Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Muxsin Awjama, a prisoner at HMP Nottingham, on 5 October 2023

A report by the Prisons and Probation Ombudsman

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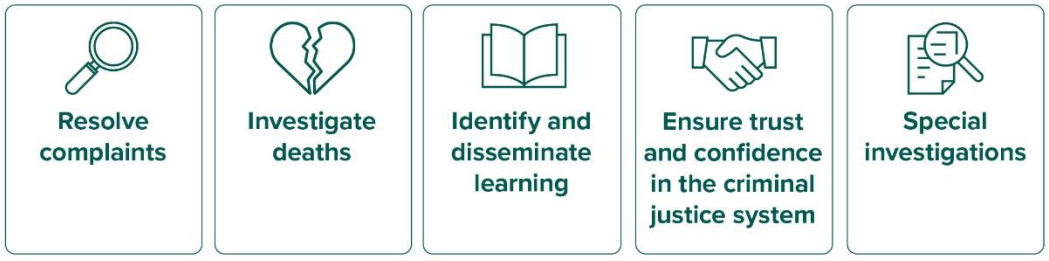
OUR VISION

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.

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 Muxsin Awjama was found hanged in his cell on 1 October 2023 at HMP Nottingham. He died in hospital four days later without regaining consciousness. He was 29 years old. I offer my condolences to Mr Awjama's family and friends.

Mr Awjama's was the third self-inflicted death at Nottingham in the previous three years.

Mr Awjama was a Somali national who entered the UK illegally at some point in a small boat and we know very little about his background or history. It was his first time in prison. Sadly, he had lost contact with his family and had no significant support outside prison. Mr Awjama left final notes that indicated that he was concerned about his mental health and did not feel he should live. However, my investigation did not find anything to indicate that staff should have realised he was at imminent or heightened risk of suicide or any reason for staff to initiate suicide and self-harm monitoring during his period in Nottingham.

Although I do not think it would have impacted the outcome for Mr Awjama, staff did not adequately complete the expected routine checks on him on the evening before and morning he was found hanged. The prison is now taking steps to address this issue. I make recommendations to widen the scope of the prison's triggers database to include significant court dates and to ensure that the prison responds to information requests from my office in a timely and robust manner, which was disappointingly absent in this investigation.

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 **October 2024**

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Summary

Events

1. Mr Muxsin Awjama was a Somali national who entered the UK illegally at some point in a small boat. In 2023 he was living in accommodation for asylum seekers when he was arrested and charged with attempting to murder another resident.

2. On 10 May 2023, Mr Awjama was remanded to HMP Hewell. He said it was his first time in prison and he had not been in contact with his family for several years. He said he had no history of mental health issues or substance misuse and had not seen a GP in the past three months. He said he had no previous or current thoughts of suicide or self-harm.

3. On 12 June, Mr Awjama transferred to HMP Nottingham. He started the English for Speakers of Other Languages (ESOL) course and appeared to settle on B Wing. He mixed with his peers and attended the gym. He did not give staff cause for concern and, apart from making several requests to be in a single cell, he did not raise any issues with staff. From 4 September, Mr Awjama was in a cell on his own.

4. On 1 October at about 11.30am, an officer found Mr Awjama hanged from the toilet privacy rail in his cell. Staff and nurses gave him cardio-pulmonary resuscitation (CPR) and paramedics arrived quickly. They managed to restart Mr Awjama's heart and took him to hospital. Scans showed no brain activity and Mr Awjama died on 5 October.

5. After his death, two prisoners gave information to staff that indicated Mr Awjama had been feeling suicidal for some weeks. Mr Awjama left final notes which indicated that he was worried he was seriously mentally ill and should not continue living.

Findings

6. Although Mr Awjama had some risk factors for suicide and self-harm, overall, we found there was little to indicate to staff that Mr Awjama was at imminent or heightened risk of suicide or any reason for them to initiate suicide and self-harm monitoring during his period in Nottingham.

7. Mr Awjama was due to appear in court the day after he hanged himself. He faced serious charges and the prospect of a significant sentence. Nottingham's safer custody department maintains a triggers database of significant dates that might increase prisoners' risk, but trial and sentencing dates are not routinely entered on to the database.

