Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Akhtar Hussain, a prisoner at HMP Manchester, on 8 July 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 Akhtar Hussain died in hospital from pneumonia due to hypoxic/ischaemic brain damage on 8 July 2021, after he was found hanging in his cell at HMP Manchester three days earlier. He was 32 years old. I offer my condolences to his family and friends.

Mr Hussain was segregated for three days before he was found hanging. I am concerned that his segregation was managed poorly. His health was not properly assessed at the start of the segregation. There is little evidence that staff interacted with him as required, he did not have access to any of his property or distraction materials, and his cell bell went unanswered shortly before he was found hanging.

In the time before he was segregated, Mr Hussain was subject to three separate uses of force. I am concerned that force was used too quickly and not as a last resort, with not enough thought given to alternative solutions. I am particularly troubled that Mr Hussain was segregated, seemingly unlawfully, for a two hour “period of reflection” after the first use of force.

Mr Hussain was a man with several long-standing risk factors for suicide and self-harm, including a diagnosis of schizophrenia and a history of self-harm. The events of the last days of his life exposed Mr Hussain to significant new risk factors and potential triggers. I am concerned that no one identified that he might be at risk or considered starting suicide and self-harm prevention procedures.

As in previous investigations at Manchester, I found that it took too long to summon emergency medical assistance when Mr Hussain was found hanging.

I am concerned about the number of poor decisions and actions by staff at Manchester and the impact that these had on Mr Hussain. This is not the first case in recent years in which we have made critical findings at Manchester, and I note that HMIP identified poor outcomes for prisoners in several key areas during their most recent inspection. It is important that the Governor recognises and seeks to address any underlying cultural or staffing issues at the prison.

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 **November 2024**

Contents

Summary

Events

1. On 8 April 2020, Mr Akhtar Hussain was remanded to HMP Forest Bank, charged with robbery and assault. Mr Hussain had a history of mental ill-health and had been diagnosed with schizophrenia. In February 2021, prison staff monitored him under suicide and self-harm prevention procedures (known as ACCT) for around four weeks. On 19 May, prison staff segregated Mr Hussain after he assaulted an officer.

2. On 21 June, Mr Hussain was transferred to the segregation unit at HMP Manchester. On 24 June, he moved to the prison's reverse cohort unit for a period of COVID-19 isolation.

3. On 1 July, staff used planned force to restrain Mr Hussain after he refused to move wings. He was taken to the prison's segregation unit for around two hours before returning to a normal wing.

4. On 2 July, Mr Hussain blocked his cell door observation panel and barricaded his cell door. Staff used planned force to enter the cell and restrained him before taking him to the segregation unit. A further unplanned use of force was used soon afterwards to take Mr Hussain from a holding cell. The following day, Mr Hussain was found guilty of disobeying a lawful order and was given a punishment of seven days' cellular confinement.

5. At around 12.54pm on 5 July, prison staff found Mr Hussain in his cell, with a ligature tied around his neck. Nurses and officers tried to resuscitate him, and paramedics later assisted. Paramedics took Mr Hussain to hospital, where he died on 8 July.

Findings

Assessment of Hr Hussain's risk of suicide and self-harm

6. Mr Hussain had several long-standing risk factors for suicide and self-harm. In the days before his death, he was exposed to significant new risk factors. There is no evidence that prison or healthcare staff considered whether his risk had increased or considered starting ACCT procedures.

Use of force

7. Mr Hussain was subject to three uses of force in the days before his death. We have concerns about each of these. Staff did not communicate effectively and did not take enough time to consider alternative options to force. We are not satisfied that planned use of force was used as a last resort, as national guidelines instruct.

Segregation

8. Mr Hussain was inappropriately segregated for two hours on 1 July for a "period of reflection". Prison staff did not complete any segregation unit paperwork and there is no record that he was held under a specific prison rule.

9. When he was formally segregated the next day, we are concerned that there was little evidence that staff tried to engage with Mr Hussain. He was segregated without any of his property, and he did not access the regime at any time. Segregation health screens, an important tool in determining whether a prisoner is well enough to be segregated, were completed without consideration of Mr Hussain's medical history.

10. On the day that he hanged himself, Mr Hussain pressed his cell bell a number of times. On several occasions, staff reset the bell without speaking to Mr Hussain. An officer completed a roll check shortly before Mr Hussain was found without looking into his cell.

Disciplinary hearing

11. We are concerned that Mr Hussain's punishment of cellular confinement was excessive for the circumstances of his offence. Although he said at his disciplinary hearing that he wanted to speak to the mental health team, no one referred him to them.

Emergency response

12. When staff found Mr Hussain hanged, there was a delay of around three minutes before anyone radioed a medical emergency code. We have highlighted this issue in previous investigations at Manchester.

Clinical care

13. The clinical reviewer found that Mr Hussain's medication compliance was not appropriately monitored at Buckley Hall, and he did not have the detailed care plan that his diagnosis merited. It is concerning that Mr Hussain's mental health was not fully assessed at Manchester, even though he had been segregated and had asked to be seen.

Recommendations

- **The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm, including that:**
    - **segregation unit staff consider and record all the known risk factors and triggers of a segregated prisoner, including environmental factors;**
    - **monitor changes in the prisoner's behaviour or circumstances when determining the risk of suicide and self-harm; and**
    - **start ACCT procedures when indicated.**

- **The Governor should ensure that staff use force in line with national guidelines, including that:**
    - **planned use of force is only used when it is reasonable and necessary, and only as a last resort when all other means of de-escalating the incident have been repeatedly tried and failed;**
    - **all staff wear and switch on body-worn video cameras during planned use of force interventions;**
    - **staff remain professional and do not use inappropriate language; and**
    - **CM A and SO B receive additional advice and guidance on the lawful use of force and de-escalation techniques.**
- **The Governor should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:**
    - **segregation is used appropriately, in line with Prison Rules, and with the authority of an operational manager;**
    - **each prisoner is assigned a designated officer responsible for their welfare;**
    - **staff engage in purposeful dialogue with each prisoner at least three times a day, and that this is recorded in the prisoner's history sheet; and**
    - **prisoners are able to access all aspects of the regime every day and have access to basic personal property and distraction materials.**
- **The Governor and Head of Healthcare should ensure that healthcare professionals completing segregation unit health screens have access to the prisoner's medical history and are always given the opportunity to speak to the prisoner.**
- **The Governor should commission a disciplinary investigation into the actions of segregation unit staff on the morning of 5 July 2021.**
- **The Governor should ensure that segregation unit staff complete their duties satisfactorily and in line with local and national requirements, including that:**
    - **staff observe prisoners subject to cellular confinement at least once every hour;**
    - **staff observe prisoners at roll checks and take appropriate action if they have concerns for a prisoner's welfare; and**
    - **staff answer cell bells promptly, take reasonable steps to answer the query and take appropriate action if they have concerns for the prisoner's welfare.**

- **The Governor should ensure that managers conducting disciplinary hearings impose punishments in line with local tariff guidelines and take into consideration mitigating circumstances when considering awarding periods of cellular confinement.**

- **The Governor should ensure that managers imposing punishments of cellular confinement fully consider the likely impact on the health and welfare of the prisoner, including referring the prisoner to the mental health team, where appropriate.**

- **The Prison Group Director for the Long Term and High Security Estate should take steps to satisfy himself that all staff at HMP Manchester understand their responsibilities during medical emergencies, including calling an immediate emergency code when there is a threat to life.**

- **The Head of Healthcare at HMP Buckley Hall should ensure that all prisoners identified as having a severe and enduring mental illness have comprehensive care plans.**

- **The Heads of Healthcare at HMP Manchester and HMP Buckley Hall should ensure that:**

    - **liaison between prisons takes place when prisoners with a history of severe and enduring mental illness are transferred to Manchester and that the outcome is fully documented in the prisoner's medical records;**

    - **all prisoners identified as requiring an urgent mental health assessment are assessed promptly and within 48 hours; and**

    - **all prisoners with a significant and current mental illness are discussed at the weekly mental health multidisciplinary meeting to ensure continuity of care.**

- **The Governor and Head of Healthcare at HMP Manchester should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

The Investigation Process

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

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

16. NHS England commissioned a clinical reviewer to review Mr Hussain's clinical care at the prison.

17. The investigator interviewed twenty-seven members of staff at Manchester, some jointly with the clinical reviewer. Some of the interviews were conducted remotely.

18. We informed HM Coroner for Manchester City of the investigation. He provided us with a copy of the post-mortem and toxicology report. We have sent the Coroner a copy of this report.

19. We contacted Mr Hussain's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked a number of questions including:\

    - Had Mr Hussain been assessed by the prison's mental health team?
    - What medication was Mr Hussain prescribed, when was it prescribed and why he did not take it?
    - Was Mr Hussain being monitored under suicide and self-harm prevention procedures or had he spoken to prison Listeners?
    - Why did Mr Hussain move to Manchester's segregation unit and what safeguarding procedures were in place? Did Mr Hussain's behaviour deteriorate in the days leading to his death and, if so, what action was taken?
    - Did Mr Hussain have access to or make telephone calls from prison?
    - Did Mr Hussain leave a note after his death?
    - Why were prison officers present at the time of Mr Hussain's death in hospital?

