

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nezam Ghalate, a prisoner at HMP Manchester, on 15 June 2024

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



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

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Nezam Ghalate was found hanged in his cell on 15 June 2024 at HMP Manchester. He was 55 years old. I offer my condolences to Mr Ghalate's family and friends.

There have been eight self-inflicted deaths at Manchester in the last three years.

Mr Ghalate had been at HMP Durham from January 2022, and during this time he had self-harmed and attempted suicide on at least eight occasions. His risk factors were known to staff when he arrived at Manchester in January 2023. While at Manchester, Mr Ghalate consistently denied thoughts of suicide and self-harm. He had good rapport with staff and his peers and received regular support from healthcare and other agencies. He was not subject to suicide and self-harm monitoring at Manchester.

My investigation found no evidence to indicate that Mr Ghalate's risk of suicide had substantially risen in the days before his death, and I do not think staff could have foreseen his actions.

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

March 2025

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Summary

Events

1. On 13 January 2022, Mr Nezam Ghalate was remanded to HMP Durham, charged with the attempted murder of his wife. On 10 September 2022, he was found guilty and sentenced to 20 years in prison. Due to the offence taking place in front of his children, the court had imposed an indefinite restraining order against Mr Ghalate, preventing him from having any contact with his wife and children. Mr Ghalate was originally from Iran but had been living in the UK since 2000 and spoke English well.
2. Mr Ghalate remained at Durham until January 2023. During this time, he was subject to suicide and self-harm monitoring (known as ACCT) on eight occasions after a suicide attempt and incidents of self-harm. The last ACCT document was closed on 4 January 2023, following a period of stability.
3. On 24 January 2023, Mr Ghalate was transferred to HMP Manchester. On his arrival, reception staff noted that Mr Ghalate had been monitored under ACCT procedures previously but that he denied any current thoughts of suicide and self-harm. Staff noted that he was cheerful, upbeat and had engaged well.
4. Mr Ghalate was located on K wing (for older prisoners) for the majority of the time at Manchester. He had good rapport with staff and his peers. Mr Ghalate often spoke about his children and, at times, not being able to have contact with them led to Mr Ghalate feeling low, and he would keep to himself and often remained in his cell.
5. While at Manchester, Mr Ghalate was not subject to ACCT monitoring, and staff recorded no concerns about his risk.
6. The day before his death, Mr Ghalate had spent most of the day in bed as he had told his friend that he had not slept well and was tired. Those who had contact with Mr Ghalate described him as being his usual self, and there were no obvious signs that he was at increased risk.
7. At 5.04am on 15 June 2024, during a routine check, staff found Mr Ghalate hanging in his cell. They radioed a medical emergency code, entered the cell and after removing the ligature, performed cardiopulmonary resuscitation. At 5.20am, paramedics arrived and took over resuscitation attempts, but at 5.52am, confirmed that Mr Ghalate had died.
8. The post-mortem report concluded that Mr Ghalate died from hanging.

Findings

9. Mr Ghalate had some risk factors for suicide and self-harm most notably the nature of his offence and consequent lack of contact with his children, and his history of self-harm and attempted suicide. However, he had settled well at Manchester, apparently had a good rapport with both staff and his peers and had consistently denied thoughts of suicide and self-harm. While it was known that Mr Ghalate had some days where he was low, we do not think that there was sufficient evidence

that his risk of suicide had substantially increased in the days before his death or that staff should have considered suicide and self-harm monitoring.

10. The clinical reviewer concluded that the physical care extended to Mr Ghalate at Manchester, was of a good standard and was equivalent to what he could have expected to receive in the community. She did, however, conclude that the mental health care was not of a good standard and not equivalent due to a lack information sharing and multidisciplinary team working.