8. Three of the four routine checks completed by two different night staff (known as the evening and early morning roll counts) on 29 and 30 September and 1 October did not involve a visual check of each prisoner as they should have done. The prison investigated the actions of one of the night patrol officers but not the other. They have taken some steps to ensure checks are completed properly but we are concerned there may be a systemic issue in the prison. They did not respond to our requests for information in a timely or robust manner.

9. The clinical reviewer concluded that Mr Awjama's healthcare was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should create a process for adding significant court dates to the safer custody triggers database.
- The Governor should ensure that staff respond to requests for information from the PPO in a timely and sufficiently detailed and robust manner.

The Investigation Process

10. HMPPS notified us of Mr Awjama's death on 5 October 2023.

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

12. The investigator visited HMP Nottingham on 12 October 2023. She obtained copies of relevant extracts from Mr Awjama's prison and medical records. The prison provided her with copies of CCTV, body worn video camera (BWVC) footage and recordings of radio transmissions from 1 October. Extra CCTV from 29 and 30 September was also provided. Further information was obtained from Nottinghamshire police, including translations of final notes written by Mr Awjama and left in his cell.

13. The investigator interviewed four members of staff between December and February 2024. She spoke to another member of staff by telephone in May 2024. Further information was provided by the Governor.

14. NHS England commissioned a clinical reviewer to review Mr Awjama's clinical care at the prison. The investigator and clinical reviewer interviewed two staff together in December 2023.

15. Our investigation was suspended between January and May 2024 while we waited for the prison to provide us with a copy of their internal investigation into routine checks of prisoners (known as roll counts) completed on 30 September and 1 October 2023. In May 2024, Nottinghamshire police began their own investigation into possible falsification of records. The police investigator asked us not to investigate or interview further, but agreed we could complete our report.

16. We informed HM Coroner for Nottingham City 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 Awjama's family representative to explain the investigation and to ask if they had any matters they wanted us to consider. The family representative asked us for details of Mr Awjama's time in prison, what healthcare he had received and whether any third party was involved in his death. We have answered these questions in the report.

Background Information

HMP Nottingham

18. HMP Nottingham is a resettlement and local prison serving the courts of Nottinghamshire and Derbyshire. Healthcare for the prison is provided by Nottinghamshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Nottingham was in May/June 2022. Inspectors reported that although incidents of self-harm were falling some self-harm prevention practice remained weak. The daily regime and interaction with staff were too limited which inhibited meaningful engagement.

20. There were 109 foreign national prisoners at the time of the inspection. Professional telephone interpreting services were largely being used when needed. 12 bilingual members of staff had been identified which was a positive initiative. Foreign national prisoners could apply for international telephone credit to keep in touch with family and friends.

Independent Monitoring Board

21. 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 February 2023, the IMB reported that acts of self-harm had continued on a downward trend since 2020 with an 18% reduction from the previous year.

Previous deaths at HMP Nottingham

22. There were two self-inflicted deaths, nine natural cause deaths and one drug related death during the three years before Mr Awjama died. We identified no similarities between the self-inflicted deaths and that of Mr Awjama. In our investigation into a death from natural causes in February 2022, we found that healthcare staff should have used translation services for clinical interactions.

Key Events

23. Mr Muxsin Awjama was a Somali national who entered the UK illegally in a small boat. We therefore know very little about his background and history. (His medical record began in 2021, but we do not know how soon after he arrived in the UK he accessed NHS services.) In 2023, he was living in accommodation for asylum seekers when he was arrested and charged with attempting to murder another resident.

HMP Hewell, 10 May – 12 June 2023

24. On 10 May 2023, Mr Awjama was remanded into custody at HMP Hewell. He told a nurse at an initial health assessment that he had no history of mental health issues or substance misuse and did not drink alcohol. He reported slight muscle soreness from the incident which had led to his arrest but was otherwise well and had not seen a GP in the past three months. Mr Awjama said it was his first time in prison. He said he had not tried to harm himself before and had no current thoughts of suicide or self-harm. The nurse noted that Mr Awjama spoke a little English and needed an interpreter. As there was no interpreter available, she used Google Translate to assess Mr Awjama and noted in his record that this worked well.