    We have tried to address these questions in this report. Mr Hussain's family also asked several questions about the care he received while in hospital, which we have been unable to review as it falls beyond the remit of our investigation.

20. Mr Hussain's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Manchester

21. HMP Manchester is a Category B raining prison, with a small Category A function. It holds up to 744 prisoners spread across nine residential units, a segregation and specialist intervention unit and a healthcare centre. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour healthcare services.

HM Inspectorate of Prisons

22. HMIP's most recent inspection of Manchester was carried out in September 2021. Inspectors reported that Manchester had made improvements since the last inspection, including an improvement in staff-prisoner relations. However, inspectors reported that there was much to be done about the lack of engagement and poor attitude of some officers. Inspectors observed that some officers remained distant and disengaged but they also saw some positive relationships between staff and prisoners. Inspectors reported on improvements in the management of the segregation unit, including that prisoners on the unit could use the phones and showers daily.

23. Inspectors found that although the use of force used was less than on previous inspections, de-escalation attempts were inadequate in many of the incidents that they reviewed. They reported that the governance and oversight of the use of force was also weak and that there was a lack of focus on learning lessons following incidents involving force. Inspectors also reported on the reluctance of officers to switch on body-worn cameras routinely during incidents. They reported that the use of special accommodation was not always justified, and oversight of its use was weak.

24. Inspectors reported that prisoners' trust in staff was being negatively affected by weaknesses in the management of property, and prisoners lacked confidence in the management of their personal property. Inspectors cited how some prisoners had moved to a different cell and their property had been misplaced during the move, which caused frustration and mistrust.

25. Inspectors reported that although death in custody action plans were raised in response to PPO recommendations, there was little evidence to show that improvements were embedded in practice.

Independent Monitoring Board

26. 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 ending February 2021, the IMB reported that the segregation unit operated a well-managed regime. The IMB reported that the use of body-worn cameras was not being used during incidents involving the use of force. They also highlighted their continuing concerns about the security of prisoner property when prisoners moved internally between wings or to the segregation unit.

Previous deaths at HMP Manchester

27. Mr Hussain was the fourth prisoner to take his life at Manchester since January 2019. We found no significant similarities between our findings about Mr Hussain's death and those in our previous investigations.

28. There were also nine natural cause deaths and four drug-related deaths at Manchester during this period. Our reports into three of those deaths found delays in calling medical emergency response codes.

29. A further three deaths have occurred at Manchester since Mr Hussain's death, including one apparent self-inflicted death.

Assessment, Care in Custody and Teamwork (ACCT)

30. 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. As part of the process a Care Plan (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

Segregation units

31. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable, under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving periods of cellular confinement after disciplinary hearings. Prisoners who are segregated are assessed by a member of healthcare staff. A senior operational manager must then be satisfied that the prisoner is fit for segregation. The unit at Manchester can hold fourteen prisoners but in the months before Mr Hussain was segregated, the unit held an average of around eight prisoners.

32. Segregation unit regimes are usually restricted, and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and to exercise outside. (At the time of Mr Hussain's death, all prisoners could exercise daily but those serving periods of cellular confinement were only able to take showers and make telephone calls on alternate days.)

33. Staff explain to prisoners when they arrive in Manchester's segregation unit that they should be dressed and ready to submit their daily application to access the unit's regime by 8.00am on weekdays and 9.00am on weekends. If prisoners are not out of bed or refuse to interact with staff, they forfeit the chance to make applications or to access the regime for that day.

Use of force

34. Prison Service Order (PSO) 1600 on the use of force in prisons says that the use of force without consent is unlawful unless justified, and that the use of force in prisons will be justified, and therefore lawful, only if it is reasonable in the circumstances, is

necessary, no more force than necessary is used, and it is proportionate to the seriousness of the circumstances.

35. PSO 1600 also says that staff should always try to prevent a conflict whenever possible and defuse the situation through communication and de-escalation skills before using force, and that force "must only be used as a last resort after all other means of de-escalating the incident have been repeatedly tried and failed".

36. PSO 1600 is clear that the refusal to comply with an order alone is insufficient grounds to initiate force. It states that force should only be used when it is necessary to prevent harm to life, limb, property or the good order of the establishment. The PSO goes on to say that it is clearly easier to justify force as necessary if there is a risk to life or limb.

37. PSO 1600 gives examples of when a planned use of force would be reasonable or necessary. It states that the refusal of a lawful order in itself (where there is no immediate threat to life, limb, property or good order) would not usually be sufficient to justify the use of force. However, subsequent refusals may eventually lead to a planned intervention once all other alternatives, such as persuasion and de-escalation, have been tried and failed.

Key Events

38. Mr Hussain had served previous custodial sentences. He had a history of self-harm and had been monitored under ACCT procedures. He also had a history of illicit drug use and of violent and aggressive behaviour and had been managed in prison segregation units.

39. Mr Hussain had been involved with mental health services in the community and had been in prison since 2013. In 2015, he was diagnosed with clinical depression and in 2016, he was diagnosed with schizophrenia. Mr Hussain periodically did not comply with treatment, which meant he became increasingly paranoid and complained of hallucinations. In May 2017, he was referred to a medium secure psychiatric hospital for assessment but was not accepted as he appeared to respond to treatment when he took his medication. Mr Hussain was released from prison in July 2017, but returned in March 2018 before he was re-released in April 2019.

40. On 8 April 2020, Mr Hussain was remanded to HMP Forest Bank, charged with robbery and assault. He was prescribed antipsychotic medication and he engaged well with mental health services. However, he continued to have some periods of non-compliance with his medication and episodes of violence. In June 2020, a prison psychiatrist noted that Mr Hussain was sensitive to missed doses of his antipsychotic medication and as a result, he could quickly develop psychotic symptoms. For most of this period, Mr Hussain complied with his medication.

41. On 16 October, Mr Hussain was sentenced to six years in prison.

HMP Buckley Hall

42. On 7 December, Mr Hussain was transferred to HMP Buckley Hall.

43. On 4 February 2021, Mr Hussain was found under the influence of an illicit substance. He threatened staff and was moved to the prison's segregation unit. Staff started ACCT procedures after Mr Hussain expressed thoughts of suicide due to issues about accessing his vapes, canteen and medication. While segregated, Mr Hussain displayed "bizarre" behaviour and threatened to refuse food when told that he would remain on the unit for ten days due to COVID-19 isolation procedures.

44. On 16 February, a prison psychiatrist reviewed Mr Hussain. She told us that he displayed no overt psychotic symptoms. She stopped Mr Hussain's antipsychotic medication as she considered that his risks appeared to be adequately managed by the prison's mental health team. She said that she believed some of Mr Hussain's issues were anxiety-related and recommended he discuss options for managing his anxiety with the mental health team.

45. On 21 February, Mr Hussain described an increase in psychotic symptoms to a mental health nurse, but said that he was managing them. At an ACCT case review the next day, he said that voices he had previously heard had stopped. Mr Hussain said that he was remorseful of his previous actions and wanted a fresh start. Prison staff told Mr Hussain that he would be transferred if he acted inappropriately again.

46. At an ACCT case review on 3 March, Mr Hussain presented with some signs of paranoia. A mental health nurse tried to persuade Mr Hussain to restart his antipsychotic medication, but he refused.

47. On 5 March, Mr Hussain told the mental health nurse that he believed his mental state was deteriorating. The nurse noted that he was increasingly paranoid and that he believed he was the victim of a conspiracy about missing property. The nurse suggested that Mr Hussain restart his antipsychotic medication, which he agreed to do. On 9 March, he told the nurse that he still heard voices and agreed to discuss a change of medication with the psychiatrist.

48. At an ACCT case review on 10 March, Mr Hussain said that he had vivid dreams and voices which told him that if he killed himself, he could "remain in the dream world".

49. On 16 March, the psychiatrist reviewed Mr Hussain. She told us that she did not see any evidence of overt psychotic symptoms, that Mr Hussain did not appear depressed and that there was no evidence of a deterioration in his mental health after he had stopped taking his medication. She planned to review him again in three months.

50. On 18 March, at an ACCT case review, Mr Hussain described how his dreams had "turned scary" but denied thoughts of self-harm. At a review on 24 March, a nurse noted that there was no evidence of psychotic symptoms, and that Mr Hussain was happy that his medication was available. Prison staff agreed to close the ACCT procedures.

51. Over the following month, Mr Husain appeared to settle at Buckley Hall. Staff noted that he had stopped taking illicit substances, exercised regularly, mixed with other prisoners and behaved appropriately.

52. On 19 May, Mr Hussain seriously assaulted an officer. Prison staff started disciplinary procedures, which were later referred to an independent adjudicator but never heard. Staff moved Mr Hussain to the segregation unit, where he refused to eat, which he said was because he was upset at being segregated. Mr Hussain said that he had no intention to end his life and staff considered that he did not need to be monitored under ACCT procedures.

