Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Khyber Nasim, a prisoner at HMP Pentonville, on 17 June 2021

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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

If my office is to best assist HMPPS reduce the number of self-inflicted deaths that occur in prisons then our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Khyber Nasim died from hanging on 17 June 2021 at HMP Pentonville. He was 42 years old. I offer my condolences to Mr Nasim's family and friends.

There were missed opportunities to provide Mr Nasim with additional support in the days before his death. I am concerned that staff did not understand the importance of identifying the reasons for Mr Nasim's distress and actions which might help to support him. In previous investigations into self-inflicted deaths at Pentonville we have identified similar failings.

Transport and court staff responsible for Mr Nasim during his trial on 16 June were not aware that he had harmed himself and received hospital treatment the day before.

In the three years prior to his death there had been six other self-inflicted deaths at Pentonville. His Majesty's Chief Inspector of Prisons' assessment in 2022 was that support for prisoners in crisis and those on ACCT was not good enough. The Independent Monitoring Board reported in March 2022 that information shared with transport and court staff continued to be inconsistent in accuracy and adequacy.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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Summary

Events

1. On 17 June 2020, Mr Khyber Nasim was remanded to HMP Thameside charged with assault, sexual assault, false imprisonment, blackmail and threats to kill.

2. Mr Nasim's trial started on Monday 7 June 2021, and, at the end of the court day, he was taken to HMP Wormwood Scrubs.

3. On 8 June, Mr Nasim attended court again and at the end of the court day, he was taken to HMP Pentonville. On arrival, Mr Nasim told a reception nurse and an officer on the first night centre that that he had no thoughts of suicide or self-harm. Mr Nasim attended court on the following three days.

4. In the late morning of Sunday 13 June, an officer unlocked Mr Nasim's cell and saw that he had cut his wrist. A nurse treated the injury and staff started suicide and self-harm monitoring procedures (known as ACCT).

5. At an ACCT assessment interview and an ACCT case review later that day, Mr Nasim spoke about not eating and agreed that it would help if he saw the mental health team. Mr Nasim's risk of suicide was assessed as raised and his observations were set at one an hour. An ACCT caremap was completed which contained one issue.

6. At 11.51pm on 15 June, Mr Nasim rang his cell bell and an officer found that he had cut his wrist again. A nurse attended and found that Mr Nasim had low blood pressure and she sent him to hospital for treatment. He returned to Pentonville from hospital at 3.40am on 16 June.

7. Mr Nasim went to court on the morning of 16 June, but his Person Escort Record (PER) was not noted to alert transport and court staff that he had cut his wrist the previous night. On his return to Pentonville from court that evening, Mr Nasim had an ACCT case review with two supervising officers. No nurse was present at the review. No adjustment was made to the frequency of ACCT observations.

8. Mr Nasim was checked that night at irregular hourly intervals in accordance with his ACCT plan. However, when an officer checked Mr Nasim at 5.12am on 17 June, he saw him hanging from a ligature tied to the window bars. The officer radioed a medical emergency code and went into the cell. The officer untied the ligature and nurses arrived. The nurses noted signs of rigor mortis but began cardiopulmonary resuscitation (CPR) as they knew that he was alive when checked around an hour before.

9. Paramedics arrived at 5.30am, but at 5.42am they confirmed that Mr Nasim had died.

10. Mr Nasim's cause of death was given as partial suspension.

Findings

11. We consider that there were deficiencies in the ACCT procedures. In particular, more effort should have been made to try to ensure Mr Nasim had a multidisciplinary ACCT review on 16 June following his self-harm and hospitalisation the previous night. We also consider that his caremap was deficient.