25. On 12 May, Mr Awjama told a resettlement worker during the first part of his Basic Custody Screening (BCS - an assessment of the prisoner's basic needs) that he found speaking, reading and writing English hard. The officer noted he struggled with English and had needed an interpreter to complete the interview. The same day Mr Awjama completed a second health assessment also with the help of a translator. (There is no further detail about whether this was an interpreter via the telephone service, or Google Translate or similar.)

26. On 14 May, a mental health nurse completed a routine triage assessment of Mr Awjama's mental health needs. She used Google Translate to complete the assessment but noted that Mr Awjama was able to answer some questions in English. Mr Awjama said he had not had contact with his family for eight years. He said he had no history of mental health issues or self-harm and had no current thoughts of harming himself. The nurse concluded that Mr Awjama did not need ongoing support from the mental health team. She identified that he might be vulnerable due to his limited English and lack of support outside prison, both of which might lead to him feeling isolated. She introduced him to the Listener (prisoners trained by The Samaritan's to provide confidential peer support) on his houseblock and spoke to wing staff about identifying any other Somali prisoners in Hewell.

27. On 24 May, Mr Awjama told an officer at a key work session that he was socialising with the other prisoners on his houseblock and had a good relationship with his cellmate. He said he was not in contact with anyone outside prison. The officer advised him to let friends and family know where he was and provided him with a form to add numbers to his prison telephone account. Mr Awjama said he was keen to attend education, go to the gym and get a prison job.

28. On 2 June, Mr Awjama was allocated to the ESOL (English for speakers of other languages) course. On 4 June, he had a fight with his cellmate. His prison record

does not indicate what this was about, but staff noted in his clinical record that Mr Awjama's cellmate had punched him. On 12 June, he appeared at Stoke Crown Court and was remanded for trial. The same day he was taken to HMP Nottingham.

HMP Nottingham, 12 June – 28 September 2023

29. A nurse completed an initial health assessment using Google Translate for some words and phrases. Mr Awjama said he could understand English if she spoke slowly. She noted that Mr Awjama engaged very well but needed time to understand her questions. Mr Awjama appeared mentally and physically well and did not raise any concerns.

30. A member of the safer custody team completed a first night safer custody interview and noted that Mr Awjama spoke English. He said he had never harmed himself and had no current thoughts of suicide or self-harm. He had no mental health issues and was not involved in gang culture. The safer custody officer wrote in the handover section that that Mr Awjama would prefer to share a cell with another Somali. (Mr Awjama did not share a cell with another Somali at Nottingham.)

31. On 14 June, Mr Awjama had a first night key work session with an officer, who noted that Mr Awjama did not speak very good English and there was a "language barrier". He said he was confident that despite this he had managed to convey the main points about key work to Mr Awjama. He said Mr Awjama understood how to use the kiosk and phone, order canteen and choose his meals. Mr Awjama attended his gym induction the same day.

32. No significant health issues were identified at Mr Awjama's secondary health assessment on 15 June. The same day a resettlement worker completed Mr Awjama's BCS. Mr Awjama said that he had been living in a Serco-run property as an asylum seeker. He said he did not need any support with his bank account, was not in debt or on any medication and did not have any substance misuse or mental and physical health needs.

33. On 20 June, Mr Awjama applied for the ESOL, English and Maths courses in education and for access to the prison gym. He received confirmation he had been added to the waiting lists for all of these on 23 June.

34. On 30 June. Mr Awjama had a key work session with an officer. The officer did not use a translation service. He said Mr Awjama was polite and happy to speak to him. He said he had ordered hair clippers via the kiosk and the officer explained the process for receiving them. Mr Awjama said he had not been in touch with his family in Somalia for nine years. He expected to be in prison for only a few months because he was in for "a mistake". He said he had often been afraid for his safety where he was living in the community. Mr Awjama said he liked watching TV and other prisoners were helping him make general applications and order meals from the kiosk.