The Investigation Process

11. HMPPS notified us of Mr Ghalate's death on 15 June 2024.
12. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator visited Manchester on 10 July. He obtained copies of relevant extracts from Mr Ghalate's prison and medical records. He viewed CCTV and body worn video camera (BWVC) footage.
14. The investigator interviewed three members of staff and one prisoner at Manchester on 2 September 2024.
15. NHS England commissioned a clinical reviewer to review Mr Ghalate's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with seven members of the healthcare and drug treatment team.
16. We informed HM Coroner for Manchester City area of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. The Ombudsman's office contacted Mr Ghalate's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Ghalate's wife raised no specific issues.
18. An inquest into Mr Ghalate's death was concluded on 8 June 2026 and a jury returned a verdict of suicide.

Background Information

HMP Manchester

19. HMP Manchester is a high security training prison which accepts long-term prisoners. There is a category A unit for prisoners posing greater security risks. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care at the prison.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Manchester was between 17 September and 3 October 2024. Following this inspection HM Inspectorate of Prisons issued an urgent notification (UN, a mechanism for the Chief Inspector to raise urgent concerns with the Secretary of State) as a result of their findings. The UN cited the number of weapons and other illicit items found in recent months was amongst the highest of all prisons holding adult men and those testing positive for drug use was very high. There was poor physical security and failing CCTV systems. The UN also highlighted that more than half of prisoners surveyed felt unsafe, and the rate of serious assaults had increased, making Manchester one of the most violent adult prisons.
21. Since the last inspection, there had been six self-inflicted deaths and a further three deaths with suspected links to drug abuse and a steep rise in the rate of self-harm, which was the highest amongst adult male prisons.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. The IMB at Manchester has not published an annual report since August 2022. Their last report covered the immediate post-pandemic period.

Previous deaths at HMP Manchester

23. Mr Ghalate was the seventeenth prisoner to die at Manchester since September 2020. Of the previous deaths, seven were self-inflicted, six were natural causes and three were from other causes or drug related. Up to the end of November 2024, there had been one self-inflicted death at Manchester since Mr Ghalate's death. There are no similarities between the circumstances of Mr Ghalate's death and those of previous deaths.

Assessment, Care in Custody and Teamwork

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to decide the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After a first assessment of the prisoner's main concerns, levels of

supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner predicting when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

25. As part of the process, a caremap (plan of care, support, and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which goes with the prisoner as they move around the prison.

Key Events

26. On 13 January 2022, Mr Nezam Ghalate was remanded to HMP Durham charged with the attempted murder of his wife. Mr Ghalate had previously spent twelve days in prison for domestic violence. The Liaison and Diversion team at court completed a Suicide and Self-Harm (SASH) warning form (which alerts the prison to any concerns) which recorded that Mr Ghalate was low in mood and had previous mental health concerns. The form went with Mr Ghalate to Durham.
27. Reception staff started suicide and self-harm monitoring procedures (known as ACCT). While at Durham, Mr Ghalate was subject to ACCT monitoring eight times either due to low mood or acts of self-harm (including cutting himself and jumping on the netting between the wings). Mr Ghalate had received support from mental health services in the community and was prescribed antidepressant medication. He was placed on the mental health caseload, and he continued to receive support.
28. On 10 September, Mr Ghalate was convicted of attempted murder and sentenced to 20 years imprisonment.

HMP Manchester

29. On 24 January 2023, Mr Ghalate was transferred to Manchester.
30. During his reception screen, it was noted that Mr Ghalate had been subject to ACCT monitoring at Durham up until 4 January, and that the post closure review had been completed. Mr Ghalate denied any current thoughts of suicide and self-harm. Staff recorded that he was cheerful, upbeat and had engaged well. Staff did not feel that an ACCT was required. Mr Ghalate was offered a reception telephone call, but he declined and said that he had no one to call. Mr Ghalate did not call anyone or receive any visits during his time at Manchester.
31. The reception health screen highlighted no significant physical health problems but noted his previous contact with mental health services. Healthcare staff referred Mr Ghalate to the mental health team.
32. On 1 February, a community mental health nurse completed a mental assessment. Mr Ghalate said that he was originally from Iran and had been in the UK since 2000. He said that he had no contact with anyone in the community, and although he had children, they had witnessed his offence and a lifetime restraining order prevented any contact. Mr Ghalate said that he had previously been prescribed mirtazapine (antidepressant), however, he did not feel that this helped. She made an appointment for the GP to review his medication. Mr Ghalate told her that he had no other concerns about his mental health.
33. The community mental health nurse asked Mr Ghalate about his previous self-harm attempts while at Durham. Mr Ghalate said that he now felt 'happy to be alive' and denied any current thoughts of suicide or self-harm. She noted that a trigger for Mr Ghalate's previous self-harm was a visit by an immigration officer, who had discussed his deportation back to Iran. Mr Ghalate had previously said that if he were deported, he would end his life. Mr Ghalate said that while in Durham he had been working, which had helped, and he wanted to get a job (he later gained