12. Mr Nasim's PER was not updated to reflect that he had self-harmed on the evening of 15 June.

13. Staff did not take any action when Mr Nasim told them that he was not eating.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:
    - ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff, where relevant;
    - ACCT caremap actions are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews;
    - case reviews consider all relevant information that affects risk; and
    - all staff in contact with prisoners are trained in ACCT procedures.
- The Governor should ensure that PERs are always updated to record relevant events.
- The Governor should ensure that staff follow the guidance in the Food Refusal Strategy when a prisoner refuses or fails to take food or fluid.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Nasim's prison and medical records. She watched CCTV footage from 8.00pm on 16 June to 7.00am on 17 June and listened to radio traffic from the emergency response.

16. NHS England commissioned Nina Murphy Associates to review Mr Nasim's clinical care at the prison. A clinical reviewer undertook the review. The investigator and clinical reviewer interviewed nine members of staff in August and September 2021. All of the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic. The investigation was subsequently reallocated to one of the investigator's colleagues. He and the clinical reviewer interviewed three further members of staff in March 2022. The interviews were again conducted by telephone.

17. We informed HM Coroner for St Pancras of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Nasim's family to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Nasim's brother asked a number of questions. Some have been addressed in separate correspondence, but those addressed in the report are:

    - Why was his brother not being observed every 15 minutes or in a constant observation cell with a camera?
    - Why was his brother not taken to hospital after cutting his wrist on 13 June?
    - Was his brother assessed by a prison psychologist or offered counselling after he harmed himself?
    - At what specific times were the last three checks made on his brother?
    - How did his brother sustain injuries to his face on the day of his death?

19. Mr Nasim's brother also asked for various documents and asked information about his brother's inquest, which we have provided.

20. The initial report was shared with Mr Nasim's family and HM Prison and Probation Service (HMPPS). Mr Nasim's family explained that they did not take a contribution from Pentonville for his funeral expenses. HMPPS did not identify any factual inaccuracies.

Background Information

HMP Pentonville

21. HMP Pentonville is a local prison in London that holds around 1,200 prisoners. The prison primarily serves the courts of north and east London. Practice Plus Group, in partnership with Enfield and Haringey Mental Health Trust, provides healthcare services.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Pentonville in July 2022. Inspectors found that support for prisoners in crisis and those on ACCT was not good enough. Few prisoners who had been on ACCT reported that they had felt cared for. Inspectors noted that while ACCT case reviews were sufficiently detailed, associated caremaps were often incomplete or not used effectively to deliver tailored care and relevant support. Inspectors also found that there was insufficient leadership and oversight of suicide and self-harm prevention work with just one formal safety meeting held in 2022.

23. Inspectors also noted that the Pentonville's reception area was bleak and in need of refurbishment. Inspectors found that prisoners could spend four hours or longer waiting in Reception, and they observed instances of officers being impatient and unwelcoming when receiving prisoners.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Report (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 March 2022, the IMB noted that staff numbers were depleted throughout the reporting year, and this had had a severe impact on prisoners. The IMB considered that reception officers treated new arrivals with decency and understanding, but they noted that the PERs that accompanied prisoners continued to be inconsistent in accuracy and adequacy.

Previous deaths at HMP Pentonville

25. Mr Nasim was the twelfth prisoner to die at Pentonville since August 2019. Of the previous deaths, six were self-inflicted, one was drug related and four were from natural causes.

26. In our investigation into a self-inflicted death at Pentonville in August 2019, we found there was no ACCT caremap and in an investigation into a death in July 2020, we found that the caremap was inadequate. In previous investigations into self-inflicted deaths at Pentonville we have identified other concerns with the ACCT process. It is very concerning that we have found similar issues in this investigation report.

Assessment, Care in Custody and Teamwork

27. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. The process includes assessing the prisoner's immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

28. On 17 June 2020, Mr Khyber Nasim was remanded to prison at HMP Thameside charged with several counts of assault, sexual assault, false imprisonment, blackmail and threats to kill. The alleged victim was his ex-partner. Mr Nasim had spent time at HMP Thameside on three previous occasions.