53. On 24 May, staff noted that Mr Hussain continued to refuse food or let healthcare staff take clinical observations. He also refused to engage with staff or accept any of the prison regime offered to him. Mr Hussain started eating again on 28 May, when it was noted that he appeared to be giving staff "the silent treatment".

54. On 1 June, a mental health nurse noted that Mr Hussain was angry because he said he had been told that he would be transferred, that he felt he should be admitted to hospital and that he was possessed by "jinns". Mr Hussain said that he had not taken illicit substances and the nurse recorded that he presented with no symptoms of schizophrenia. (Mr Hussain had no further contact with mental health staff at Buckley Hall.)

55. On 6 June, prison staff recorded that Mr Hussain displayed "bizarre" behaviour and accused staff of stealing his money. They used force to return him to his cell on 6

and 11 June. Over the following days, staff again noted that he had displayed "bizarre" behaviour. They referred him to the mental health team.

56. On 16 June, and over the following days, staff noted that Mr Hussain made full use of the prison regime and raised no concerns. During the day, it was confirmed that he was to be re-categorised to a Category B prisoner due to his assault of the officer.

57. On 21 June, Mr Hussain was transferred to the segregation unit at HMP Manchester. A mental health nurse assessed him before the move and confirmed that he was medically fit to be transferred. She recorded that Mr Hussain had refused to take his antipsychotic medication for several weeks and would need to be reviewed when he arrived at Manchester.

HMP Manchester

58. A nurse completed a reception health screen when Mr Hussain arrived at Manchester. She noted that he appeared in good spirits. Mr Hussain told her about his diagnosis of schizophrenia and said that he was not taking his medication as he wanted to try and manage without it. She recorded that Mr Hussain had recently been monitored under ACCT procedures but said that he had no thoughts of suicide or self-harm. She referred him to the prison's mental health team.

59. A mental health nurse also reviewed Mr Hussain as part of the reception health screen and noted that he was reluctant to answer questions. He confirmed his diagnosis of schizophrenia, and that Mr Hussain was not taking any medication. He recorded that Mr Hussain required an urgent mental health assessment.

60. An officer interviewed Mr Hussain as part of the first night process. He noted that Mr Hussain had previously been monitored under ACCT procedures, denied thoughts of self-harm and raised no issues. Mr Hussain was offered the chance to make a telephone call (which he did not do) before he was taken to the segregation unit. No one assessed his fitness for segregation.

61. On 22 June, an officer asked Mr Hussain if he wanted to make any applications to access the segregation unit's regime. The officer noted that Mr Hussain was in his bed, refused to sit up and said that he was "not interested". As Mr Hussain had only just arrived on the unit, the officer explained what was expected of him, the regime available to him and how applications were made.

62. A nurse completed Mr Hussain's secondary healthcare screen. She identified no additional issues and noted that he did not want to discuss his schizophrenia. Mr Hussain declined support from the substance misuse team. A medical technical officer recorded that Mr Hussain's medication should be reviewed by a prison GP.

63. On 23 June, Mr Hussain declined to take part in any of the segregation unit regime.

64. That day, a prison GP saw Mr Hussain as part of her regular segregation unit rounds. She noted that he was medically fit to be segregated. (There is no indication that Mr Hussain's antipsychotic medication was reviewed by the GP.)

65. On 24 June, Mr Hussain moved from the segregation unit to H Wing, the induction unit and reverse cohort unit, where he was to spend a period of isolation in line with COVID-19 prevention procedures.

66. That day, Mr Hussain made two calls on his telephone account, requesting a balance. He made no further telephone calls during his time at Manchester.

67. On 30 June, an officer noted that Mr Hussain had refused to return to his cell and displayed "petulant, obnoxious behaviour". The officer noted that when Mr Hussain was unlocked for his evening meal, he "glared dismissively". The officer took Mr Hussain's response as a refusal and noted he "might not be of sound mind". He referred Mr Hussain him to the prison's mental health team.

1 July 2021

68. On 1 July, a Supervising Officer (SO) A told Mr Hussain that he would be moved to B Wing as his COVID-19 isolation had ended and space was needed on H Wing. Mr Hussain initially agreed to move, but later told staff that he did not want to do so. The SO told him that force would be used to move him if he continued to refuse. He said that Mr Hussain was calm and understood what he was being told. He told the prison's use of force team that a planned intervention and use of force might be necessary to move Mr Hussain. He also told SO B, his relief on H Wing.

69. SO B told us that he could not recall SO A telling him about Mr Hussain. He said that when he arrived on the wing, the use of force team had assembled to move Mr Hussain to B Wing, if required. He said that he learnt from wing staff that Mr Hussain had been asked three times to move cells. He therefore decided that force should be used to move Mr Hussain because of his continued non-compliance and because he had no justifiable reason not to move. A Custodial Manager (CM) approved the use of force.

70. SO B told us that it was agreed that he would give Mr Hussain a further chance to move. He said that if Mr Hussain did not agree, the use of force team would move him by force. He said that they agreed that if Mr Hussain did not comply, he would be taken to the segregation unit for a "period of reflection".

71. SO B and the use of force team then went to Mr Hussain's cell. He had not spoken to Mr Hussain before they did so. He asked him if he was going to comply with the order to move to B Wing. Mr Hussain said that he would not. He told Mr Hussain to step back from the door, which he refused. Mr Hussain tried to prevent the use of force team from entering. Handheld camera footage shows that Mr Hussain fought with the officers after they entered the cell.

72. Mr Hussain was taken to the floor by prison staff and put in the prone position. SO B then handcuffed Mr Hussain, after which he stopped struggling. (The camera footage does not record exactly what happened in the cell. However, an unidentified officer from the use of force team appeared to raise his elbow and bring it down towards Mr Hussain's body, twice in succession. Due to the camera angle, it is not possible to see if any contact was made with Mr Hussain or the circumstances of the apparent strikes and as we can see no contact, we cannot come to a conclusion on this. Camera footage shows that during the use of force, Mr Hussain received an injury to his forehead. It was apparently a graze.)

73. Mr Hussain was brought to his feet and staff used the under-hook technique to keep his head down as he was walked, under restraint, from the cell. SO B asked him if he was "going to comply with instructions". Mr Hussain asked the SO what the instruction was, and he told him that it was to "comply with the instruction". No further explanation was offered, and Mr Hussain was walked under restraint to the segregation unit.

74. When Mr Hussain arrived at the segregation unit, he complied with the instructions of the receiving officer. He was put in a holding cell, which had no furniture or other facilities, and he was searched.

75. Mr Hussain then spent an unknown "period of reflection" in the cell, likely to have been less than two hours. He was then moved to B Wing, during which he co-operated fully, walked unaided, and was allocated a regular cell. (Mr Hussain's property and other personal effects remained in his cell on H Wing until after his death.)

2 July 2021

76. On the morning of 2 July, staff discovered that Mr Hussain had blocked his observation panel and barricaded his cell door. He did not respond to any attempts to engage with him. An officer said that he saw Mr Hussain lying on the top bunk of the bed, that he was breathing and had his hands down his trousers. He did not respond to staff who tried to engage with him. The officer remained at the cell door and continued in his attempts to engage with Mr Hussain.

77. Shortly afterwards, a nurse went to carry out a mental health triage assessment on Mr Hussain, but officers told him that it would not be appropriate to open Mr Hussain's cell door. The nurse noted that he would try to see Mr Hussain the following day.

78. An operational manager authorised for the use of force team to enter the cell and, if necessary, use force to remove Mr Hussain. He recorded that this was to prevent self-harm or harm to others. He told us that the reason for removing Mr Hussain was because he had a duty of care as he might, or might have already, self-harmed and that he had taken into consideration his previous custodial history. CM A, a use of force instructor, noted in the use of force paperwork that because of events the previous day, it had been decided to remove Mr Hussain from his cell.

79. During the briefing, the operational manager told the use of force team that intervention was necessary as Mr Hussain had restricted access to his cell and was being monitored under ACCT procedures. (Mr Hussain was not subject to ACCT at the time.) He told the use of force team that Mr Hussain was lying on the top bunk of his bed, had his hands down his trousers and might be concealing a weapon. He said that if Mr Hussain remained non-compliant force would be used to restrain him and move him to the segregation unit, but if compliant he would be told to stand at the back of his cell.

80. The use of force team arrived at Mr Hussain's cell and an SO opened the cell door. He did not speak with Mr Hussain. The use of force team went into the cell, removing the barricade as they did.

81. CM A was one of the first officers to enter the cell. He said that Mr Hussain was lying on his bed, had his eyes shut and his hands down his trousers. He shook Mr Hussain's arm and asked him several times to get out of his bed and stand up. Mr Hussain did not respond and ignored the instructions to remove his hands from his trousers. He took hold of Mr Hussain's arm and an SO took hold of his other arm. Mr Hussain, who was still not responding, was taken by force from his bed to the floor of the cell and put in the prone position. An officer said Mr Hussain remained non-compliant, did not respond and was clearly "feigning unconsciousness". The SO applied handcuffs.