employment in the workshop). He denied any current substance misuse issues. The Drug and Alcohol Rehabilitation Services supported Mr Ghalate during his time at Manchester to help progress his sentence plan. (Mr Ghalate had some history of substance misuse and it was considered a contributory factor to his offence. He was not suspected of using drugs or alcohol in prison.)

34. Mr Ghalate was later prescribed trazodone (an antidepressant) and medication for blood pressure and asthma.
35. In April 2023, Mr Ghalate moved to K wing (incentivised substance free living wing and for those on enhanced privileges). Mr Ghalate developed a close friendship with Prisoner A. Prisoner A is a mentor for the Shannon Trust and assists prisoners (including Mr Ghalate) who struggle with reading and writing. He said that Mr Ghalate had spoken about his previous self-harm and that not being allowed to have contact with his children was the biggest issue for him and caused low mood. However, he said that he never had any reason to be concerned that Mr Ghalate would harm himself and he never mentioned thoughts of suicide or self-harm.
36. On 18 August, Mr Ghalate complained of chest pain. He was seen by a nurse, who referred Mr Ghalate to the mental health team as he appeared to be in a low mood.
37. On 19 August, an officer spoke to Mr Ghalate as his appointed keyworker. She asked Mr Ghalate about the events of the previous day when he was reported as being in a low mood and having chest pains. Mr Ghalate said he was feeling much better, had collected his medication and his lunch meal. Mr Ghalate said that he no longer had any chest pain, and had been seen by nursing staff, and that he usually experienced chest pain and headaches when he did not take his medication. She told Mr Ghalate that if he felt low, he could talk to her or other staff if she was unavailable. This was the only keywork contact Mr Ghalate received while at Manchester.
38. On 16 September, a nurse spoke with Mr Ghalate when he attended the medication hatch, and he asked her about his mental health appointment. She told him that it was yet to be allocated, but she would chase this for him. She asked Mr Ghalate what he wished to speak to the mental health staff about and he said that he felt upset and had not been eating. She spoke with wing staff who said that they did not know that Mr Ghalate was not eating.
39. The nurse asked Mr Ghalate whether he had thoughts of suicide or self-harm, which he denied. Wing staff told her that they would keep an eye on Mr Ghalate and open an ACCT if necessary. She told the staff that she would also monitor Mr Ghalate and would open an ACCT if she felt he was not improving.
40. During the afternoon of 17 September, an officer spoke with Mr Ghalate, after Prisoner A raised concerns that Mr Ghalate had not collected meals from the servery for a few days. Mr Ghalate told the officer that he was experiencing a low mood due to a number of factors, including wanting to return to Iran. She said that this could be followed up with the Offender Management Unit (OMU) and the foreign national officer. Mr Ghalate told her that although he was feeling low, he had no thoughts of suicide or self-harm. She noted that Mr Ghalate had food in his cell and recorded that she did not feel Mr Ghalate needed the support of the ACCT

process at that time. However, she reminded Mr Ghalate that if he was struggling, he could speak to staff, listeners and the chaplaincy team.