HMP Thameside

29. Mr Nasim remained at Thameside from 17 June 2020 to 7 June 2021, while awaiting his trial. His records show instances when drugs and hooch (illicitly brewed alcohol) were found in his shared cell. On several occasions he was found collapsed, possibly due to taking illicit substances. Mr Nasim was also believed to have been in possession of or had access to a mobile telephone. Mr Nasim complained frequently about not getting the correct medication: most often this was when short prescriptions for co-codamol (a painkiller) ended and were not immediately re-prescribed.

30. While at Thameside, Mr Nasim was supported on four separate occasions by prison suicide and self-harm prevention procedures (known as ACCT). The reason for starting ACCT procedures was usually following incidents of self-harm which Mr Nasim said he had done due to not being prescribed the correct medication. On another occasion, a recently closed ACCT was re-opened when Mr Nasim reported feeling depressed because his children did not want to have any contact with him. Mr Nasim's final ACCT at Thameside was opened on 16 April 2021, when he used his fingernails to make slight scratches to his wrist as he felt stressed about not having a wing job and spending 23 hours a day locked in his cell. The ACCT was closed at the first case review on 17 April.

HMP Wormwood Scrubs

31. Mr Nasim's trial started on 7 June and was expected to last around a week. Mr Nasim went from Thameside to court but by the end of the court day Thameside was full, so Mr Nasim was taken to HMP Wormwood Scrubs, where he remained overnight before returning to court on the morning of 8 June. At Wormwood Scrubs he was re-prescribed the medication he was receiving at Thameside: mirtazapine (antidepressant) and pantoprazole (to lower stomach acid).

HMP Pentonville

32. At the end of the court day on 8 June, Wormwood Scrubs was full, so Mr Nasim was taken to HMP Pentonville, where he arrived at around 7.00pm.

33. A nurse saw Mr Nasim for a reception health screen. Mr Nasim repeated that he had no present thoughts of suicide or self-harm, although he also said that he had cut his wrists several weeks earlier due to being bullied while at Thameside: there is no information to indicate that Mr Nasim reported incidents of bullying at Thameside but instead said that he had scratched his wrists because he had no job. The nurse told the investigator that she had worked in prisons in the past but had only recently

started working at Pentonville as a part time agency nurse and that she had not received any ACCT training.

34. An officer in the first night centre at Pentonville noted that Mr Nasim said that he felt fit and well and had no current thoughts of suicide or self-harm.

35. Mr Nasim went to court on 9, 10 and Friday 11 June and his case was then adjourned until the following Monday. Mr Nasim's Person Escort Records (PERs) that tracked his transfer to and from court, noted previous concerns for Mr Nasim of self-harm through cutting his wrists, of concealing drugs and a medical history of type 2 diabetes and depression. However, no new or further concerns were noted that week.

Events of 13 June (Sunday)

36. At just before 11.30am on 13 June, Officer A opened Mr Nasim's cell door to give him his lunch. He saw that Mr Nasim appeared to be hiding his hand under his bed. He asked Mr Nasim what he was doing, and Mr Nasim replied, "Nothing". The officer then noticed blood on the floor and that Mr Nasim had a cut to his wrist and was holding his hand over a waste bin. He radioed a code red emergency (indicating a prisoner is bleeding). He asked Mr Nasim why he had cut himself and Mr Nasim said that he could not cope with being in prison and said that his father had died recently, and his mother was in hospital.

37. A nurse responded to the code red call. He noted that the injury to Mr Nasim's wrist was two to three centimetres long. He treated the injury with saline, medical glue and a dressing. The nurse spoke with Mr Nasim and noted that he was alert, made good eye contact and was coherent. Mr Nasim said that the reason he had harmed himself was because he had not been able to telephone his mother.

38. Officer A started ACCT procedures. He completed the concern and keep safe form and a Supervising Officer (SO) completed the immediate action plan. The SO set observations at once an hour pending the next step of the ACCT process, the assessment interview.