35. On 7 July, Mr Awjama applied to add three numbers to his phone account. These were added on 9 July.

36. On 8 July, Mr Awjama applied to safer custody to be moved to a single cell. He wrote, "I need a single cell, I got mental health problems I feel like attacking my cell

mate when I get depressed." On 11 July, he received a reply asking him if he had spoken to the mental health team, but no further action was taken.

37. On 10 July, Mr Awjama began an ESOL course in the education department. The same day he completed a diversity questionnaire with the help of his ESOL tutor. The results showed that he might need support with reading, writing and maths but had few or no difficulties with communication and interaction.

38. On 24 July, Mr Awjama's ESOL tutor recorded that he had worked hard in class and had an exemplary attitude.

39. On 28 July, Mr Awjama had a key work session with an officer. He said that he was doing well. The officer asked him if he had contacted his friends or family and Mr Awjama said he had not. He said he liked to be out of his cell and active and enjoyed going to the gym. Mr Awjama asked if he could move to a single cell and the officer advised him to apply. Mr Awjama said he struggled with English and got his cellmate to use the kiosk for him. The officer said Mr Awjama did not give him a reason why he wanted to be in a single cell beyond the fact that did not like his cellmate, and he wanted to be on his own. The officer said he would speak to safer custody and told Mr Awjama that someone would speak to him in private. There is no evidence that this happened.

40. On 11 August, the security department received intelligence that Mr Awjama's cellmate had complained that Mr Awjama had been discussing "disturbing things" and making him feel uncomfortable. On 12 August, the cellmate's record showed that his brother had raised concerns about his mental health and Mr Awjama, via the safer custody hotline, after visiting him. There is no evidence that anyone spoke to Mr Awjama in light of the intelligence or his cellmate's brother's concerns.

41. On 13 August, the cellmate told an officer that he wanted to move cells because Mr Awjama was behaving in a 'bizarre' manner. He said they had not argued, he just wanted a better cellmate. (Nottinghamshire police asked the investigator not to interview the cellmate until they had interviewed him and, once this had happened, they asked us not to continue investigating while they carried out their own investigation at Nottingham. Despite requests, the police did not provide a copy of the cellmate's interview transcript or statement.)

42. A Supervising Officer (SO) said he remembered Mr Awjama well from his time on B Wing. He said Mr Awjama was an 'ideal' prisoner. He attended education and the gym, got on well with prisoners and did not cause any problems for staff. He had limited English but was able to hold a conversation. Mr Awjama was always pleasant and said hello.

43. An officer saw Mr Awjama for another key work session on 14 August. Mr Awjama said he was enjoying education. He said he felt better about having a cellmate now he got out of his cell more. Mr Awjama said he had been in contact with his friends and family, although his phone records showed this was not true. The officer said Mr Awjama appeared well and raised no concerns.

44. The officer held another key work session on 21 August. Mr Awjama asked if he had to move to G Wing (the prison's vulnerable prisoner unit). The officer explained what G Wing was and Mr Awjama said that other prisoners often teased him in a

fun way because his English was not good. Mr Awjama said he was currently talking to his solicitor about trying to retrieve numbers for his family from his mobile phone which the police had taken in evidence. He said he was getting on better with his cellmate but would still prefer to be in a single cell.

45. The cellmate moved out of their cell on 25 August. A SO said no one had ever made him aware that Mr Awjama and his cellmate were not getting on and he was not aware of the reason why the cellmate had moved out of their cell.

46. On 29 August, another prisoner moved into Mr Awjama's cell. He moved out again on 4 September. There is nothing in the record to indicate they had any issues with sharing. Mr Awjama remained in the cell alone from 4 September onwards.

47. Mr Awjama did not have a key work session with an officer during September because the officer was allocated to the prison's reception when he was scheduled for key work.

48. On 26 September, a SO reviewed Mr Awjama's Incentives and Earned Privileges (IEP) Scheme level after he refused to share his cell with a new cellmate and reduced him to the basic level of the scheme. The SO said he would review Mr Awjama again on 1 October. The next morning Mr Awjama did not attend education, but his record did not show why. The SO said the prison was under a lot of pressure to take prisoners from the courts and there was less scope for agreeing to prisoner's having single cells unless they were considered extremely vulnerable or at high risk of harming someone else.