41. On 18 September, a psychological wellbeing practitioner saw Mr Ghalate as a result of the mental health referral. Mr Ghalate was very worried about his daughters as he was unable to have any contact. He was also unhappy that he was not allowed to keep his medication in his cell. She noted Mr Ghalate's history of overdose, but Mr Ghalate said that he had no intention of harming himself. She noted that she would discuss with a GP whether in possession medication was a possibility. On 26 September, an in-possession risk assessment was completed, and Mr Ghalate was allowed to keep his medication in his cell.
42. On 12 October, an officer recorded that he had looked into Mr Ghalate's request to be returned to Iran. He noted that he had contacted the immigration team at HMP Risley and been told that there was currently no repatriation agreement between the UK and Iran. Mr Ghalate was informed of this, and he raised no further concerns.
43. In December, Mr Ghalate asked to speak with someone from the mental health team. On 12 December, a community mental health nurse spoke with Mr Ghalate. Mr Ghalate said that he heard a voice and reported seeing a 'black dot' in his cell. He said that the voice told him to harm himself because he was useless, due to not having contact with his daughters. Mr Ghalate denied having thoughts of suicide and self-harm and said that he had a good relationship with staff and other prisoners who he spoke with daily. Mr Ghalate said that he wanted to know that his children were safe as he had not had contact with them for over two years. She said that she would find out whether this was possible. She referred Mr Ghalate to a GP for a medication review. (Prison staff were not able to contact Mr Ghalate's children on his behalf due to the restraining order in place.)
44. On 18 December, a GP at the prison completed a medication review by telephone consultation and Mr Ghalate agreed for his antidepressant medication dose to be increased from 100mg to 150mg. The GP had previously seen Mr Ghalate for other issues and said that he always took the opportunity to ask Mr Ghalate about his mood, which Mr Ghalate said was improving. Mr Ghalate denied thoughts of suicide and self-harm.
45. On 18 January 2024, the wellbeing practitioner met with Mr Ghalate and completed an Improving Access to Psychological Therapies (IAPT) assessment for psychological treatment of depression and anxiety disorders. Mr Ghalate said that his main concern was about his daughters. He said that the worry was worse when he was in his cell and unoccupied. He said that he was hearing a negative voice in his head at night, but that he had no thoughts of suicide or self-harm. She concluded that Mr Ghalate was future focused, and did not need further psychological well-being input, but that she would check on him again once he had started education.
46. On 2 February, Mr Ghalate submitted an application to the Drug and Alcohol Services (Delphi) team requesting to complete work with them as part of his sentence plan, (rather in relation to any current use or problems) and was added to their waiting list.