82. Mr Hussain was brought up from the floor, so that he was sat on his haunches. He continued not to cooperate. A nurse went into the cell to assess him and raised no concerns about him being moved but noted that his eyes were shut tightly. Staff brought Mr Hussain to his feet by using the under-hook technique as he refused to comply with instructions.

83. Mr Hussain was taken from the cell under restraint and moved to the segregation unit. He was passive throughout the move, and he lifted his legs, making it difficult for the officers to carry him. At the top of the landing stairs, Mr Hussain was asked if he would comply, but he did not respond. On the way to the segregation unit, a nurse told officers that they might damage Mr Hussain's shoulder if they continued to carry him in the way that they were and asked them to carry him also by his legs. He was carried by four members of staff, face down. CM A noted that this "was not ideal" but thought that it was the best way, given that Mr Hussain continued to refuse to cooperate or comply with staff instructions.

84. When Mr Hussain arrived on the segregation unit, he was put into the holding cell and the handcuffs were removed. An officer commented to the handheld camera operator that it was like something that "might be on Channel Four".

85. A nurse completed an initial segregation health screen to ascertain if there were any health reasons why Mr Hussain could not be segregated. She noted he had not harmed himself in the current period of custody, showed no signs of psychosis or being acutely unwell, and was not taking any antipsychotic medication. The nurse concluded that Mr Hussain was able to cope with a period of segregation and that no further healthcare intervention was needed at the time. She also noted redness to Mr Hussain's wrist and to the front of his shoulders following the use of force. A senior manager signed the segregation algorithm, approving Mr Hussain's segregation.

86. The nurse told us that she had not checked Mr Hussain's medical records before approving his segregation. However, she said that before completing the algorithm, she had spoken to healthcare colleagues to see if there was any reason why he might not be suitable for segregation. She said that her colleagues raised no concerns about Mr Hussain, but she could not recall if she was told about his diagnosis of schizophrenia.

87. Segregation paperwork noted that Mr Hussain had been segregated under Prison Rule 53 (to allow prisoners to be held in segregation before a disciplinary hearing), and that he was not subject to ACCT procedures but had previously been.

88. SO C, and two officers then went to the holding room to tell Mr Hussain that he would stay on the segregation unit. The SO noted in the use of force paperwork that Mr Hussain was sitting on the heating pipes at the back of the cell and refused to sit up or acknowledge the officers. He said that because of Mr Hussain's non-compliance, he and Officer A initiated an unplanned use of force to move Mr Hussain from the holding cell to a regular cell on the unit.

89. Officer A noted that the SO tried several times to engage with Mr Hussain and that Mr Hussain refused to engage. He recorded that it was apparent that Mr Hussain would have to be moved by force. He said that he approached Mr Hussain with the intention of taking control of his arm but, as he got closer, he became aware that Mr Hussain had clenched his fist. He said that he was aware that Mr Hussain displayed "unpredictable behaviour". He recorded that he was concerned for his immediate safety and that he therefore extended his right knee into the "centre mass" of Mr Hussain's body. The officer said that he did not apply much force, as it was a pre-emptive strike to prevent Mr Hussain from having the opportunity to get close enough to be able to punch him.

90. The officers used force to restrain Mr Hussain, who offered a small amount of resistance, and he was moved to a regular cell on the segregation unit. Mr Hussain did not walk and dragged his legs. The use of force paperwork completed by officers noted that positive communication was used to de-escalate the situation, that a guiding hold, pain-inducing techniques and shoulder control were also used. It was noted that Mr Hussain had not sustained any further injuries during the move.

91. In their Use of Force forms, staff recorded that the use of force was captured on body-worn video camera (BWVC) footage. When we asked for this, we were told that it was unable to be downloaded. We have not therefore been unable to view it. SO C said that although he noted that BWVC was used, he could not recall whether anyone switched on their camera.

92. That morning, Mr Hussain refused to engage with the duty governor during their daily round of the segregation unit. An officer noted that Mr Hussain had collected his lunchtime and evening meals. Officer A recorded that Mr Hussain appeared to have a bad attitude towards staff.

93. An officer said that a segregation unit officer went to B Wing to collect Mr Hussain's property. However, there was no property in the cell as it had not been brought over from H Wing the previous day.

94. In the afternoon, Officer A issued Mr Hussain with disciplinary paperwork about three separate charges of indiscipline which had led to him being restrained by staff and located in the segregation unit. (The charges were for his refusal to obey a direct order to move cells on 1 July, that he had denied access to his cell on 2 July, and for disobeying a lawful order to move cells, also on 2 July.)

3 July 2021

95. At around 8.00am on 3 July, officers went to Mr Hussain's cell and asked if he wanted to make any applications to access the prison regime. Officer B said that as Mr Hussain remained in bed, he was not permitted to make applications to access the regime under local rules.

96. The interim Deputy Governor chaired Mr Hussain's disciplinary hearings. He heard the charge that Mr Hussain had disobeyed a lawful order to move cells on 1 July, to which Mr Hussain pleaded guilty. He asked Mr Hussain if he had anything to say in mitigation. Mr Hussain apologised for his behaviour and said that he had just wanted to get his medication sorted out and to speak to the mental health team. The Deputy Governor punished him with seven days of cellular confinement. (Prison rules require all prisoners segregated under cellular confinement to receive a welfare check every hour.)

97. The interim Deputy Governor also heard Mr Hussain's charge of denying access to his cell on 2 July. Mr Hussain said that he could not recall the incident as he had mental health issues and sometimes did things that he could not remember doing. The Deputy Governor adjourned the hearing for further evidence. He heard Mr Hussain's final charge for disobeying a lawful order to move cells in the segregation unit on 2 July. Mr Hussain said that although he understood the evidence, he could not recall if it was correct as he could not remember what he was told. Again, the Deputy Governor adjourned the hearing for further evidence.

98. A nurse completed a further segregation health screen as Mr Hussain was now subject to cellular confinement. She did not have access to Mr Hussain's medical records. She noted that he presented with no evidence of mental illness, was not acutely unwell, was not receiving any antipsychotic medication, had not harmed himself in his current period of custody and denied thoughts of self-harm. She concluded that Mr Hussain could cope with a period of cellular confinement and that no healthcare intervention was needed. The nurse planned for the GP to review Mr Hussain during the segregation round the following day. The interim Deputy Governor signed the algorithm to confirm that he had read the assessment and agreed that Mr Hussain could be segregated.

99. In the afternoon, Mr Hussain requested a newspaper. Officer B told us that Mr Hussain was "fixated" with getting his newspaper and became angry when told that it and his purchases from the prison shop were not on B Wing. He described Mr Hussain as "disruptive" and a "discipline problem".

100. A nurse saw Mr Hussain during the mental health team's daily check of prisoners in the segregation unit. He told us that he also intended to complete Mr Hussain's mental health assessment. He noted that Mr Hussain refused to engage and that he was due a mental health triage assessment, which would be attempted on 5 July.

4 July 2021

101. No one recorded whether Mr Hussain was asked if he wanted to access the wing regime.

102. A mental health nurse saw Mr Hussain as part of the routine daily healthcare round. Mr Hussain told her that he would like to restart his antipsychotic medication as it helped to "slow down his brain", which he said he felt was "moving too fast". She said that Mr Hussain did not express any urgency about his medication and did not appear distressed. She referred Mr Hussain to the prison GP and told him that he could discuss his medication at his mental health assessment the following day. She said that Mr Hussain did not present with any acute psychotic symptoms that

warranted urgent intervention and he did not need medication urgently. Mr Hussain had no further contact with mental health services before his death.

103. Mr Hussain was given his lunch. He raised no issues with the duty governor during their daily round. During the afternoon, staff noted that he appeared asleep.

104. Although the officers we interviewed could not recall much about Mr Hussain, Officer B said that Mr Hussain did not engage with staff, was disruptive, abusive, "anti-everything", seemed very angry towards staff and questioned staff when they went to his cell door. He described Mr Hussain as a "disciplinary problem".

105. Officer A noted that Mr Hussain had shown a bad attitude towards staff and had no intention of complying with the segregation regime. He noted that staff would continue to try to engage positively with Mr Hussain over the coming days. (There is no evidence that this happened.)

106. That evening, Mr Hussain asked an officer for his newspaper, but the officer could not find it. He said that Mr Hussain caused staff no concerns.

5 July 2021

107. At around 7.57am, three officers went to Mr Hussain's cell to ask if he wanted to make applications to access the wing regime. Two of the officers completed a cell fabric check. Officer C later noted that as Mr Hussain remained in his bed, he would not have access to the wing regime. The other two officers told us that they could not recall if they had spoken to Mr Hussain, and Officer B said that it was likely that Mr Hussain had ignored them.

108. At 9.12am, a prison chaplain noted that Mr Hussain appeared asleep.

109. At 9.42am and 10.40am, Officer B checked on Mr Hussain, who still appeared to be asleep. When he checked on him at 10.54am, he noted that Mr Hussain had been lying on his bed, talking to himself.

