Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shahrooz Ghassemian, a prisoner at HMP Wandsworth, on 21 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

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

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

Mr Shahrooz Ghassemian died in hospital on 21 June 2021 of a drug overdose after he was found unconscious in his cell at HMP Wandsworth having taken an apparently deliberate overdose of tablets. Post-mortem toxicology results found the presence of tramadol at potentially fatal blood concentrations, paracetamol and ibuprofen at toxic levels and mirtazapine at high therapeutic levels. He was 47 years old. I offer my condolences to Mr Ghassemian's family and friends.

Mr Ghassemian was monitored under suicide and self-harm prevention procedures, known as ACCT, on three occasions when he was concerned about his mother's illness and subsequent death. I am concerned about the quality of ACCT management, which was not multidisciplinary and did not put in place plans to address Mr Ghassemian's issues. No one assessed Mr Ghassemian's risk of suicide and self-harm when he was sentenced by video link, despite evidence that this might increase his risk. There was also a lack of regular key work and contact with Mr Ghassemian.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2024**

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Summary

Events

1. On 27 August 2020, Mr Shahrooz Ghassemian was remanded into custody at HMP Wormwood Scrubs. On 9 September, he was transferred to HMP Wandsworth.

2. Staff supported Mr Ghassemian using suicide and self-harm prevention procedures, known as ACCT, on three occasions at Wandsworth. They were all triggered by his concern for his mother who was ill and subsequently died. The last period of ACCT monitoring ended on 20 April 2021. There was little healthcare input at Mr Ghassemian's ACCT case reviews and ACCT caremaps, which should have been used to identify key issues and means of support, were left blank.

3. During the last period of ACCT monitoring, Mr Ghassemian was referred to the mental health team as he displayed delusional behaviour. Following a mental health assessment, staff identified no mental health problems but referred him for bereavement counselling.

4. Mr Ghassemian told staff that he wanted to be with his deceased mother and wanted their bodies to be buried in Iran. He said that he was waiting for the outcome of his court hearing after which, if he was not released from prison, he would go on "hunger strike".

5. On 27 May, Mr Ghassemian was sentenced to serve 42 months in prison. Following his sentence, staff did not assess his risk of suicide and self-harm.

6. At 11.25am on 21 June, an officer found Mr Ghassemian unconscious in his cell. Healthcare staff administered emergency care, during which they found Mr Ghassemian's mouth and airway blocked with tablets. It was suspected that he had taken an overdose. Paramedics took him to hospital, where his death was confirmed at 12.21pm.

7. The post-mortem report found that Mr Ghassemian died of a drug overdose. Post-mortem toxicology results established that he died of potentially fatal blood concentrations of tramadol and toxic plasma concentrations of paracetamol and ibuprofen. He also had high therapeutic amounts of mirtazapine in his blood. Mr Ghassemian was prescribed paracetamol and ibuprofen at Wandsworth, but not tramadol or mirtazapine.

Findings

Assessment of risk

8. We found some deficiencies in the prison's management of ACCT procedures. Healthcare staff were not involved in all case reviews, caremap actions were not set, and the outcome of the ACCT post-closure review was not properly recorded.

9. We also consider that staff underestimated Mr Ghassemian's risk of suicide and self-harm. He had, on more than one occasion, identified his court hearing outcome as a potential trigger for self-harm or food refusal, yet no support was put

in place after he was sentenced, and no one considered his risk of suicide and self-harm at the time. We are concerned that there is no evidence prison staff had any meaningful interaction with Mr Ghassemian after he was sentenced by video link or through the key worker scheme.

Emergency response

10. Although the emergency response when Mr Ghassemian was discovered was swift, the first officers on the scene did not immediately start first aid medical treatment.

Clinical care

11. Although the clinical reviewer found that, overall, the care that Mr Ghassemian received at Wandsworth was equivalent to that which he could have expected to receive in the community, she identified some concerns about the provision of the mental health service and ensuring adequate risk assessments to determine whether a prisoner can keep and administer his own medication (in-possession medication risk assessments) are completed when prisoners are subject to ACCT procedures. It is also concerning that Mr Ghassemian was able to obtain potentially fatal levels of illicit medication.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:
    - ACCT case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate;
    - staff set specific and meaningful ACCT support actions that are aimed at reducing prisoners' risks to themselves and review them at each case review; and
    - staff should complete post-closure ACCT reviews in line with PSI 64/2011.
- The Governor should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.
- The Governor and Head of Healthcare should ensure that staff manage prisoners appearing in court by video link in line with national instructions, including that:
    - prison records (NOMIS) are updated with details of the hearing and the outcome;
    - any information indicating a risk of suicide and self-harm is shared with relevant staff before the hearing; and
    - following the hearing, staff consider any new information about risk and start ACCT procedures when indicated.

- The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies.

- The Head of Healthcare should ensure that prisoners are kept informed of the status of their referrals to healthcare services, particularly when referrals are rejected. Information about repeated referrals should be clearly recorded and identify follow-up action.

- The Governor and Head of Healthcare should ensure that pharmacy teams are notified when ACCT procedures are started and that they complete an in-possession medication risk assessment.

- The Governor should ensure that prison staff provide all relevant information requested by the Prisons and Probation Ombudsman's office, in line with PSI 58/2010.

- The Governor should review the provision of CCTV footage and ensure the system works and is able to provide footage to relevant stakeholders, including the Ombudsman.