47. On 8 February, a mental health nurse, who works for Delphi, completed a telephone assessment with Mr Ghalate. Mr Ghalate said that he had previously only ever used cannabis and alcohol. Mr Ghalate spoke about previous self-harm and told her that in Iranian culture it was more honourable for a man to kill himself if his wife had cheated on him. Mr Ghalate said that it reduced the worth of a man if he was cheated on. Mr Ghalate said that he had previously made several attempts to end his life, but said that he had no thoughts, plans or intention of harming himself at the time of assessment. At interview, she said that in her view, Mr Ghalate was stating a fact about his culture, rather than indicating that he had any intent to harm himself. She said that they had also spoken about religion, and that it was against his religion to end his life.
48. Mr Ghalate told the nurse that he was prescribed medication for anxiety and depression but had no concerns about his physical health. Mr Ghalate confirmed that he wanted to work with Delphi as part of his sentence plan targets but also to 'better himself'. She recorded that Mr Ghalate would be allocated a Delphi keyworker, but she did not record their conversation about suicide and self-harm in Mr Ghalate's medical record (Delphi maintains a separate record system.)
49. Mr Ghalate was allocated a Delphi keyworker and met with him on 27 February. Mr Ghalate told him that he had no current issues with illicit drug use but wanted to complete work for his sentence plan. Mr Ghalate agreed with him that he would complete in-cell work and would receive certificates for it. He recorded that Mr Ghalate was also connecting with the Delphi Orderly Recovery Peer (trained prisoner) on the wing for support when required.
50. Over the months that followed, no concerns were raised by or about Mr Ghalate. He continued to attend work, helped around the wing, and had a good rapport with both staff and peers.
51. On 28 May, a registered general nurse (RGN) saw Mr Ghalate. She noted that Mr Ghalate showed no signs nor raised any thoughts of suicide or self-harm. He engaged well, maintained good eye contact, showed positive body language and was in a good mood. Mr Ghalate spoke about being unable to sleep and it was noted that an appointment had already been booked with a GP.
52. On 4 June, a prison GP saw Mr Ghalate and prescribed zopiclone (a sleep aid) for three days. He noted that Mr Ghalate was polite, engaging, and his mood was stable with no evidence of suicidal thoughts. He planned to review Mr Ghalate again in five weeks.
53. At 7.15am on 13 June, wing staff asked a healthcare assistant (HCA) if she would see Mr Ghalate as they were concerned about his physical health. She said that when she went to see Mr Ghalate, he was in his cell talking with another prisoner. Mr Ghalate was polite, engaging, and pleasant, although he had told staff that he had been unable to sleep and appeared low in mood. She asked a prison GP if he would provide a sick note for Mr Ghalate to be excused from work, but the GP declined because he considered that socialising could help Mr Ghalate's low mood. No further concerns were reported by Mr Ghalate about feeling unwell.
54. Prisoner A told the investigator that on the morning of 14 June, he had spoken with Mr Ghalate after their cells were unlocked. Mr Ghalate told him that he had a bad

night's sleep. He told him to go back to bed, which he did, and he slept for most of the day. He collected Mr Ghalate's lunch, canteen and evening meal for him as he stayed in bed. Despite looking tired, he said that Mr Ghalate appeared no different from his usual self.

Events of 15 June

55. The following account is based on written and documented evidence provided by Manchester, CCTV and Body Worn Camera (BWVC) footage and transcripts of interviews with staff.
56. At 5.00am on 15 June, Officer A, who had been working a night shift, undertook a morning routine roll count of the wing. Upon reaching Mr Ghalate's cell, she looked in through the observation panel but could not see him on his bed. She said that she had turned the cell light on and used her torch but could not see Mr Ghalate and she got no response when calling to him. She radioed and asked for a patrol officer to attend so they could unlock the cell to check (there must be two staff present to unlock a cell during the night state unless there is a clear threat to life). Another officer responded and made his way to Mr Ghalate's cell.
57. An Operational Support Grade (OSG) was working on an adjoining wing and on hearing the radio call from Officer A went across to K wing to see if he could assist. The officer told the OSG that she was unable to get a response from Mr Ghalate and when he looked into the cell, he noticed Mr Ghalate in the corner by his bed with a ligature tied to the bunk. At 5.04am, the OSG radioed a medical code blue (indicating the prisoner is unconscious or having breathing difficulties). When interviewed, the officer said that it was not easy to see Mr Ghalate from the observation panel, due to his position and she had not noticed him when she initially looked into the cell.
58. Officer B arrived at 5.05am and along with the OSG and Officer A entered Mr Ghalate's cell. The control room called an emergency ambulance immediately. Officer B cut the ligature from around Mr Ghalate's neck while the OSG cut a binding that Mr Ghalate had tied around his legs. Mr Ghalate was positioned at the end of his bed in between the bed and the wall, and the staff moved him to the floor. They established that he was not breathing, and had no pulse, and staff began cardiopulmonary resuscitation (CPR). Nursing staff and further officers arrived at 5.07am and took over treatment, attaching a defibrillator. Efforts to resuscitate Mr Ghalate continued until the paramedics arrived at 5.20am. Paramedics continued treatment but at 5.52am, they confirmed that Mr Ghalate had died.

Contact with Mr Ghalate's family

59. Following Mr Ghalate's death, the prison appointed a family liaison officer (FLO). Staff noted that Mr Ghalate's ex-wife was listed as his next of kin and lived in the Gateshead area. Managers decided to ask staff at HMP Durham to visit the family (as they were geographically closer). Durham agreed, but informed Manchester that the police had asked for them to wait so that their victim support officers could accompany them due to Mr Ghalate's index offence.