110. At 11.15am, Officer D answered Mr Hussain's cell bell. She said that she could not recall what they talked about.

111. At 11.20am, Mr Hussain rang his cell bell again. At 11.23am, three officers went to Mr Hussain's cell to give him his lunch. Mr Hussain refused to stand at the back of the cell and therefore they could not open the door, in line with segregation unit procedures. Although the officers appeared to reset the cell bell before leaving, it continued to flash.

112. At 11.25am, Officer E walked past Mr Hussain's cell and pushed the door to check if it was locked. (It was.) This was not a scheduled roll check, and she did not look into the cell or reset the cell bell. At 11.35am, Officer D reset Mr Hussain's cell bell and looked into the cell as she did.

113. At 11.39am, Mr Hussain rang his cell bell. Officer D reset it 30 seconds later but did not look into the cell. At 11.49am, Mr Hussain rang his cell bell again. Officer E reset it around seven minutes later, without looking into the cell. At 11.57am, Mr Hussain rang his cell bell again.

114. At 11.59am, the Head of Safer Custody and Equalities, who was completing the duty governor's segregation daily round, arrived at Mr Hussain's cell with several officers. She remained at the cell door for around fifteen seconds before she and the officers moved on to check on other prisoners on the unit. She noted that Mr Hussain refused to speak, and she said that he had no concerns.

115. At 12.00pm, Mr Hussain rang his cell bell. Officer B reset the bell without looking into the cell. Seconds later, Mr Hussain rang the bell again. An officer went to the cell and appeared to listen before he moved away from the door to stand with other colleagues on the landing. The officer did not reset the bell and it continued to flash.

116. At 12.02pm, Officer E reset the bell outside Mr Hussain's cell, but did not speak to him. Seconds later, Mr Hussain rang his cell bell again. Officer B reset the bell around a minute later but again, did not look into the cell. Mr Hussain then rang the cell bell again. Around a minute later, the officers who accompanied the Head, walked past Mr Hussain's unanswered bell and left the wing.

117. At 12.07pm, Officer B completed the lunch time roll check. He walked down the landing and checked the cell doors, including Mr Hussain's, but did not look into Mr Hussain's cell or the other cells on the unit. He did not reset Mr Hussain's cell bell.

118. At 12.20pm, Officer F started his shift on the unit and Officer A gave him a brief handover. Officer F said that he was told that Mr Hussain had recently arrived on the unit from B Wing, had been kicking his cell door persistently, ringing his cell bell and shouting. He said that he was told that Mr Hussain was unhappy that he was not given his newspaper or canteen. He told us that Mr Hussain was not kicking his cell door when he arrived. There is no record in Mr Hussain's segregation records that he had ever kicked the cell door.

119. At 12.24pm, Officer G, who had just started his shift, answered Mr Hussain's cell bell. Mr Hussain said that he wanted his newspaper. The officer told him that he would chase it up. When he asked Mr Hussain which wing he was from, Mr Hussain said, "It doesn't fucking matter". The officer said that given Mr Hussain's response, he shut the observation panel and walked away. He then made an entry in Mr Hussain's records about his contact with him. This is the last time that Mr Hussain was seen alive.

120. At around 12.40pm, Officer G told Officer F that Mr Hussain had asked for his newspaper and canteen. Officer F said that he would try to deal with it that afternoon.

121. At 12.54pm, Officer F went to carry out Mr Hussain's hourly cellular confinement check. He looked through the cell door observation panel and saw Mr Hussain on his knees, facing the back wall of the cell, with a bed sheet tied around his neck which he had tied to the window bars. He told us that he was about to radio for assistance when he remembered that he was in a radio blind spot and could not rely on it working. He did not therefore use his radio but instead immediately left the cell and walked to the room used for the unit's disciplinary hearings and told colleagues there that Mr Hussain was hanging.

122. Staff responded and walked back to the cell with Officer F. At 12.55pm, Officer F opened the cell door, and the officers went in.

123. An officer cut the ligature from around Mr Hussain's neck and, at 12.57pm, another officer called a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties). Control room staff telephoned for an ambulance. The officer who called the emergency code said that Mr Hussain appeared to be unconscious and that there were no apparent signs of life. An SO checked for a pulse but could not find one. The officers immediately started cardiopulmonary resuscitation (CPR) and took turns giving chest compressions.

124. At 1.01pm, two nurses arrived with the medical emergency response bag. Another nurse arrived a minute later. The nurses went into the cell and with the support of officers, they continued resuscitation efforts. A defibrillator was attached and initially advised no shock but later advised that a shock should be applied.

125. At 1.07pm, the first emergency paramedic arrived and led resuscitation efforts, with the continued assistance of healthcare staff and a prison GP, who arrived at around the same time.

126. Paramedics stabilised Mr Hussain and at around 1.32pm, he was taken from the cell. He was transferred to hospital at around 1.58pm.

127. On the afternoon of 8 July, Mr Hussain's life support was switched off in hospital. He was pronounced dead at 3.40pm. Family members were present when he died.

Contact with Mr Hussain's family

128. At around 3.00pm on 5 July, a prison family liaison officer telephoned Mr Hussain's sister and told her that her brother had been taken to hospital.

129. After Mr Hussain's death, Manchester contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

130. Following the incident on 5 July, the interim Deputy Governor 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. On 8 July, a safer custody manager held a further debrief for the staff who had accompanied Mr Hussain in hospital.

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

Post-mortem report

132. The post-mortem examination found that Mr Hussain died from pneumonia due to hypoxic/ischaemic brain damage after hanging. The pathologist noted the possibility that pre-existing ischaemic heart disease made a lesser, albeit potentially

significant, contribution to his death. Toxicology results found no illicit substances in Mr Hussain's body when he was admitted to hospital.

133. The post-mortem examination found that Mr Hussain had some very minor superficial incised wounds on his left wrist, which might have represented an attempt to harm himself. We do not know when this injury occurred.

Findings

Assessment of Mr Hussain's risk of suicide and self-harm

134. Prison Service Instruction (PSI) 64/2011 on safer custody 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.

135. When Mr Hussain arrived at Manchester, he had several risk factors for suicide and self-harm, including a significant mental health diagnosis and a history of self-harm.

136. In the days before his death, Mr Hussain was exposed to a number of significant new risk factors. He was subject to three uses of force. He was concerned about getting his mental health medication and wanted to speak to the mental health team. He was segregated under cellular confinement and had no access to property or distraction materials, including a radio (which all segregated prisoners should be allowed to have in their cell) and the newspaper that he often requested. He did not engage with staff, remained in his bed for much of the time and did not leave his cell for three days to access the regime available. We also note that Mr Hussain's last period of ACCT monitoring in March 2021, resulted from the stress he felt at being segregated and his lack of access to his canteen and vapes.

137. There is no evidence that prison or healthcare staff considered whether Mr Hussain's risk had increased or whether he should have been monitored under ACCT procedures. We consider that his increased risk, including environmental risks, would likely have affected his mental health and feelings of isolation and paranoia which he experienced during his time in custody. We are concerned that staff appeared to accept Mr Hussain's isolation and lack of communication as 'normal' for prisoners who lived on the unit, and there is no evidence that they tried proactively to engage with him.

138. While we cannot say whether starting ACCT procedures would have led to a different outcome for Mr Hussain, it would have given staff the opportunity to identify and address Mr Hussain's issues and triggers and to encourage him to engage with them and with the prison regime. Starting ACCT procedures should also have led a multidisciplinary team of staff to reconsider whether the segregation unit was an appropriate place for Mr Hussain. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm, including that:

- **segregation unit staff consider and record all the known risk factors and triggers of a segregated prisoner, including environmental factors;**
- **monitor any changes in the prisoner's behaviour or circumstances when determining the risk of suicide and self-harm; and**

- **start ACCT procedures when indicated.**

Use of force

139. Mr Hussain was subject to the use of force on three occasions in the days before he was found hanged in his cell. He did not sustain any serious injuries as a result, and we do not consider that it contributed directly to his death. However, it did result in his segregation. The use of force, even when performed in line with control and restraint procedures, is likely to be a painful and humiliating experience for a prisoner and may have contributed to Mr Hussain's state of mind, particularly as he felt low.

Use of force on 1 July 2021

140. When Mr Hussain was asked to move cells on 1 July, he initially agreed but later told staff that he did not want to move. He spoke calmly and was "matter of fact" but despite being asked several times, he refused to move. Given his non-compliance and refusal to comply with an order, staff decided to move Mr Hussain using planned force.

141. When SO B arrived at Mr Hussain's cell, he asked him if he was going to comply with the order to move cells. Mr Hussain said that he would not and prevented access to his cell by standing behind the cell door as the use of force team entered.