39. Officer B saw Mr Nasim for an ACCT assessment interview between 2.30pm to 3.00pm. Mr Nasim said he had been feeling suicidal since his trial started and had cut his wrist in an attempt to kill himself; he said that if he had a bigger blade, he would kill himself that night. He also said he had tried to kill himself in prison three times previously. He said that his mother was ill, he was worried about receiving a long sentence and that he was worried that he would be attacked because of his offences. He also said he had not eaten for three days. the officer noted that Mr Nasim was tearful at the interview. Mr Nasim and the officer agreed that it would help for him to see someone from the mental health team and by maintaining contact with his mother.

40. The SO chaired the first ACCT case review at 4.00pm, with Mr Nasim and the nurse. The SO noted that Mr Nasim appeared calm and composed. He said that he was feeling frustrated at being in prison as he was innocent of the charges against him. He said though, that he was unhappy with his legal representation at his trial and that he was frustrated with the amount of time he was kept locked in his cell, especially in the hot weather. Mr Nasim said that his relationship with his mother

was his greatest protective factor. He also said that suicide was forbidden in the Muslim faith and that he had no current plans to take his own life. Mr Nasim spoke about getting a job in the prison kitchen in the near future. The SO made no reference to Mr Nasim's admission that he had not eaten for several days.

41. The SO concluded that Mr Nasim's risk was 'raised' because he had harmed himself, but he considered that the combination of the protective factors of his mother and his faith, and the fact that he was looking forward to getting a job, meant that one observation an hour and two quality interactions each day was sufficient. He noted that the ACCT review team was limited to himself and a nurse, as it was a Sunday, and no other staff were available. He arranged for a further case review the next day when more people from different disciplines would be able to attend. He added a single action to the caremap: this was for Mr Nasim to telephone his mother, which he did at 4.35pm.

42. At 4.45pm, an officer noted that Mr Nasim was crying. He said that it would be easier if he was dead as his mother was old and would probably be dead by the time he was released from prison.

43. At 6.38pm, Mr Nasim told the officer that the dressing had come off his wound. The officer telephoned healthcare, but a nurse told him that Mr Nasim had steri-strips and his wound would be fine. The officer telephoned healthcare again at 7.01pm and this time, a nurse came to the wing to check Mr Nasim. The nurse told the investigator that he put a new dressing on the wound and also gave Mr Nasim paracetamol because he had a headache. He recorded that he had given Mr Nasim the paracetamol but did not record that he had redressed Mr Nasim's wound.

44. Entries in Mr Nasim's ACCT document show that he was still awake watching television at 1.00am, but that he then slept until the morning.

Events of 14 June

45. At 9.19am on 14 June, Mr Nasim went to court, but his hearing did not go ahead that day. Court custody staff changed his bandage because blood was seeping through from his wound. Mr Nasim returned to Pentonville at 4.23pm.

46. At 5.15pm, a SO held an ACCT review with Mr Nasim. The only other person at the review was another SO. He told the investigator that due to the time of day there were no nurses available to attend. He noted that Mr Nasim said that he was not going to harm himself while he was going to court as his main trigger for harming himself was the amount of time he was spending locked in his cell, which was very hot during the day. Mr Nasim also said that he suffered from sleep apnoea (abnormal breathing patterns). He said that he had not been sleeping well but had not been able to see a doctor. The SO kept Mr Nasim's observations to one an hour with three quality conversations a day. He scheduled the next ACCT case review for Friday 18 June, when it was anticipated Mr Nasim's trial would finish. He told the investigator that Mr Nasim had seemed relaxed about his court case.

Events of 15 June

47. Mr Nasim should have gone to court on 15 June, but he did not go, and his records contained no explanation. Entries in Mr Nasim's ACCT through most of the day showed no concerns. However, at 11.51pm, an Operational Support Grade (OSG) responded to Mr Nasim's cell bell, and she saw that he had cut his wrist and was bleeding into a waste bin. She radioed a medical emergency code red.