- The Governor should ensure that the staff named in this report are given the opportunity to read this initial report in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

12. The investigator issued notices to staff and residents at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Ghassemian's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Ghassemian's clinical care at the prison. The investigator and clinical reviewer jointly interviewed five members of staff. One member of prison staff provided a statement. Interviews were completed by MS Teams and telephone due to the restrictions imposed by the COVID-19 pandemic.

15. We informed HM Coroner for Inner West London of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Ghassemian's next of kin to explain the investigation and ask if he had any matters he wanted us to consider. He did not ask any specific questions.

17. Mr Ghassemian's next of kin received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Wandsworth

19. HMP Wandsworth is a local Category B prison in London. It holds up to 1,452 men in eight residential wings. Oxleas Foundation Trust provides physical healthcare services at the prison. There is an inpatient unit for up to six prisoners. Mental health services are provided by South London and Maudsley NHS Foundation Trust.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wandsworth was an unannounced inspection in September 2021. Inspectors found there were not enough staff to make sure prisoners received even the most basic prison regime. For example, they sometimes had to choose between exercise, ordering from the kiosk and having a shower. Nearly half of the prisoners at Wandsworth were foreign nationals and the prison, the education service and Home Office staff were not doing enough to support this group of prisoners. Key work was very limited, with contact irregular or completed remotely, although prisoners recognised that staff often tried their best. Procedures for identifying prisoners at increased risk of suicide and self-harm following court appearances had improved. The quality of ACCT case management documentation for prisoners at risk varied too widely across the prison.

21. Inspectors conducted a review of progress at Wandsworth in June 2022. They found that progress was mixed. A clear priority for the new Governor who was due imminently was the problem of very high rates of non-effective staff which remained unchanged since their last inspection. Time out of cell remained limited, and the prison was overcrowded, with many prisoners living in poor conditions. Violence had increased since their last inspection. Although leaders were making good use of data to measure daily and weekly progress, governance arrangements were not sufficient to make sure that longer-term plans, targets and monitoring were taking place in a number of important areas, including violence reduction, key work and safety.

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. In its latest annual report for the year to June 2022, the IMB said that the prison remained unsafe and there was a rising level of violence. They noted that attendance at multidisciplinary ACCT reviews varied, often due to staff shortages. The IMB was concerned that reviews were often chaired by officers from other wings who did not know the prisoners.

23. The high number and length of ACCT reviews resulted in irregular attendance by the multidisciplinary agencies. The absence in particular of mental health representatives was an issue in a number of the reviews. They observed an increase in the number of court hearings decided by video link. The widespread availability of drugs, principally psychoactive substances, continued to be of great

concern. Although the MOJ authorised funding for an upgrade to the CCTV system over two years ago, completion has been pushed back to 2025.

Previous deaths at HMP Wandsworth

24. Mr Ghassemian was the thirteenth prisoner to die at Wandsworth since June 2019. Of the previous deaths, three were from natural causes, one was drug-related and eight were self-inflicted. There were no notable similarities between our investigation findings about these deaths and those about Mr Ghassemian's death. There have been a further three deaths at Wandsworth since Mr Ghassemian's death, all of which are currently under investigation.

Assessment, Care in Custody and Teamwork

25. 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 determine 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 an initial 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 anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

26. As part of the process, a support plan (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the support plan 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 accompanies the prisoner as they move around the prison.

Key worker scheme

27. HMPPS's policy document, Managing the Custodial Sentence Policy Framework, sets out the minimum requirements for managing those in custody from reception to the end of post-release supervision. This included the gradual introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:

- All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.

- All prison officers who work on a residential unit will be allocated a maximum of six prisoners. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of key work. Key workers will record meetings, discussions and any progress that has been made.

28. Key work was formally suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. In May 2020, the Prison Service issued an Exceptional Delivery Model for key work. This provided a framework of principles within which prisons must operate but left it to individual prisons to decide how to deliver key

work safely during the pandemic. The Exceptional Delivery Model recommended that key work should continue for certain identified priority prisoner groups, including those prisoners at risk of suicide or self-harm and those who were clinically extremely vulnerable to COVID-19 and had been advised to shield.

Key Events

29. On 27 August 2020, Mr Shahrooz Ghassemian was remanded in custody to HMP Wormwood Scrubs, charged with perverting the course of justice. It was not his first time in prison.

30. From his reception screen, staff noted that Mr Ghassemian had no history of attempted suicide or self-harm, mental ill health or substance misuse. He identified his mother as his next of kin. At the time, she was ill in hospital and a harassment court order was in place that prevented him from contacting her.

HMP Wandsworth

31. On 9 September 2020, Mr Ghassemian was transferred to HMP Wandsworth.

32. A nurse completed Mr Ghassemian's initial health screen. He told her that he had no thoughts of suicide or self-harm. However, he said that he sometimes experienced a "subconscious state" during which he was unaware of his actions and could therefore be a danger to other people. He said that he had received treatment at a private mental health facility but had no diagnosis. The nurse referred Mr Ghassemian to the mental health inreach team.

33. The next day, the mental health team held a multidisciplinary meeting and discussed Mr Ghassemian, having reviewed his referral from the reception nurse. They rejected Mr Ghassemian's referral and noted that there was no current evidence that he needed mental health intervention. They noted that he was due to be reviewed by the GP who could, if necessary, refer him back to the mental health inreach team.