142. We are concerned that staff took the immediate decision to use planned force to move Mr Hussain. We would have expected them to consider other options, particularly as he had not threatened the safety of others or himself, and he had not posed a risk to the operation of the prison regime. Prison staff should have considered alternative options such as leaving him in his cell on H Wing, trying to discuss the issue with him again or dealing with his refusal to move as a disciplinary issue. These options would have been proportionate, legitimate and reasonable in the circumstances. We consider that the planned use of force was excessive at this point. (It also appears that there was no urgent operational need for Mr Hussain to vacate his cell on H Wing as the cell remained locked and unused, with his property left inside, until after the incident on 5 July.)

143. Staff might have believed that the planned use of force was necessary as a last resort. However, we do not consider that three lawful orders, in these circumstances, were enough and SO B should have done more to try and persuade Mr Hussain to move. Even if we accept that force was necessary to protect the good order of the prison, the SO made no effort to persuade Mr Hussain to move once the use of force team had arrived at the cell door. We also note that Mr Hussain later said that he was unsure which instruction he had not complied with. We recognise that Mr Hussain had to move cells at some point but there was no immediate threat to the good order of the prison at the time staff intervened.

144. We recognise that there are occasions when a prisoner is so verbally aggressive and threatening that officers might reasonably feel at imminent risk of assault, even if the prisoner has not been physically aggressive. In such situations, the pre-emptive use of force to prevent harm may be justifiable. However, we do not consider that this was the case with Mr Hussain, and we are concerned that staff

escalated the incident unnecessarily by wearing PPE because this should only have been done as a last resort.

145. We conclude that the planned use of force on 1 July was unreasonable and excessive in the circumstances. Had Mr Hussain been allowed a "period of reflection" in his own cell on H Wing, rather than in the segregation unit, the safety of Mr Hussain and the prison staff who used force would not have been put at risk.

First use of force on 2 July 2021

146. Two staff members, one of whom was a trained negotiator, spent an hour trying to communicate with Mr Hussain, trying to get a response and convince him to remove the barricade from his cell door. This form of extended negotiating and de-escalation is good practice and aligns with PSO 1600.

147. The duty manager reported that the use of force team wanted to go into the cell because they had a duty of care to Mr Hussain, and they were concerned that he might have harmed himself or was at risk of self-harm. He said that his decision-making process included consideration of Mr Hussain's previous custodial and mental health history.

148. Prison staff were also concerned that Mr Hussain might have posed a risk of violence. They thought that he may be hiding a weapon because he had his hands down the front of his trousers. Staff were also aware that Mr Hussain had a history of violence and had physically resisted a restraint the day before.

149. When an SO arrived at the cell door, he did not give Mr Hussain a further opportunity to comply with orders before sending the use of force team into the cell. This was poor practice.

150. The use of force team entered the cell and removed the barricade. During this time, Mr Hussain was still lying on his bed, unresponsive, with his eyes closed and his hands down his trousers.

151. Once in the cell, CM A twice asked Mr Hussain to remove his hands from his trousers. Mr Hussain did not respond.

152. CM A and other staff then decided to initiate force by pulling Mr Hussain's hands from his trousers, moving him from his bed to the floor, and restraining him. He was then carried, under restraint, to the segregation unit.

153. Mr Hussain did not respond. He had a history of staff assault and was potentially concealing a weapon. Considering these circumstances and the policy requirements of PSO 1600, we are satisfied that at the point of physically removing Mr Hussain's hands from the front of his trousers, the force was necessary because it was reasonable for the prison staff involved to consider that Mr Hussain posed a potential risk to himself and staff. We are satisfied that this force was reasonable, proportionate, and that no more force was used than necessary.

154. However, it would have become apparent at this point that Mr Hussain did not have a weapon and that he did not pose a risk of harm to himself or others. He had not been violent and was not searched in his cell, which indicates that staff were not concerned that he had a weapon. It also would have been apparent that Mr

Hussain had not harmed himself. Alternatives to segregation such as leaving him in his cell to calm down should have been considered. This would have reduced the need for staff resources and lessened the impact on the wing regime. CM A told us that he had not considered alternatives as the use of force team had been instructed to take Mr Hussain to the segregation unit. This is concerning.

155. At this point, as the perceived risk was no longer present, the use of force was no longer necessary, and the continuation of force was no longer justifiable.

Second use of force on 2 July 2021

156. We are concerned that, after Mr Hussain was moved to the segregation unit, force was used for a second time after he had only spent around ten minutes in the unit's holding cell.

157. When the prison officers went into the cell to tell Mr Hussain that he would remain in the segregation unit, he was sitting on the pipes at the back of the cell and refused to engage with them or move. Officer A said that it was apparent that Mr Hussain would have to be moved by force and that he and his colleagues then initiated a further use of force to remove him from the holding cell. Mr Hussain, who offered some resistance by dragging his legs, was moved to a standard cell in the segregation unit.

158. PSO 1600 states that, “Force must only be used as a last resort after all other means of de-escalating the incident without the use of force (for example, through persuasion or negotiation) has been repeatedly tried and failed". Our view is that there was no imminent threat to the good order of the prison, property or anyone’s safety. Officer A and the other staff present spent insufficient time considering alternative options to force and did not try to de-escalate the incident or negotiate with Mr Hussain, particularly as Mr Hussain did not pose a risk to anyone while in the holding cell. Attempts to find alternatives to force should have been extended for a longer period, and we conclude that the use of force was not “necessary” and therefore in breach of PSO 1600.

159. We are also concerned about Officer A’s attitude after Mr Hussain was put in the segregation holding cell. He made a comment that appeared to refer to prison documentaries broadcast on Channel Four television. We recognise that the use of force, where the safety of officers and the prisoner may be at risk, is a stressful situation but throwaway comments made at such moments are inappropriate and unprofessional.

Officer A’s knee to Mr Hussain

160. Officer A said that as he approached Mr Hussain to take his arm, Mr Hussain clenched his fist. He said that because of Mr Hussain's unpredictable nature and a concern for his safety, he extended his right knee into the centre of Mr Hussain's body as a pre-emptive strike to prevent Mr Hussain from getting close enough to punch him.

161. Officer A said that he did not use much force when performing this pre-emptive strike. When asked about Mr Hussain clenching his fist, he said, "It was almost as if

when we moved towards him, it was almost like he was sitting there waiting. It's like he almost wanted us to come and put hands on him".

162. PSI 30/2015, which contains amendments to the use of force policy, states that a knee to a prisoner from staff can be justifiable in a "personal protection" scenario, where staff reasonably perceive an imminent threat to their safety. No BWVC footage covers what happened inside the holding cell, and we have no evidence to either support or challenge Officer A's account that Mr Hussain clenched his fist. Therefore, we cannot say whether or not his action of kneeing Mr Hussain was justified.

Use of Body-Worn Video Cameras (BWVC)

163. PSI 04/2017 on body-worn video cameras (BWVC) states that BWVC must be used when a user has or may be required to exercise force against a person.

164. We were only given BWVC footage for the second use of force, and even then, we do not know which officer wore the camera (the camera was booked out to an officer who was not involved in the incident). A member of staff recorded that BWVC was used during the third use of force, but it is unclear if this was the case, and we were not given any footage.

165. We were initially told by Manchester that BWVC footage could not be downloaded, which suggested that it was used. However, we also note that HMIP reported on the reluctance of officers to switch on body-worn cameras routinely during incidents. The absence of BWVC footage for two uses of force is concerning.

Use of force conclusions

166. Being subjected to use of force is likely to be traumatic and to be experienced as an assault. It is possible that the trauma experienced by Mr Hussain due to the force used on him on 1 and 2 July was still fresh in his mind when he chose to end his life.

167. However, we recognise that it is not automatically the case that force is unjustified or incorrectly applied on a prisoner because a prisoner takes his own life shortly after an incident.

168. We are keenly aware of 'hindsight bias', where learning the outcome of an event, particularly a serious event such as someone's death, can lead to an overestimation of our ability to have foreseen the outcome. To challenge such bias, we remind ourselves that the test for what staff should have done in these incidents is not what we think that we would have done. Instead, the test is 'what was a reasonable and policy-compliant response' in these incidents.

169. We are concerned about some elements of the use of force incidents involving Mr Hussain on 1 and 2 July. Staff, at times, did not communicate effectively. They did not take enough time to consider alternative options to using force, to de-escalate or negotiate with Mr Hussain. We have concluded that force was used unlawfully, breaching PSO 1600.

170. We also note that HMIP reported that de-escalation techniques at Manchester were inadequate and not always used well enough, of little dialogue between staff and

prisoners and that the governance and oversight of the use of force was weak and that there was a lack of focus on learning lessons following incidents involving force. We make the following recommendations:

The Governor should ensure that staff use force in line with national guidelines, including that:

- **planned use of force is only used when it is reasonable and necessary, and only as a last resort when all other means of de-escalating the incident have been repeatedly tried and failed;**
- **all staff wear and switch on body-worn video cameras during planned use of force interventions;**
- **staff remain professional and do not use inappropriate language; and**
- **CM A and SO B receive additional advice and guidance on the lawful use of force and de-escalation techniques.**

Segregation

Inappropriate use of segregation

171. On 1 July, planned use of force was used to move Mr Hussain from H Wing to the segregation unit for a "period of reflection".