29 and 30 September 2023

49. On 29 September, CCTV showed Mr Awjama left his cell to collect his lunch between 11.14am and 11.17am. Mr Awjama remained in his cell until 2.38pm, when he came out for social time on the wing. Mr Awjama appeared to interact well with other prisoners on B Wing. At 3.00pm, he left the wing for a legal visit. We spoke to Mr Awjama's solicitor who said he had around 10 legal visits with Mr Awjama while he was in prison, always accompanied by the same Eritrean interpreter. The solicitor said that Mr Awjama maintained that he was innocent of the offence but that he did not have any concerns about Mr Awjama's risk to himself. He said Mr Awjama's death had come as a great shock.

50. Mr Awjama returned to the wing at 4.51pm, collected his evening meal and returned to his cell where he was locked in for the night.

51. At 7.46pm, an officer made a routine check of all the prisoners on the wing (known as the evening roll count, the primary purpose of which is to check the right number of prisoners is contained on each prison wing). He did not look through any cell observation panels but checked that every door was locked. He signed the night patrol report to confirm that he had checked every prisoner. On 30 September at 5.39am, the officer completed another routine check (known as the early morning roll count) of every prisoner on the wing and looked through the cell observation panels as well as checking every door.

52. On 30 September, CCTV showed Mr Awjama collected his lunch at 11.20am and returned to his cell. Between 2.09pm and 4.23pm, Mr Awjama socialised with several other prisoners on the wing.

53. Nottinghamshire police provided the investigator with a statement from a prisoner who was released after Mr Awjama died. The prisoner said he lived in the cell opposite Mr Awjama's and they had become friends. They talked about their mutual interest in the gym. He said they did not talk about their personal lives as there was a bit of a language barrier, but Mr Awjama told him he had lived in Germany and was divorced. On 30 September, the prisoner said Mr Awjama gave him a model he had made of a house with a man hanging by the neck from the roof. He asked Mr Awjama what it was and said Mr Awjama smiled at him but did not reply. The prisoner said he did not tell the staff about the model because he was not concerned about Mr Awjama. The prisoner said Mr Awjama seemed his usual self and showed him some ju-jitsu moves during social time.

54. CCTV showed Mr Awjama collected his evening meal and was locked in his cell at 4.25pm. At 7.47pm, an officer completed the evening roll count. He did not look through any cell observation panels but checked that every door was locked. He signed the night patrol report to confirm that he had checked every prisoner.

Events of 1- 5 October 2023

55. CCTV showed that at 7.46am, an officer checked Mr Awjama's door but did not look through the observation panel when he completed the early morning roll count. Again, he signed the night patrol report to confirm that he had checked every prisoner.

56. CCTV showed that at 11.28am, Officer A opened Mr Awjama's cell door to let him out to collect his lunch. The officer said he saw Mr Awjama hanging from the privacy curtain rail above his toilet by a ligature made from a sheet and J-cloths. Mr Awjama's hands and feet were also tied together using bits of sheet. He shouted 'code blue' to a SO who was standing nearby and then radioed a code blue emergency. Radio transmissions showed the code blue was called at 11.28am.

57. The SO and Officer B joined Officer A within 20 seconds. Between them they cut the sheet from Mr Awjama's neck and laid him on the floor. Officer B checked for a pulse but could not find one. The officers also removed the pieces of sheet from Mr Awjama's wrists and ankles and started cardio-pulmonary resuscitation (CPR).

58. A nurse and other healthcare staff arrived at the cell at 11.30am with the emergency medical equipment. She told us that she was not the dedicated response nurse that day, but she could hear from the radio call that it was a serious incident, so she went straight to B wing.

59. The nurse attached a defibrillator which assessed Mr Awjama and advised them to continue CPR. She said Mr Awjama's throat was very swollen, which made it very hard to insert an airway. She gave him oxygen via an ambu-bag and noticed minimal air entry into his chest. Once the other prisoners on the landing were locked in their cells staff moved Mr Awjama to the landing so they had more space to work on him. The nurse and the other healthcare staff took it in turns to give Mr Awjama CPR.