48. An officer told the investigator that he had responded to the code red call and Mr Nasim asked him a number of times about going to court. He thought that Mr Nasim had harmed himself to avoid going to court the next day.

49. The night nurse responded to the emergency. She noted that Mr Nasim had made deep cuts to his wrist, his blood pressure was low, and he had a rapid pulse. She telephoned for an ambulance and then cleaned and dressed Mr Nasim's injury. She told the investigator that her main concern was Mr Nasim's low blood pressure.

50. Mr Nasim was taken to hospital at around 12.30am on 16 June and returned to Pentonville at around 3.40am. The night nurse noted that Mr Nasim was alert and orientated on his return. She told the investigator that Mr Nasim just seemed tired and wanted to return to his cell to sleep.

Events of 16 June to early hours of 17 June

51. Mr Nasim left Pentonville for court at 8.21am on 16 June, but his PER was not updated to alert transport and court staff that he had harmed himself the previous night and had attended hospital for treatment.

52. Mr Nasim returned from court at 7.00pm, and an SO and a colleague saw him on reception. Mr Nasim said that the reason he re-opened his wound the previous night was because he was still not receiving the correct medication: his medical record show that he did not receive mirtazapine on 9 and 11 June, with no explanation given. His medical record also shows that he refused pantoprazole on 16 June, but no explanation was given for his refusal. The SO told the investigator that Mr Nasim did not appear to have any significant concerns. The only issues he raised was that his cell was too hot and that he wanted medication to help him sleep. He noted that it seemed that Mr Nasim's trial would continue into the following week, but he still planned a further ACCT case review the following day (Friday 17 June). He maintained the same level of observations and made no additions to Mr Nasim's caremap. He confirmed that there was no nurse at the ACCT review. He said that he had tried to get a nurse to attend, but all the nurses were busy interviewing newly arrived prisoners. He said that after the review he spoke to a nurse for Mr Nasim to be given sleeping tablets. A nurse prescriber noted that Mr Nasim received a three day prescription of two medications prescribed for insomnia, mirtazapine and promethazine hydrochloride.

53. At around 8.05pm, Mr Nasim rang his cell bell and an officer responded. He told the investigator that Mr Nasim said that he wanted to telephone his solicitor. He told Mr Nasim that the solicitor's office would be closed at that time of the evening, and he would not be allowed to telephone his solicitor's mobile number as it was not on his prison telephone account. He said that he told Mr Nasim that staff would contact the

solicitor for him the following morning and Mr Nasim thanked him. He said that there was nothing about Mr Nasim's demeanour to cause him concern.

54. At 9.16pm, officers unlocked Mr Nasim for him to go to the medication hatch where he was given promethazine hydrochloride for insomnia.

55. CCTV shows that Officer C and an OSG took turns to make irregular hourly ACCT checks on Mr Nasim throughout the evening and night in accordance with his ACCT. ACCT entries showed that he was asleep when checked at 10.03pm and that he slept through most of the night. Mr Nasim woke at 4.03am when he was disturbed by the OSG when she checked on him. Mr Nasim said that he was okay. (4.03am is the time indicated by CCTV, while the OSG's ACCT entry states the time of the check by her watch was 3.56am.)

Emergency response

56. At 5.10am on 17 June, Officer C and the OSG started the routine early morning check of all prisoners on A5 landing. They checked opposite sides of the landing, with the officer checking Mr Nasim's side. At 5.11am, the officer paused half-way down the landing and he and the OSG had a conversation for just over 30 seconds, a few feet from Mr Nasim's cell.

57. At 5.12am, Officer C resumed his check and checked Mr Nasim. CCTV and radio transmissions show that he looked into Mr Nasim's cell and then radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties) and a few seconds later, radioed to say he was going into the cell. He went into the cell at 5.13am.