172. Several staff told us that it was not unusual for prisoners to be taken to the segregation unit for a "period of reflection" and it appeared to be an accepted method of enforcing discipline at Manchester. The segregation unit should not be used by staff as an alternative form of punishment. We consider that moving prisoners to a holding cell in the segregation unit for this purpose is a worrying and inappropriate use of the unit. It is also unclear why staff did not consider that this "period of reflection" could have been completed on H Wing, which would have mitigated risks for Mr Hussain and the officers carrying out the use of force.

173. We are concerned that, when Mr Hussain was taken to the segregation unit for a "period of reflection", staff did not complete any segregation unit paperwork and there is no record to explain the reason for his location in the unit or what prison rule he was held under. We were told that that if prisoners returned to a regular wing within two hours of arriving on the segregation unit, the completion of paperwork was not necessary. This is not acceptable practice. The fact that no record exists of Mr Hussain's time in the unit meant that no protections would have been put in place to consider the risk he might have posed to himself, levels of observation or other security matters. This not only posed a risk to Mr Hussain but also to staff and was not in line with the requirements of Prison Service Order (PSO) 1700 on the use of segregation.

Record keeping and engagement with Mr Hussain

174. On 2 July, Mr Hussain was uncommunicative and upset when he arrived in the segregation unit after being restrained. PSI 30/2015 (which makes some amendments to PSO 1600) says that after a use of force, there should be a de-brief

in which someone unconnected with the incident speaks to the prisoner about what happened. It is concerning that there is no evidence that this took place.

175. PSO 1700 requires each prisoner in segregation to have a designated or personal officer who is required to engage in purposeful dialogue and record this in the prisoner's history sheet, with at least three quality entries required each day. The PSO also requires that, where possible, the segregation unit officer engages in dialogue when completing hourly observations of prisoners serving punishments of cellular confinement.

176. We found general processes and record keeping in the segregation unit were poor. There is no record that anyone made a meaningful attempt to engage with Mr Hussain while he was there, and he was not assigned a personal officer. Staff made very few entries in his segregation records, which is particularly surprising given the challenging behaviour they described. Visitors to the unit did not sign in. If staff had been more proactive in engaging with Mr Hussain, and if they had interacted with him in a more meaningful manner, they might have been aware of his increased risks.

Access to the segregation regime

177. When prisoners arrive in the segregation unit, prison staff explain what is expected of them each morning when making applications to access the unit's regime. Prisoners are expected to be out of bed, dressed, and standing at the back of their cell at 8.00am on weekdays or 9.00am on weekends. If prisoners are not ready, they forfeit the chance to make applications or to access the regime for the whole day. Prisoners who are serving a period of cellular confinement can exercise in the open air daily but are only permitted to take a shower or make a telephone call on alternate days.

178. From Mr Hussain's arrival in the segregation unit on 2 July until he was found on 5 July, he made no applications to access the regime. He did not shower or take exercise and appeared to have left his cell only once to attend his disciplinary hearing on 3 July. As we have previously noted, withdrawal from the prison regime is a risk factor for suicide and self-harm, and there is no evidence that segregation unit staff made proper efforts to engage with Mr Hussain.

179. We understand that prisoners in the segregation unit are now required to leave their cells and walk to a desk on the wing before being asked what aspects of the regime they want to access. Manchester has introduced this since Mr Hussain's death to promote greater staff-prisoner engagement and to encourage greater activity and interaction with prisoners serving periods of cellular confinement and for staff to consider their welfare needs.

180. Although we welcome these changes, we remain concerned that prisoners subject to cellular confinement only have access to showers and telephone calls on alternate days.

Access to personal property and distraction materials

181. For five days, four of which were in the segregation unit, Mr Hussain had no access to any of his basic personal property such as his toiletries, prayer mat, reading

material or a radio, to which he was entitled as a prisoner serving a period of cellular confinement. During the investigation, it became apparent that neither wing nor segregation unit staff were clear about whose responsibility it was to transfer Mr Hussain's property from his original wing to the segregation unit. We also note that, given Mr Hussain's lack of property, there is no evidence that he was offered any distraction materials during his time in the segregation unit, despite him asking for a newspaper for several days. (Mr Hussain's property remained locked in his cell on H Wing until after he was taken to hospital on 5 July.)

182. It is possible that not having access to any of his property or other distraction materials on the night of 1 July, might have contributed to Mr Hussain's reasons for covering his cell door observation panel, barricading his cell the following morning and taking his life. The clinical reviewer also noted that this might have impacted on Mr Hussain's state of mind. The Head of Healthcare agreed with the clinical reviewer that healthcare staff should be more mindful of what prisoners have access to when segregated and how to encourage them to leave their cells.

183. It is essential that segregation and healthcare managers ensure that officers and nurses work together to facilitate and encourage prisoners to leave their cells in the segregation unit, when able to, and to ensure that they have access to their basic property and in-cell distractions. We note that HMIP had also identified issues about prisoner property, including how some prisoners had moved to a different cell and how their property had been misplaced during the move, which caused frustration and mistrust.

Segregation health screens

184. Segregation is stressful for prisoners and can increase their risk of suicide and self-harm. PSO 1700 therefore requires a member of healthcare staff to complete an initial segregation safety health screen for all segregated prisoners to assess their physical, emotional and mental wellbeing when deciding whether it is safe to segregate them. The health screen must be completed within two hours of a prisoner being segregated, after a discussion with the prisoner. The screen should also be completed if a prisoner is awarded a period of cellular confinement at a disciplinary hearing.

185. On 2 July, a nurse completed a health screen. The nurse said that although she did not personally check Mr Hussain's medical records, she would have telephoned healthcare colleagues to see if there were any reasons why he could not be segregated. She said that no concerns were raised. (She did not make a record of any conversation with colleagues.)

186. Another nurse completed a further health screen on 3 July, as Mr Hussain was to serve a period of cellular confinement. The nurse had not been told that during the disciplinary hearing that Mr Husain had asked to speak to the mental health team and, although she checked to see if he was taking any medication, she did not check his full medical history before completing the assessment. She said that had she known about Mr Hussain's mental health history, she would have called the emergency on-call mental health nurse to complete and sign the assessment.

187. For healthcare professionals to be able to properly assess a prisoner's physical, emotional and mental wellbeing before segregation, they must have access to all

relevant information. This was a missed opportunity. Had the assessing nurse known of Mr Hussain's request to speak to a member of the mental health team, consulted his medical records fully, known of his diagnosis of schizophrenia and the issue about his antipsychotic medication, she might have identified concerns about his suitability for segregation. This might have led to additional support for Mr Hussain or to the conclusion that he was not fit to be segregated.

188. We also note that an officer asked a nurse to complete the segregation unit health screen, without first seeing Mr Hussain. This was inappropriate. The nurse correctly refused to complete the assessment without seeing Mr Hussain.

189. We understand that following Mr Hussain's death, the responsibility for completing segregation health screens now lies with the emergency response mental health nurse, who is required to speak to prisoners before completing the algorithm. We make the following recommendations:

The Governor should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:

- **segregation is used appropriately, in line with Prison Rules, and with the authority of an operational manager;**
- **each prisoner is assigned a designated officer responsible for their welfare;**
- **staff engage in purposeful dialogue with each prisoner at least three times a day, and that this is recorded in the prisoner's history sheet; and**
- **prisoners are able to access all aspects of the regime every day and have access to basic personal property and distraction materials.**

The Governor and Head of Healthcare should ensure that healthcare professionals completing segregation unit health screens have access to the prisoner's medical history and are always given the opportunity to speak to the prisoner.

Emergency cell bell, welfare checks and roll count

190. It became apparent during our investigation that segregation unit staff did not answer cell bells, complete welfare checks or complete the roll check to a satisfactory standard.

191. On 5 July, Mr Hussain rang his emergency cell bell several times from 11.35am, before his death. However, some officers walked past the ringing bell and did not answer it. When some staff did respond to the cell bell, they reset it without speaking to Mr Hussain or checking on his welfare. SO C said that his expectation was for staff to answer the emergency cell bell as soon as possible, and within a couple of minutes, if possible.

192. Some staff told us that they did not answer cell bells because prisoners could be abusive or aggressive. A CM said that if a prisoner misused the emergency cell

bell, the reason for the misuse should be documented. There are no records to indicate that this was the case for Mr Hussain. We cannot know why Mr Hussain pressed his cell bell, but we are concerned that this was a missed opportunity to identify and address his concerns or to identify increased risk.

193. PSO 1700 instructs that prisoners serving periods of cellular confinement should be observed at least once an hour. Although Mr Hussain was observed regularly on 5 July, no check was completed between 7.58am and 9.42am, as it should have been.

194. The purpose of a roll check is to ensure that all prisoners are accounted for, by observing the prisoner through their cell door observation panel. If staff see something that gives them immediate concern for the welfare of a prisoner, they are expected to take appropriate action. Officer B completed the roll check at lunch time on 5 July, but he did not look into the cell as he should have done and as he acknowledged at interview. We make the following recommendation:

The Governor should commission a disciplinary investigation into the actions of segregation unit staff on the morning of 5 July 2021.