34. Afterwards, a GP operating at Wandsworth saw Mr Ghassemian who told her that his mother was ill, had dementia and was due to start chemotherapy. He hoped that he would be released on bail at his court hearing the following week. The GP recorded no concerns about Mr Ghassemian's mental health.

35. Healthcare staff recorded that Mr Ghassemian was allowed to keep and administer his medication.

36. On 30 September, Mr Ghassemian moved to C Wing.

37. On 2 October, Mr Ghassemian alleged that his cellmate had sexually assaulted him. Prison staff began an investigation, and the incident was reported to the police. Mr Ghassemian was moved to the Trinity Unit on G Wing. Staff recorded that it was possible that Mr Ghassemian was trying to orchestrate a move to a single cell.

38. On 6 October, Mr Ghassemian twice asked officers to ask the chaplaincy team to facilitate contact with his mother. (He knew that he was not allowed to have direct contact with her because of a court order.) The chaplaincy team was only authorised to contact Mr Ghassemian's mother to ascertain her wellbeing if she was admitted to a hospital or care home or was otherwise at risk.

39. On 7 October, a GP at Wandsworth asked prison staff to move Mr Ghassemian to a single cell. This was granted.

40. In November, Mr Ghassemian submitted an application to ask to visit his mother. Prison staff rejected this.

41. On 22 December, staff started suicide and self-harm prevention procedures, known as ACCT, after Mr Ghassemian was found crying in his cell. He asked staff and prisoners to pray for his mother as he said she could die at any moment.

42. The next day, a Supervising Officer (SO) held the first ACCT case review. A wing officer also attended but no one from the healthcare team was present. Mr Ghassemian stated that he had no plans to harm himself and was upset the previous day because he missed his mother. He claimed that he was the only person alive that could support her and was unable to do so because of the court restraining order. The SO confirmed that the restraining order was still active despite Mr Ghassemian's views that the court had rescinded it. The SO noted that Mr Ghassemian's risk level was low and stopped ACCT monitoring.

Events from January 2021

43. On 18 February, a member of the chaplaincy team saw Mr Ghassemian after he raised concerns about his mother. He said that he had paperwork to prove that he was allowed to contact her. She said she would raise this with wing staff.

44. On 22 February, an officer observed that Mr Ghassemian appeared upset. He told her that his mother's solicitor had told him that his mother was dying.

45. On 24 February, an officer completed a welfare check on Mr Ghassemian, who appeared distressed. He said it was because he was unable to contact his mother. He said that he also had problems sleeping. Mr Ghassemian showed the officer a solicitor's note that he claimed provided valid grounds for him to be able to contact his mother. The officer passed this information to the security team.

46. The next day, an entry in Mr Ghassemian's prison records stated that his order not to contact his mother had been removed. No one recorded that they had told Mr Ghassemian this.

47. On 5 March, Mr Ghassemian's mother died. A member of the chaplaincy team broke the news to him. Mr Ghassemian was upset and became erratic on hearing the news. He told staff that he had been extremely close to his mother. He was offered bereavement support and prison staff explained the procedure for funeral arrangements. Staff confirmed that Mr Ghassemian would not be able to attend the funeral due to COVID-19 restrictions, but a video link would be arranged.

48. That evening, staff started ACCT procedures after Mr Ghassemian said he felt worthless and had lost everything.

49. On 6 March, a member of the chaplaincy team saw Mr Ghassemian and completed a welfare check. Mr Ghassemian asked a number of questions about his mother's funeral arrangements. He said that he felt much better and calmer than the previous day.

50. Afterwards, an officer completed Mr Ghassemian's ACCT assessment. Mr Ghassemian said that he had taken his mother's death badly as she was his only family. He was very emotional and cried a lot. He said that he did not want to die and had no thoughts of self-harm but admitted his mood was fluctuating. The officer noted Mr Ghassemian's main concern was that he wanted to attend his mother's funeral in person rather than by video link.

51. A SO completed Mr Ghassemian's first ACCT case review. A wing officer and a member of the chaplaincy team attended. No member of the healthcare team was present. The SO noted that Mr Ghassemian fluctuated from interacting and talking to sobbing and crying. Mr Ghassemian said that he had no intention of harming himself and wanted to fulfil a promise to his mother to decorate their home. Mr Ghassemian asked if the prison would inform the court of his mother's death as he hoped that this information might help to accelerate his court hearing. The SO said that he would look into this. He referred Mr Ghassemian to the mental health team and noted that his recent bereavement was affecting his mental health. He noted that Mr Ghassemian had no thoughts of suicide or self-harm, lowered his ACCT observations and scheduled a follow up ACCT review on 8 March. No issues or actions were recorded on the ACCT caremap which was left blank.

52. On 8 March, a SO completed an ACCT case review. A wing officer and a social care support worker attended but no one from the healthcare team was present. The SO recorded that Mr Ghassemian was grieving and upset but denied any thoughts of self-harm. He said that he had managed to speak to his mother the day before she died and that the Imam had given him bereavement support. Mr Ghassemian also talked about his court hearing. The SO assessed that he posed no risk to himself and noted that ACCT monitoring would end. He noted some actions to complete: that Mr Ghassemian had agreed to contact his solicitor to ask for his court hearing to be brought forward, that he should be granted compassionate leave and that staff would review Mr Ghassemian's request to add further family members to his PIN phone account.

53. On 9 March, the mental health inreach team reviewed Mr Ghassemian's referral. It was agreed that he did not need any mental health intervention at the time as he was receiving bereavement support.