60. The control room log showed an ambulance was called at 11.29am, as soon as the code blue was received. (Although the Ambulance Service recorded the call at 11.31am, we think that this is due to a difference between the ambulance service and prison clocks and did not represent a delay.) The control room officer told the call handler that Mr Awjama had no pulse, and an ambulance was dispatched with the highest priority.

61. CCTV showed the first paramedic arrived at Mr Awjama's cell at 11.38am, followed by a second crew at 11.46am. They took over CPR, inserted a smaller airway and gave Mr Awjama adrenaline. After the adrenaline, Mr Awjama's heart started to beat, but he was unable to breathe unaided. The air ambulance crew arrived at 12.08pm. At 12.22pm, Mr Awjama was taken to hospital. No restraints were applied at any point.

62. Mr Awjama had been due to attend court for his trial the following morning on 2 October.

63. A scan of Mr Awjama's brain showed he had suffered extensive injury due to lack of oxygen after hanging himself. He remained in hospital and died on 5 October 2023.

Information from other prisoners, 2 – 7 October

64. On 2 October, after staff had examined CCTV from B Wing, an officer asked a prisoner what Mr Awjama had given him the day before. The prisoner handed him the model of the house with the man hanging from the roof. The police subsequently took the model as evidence. The prisoner also told the officer that Mr Awjama's previous cellmate had made allegations that Mr Awjama had encouraged him to kill himself.

65. The same day, two officers spoke to the previous cellmate after he gave information to another officer in the prison library. He told them that Mr Awjama's suicidal thoughts had affected him when they shared a cell and had caused him to self-harm.

66. On 5 October, a mental health nurse and an officer from the safer custody team visited the previous cellmate to break the news of Mr Awjama's death.

67. The next day, 6 October, an officer completed a welfare check on the previous cellmate and the cellmate gave him a letter for a nurse. The nurse read the letter within the hour and discovered that it contained references to a joint suicide plan with Mr Awjama. She immediately started Prison Service suicide and self-harm monitoring procedures (known as ACCT) for him.

68. Nottinghamshire police provided the investigator with a copy of the letter. The previous cellmate said that when he shared a cell with Mr Awjama, there had been a rope attached near the toilet so they could hang themselves. He said they both talked about killing themselves if they received prison sentences. He said he had wanted to leave the cell because most of their conversations were about suicide. He said he heard voices, and these got worse during this period, and he had constant suicidal thoughts. He said Mr Awjama also heard voices. He said he had told wing staff about the rope, but nothing had been done about it. We found no recorded evidence that staff were aware of the rope. A SO confirmed that staff did

daily cell checks and there is no record of staff recovering a rope from Mr Awjama's cell.

Notes found in Mr Awjama's cell

69. The police removed three handwritten notes from Mr Awjama's cell and had them translated. In one dated 27 September, Mr Awjama said that this was the last day of his life because he felt he had a problem with mental illness. In a second note written on two scraps of paper, he said he believed that if a person felt they had mental health problems they should kill themselves so they could not harm anyone else. He said he sentenced himself to death because as a criminal he would not get mental health medication. He said he did not come to the UK to harm anyone and asked for his 'brothers' to excuse him.

70. A third note which body worn video camera footage showed was left prominently on his desk was addressed in English to "Govs, friends, teacher, family", and began "All sorry. I love you." The rest of the note was in Somali. Mr Awjama said he regretted his offence and thought it came about from weakness and mental illness. He said no one had harmed him in prison and asked for a Muslim burial. He said in 2021 he had asked to be moved to a Somali community where he could receive advice about his mental health and had told people that he would become ill by being lonely.

Prison investigation into roll count/welfare checks on 30 September and 1 October

71. On 13 October, the Deputy Governor commissioned a senior prison manager to investigate an officer's roll counts on 30 September and 1 October to see if there was sufficient evidence to proceed to a disciplinary hearing. The manager reported on 18 November 2023 that she had found sufficient evidence for a disciplinary hearing. However, the officer resigned from the Prison Service before this could take place. The prison did not investigate another officer's roll count or consider whether there might be a wider issue with roll counts across the prison.