The Governor should ensure that segregation unit staff complete their duties satisfactorily and in line with local and national requirements, including that:

- **staff observe prisoners subject to cellular confinement at least once every hour;**
- **staff observe prisoners at roll checks and take appropriate action if they have concerns for a prisoner's welfare; and**
- **staff answer cell bells promptly, take reasonable steps to answer the query and take appropriate action if they have concerns for the prisoner's welfare.**

Disciplinary hearings

Award of cellular confinement

195. PSI 47/2011 sets out the process and procedures that must be followed when a prisoner is charged with a breach of prison rules. It states that any punishment the adjudicator may impose must be proportionate and in line with the Prison Rules. The adjudicator must take into account the seriousness of the offence, local punishment guidelines, the prisoner's previous disciplinary record, the likely effect of the punishment on the prisoner, and any mitigation the prisoner may offer. The punishment and any reasons for departure from local guidelines must be recorded on the record of hearing and explained to the prisoner.

196. On 3 July, Mr Hussain pleaded guilty to disobeying a lawful order for refusing to move cells two days earlier. He apologised for his behaviour and offered mitigation: he said he wanted to "sort" his medication and speak to the mental health team. Mr Hussain was punished with seven days of cellular confinement. The adjudicator, the interim Deputy Governor, said that he believed the award to have been at the lower end of the tariff scale and proportionate to Mr Hussain's guilty plea.

197. Manchester's local adjudication tariff guidelines for disobeying a lawful order state that adjudicators should consider whether the offence was premeditated, whether the refusal relates to underlying risk to the prisoner, any previous offences and whether the refusal formed part of a more serious offence such as a general protest by several prisoners. The guidelines state that mitigating circumstances include any medical issues, remorse or apology and a guilty plea.

198. Manchester's guidelines state that for a minor offence, the prisoner should not receive cellular confinement. A 'medium' offence could receive one to seven days of cellular confinement. A serious offence could receive seven to 28 days of cellular confinement.

199. Mr Hussain was punished with seven days of cellular confinement, which is on the borderline between a medium and serious offence according to local guidelines. We are not satisfied that this was appropriate. Mr Hussain had pleaded guilty and provided relevant mitigating circumstances. We also note that Mr Hussain moved to B Wing without further issue after he had spent two hours in segregation, which could also have been considered in mitigation. It was his first disciplinary hearing at Manchester in which he had pleaded guilty, and he had not been found guilty of any disciplinary offence for some time at his previous prison. We make the following recommendation:

The Governor should ensure that managers conducting disciplinary hearings impose punishments in line with local tariff guidelines and take into consideration mitigating circumstances when considering awarding periods of cellular confinement.

Referrals to the mental health team following disciplinary hearings

200. After Mr Hussain pleaded guilty, he asked to speak to a member of the mental health team. The interim Deputy Governor and the Head of Healthcare said that if a request to see the mental health team had been made during a disciplinary hearing, the expectation would have been for segregation unit staff to contact the mental health team to tell them of the request.

201. At his disciplinary hearing, Mr Hussain said that his actions were based on a desire to speak to the mental health team and for his medication to be "sorted". It is concerning that staff did not initiate a mental health referral and instead relied on Mr Hussain to initiate contact with the mental health team. Not making a referral, especially when Mr Hussain was punished with cellular confinement which might have exacerbated his mental ill-health, was a missed opportunity to identify and support any immediate mental health needs. We make the following recommendation:

The Governor should ensure that managers imposing punishments of cellular confinement fully consider the likely impact on the health and welfare of the prisoner, including referring the prisoner to the mental health team, where appropriate.

Emergency response

202. PSI 03/2013 on medical emergency response codes sets out the actions staff should take in a medical emergency. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Manchester uses the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious. In July 2020, the prison issued a Governor's Order to remind staff of the local protocol.

203. When Officer F found Mr Hussain hanging, he should have immediately called an emergency code blue to indicate that Mr Hussain was unresponsive and that it was a life-threatening situation. He told us that he could not do so immediately as there was a radio blind spot and he could not rely on his radio working. Instead, he walked to an office nearby to alert staff to the emergency before returning to the cell with colleagues.

204. It was not until 12.57pm, a delay of around three minutes from when Mr Hussain was first found, that another officer radioed a code blue. We are concerned that this was an avoidable delay, and that Officer F should have attempted to radio a code blue when he found Mr Hussain or, if this did not work, immediately on his return to the staff office.

205. We appreciate that radio black spots exist in the segregation unit and around other parts of the prison. However, another officer was able to make the call when standing outside the cell. Officers should still try to call a code blue even if they believe this to be the case, and if a radio does not work, they should shout for assistance or ring the emergency alarm. The delay in calling a code blue led to a delay in calling an ambulance for Mr Hussain. Any delay can have a significant impact on a person's chance of survival. Given that staff and paramedics were able to establish Mr Hussain's pulse, we cannot know whether earlier intervention might have affected the outcome for him.

206. We have made similar recommendations about the delay in staff calling emergency codes at Manchester in our reports into the death of men in June 2019, August 2020 and November 2020. It is important that staff understand their roles in a medical emergency, and it is concerning that we have repeatedly made these similar findings. We make the following recommendation:

The Prison Group Director for the Long Term and High Security Estate should take steps to satisfy himself that all staff at HMP Manchester understand their responsibilities during medical emergencies, including calling an immediate emergency code when there is a threat to life.

Clinical care

207. The clinical reviewer concluded that the clinical care that Mr Hussain received was of a mixed standard and not wholly equivalent to that which he could have expected to receive in the community.

Mental healthcare

208. The clinical reviewer stated that Mr Hussain had a complex presentation of paranoid schizophrenia and concluded that there had been seamless care between his previous periods of custody and treatment in the community, with good liaison between each.

209. The clinical reviewer noted that during periods of custody, there appeared to be a clear pattern of an increase in Mr Hussain's apparent psychotic symptoms following his non-compliance with medication. This was often followed by assaults and periods of segregation. A prison psychiatrist told us that she could find no overt psychotic symptoms when she last saw Mr Hussain on 16 March. She told us that given that Mr Hussain had been without medication at the time, she believed it reasonable to continue to observe him and review whether antipsychotic medication was needed.

210. However, the clinical reviewer found a lack of clarity in Mr Hussain's medical record about his medication status at Buckley Hall and whether he was taking it, as his medication compliance was not monitored. The clinical reviewer also reported his concerns that, given Mr Hussain had a diagnosis of a severe and enduring mental illness, he did not have a detailed care plan in place at Buckley Hall to set out required interventions for his treatment.

211. The clinical reviewer noted that when Mr Hussain arrived at Manchester, he was appropriately reviewed by a mental health nurse who assessed that he needed a further urgent mental health assessment. However, due to the restrictions in place due to the COVID-19 pandemic, only emergency mental health assessments were completed for newly arrived prisoners during their ten-day isolation period. This meant that despite being segregated, Mr Hussain's mental health was not assessed when he requested it. The clinical reviewer reported that it might have been prudent to have completed Mr Hussain's assessment during his period of isolation.

212. The Head of Healthcare told us that a prisoner transfer telephone call should have taken place between Buckley Hall and Manchester before Mr Hussain's transfer. She said that he should have been discussed at the weekly mental health multidisciplinary team meeting on 22 June, given that he had been identified as needing a full assessment. The clinical reviewer reported that there was no evidence that the transfer call took place or that he was discussed at the team meeting.

213. The clinical reviewer also identified a missed opportunity to ensure continuity of care, given that the psychiatrist provided psychiatry services at both Buckley Hall and Manchester. Instead, she told us that she was not aware that Mr Hussain had transferred to Manchester. We make the following recommendations:

The Head of Healthcare at HMP Buckley Hall should ensure that all prisoners identified as having a severe and enduring mental illness have comprehensive care plans.

The Heads of Healthcare at HMP Manchester and HMP Buckley Hall should ensure that:

- **liaison between prisons takes place when prisoners with a history of severe and enduring mental illness are transferred to Manchester and that the outcome is fully documented in the prisoner's medical records.**

- **All prisoners identified as requiring an urgent mental health assessment are assessed promptly and within 48 hours.**

- **All prisoners with a significant and current mental illness are discussed at the weekly mental health multidisciplinary meeting to ensure continuity of care.**

Learning lessons

214. We have identified a significant number of concerns in this report. We consider that it is important for staff to learn from our findings. We make the following recommendation:

The Governor and Head of Healthcare at HMP Manchester should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest verdict

215. The inquest hearing into the death of Mr Hussain was held on 1 December 2023. It confirmed the medical cause of Mr Hussain's death as pneumonia and hypoxic/ischaemic brain damage as a consequence of hanging. The inquest concluded that Mr Hussain died by suicide and that the failure to answer his emergency cell bell on 5 July 2021, possibly contributed to his death.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100