60. At 3.25pm that afternoon, the FLO received a call from Durham informing her that staff had visited the address, but the family had moved. A senior manager spoke with Northumberland police who were able to assist with identifying the new address and arrangements were made for staff from HMP Low Newton to visit the address and inform the family of Mr Ghalate's death. On Sunday 16 June, staff from Low Newton attended the address, and informed Mr Ghalate's daughter of her father's death. She said that her mother was at work, and she did not wish to disturb her, but would update her on her return at 8.00pm. Staff from Low Newton told the family that the family liaison officer from Manchester would be in contact on Monday 17 June.
61. On 17 June, the FLO telephoned Mr Ghalate's wife and spoke with her at length, and explained the process that would follow. She also liaised with the Coroner, so the family could visit Mr Ghalate. The family visited Manchester on 21 June, where they met with Mr Ghalate's friends on K wing.
62. The prison contributed towards funeral costs in line with national policy.

Support for prisoners and staff

63. After Mr Ghalate's death, a custodial manager 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.
64. The prison posted notices informing other prisoners of Mr Ghalate's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the death.

Post-mortem report

65. The Coroner gave Mr Ghalate's cause of death as hanging. Toxicology tests identified no substances of concern in Mr Ghalate's system.

Findings

Assessment of Mr Ghalate's risk

66. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Ghalate had several factors that increased his risk of suicide including being convicted of a violent offence against his wife and subsequent estrangement from his children, a history of suicide attempts and self-harm and a history of drug and alcohol use. These risks were appropriately identified when he first arrived at Manchester, but he was not considered to need ACCT support at the time.
67. Mr Ghalate had contact with the GP, nurses and a psychological well-being practitioner, all of whom routinely asked about his risk of suicide and self-harm and were satisfied that he did not pose a significant risk or need ACCT monitoring.
68. Mr Ghalate was settled on K wing, apparently got on well with staff and had a good friendship with Prisoner A. He said that Mr Ghalate had never mentioned thoughts of suicide or self-harm. The day before his death, Mr Ghalate told him that he was tired and had returned to bed and slept most of the day. He had no concerns about his well-being.
69. We consider that Mr Ghalate received consistent and personalised support from staff at Manchester, particularly on K wing. Mr Ghalate was never considered at raised risk of suicide or self-harm, or subject to ACCT monitoring at Manchester, and the reasons provided for reaching those conclusions are well documented and reasonable. We consider that, on the evidence available, there were no clear indications that Mr Ghalate's risk of suicide had significantly increased in the days before his death. We do not think that staff could have foreseen his actions.

Clinical care

70. The clinical reviewer concluded that the physical health care Mr Ghalate received at Manchester was of a good standard and equivalent to what he could have expected to receive in the community.
71. However, she concluded that the mental health care Mr Ghalate received was not of a good standard and not equivalent. She found that there was a lack of information sharing between healthcare staff, psychology and substance misuse services and a lack of a multidisciplinary team approach to Mr Ghalate's care. The clinical reviewer has made a recommendation about record keeping, which the Head of Healthcare will wish to address.

Governor to note

Postvention Support

72. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
73. There was no evidence that these procedures were followed after Mr Ghalate's death, and Manchester's current contingency plans following a death in custody dated February 2019, do not reflect this update as an action. The Governor will want to ensure that local contingency plans reflect all current actions that must be followed after a death in custody, including postvention.

Keyword

74. The key worker scheme provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.
75. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.
76. The investigator was told that Manchester is currently delivering an adapted version of the scheme due to staffing pressures. Mr Ghalate only received one keyword session during his time at Manchester and, while this does not appear to have adversely impacted him due to his good rapport with wing staff, the Governor should be aiming for full delivery as soon as possible so that all prisoners can benefit from keyword.

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