54. On 14 March, an officer completed Mr Ghassemian's ACCT post-closure review but did not consider his wellbeing or risk status. It simply highlighted that Mr Ghassemian had said that the security team had not accepted his request to add additional family numbers to his PIN account to make funeral arrangements. Mr Ghassemian also said that he wanted his court hearing date brought forward.

55. On 15 and 18 March, staff facilitated phone calls for Mr Ghassemian to contact funeral homes to organise arrangements for his mother. Members of the chaplaincy team continued to visit him and provide support.

56. On 22 March, Mr Ghassemian complained of having influenza-like symptoms. A member of the healthcare team prescribed him a pack of 16 paracetamol tablets.

57. On 24 March, Mr Ghassemian made an application to see a member of the mental health team. He said that he was "facing extreme trauma" and having "extreme delusions".

58. On 26 March, the mental health inreach team discussed Mr Ghassemian's referral. They noted that a welfare check should be completed but there is no record that this took place.

59. On 31 March, it was recorded in Mr Ghassemian's medical record that he was prescribed 32 paracetamol tablets, after he complained of having spinal pain.

60. That day, a member of the chaplaincy team received a phone call from Wandsworth Council. The caller stated that Mr Ghassemian had contacted the council to register his mother's death and that, during conversation, he had said, "I look forward to being with my mother soon". He told a prison wing manager, who noted this in the wing observation book. There is no evidence that any further action was taken.

61. On 1 April, a SO conducted a welfare check on Mr Ghassemian. He said that he did not feel well, had lost his appetite and complained of having back pain. He said that he was waiting to see the nurse. The SO noted that Mr Ghassemian had no thoughts of self-harm.

62. On 7 April, a nurse saw Mr Ghassemian. He told her that he had thoughts of self-harm. He was tearful, restless, distressed and rocked continuously while he spoke. Mr Ghassemian said that he would starve himself to death so that he could join his mother. He said that he believed his mother was visiting him in prison daily and that he could hear her voice. She started ACCT procedures. She referred Mr Ghassemian to the prison GP and for an urgent mental health assessment.

63. The next morning, an officer completed Mr Ghassemian's ACCT assessment. He noted that Mr Ghassemian appeared confused, tearful and was flitting between knowing his mother had died to stating that she was currently alive and had been visiting him in prison. Mr Ghassemian also believed that his dead grandparents had visited the prison and had had lunch with him in his cell. Mr Ghassemian said that he wanted to starve himself to death, although he also said that he had been eating left over food in his cell.

64. Afterwards, a SO completed the first ACCT case review. An officer and a nurse from the mental health inreach team were also present. The review panel noted that Mr Ghassemian's eyes were closed throughout most of the meeting and tears could be seen on his face. He said that he believed his mother was "still with us" and said that he had seen her "on a spiral staircase in the Trinity centre". Mr Ghassemian said that he had made food for his mother, though he had eaten it himself. Mr Ghassemian said that he would not harm himself because he had to cook for family members who were coming to visit him. He then said that he intended to go on hunger strike. The nurse noted that he needed an urgent mental health assessment. The SO scheduled the next review for 12 April. He did not record any issues or actions on the ACCT caremap.

65. That day, a prison chaplain saw Mr Ghassemian. They talked about arrangements for Mr Ghassemian's mother's funeral, and he asked whether she could be buried in Iran.

66. On 9 April, a mental health nurse assessed Mr Ghassemian who said that he had no mental health problems and attributed feeling low to his mother's death. He said

he felt better than he had the previous day and denied psychotic symptoms or mental health problems. She noted that Mr Ghassemian engaged well during the assessment and displayed no evidence of hallucinations or false perceptions. She noted that Mr Ghassemian should be referred to the chaplaincy for bereavement counselling (and this action was completed). No follow-up action was deemed necessary from the mental health inreach team.

67. On 12 April, a SO completed an ACCT case review. An officer and a social care support worker also attended. Mr Ghassemian said that he had a burial plot in Iran and wanted his body and that of his mother to be buried there. However, he said that he did not have enough money to pay for the repatriation of both their bodies. He said that once he had enough money, he planned to go on hunger strike. While Mr Ghassemian confirmed that the chaplaincy team had been supporting him, he felt it was too late for anyone to help him. He said that his trial was scheduled for May, and he hoped that this would not be delayed as it would affect his travel plans. Mr Ghassemian added that if he was found guilty at court or if the court hearing was delayed, he would go on hunger strike. The SO noted that support should be put in place for Mr Ghassemian around the time of his court hearing. She added that while Mr Ghassemian remained tearful and upset about his mother's death, he was not at imminent risk of suicide or self-harm and noted that his risk trigger was linked to the outcome of his court hearing. ACCT monitoring continued.

68. That day, healthcare staff recorded that Mr Ghassemian was prescribed 32 paracetamol tablets. There is no information about the reason for the prescription.

69. On 20 April, a SO completed an ACCT case review with another SO. Mr Ghassemian complained of back pain which he had had for many years. When asked if he had booked an appointment to see a GP, Mr Ghassemian said nothing could be done about it. He said that he felt a lot better than he had and was happy that he was to be allowed out of his cell that day to take a shower. Mr Ghassemian said that he was still waiting for confirmation about when his mother would be buried and that he had recently had an appointment with his solicitor cancelled due to the COVID restrictions. The ACCT panel noted that Mr Ghassemian had not harmed himself and had no thoughts to do so. They agreed to stop ACCT monitoring.

