HM Prison and Probation Service

The list of documents to be retained as set out in PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults where an independent investigation will be necessary should mirror that in PSI 64/2011, Management of Prisoners at risk of harm to self, to others and from others (Safer

[189] PSI 64/2011 Safer Custody Chapter 12

[190] PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults, paragraph 19

Custody).

5.3 The Appropriate Level of Public Scrutiny

The Commission to conduct the Article 2 Investigation requires the provision of a view by the independent investigator about the appropriate element of public scrutiny in all the circumstances of the case. Public scrutiny forms an important aspect of the investigative obligation under Article 2 of the European Convention on Human Rights. We have considered carefully whether the publication of the final version of this report will be sufficient to satisfy the requirement for public scrutiny or whether some further stage in the investigation is needed, such as a public hearing. We have reached the view that the publication will suffice and a public hearing is not needed in this case.

In reaching this view we have considered two questions. The first is whether there are serious conflicts in the evidence, which require the questioning of witnesses in a public setting to test the credibility of what they say. There are some inconsistencies in the evidence given to us, for example about whether or not concerns were raised by some staff about the decision to reduce the level of supervision of Mr Lamproite on the date of the incident and whether or not managers were present on Ward Two prior to the incident. We were surprised that the staff involved following the incident did not produce statements before going off duty. We were told that this was because police statements were taken quickly, but in fact the police statements were taken weeks after the incident. We recognise the difficulty of remembering events of over five years previously, which may account for some of the inconsistencies.

The second question is whether the investigation has uncovered convincing evidence of widespread or serious systemic failures, such that a public hearing might be warranted to maintain public confidence.

We appreciate that staff were working in a difficult environment with prisoners who often exhibited difficult and challenging behaviour. However, we have made a total of 31 findings and 18 recommendations and it is clear that mistakes were

made and that policy and practice directions were not always followed. We take the view that had different decisions been taken at key points during the time Mr Adakite and Mr Lamproite were in HMP Birmingham the risk of the assault occurring would have been dramatically reduced. The key issues were: the decision to locate Mr Lamproite in a shared cell on his reception, the delay in receiving information from HMP Nottingham and the subsequent failure to act on it, the decision to reduce the level of Mr Lamproite's supervision on 16 June 2011 and the failure to effectively observe the shower recess.

We very much hope that our findings and recommendations will make a significant contribution to the improvement of the management of prisoners such as Mr Adakite and Mr Lamproite in the future. We do not, however, consider that any further element of public scrutiny is required in this particular case.