58. Officer C said that Mr Nasim was suspended by ligature made from a bedsheet that was tied to the window bars at the back of the cell. Although Mr Nasim's feet were touching the floor, his knees were bent so the ligature was taking all of his weight. He found that the ligature was too thick for him to cut with his cut down tool, so he untied it with his hands. As he untied the ligature, he could no longer hold Mr Nasim's body weight and he slipped to the floor and hit his head on the central heating pipe, causing a cut to his forehead. The OSG came into the cell and the two officers moved Mr Nasim into a position to start cardio-pulmonary resuscitation (CPR). However, before they could start, nurses arrived and took over.

59. CCTV showed two nurses arrived at 5.15am. Nurse A noted that Mr Nasim was not breathing, and he had no pulse. She also noted that there were signs of rigor mortis. The nurses started CPR. She told the investigator that she had responded to other deaths in the past when she had not started CPR due to the presence of rigor mortis. However, she was aware that Mr Nasim was on an ACCT and was being checked every hour. She considered that, as Mr Nasim was still alive around an hour earlier, it would be best for her and her colleague to attempt resuscitation pending the arrival of paramedics. The nurses also checked Mr Nasim with a defibrillator.

60. CCTV showed paramedics arrived at Mr Nasim's cell at 5.30am. At 5.37am, Mr Nasim was moved to the landing and paramedics continued with efforts to resuscitate him. At 5.42am, the paramedics confirmed that Mr Nasim had died.

61. Several notes were found in Mr Nasim's cell after his death. Mr Nasim wrote in one of them, "I can't bear this heartache, I would rather be a ghost next to you than to enter heaven without you. Allah forgive me." In another, he wrote, "I don't want to hate till the day I'm free, let this be the end, I'll go."

Contact with Mr Nasim's family

62. The prison appointed a family liaison officer (FLO). The FLO arranged to meet one of Pentonville's Muslim chaplains before going on to the home of Mr Nasim's next-of-kin, his mother. When he telephoned Mr Nasim's mother at around 10.00am to confirm she was at home, he learned that the family had already heard from the courts and from his solicitor that Mr Nasim had died. Mr Nasim's brother and sister had then gone to their mother's home. The FLO and Muslim chaplain arrived at the home at around 10.15am. The FLO gave the family as much information as he could about Mr Nasim's death and the chaplain led the family in prayer.

63. Mr Nasim's family did not accept any contribution from Pentonville towards his funeral costs.

Support for prisoners and staff

64. After Mr Nasim's death, the prison care team leader debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

66. The pathologist gave Mr Nasim's cause of death as partial suspension. Mr Nasim's toxicology report showed that he had a high therapeutic level of prescribed mirtazapine in his blood.

Findings

Management of risk of suicide and self-harm

67. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* says that staff must identify prisoners at risk of self-harm and suicide, must identify triggers for acts of self-harm, and must decide how the prisoner will be supported, including through conversations and observations. PSI 64/2011 also says that case review teams should be multi-disciplinary where possible and that that additional case reviews must be held following a significant event.

68. ACCT procedures were started for Mr Nasim when he was found to have cut his wrist on 13 June. In the late evening of 15 June, Mr Nasim was found to have cut his wrist again and was bleeding into a waste bin. He went to hospital in the early hours of 16 June, returning to Pentonville at around 3.40am. Mr Nasim went to court on the morning of 16 June so it would have been difficult to arrange an additional ACCT case review before he went. Mr Nasim returned to Pentonville at 7.00pm and he had an ACCT review with a SO and his colleague. However, it seems there were no nurses available to attend.

69. While we appreciate the difficulty in arranging multi-disciplinary ACCT reviews at a time in the evening when Pentonville staff will be dealing with many prisoners who have returned from court, every effort needs to be made to ensure that meaningful ACCT reviews are held for prisoners such as Mr Nasim. In his case, he had committed a further act of self-harm which led to hospital treatment, and he then spent the next day in court, potentially adding to his anxiety.