70. Mr Ghassemian attended court by video-link four times between 23 April and 18 May. Each time, he was assessed as medically fit and no concerns were noted.

71. On 25 April, a SO completed Mr Ghassemian's ACCT post-closure review. He recorded that Mr Ghassemian was still grieving for his mother.

72. That day, an officer saw Mr Ghassemian for a welfare check. She recorded that Mr Ghassemian had been upset and crying that afternoon and had said that he wanted to be with his mother. Mr Ghassemian said that if he was not released from custody after his hearing, he would go on hunger strike until he died. He said that he wanted to be buried next to his mother but was aware that this might not possible because he could not afford to have their bodies repatriated to Iran. However, Mr Ghassemian said that he had no current suicidal intentions and would wait for the outcome of his court hearing in mid-May. He said that if he was to take his life, he would go on hunger strike and starve himself. She noted that Mr Ghassemian had been eating. She recorded that she considered starting ACCT

procedures, but Mr Ghassemian had clearly stated that he had no intention to harm himself at that time. She discussed Mr Ghassemian's risk with a SO and other wing staff, and they agreed that ACCT monitoring was not necessary at that time.

73. On 12 May, Mr Ghassemian was prescribed 32 paracetamol tablets.

74. On 14 May, Mr Ghassemian requested an appointment with a member of the mental health inreach team. He did not describe any symptoms or say why he wanted to see them. On 17 May, the mental health team reviewed and rejected his application as there was no evidence of any serious mental illness. They made a referral for him to see a GP operating at Wandsworth.

75. On 27 May, Mr Ghassemian attended court by video link and was sentenced to serve 42 months in prison custody. Prison staff booked him out of the court video suite at 2.00pm and recorded "unknown" in reference to the outcome of his court hearing. The Safer Custody team told us that this meant that Mr Ghassemian had not told prison staff the outcome of his hearing. We were also told that, by 5.00pm that day, the court would have told the prison's Offender Manager Unit that Mr Ghassemian had been sentenced. This was subsequently recorded in his prison record that day. However, no one recorded in Mr Ghassemian's prison or medical record whether his risk of suicide and self-harm was assessed after attending the hearing.

76. An entry in Mr Ghassemian's medical record that day noted that he had been prescribed 32 paracetamol tablets which he had requested through the wing kiosk.

77. On 3 June, a prison GP saw Mr Ghassemian in his cell. Mr Ghassemian reported that he had no mental health issues apart from feeling low which he said was due to his mother's death. The GP noted that Mr Ghassemian appeared fit and well, other than a bowel problem.

78. On 7 June, a prison GP saw Mr Ghassemian. The GP told us that this was an unscheduled appointment as Mr Ghassemian went into the clinic treatment room and asked him a question. He exchanged information with Mr Ghassemian about his bowel symptoms, examined him and provisionally diagnosed him with irritable bowel syndrome. He gave him treatment advice and prescribed fybogel and ibuprofen for Mr Ghassemian's back pain. He said that he had no concerns about Mr Ghassemian or his mental health.

79. On 14 June, it was recorded in Mr Ghassemian's medical record that he was prescribed ibuprofen.

80. On 18 June, Mr Ghassemian made a request through the wing kiosk to see a prison GP.

Sunday 20 June

81. On the afternoon of 20 June, an officer was on duty and answered Mr Ghassemian's cell bell. Mr Ghassemian asked him if he could leave his cell for a few minutes to speak to another prisoner who lived in the opposite cell to pass on some legal advice Mr Ghassemian had obtained for him. The officer agreed.

Approximately five minutes later, Mr Ghassemian returned, and the officer locked him back in his cell. He did not record any concerns about Mr Ghassemian.

82. In his prison statement, an Operational Support Grade (OSG) said that he completed the night roll check at around 8.30pm. He reported no concerns about Mr Ghassemian.

83. Wandsworth failed to provide the investigator with CCTV footage, so he was unable to verify the accuracy of the timings when Mr Ghassemian was checked.

21 June

84. On 21 June, the OSG said that he completed the morning roll check at around 4.00am. He reported no concerns when he checked on Mr Ghassemian.

85. Prisoners on the fourth floor landing were due to mix with other prisoners and exercise that afternoon so staff did not unlock their cells that morning.

86. At approximately 11.20am, two officers started unlocking prisoners on the fourth floor landing for lunch. Officer A unlocked Mr Ghassemian's cell door at 11.24pm and shouted into his cell that it was time to collect his lunch. When Mr Ghassemian failed to respond, he looked into his cell and saw him lying flat on his back on his bed, completely naked. The officer told us that he closed the cell door for privacy reasons and to prevent other prisoners passing by from seeing Mr Ghassemian naked. He tried to engage with him by knocking and then shouting through the cell door, asking him to put on some clothes. He was simultaneously looking through the cell door observation panel and said that he realised that Mr Ghassemian had not moved or responded to him.

87. As he thought that something might be wrong, Officer A alerted Officer B (who was on the landing), as he knew Mr Ghassemian better. In his statement, Officer B recorded that he arrived at Mr Ghassemian's cell in seconds and went in. He tried to get a response from him, but he did not move. Officer B told Officer A that Mr Ghassemian did not appear to be breathing. He then immediately radioed a medical emergency code blue (indicating a life-threatening situation). (The investigator was unable to interview Officer B as he has since been suspended from duty for an unrelated matter.) Officer A remained at the cell door throughout and did not go into the cell.

88. The control room recorded that the emergency radio message was made at 11.25am. They called an ambulance straightaway.