Contact with Mr Awjama's family

72. The prison appointed a family liaison officer (FLO) on 1 October after Mr Awjama was taken to hospital. Mr Awjama did not give the details of his next of kin when he arrived at Hewell or Nottingham, so the FLO called several numbers listed on Mr Awjama's prisoner telephone account and his prison record. No one that answered appeared to know Mr Awjama or be related to him. On 2 October, the FLO telephoned Mr Awjama's solicitor and left a voicemail. She also contacted the HMPPS national FLO support team for advice. As a result, she contacted the Somali Embassy and the Home Office.

73. Mr Awjama's solicitor returned her call on 5 October and told her he would try to find his next of kin. The solicitor also said he would contact a Somali community and try to arrange an Islamic funeral for Mr Awjama. On 13 October, Mr Awjama's solicitor told the FLO that he had contacted Mr Awjama's sisters, who lived in Belgium, and they had identified a representative living in the UK who would act on

their behalf. She subsequently liaised with the family representative. The prison returned Mr Awjama's property to him and offered a financial contribution to Mr Awjama's funeral in line with national guidance.

Support for prisoners and staff

74. After Mr Awjama was taken to hospital on 1 October, a senior prison 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. A second debrief took place after Mr Awjama died on 5 October.

75. A SO told the investigator that he had been frustrated at the lack of support from senior management immediately after Mr Awjama's death. He said he had only comparatively recently received the help that he needed. He said that other staff had also not felt appropriately supported.

76. The prison posted notices informing other prisoners of Mr Awjama'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 Mr Awjama's death. Listeners attended the wing to speak to prisoners.

Post-mortem report

77. The pathologist gave Mr Awjama's cause of death as acute cerebral hypoxia (deprivation of oxygen to the brain) due to hanging.

78. The police found no evidence of third party involvement in Mr Awjama's death.

Inquest

79. The Coroner's inquest was heard on 19 August 2024 and the jury returned a verdict of suicide.

Findings

Assessment of risk

80. Mr Awjama had some risk factors that indicated he might be at risk of suicide or self-harm including that it was his first time in prison, he was facing the prospect of a significant sentence, he was a foreign national and had lost touch with his friends and family.

81. Mr Awjama consistently told healthcare staff in both Hewell and Nottingham, that he had no mental health concerns. The only time he said differently was in an application to safer custody on 8 July made via the kiosk system, in which he asked for a single cell because he had mental health problems and felt like harming his cellmate. Mr Awjama said more than once that his written English was not sufficient for him to complete applications on his own and told staff that his cellmate helped him to use the kiosk, we cannot therefore be certain that Mr Awjama was aware of the exact content of this application. He was clearly keen to have a single cell and although he briefly had another cellmate after his cellmate moved out, he had been a sole occupant since 4 September.

82. We have considered whether Mr Awjama was properly supported as a foreign national prisoner (FNP) at Nottingham. We note that translation and interpretation services are available to staff but were not always used when interacting with Mr Awjama because staff felt that he was able to communicate sufficiently well without them. This was backed up by the results of the assessment he completed with the ESOL tutor. We have not seen any evidence that Mr Awjama tried and failed to make staff aware of any pressing matters due to a language barrier.

83. Mr Awjama had lost contact with his family and was far from a Somali community and we consider it would have been natural for him to feel lonely without their contact and support. The prison tries to place foreign national prisoners from the same community on the same wing, but this is reliant on their prison population at any given time. The prison's diversity and inclusion advisor told us that the prison is trialling a new approach to managing FNPs in a cohort with a dedicated senior manager and we welcome this initiative.

84. Overall, Mr Awjama appeared to be settled on his wing, did well on the ESOL course and started going to the gym. The last time he was seen on CCTV he appeared to be mixing well with his peers. Very sadly, Mr Awjama's final notes and the evidence given to staff after he died by a prisoner and the cellmate told a very different story. He had serious concerns about his mental health and felt he should not continue living. We note he also apologised to the staff at Nottingham and his friends and family and said that he had not come to any harm in prison.

85. We consider that the staff response to Mr Awjama's application in July was insufficient and staff should have spoken directly to him to explore the nature of his concerns. However, in the broader context of his presentation over the following months, we think it unlikely that he would have been subject to ACCT monitoring or closer supervision by the time he died.