70. The SO made no change to Mr Nasim's level of observations. The setting of ACCT observations is a matter of staff judgement, but we are concerned that one check an hour offered a low level of support to Mr Nasim who had now harmed himself twice in four days. We cannot speculate on what might have been said by any nurse who might have attended the review, but it is important that ACCT reviews take into account the broadest range of opinion possible.

Caremap

71. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress and must aim to address the issues identified at the assessment interview. Mr Nasim's caremap contained only a single issue: that he wanted to telephone his mother. However, in his assessment interview Mr Nasim spoke repeatedly about his concern about his court case and he said he had wanted to die since the start of the trial. Mr Nasim also said in the assessment interview that he had not eaten for three days and that it would help if he could be seen by the mental health team. We also note that no further additions were made to the caremap at subsequent reviews, despite Mr Nasim complaining that he wanted to see a doctor as he was having difficulty sleeping. We are not satisfied that Mr Nasim's concerns were properly addressed through his ACCT plan and caremap.

72. We also note that one of the nurses interviewed by the investigator said that she had not been trained in ACCT procedures. We make the following recommendation:

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

- **ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff, where relevant;**
- **ACCT caremap actions are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews;**
- **case reviews consider all relevant information that affects risk; and**
- **all staff in contact with prisoners are trained in ACCT procedures.**

Person Escort Record (PER)

73. Each time a prisoner is passed from one custodial setting to another they are accompanied by a PER to set out the prisoner's risks. When Mr Nasim left Pentonville to go to court on the morning of 16 June, there was no entry made in his PER to alert transport staff and court staff that he had cut himself the previous night and had needed hospital treatment. Mr Nasim did not harm himself further at court, nor while travelling either to or from court, even so, we make the following recommendation:

The Governor should ensure that PERs are always updated to record relevant events.

Food refusal

74. Pentonville has a Food Refusal Strategy that explains the danger to health when a prisoner is not regularly taking food or fluid. The Strategy explains that, in law, the decision to refuse food or fluid is not considered to be a form of self-harm, but the Strategy also says that that every effort must be made to find out why the prisoner is refusing food. The Strategy states that the refusal should be reported to managers and to the safer custody and healthcare teams. The Strategy also sets out the process for monitoring the prisoner's food and fluid intake and for assessing the level of risk.

75. We have no information about Mr Nasim's food intake other than his comment to the ACCT assessor on 13 June that he had not eaten for three days. It is possible that Mr Nasim's comment was an exaggeration; for instance, he might just have missed a few meals. It is also possible that he was not feeling well and was not eating normally for several days for that reason. We simply do not know. Had staff followed the guidance set out in the Strategy, the true situation would have been clarified. We make the following recommendation:

The Governor should ensure that staff follow the guidance in the Food Refusal Strategy when a prisoner refuses or fails to take food or fluid.

Clinical care

76. The clinical reviewer concluded that the overall healthcare Mr Nasim received was equivalent to that which he could have expected to receive in the community. However, she has commented on several aspects of the provision of care specific to the prison environment. This includes the adequacy of recording in Mr Nasim's clinical records his fitness to attend court.

77. The clinical reviewer has noted omissions in the approach to establishing the medical diagnoses that pre-date his arrival at Pentonville. The clinical reviewer concluded that the omissions did not affect equivalence of care but has made a recommendation which we do not repeat in this report but which the Head of Healthcare should address.

78. The clinical reviewer identified that Mr Nasim was not given his prescribed mirtazapine on 9 and 11 June and that he refused his prescribed pantoprazole on 16 June. The clinical reviewer noted however that neither of the medications are considered to be 'critical medications' (a critical medication is one which should not be omitted or delayed without clinical reason).

Inquest

79. At an inquest into Mr Nasim's death held from 23 May to 31 May 2024, an inquest jury concluded that Mr Nasim intentionally chose to suspend himself by ligature, although it was unclear whether he intended the outcome to be fatal.

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