89. A Custodial Manager (CM) responded to the emergency alarm. He said that he arrived at Mr Ghassemian's cell in less than 30 seconds and found the two officers there. He went into the cell and saw Mr Ghassemian laying naked on his bed, with dried vomit on the bed and floor. Mr Ghassemian remained unresponsive. He radioed for healthcare assistance.

90. The CM told us that Mr Ghassemian initially looked like he was dead, he was unresponsive, pale and showed no immediate signs that he was breathing. However, when he checked on him more closely, he noticed that Mr Ghassemian's stomach and chest were slightly rising up and down, an indication that he was

breathing. He updated the control room about Mr Ghassemian's condition and awaited the healthcare response.

91. Two nurses arrived shortly afterwards with emergency equipment. On examining Mr Ghassemian, the nurses noted that he was totally unresponsive but recognised that there were signs of him breathing. Prison staff had brought the emergency medical bags to the cell. Full physical observations were then taken, and treatment administered while the nurses monitored Mr Ghassemian. The nurses found that his airway was obstructed with a significant amount of white substances that looked like tablets in and around his mouth and throat. The nurses used suction to clear Mr Ghassemian's airway. One nurse noted that she saw two half-filled cups that contained white tablets, which she thought was paracetamol.

92. At 11.32pm, ambulance paramedics arrived and took over Mr Ghassemian's care. Mr Ghassemian remained unconscious throughout. At 11.56am, the paramedics placed Mr Ghassemian in the ambulance to escort him to St George's Hospital. At 11.59am, Mr Ghassemian went into cardiac arrest and the paramedics administered cardiopulmonary resuscitation (CPR), which continued on the way to the hospital. When the ambulance arrived at the hospital, Mr Ghassemian was declared dead. His death was confirmed at 12.21pm.

Contact with Mr Ghassemian's next of kin

93. From a note left in his cell, Mr Ghassemian had identified a friend as his next of kin. An officer was appointed as the prison's family liaison officer. After Mr Ghassemian's death, the officer tried to contact Mr Ghassemian's friend several times by telephone but was unsuccessful. He eventually spoke to him at 4.40pm on 22 June and broke the news to him.

94. The prison contributed to the cost of Mr Ghassemian's funeral in line with national instructions.

Support for prisoners and staff

95. After Mr Ghassemian's death, an operational 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.

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

Information discovered after Mr Ghassemian's death

97. Mr Ghassemian's noted next of kin provided the prison with a letter that he had received in the post the day after Mr Ghassemian's death. In the letter, Mr Ghassemian implied that he would no longer be around and asked his friend to take care of his affairs, including his funeral, finances and repatriation of his body and that of his mother.

98. Prison staff also found a note in Mr Ghassemian's cell, which contained instructions about what to do with his food. There were also some letters to be posted.

Post-mortem report

99. The post-mortem report established that Mr Ghassemian died from a drug overdose. The post-mortem toxicology report found that Mr Ghassemian had potentially fatal blood concentrations of tramadol and toxic plasma concentrations of paracetamol and ibuprofen. He also had high therapeutic amounts of mirtazapine in his blood. As Mr Ghassemian had not been prescribed tramadol or mirtazapine, it is likely that he obtained these illicitly.

Findings

Management of Mr Ghassemian's risk of suicide and self-harm

100. Prison Service Instruction (PSI) 64/2011 on safer custody sets out the procedures (known as ACCT) that staff should follow when a prisoner is assessed as at risk of suicide and self-harm. It requires that ACCT case reviews are multidisciplinary, and that case manager (now case coordinators) ensure that healthcare staff are always invited to attend case reviews or provide a written contribution to them.

101. Mr Ghassemian was supported under ACCT procedures on three occasions at Wandsworth. When ACCT monitoring started on 22 December 2020 and again on 5 March 2021, no one from the healthcare team attended Mr Ghassemian's case reviews. There is no evidence that the healthcare team were aware of the ACCT monitoring in place.

102. When ACCT procedures were started on 7 April, a member of the mental health team attended the first case review. However, no one from the healthcare or the mental health team attended the case review held on 12 April. Given that the mental health inreach team had referred Mr Ghassemian for an urgent mental health referral after the first case review, we would have expected healthcare involvement at further case reviews. Before ACCT procedures ended on 20 April, there was no recorded evidence that healthcare staff or the mental health team had been invited to attend the case review or if their input was sought. We found this very concerning given the urgency of the initial concerns about Mr Ghassemian's mental health.

103. PSI 64/2011 says that at the first case review, a prisoner's most pressing needs in relation to his risk of suicide and self-harm should be identified and a caremap should be completed, giving detailed and time-bound actions aimed at reducing the level of risk posed. When ACCT procedures were started on 5 March, no caremap actions were identified at any of the case reviews and the caremap in the ACCT document was left blank.

104. PSI 64/2011 also states that after ACCT monitoring stops, a post-closure review should be held. The review should take into consideration how the prisoner is feeling, their access to support and their progress made since ACCT monitoring stopped. It is unclear who completed Mr Ghassemian's post-closure review on 14 March. However, it was recorded that Mr Ghassemian stated that his only support was his mother, he was still having problems arranging his mother's funeral because the security team had not allowed him to add family numbers to his PIN, and he wanted his court hearing date brought forward. The post-closure review made no comment about any of these issues or how to address them and did not refer to his risk of self-harm. While this would not necessarily have led to the ACCT procedures being restarted, staff should have tried to address his concerns and recorded the action agreed. 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 instructions, including that:

- **ACCT case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate;**

- **staff set specific and meaningful ACCT support actions that are aimed at reducing prisoners' risks to themselves and review them at each case review; and**

- **staff should complete post-closure ACCT reviews in line with PSI 64/2011.**

Identifying the risk of suicide and self-harm

105. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Wandsworth should have recognised that Mr Ghassemian was at risk and started ACCT procedures to support him in the time leading to his death.