86. We consider that, overall, there was little evidence available to staff to indicate that Mr Awjama was at imminent or heightened risk of suicide or any reason for staff to initiate suicide and self-harm monitoring.

87. We note that Mr Awjama was due to appear in court the day after he hanged himself. He faced serious charges and the prospect of a significant sentence. Nottingham's safer custody department maintains a triggers database of significant dates that might increase prisoners' risk. The safer custody team visit prisoners on the database in advance of these dates to check on their welfare. We consider this is good practice and we have seen similar databases used to good effect in other prisons. The investigator was told that trial dates were not routinely entered on to the database. Given that trial and sentencing dates are a known risk factor we think it makes sense for the prison to attempt to identify and add these dates. We make the following recommendation:

The Governor should create a process for adding significant court dates to the safer custody triggers database.

Roll counts

88. In line with national guidance, Nottingham's local security strategy (LSS) requires night staff to complete two roll counts and welfare checks of every prisoner by 9.00pm and 6.00am. The primary purpose of a roll check is for security, to check that all prisoners are present. Staff should also satisfy themselves of each prisoner's safety. Neither of these functions can be properly completed unless staff make a visual check of each prisoner. Very quickly after Mr Awjama died, Nottingham identified that the roll counts on the evenings of 29 and 30 September and the morning of 1 October had not been completed as required. A local investigation subsequently identified grounds for disciplinary charges against an officer who failed to complete the 30 September and 1 October checks. He resigned before the disciplinary hearing could take place. Nottinghamshire police investigated the falsification of the night patrol sheets on 30 September and 1 October but decided not to take any further action. We are satisfied that the prison investigated him appropriately.

89. Despite the early learning review completed shortly after Mr Awjama's death identifying that another officer had not properly completed the evening roll count on 29 September, the prison did not investigate his actions. On 13 July 2024, following several emails of concern from us over several months, the Governor commissioned an investigation into this check and whether there is a more systemic issue with improper completion of roll counts in the prison. He also told us that the prison was doing random CCTV checks to ensure roll counts were being done as documented. The prison did take a number of actions after Mr Awjama's death including updating their LSS and wing documents to include specific roll check timings and the requirement for simultaneous welfare checks. These were highlighted to staff in a Staff Information Notice issued on 22 March 2024.

90. The Head of Residence also introduced an assurance check of wing documents by custodial managers to ensure the correct signing for roll counts and welfare checks. These assurance checks are in turn monitored by the Head of Residence.

91. We cannot say that a visual check of Mr Awjama on the morning of 1 October would have changed the outcome for him. Given that paramedics managed to restart his heart at about midday it is extremely unlikely that he was suspended at 7.46am when an officer checked his cell. Clearly however, it is vital to the security of the establishment and the safety of all prisoners that the required checks take place as they should. Given the actions the Governor is now taking to investigate this more fully, we make no recommendation.

92. However, of continued concern is the protracted time that the prison took both to respond to our queries and commission this more robust investigation. The first investigation concluded at the end of 2023 when the officer resigned. However, it then took until May 2024, following us escalating the matter to the Governor, for the prison to confirm the outcome of this investigation. We outlined at this point that we were concerned that the issue was potentially more widespread and asked whether another officer had also been investigated. It took a further two months for the prison to respond and commission the latest investigation into events that had happened nearly ten months earlier. This has impacted both on the timeliness of our investigation and who we have interviewed and had safety implications for the prison. We make the following recommendation:

    The Governor should ensure that staff respond to requests for information from the PPO in a timely and sufficiently detailed and robust manner.

Clinical care

93. The clinical reviewer concluded that Mr Awjama's healthcare was equivalent to that which he should have expected to receive in the community.

Governor to note

Staff support

94. We bring a SO's frustration at the lack of the support from senior managers following Mr Awjama's death to the Governor's attention. The Governor will wish to assure himself that staff receive appropriate and timely support after traumatic events.

Good practice

Family liaison

95. Despite Mr Awjama having no registered next of kin and his family not being in this country, the FLO was tenacious in her attempts to contact them. She exhausted all avenues of enquiry and assistance and was eventually successful in getting a message to his sisters in Belgium. She should be commended for her actions.

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