106. There were some missed opportunities to identify and manage Mr Ghassemian's risk and offer support. On 31 March, Mr Ghassemian told a council worker that he "looked forward to being with his mother soon", while discussing her funeral arrangements. While this information was apparently shared with prison staff, there is no evidence that they took any action to support Mr Ghassemian or consider starting ACCT procedures. On 25 April, Mr Ghassemian stated that he wanted to be buried with his mother and would not kill himself as he could not afford to fly their bodies to Iran. He added that his suicidal intention could be triggered by the outcome of his court hearing in May. While staff decided that starting ACCT procedures was not appropriate at that time, there is no evidence that they offered Mr Ghassemian additional support in the lead up to his court hearing.

107. PSI 07/2015 on early days in custody states that there must be arrangements in place to assess whether prisoners' status or demeanour has changed after a court appearance by video link. An increasing number of prisoners are being sentenced by video link. As they do not leave the prison, they are not always subject to the standard screening that they would receive when returning to the prison from court and passing through Reception. Prisoners with a change in status (such as those who have been sentenced like Mr Ghassemian) should be assessed to see if their risk of suicide and self-harm has increased so that they can be promptly referred to healthcare staff. From previous PPO investigations, we are aware that this does not always happen when prisoners attend court by video link. Following our recommendations to address this issue, the Director General wrote to all Governors and Directors in March 2021, requiring them to review local processes to ensure that similar health screen arrangements and the same processes for assessing risk of self-harm or suicide were followed after video link appearances as on Reception following a physical appearance in court in line with PSI 07/2015 and PSO 3050.

108. In April 2021, HM Prison and Probation Service (HMPPS) issued a Safety Briefing, containing early learning review analysis covering, "Assessing risk of harm in residents attending court and other appointments by video link". In this, it stated that prisoners are just as likely to receive bad news or unfavourable or unexpected

outcomes on video calls as when attending court or being visited by family in person. It goes on to state that it is vital that staff engage with prisoners after a video court appearance or a call, and that staff assess risk on the basis of official information, as well as the individual's presentation. The Safety Briefing states that, if necessary, concerns must be escalated (including starting ACCT procedures, where appropriate) and any new risk information must be recorded and shared.

109. On 27 May 2021, Mr Ghassemian was sentenced by video link to serve 42 months in prison. Wandsworth use a proforma for video link staff to record information after a hearing. The proforma prompts staff to record the outcome of the hearing "as reported by the prisoner". The outcome was recorded as "unknown". The Safer Custody team told us that the sentencing court would inform the prison of the outcome of the hearing, normally by 5.00pm on the day of sentencing. While it was recorded in Mr Ghassemian's prison record that he had been sentenced on 27 May, we found no information about how or if this information was shared as nothing was recorded in his prison or medical record about his change in status or whether his risk had been assessed after his court appearance.

110. His statements over the previous weeks indicated that Mr Ghassemian's court hearing was likely to be a trigger for him, and one that he had specifically linked with possibly harming himself if the outcome was not favourable to him. Despite this, we found no evidence to suggest that this information was shared with prison or healthcare staff to ensure support was offered. We consider that wing staff should have alerted the staff on duty in the video suite that the hearing was causing Mr Ghassemian significant concerns and that he was likely to be contemplating harming himself if he was not released from prison. His risk should also have been assessed on his return to his wing from the hearing. This was a missed opportunity to put support in place for him and consider whether suicide and self-harm monitoring was appropriate. We make the following recommendations:

The Governor should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

The Governor and Head of Healthcare should ensure that staff manage prisoners appearing in court by video link in line with national instructions, including that:

- **Prison records (NOMIS) are updated with details of the hearing and the outcome;**
- **any information indicating a risk of suicide and self-harm is shared with relevant staff before the hearing; and**
- **following the hearing, staff consider any new information about risk and start ACCT procedures when indicated.**

Key worker scheme

111. Under the Offender Management in Custody model, each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner. In March 2020, HMPPS suspended key work due to the COVID-19 pandemic. On 12 May 2020, key work was reintroduced but delivered in a more limited way in line with an Exceptional Delivery Model, where priority prisoners received key work.

112. The restricted COVID-19 regime meant that prisoners spent less time out of their cells and staff therefore had less time to engage with them or to observe how they interacted with other prisoners. This made it harder to identify signs of deteriorating mood or of problems with other prisoners that might normally have been picked up through regular and consistent key work.

113. We are concerned that Mr Ghassemian was not assigned a key worker at Wandsworth, despite him displaying regular signs of deteriorating mood, distress and other problems. He was allegedly assaulted in October 2020 and was monitored under ACCT procedures on three separate occasions. Prisoners monitored under ACCT procedures would usually be classed as 'priority' prisoners and would therefore automatically qualify for key work. In addition, Mr Ghassemian's ongoing worries about his mother's health and her subsequent death and funeral arrangements might have prompted staff to consider monitoring him more frequent. As noted, there is no evidence that anyone completed a welfare check when Mr Ghassemian was sentenced in May 2021.

114. While we note that staff completed welfare/wellbeing checks on Mr Ghassemian on five separate occasions, we consider that this was inadequate for the consistent concerns, issues and risks that he displayed. The lack of a key worker meant that staff were unable to build a relationship with Mr Ghassemian. More consistent or meaningful key work sessions might have helped staff identify any potential evidence of developing problems he might have had. We make the following recommendation:

The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.

Emergency response

115. When the two officers discovered Mr Ghassemian, they quickly raised the alarm. Although Mr Ghassemian was unresponsive, neither officer provided medical assistance, and instead waited for colleagues to assist. Staff told us that this took approximately 30 seconds but without access to CCTV footage, we cannot know the timings or if any delay changed the outcome for Mr Ghassemian.

116. We recognise that it can be difficult for staff in challenging circumstances to make instant decisions. However, when there is a potentially life-threatening situation, it is critical that staff act quickly and exercise sound judgement. All prison officers are trained in first aid and basic life support, and we would normally expect them to attend to a prisoner who is unresponsive or having difficulty breathing rather than waiting outside a cell. In emergencies, even the shortest delays can have a

significant impact on a person's chance of survival and early intervention may save a life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies.

Clinical care

117. The clinical reviewer noted that the care Mr Ghassemian received was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. However, she made a number of recommendations which the Head of Healthcare will need to address.

118. Mr Ghassemian had no recorded mental health diagnoses before he arrived at Wandsworth. The mental health inreach team rejected four referrals to them and noted that he had not presented with any mental health concerns. However, the clinical reviewer noted that there was no evidence that the mental health inreach team had planned to assess Mr Ghassemian. There was also no evidence that they communicated the outcome of the rejected referrals to him. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are kept informed of the status of their referrals to healthcare services, particularly when referrals are rejected. Information about repeated referrals should be clearly recorded and identify follow-up action.

Substance misuse and medicines management

119. Mr Ghassemian's death was due to an overdose of multiple medications. He was able to stockpile significant quantities of paracetamol, ibuprofen, tramadol and mirtazapine which contributed to his death. COVID-19 restrictions in place resulted in a reduced number of cell searches, and searches that were conducted were led by intelligence. There was no intelligence that Mr Ghassemian was misusing medications, prescribed or otherwise. In addition, Mr Ghassemian had not been prescribed any medications that might have alerted the pharmacy or nursing teams that he was at risk of stockpiling medications.

120. Mr Ghassemian was able to obtain paracetamol and ibuprofen through legitimate routes within the prison, including through the healthcare team. The clinical reviewer noted that the prescribed quantities and dose of Ibuprofen and paracetamol were within appropriate levels for the conditions for which they were issued. However, Mr Ghassemian also obtained tramadol and mirtazapine, which were never prescribed to him and, therefore, must have been obtained illicitly in prison.

121. The clinical reviewer found that healthcare staff completed an appropriate in-possession medication risk assessment when Mr Ghassemian arrived at Wandsworth. However, we found no evidence that his status was later reviewed, even though he was referred to the mental health team on a number of occasions and was monitored under ACCT procedures.

122. The prison's lead pharmacist told us that after Mr Ghassemian's death, the prison had taken a number of actions, such as removing paracetamol and medications containing paracetamol from prison canteen sheets. This was because when a prisoner ordered paracetamol products, their purchase was not reconciliated with their prescribed medications in their medical record. The lead pharmacist said that work was underway at Wandsworth to improve collaborative working between the prison and healthcare teams to perform checks within cells to address the potential stockpiling of medication, particularly for those prisoners at high risk of deliberate self-harm or suicide attempts. We make the following recommendation:

The Governor and Head of Healthcare should ensure that pharmacy teams are notified when ACCT procedures are started and that they complete an in-possession medication risk assessment.

Providing relevant evidence and information for PPO investigations

123. In line with PSI 58/2010, the investigator asked Wandsworth for relevant evidence needed to investigate the circumstances of Mr Ghassemian's death immediately after he died. However, Wandsworth failed to provide the investigator with important information relating to Mr Ghassemian's death. In particular, the prison incorrectly identified a key member of staff from whom evidence was needed and CCTV footage was not provided despite several requests. Initially, we were told that CCTV footage could not be provided because of an issue with the system. Later, we were told that the CCTV footage for the relevant period was lost. We were then told that the prison had not retained the footage. We also note that in the IMB's report, the IMB raised concerns about the CCTV system being unreliable and not fit for purpose. We therefore make the following recommendations:

The Governor should ensure that prison staff provide all relevant information requested by the Prison and Probation Ombudsman's office, in line with PSI 58/2010.

The Governor should review the provision of CCTV footage and ensure the system works and is able to provide footage to relevant stakeholders, including the Ombudsman.

Learning Lessons

124. We consider that it is important that staff involved in Mr Ghassemian's care learn from the findings of our investigation. We make the following recommendation:

The Governor should ensure that staff named in this report are given the opportunity to read this initial report in line with paragraph 1.11 of PSI 58/2010.

Inquest

125. The inquest into Mr Ghassemian's death was held in May 2024. The conclusion of the jury was that Mr Ghassemian's death was by suicide through a fatal overdose of a combination of tramadol and paracetamol, stockpiled and sourced by acquisition

at the prison's kiosk, prescribed by the prison's GPs, provided by the prison's pharmacy, and/or acquired illicitly.

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