Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Moses Hailemichel, following his release from HMP Pentonville, on 3 March 2025

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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Summary

1. 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.

2. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

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

4. Mr Moses Hailemichel died from suspension by ligature after he was found hanged on 3 March 2025, following his release from HMP Pentonville six days earlier. He was 20 years old. We offer our condolences to those who knew him.

5. The clinical reviewer concluded that the clinical care Mr Hailemichel received leading up to his release from Pentonville was only partially equivalent to that which he could have expected to receive in the wider community. While she found that Mr Hailemichel received more timely and regular input from the mental health team in prison than he could have expected in the community, she concluded that there was a breakdown of communication between community services, healthcare and prison teams which affected the continuity of care provision and release planning for him.

6. We found that there was a delay in Mr Hailemichel's sentence calculation, and he was not allocated a Prison Offender Manager (POM) at Pentonville. When healthcare staff contacted Mr Hailemichel's community offender manager (COM), he did not share important information about Mr Hailemichel's release address and that he was under the care of social services.

Recommendations

- The Head of Healthcare, Release and Transfer Mental Health Lead and the London Prisons Mental Health Service Lead should:
    - work with the Offender Management Unit (OMU) to ensure there is a collaborative policy in place to support pre-release planning for short-term sentences (of less than twelve weeks); and
    - ensure that when there are urgent concerns about a prisoner following release, onward referrals are completed urgently by telephone, where possible, so that a full handover and context can be provided to community services.

- The Head of Healthcare should ensure that an interpreter is arranged for patients who have an alert on their medical records to indicate that they need interpretation services.

- The Head of Redbridge and Waltham Forest Probation Delivery Unit should ensure that probation practitioners share with relevant prison and healthcare staff safeguarding information about whether a prisoner is known to social care services.

The Investigation Process

7. HMPPS notified us of Mr Hailemichel's death on 18 August 2025.

8. The PPO investigator obtained copies of relevant extracts from Mr Hailemichel's prison and probation records.

9. NHS England commissioned an independent clinical reviewer to review Mr Hailemichel's clinical care at HMP Pentonville.

10. The PPO investigator and clinical reviewer interviewed two members of staff on 30 September and 14 October 2025. They also spoke to a social worker for information purposes only on 11 November.

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

12. The Ombudsman's office contacted Mr Hailemichel's next of kin, a friend, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Pentonville

14. HMP Pentonville is a category B prison which holds remanded and convicted male prisoners. Practice Plus Group is the healthcare provider.

Probation Service

15. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Pentonville was in June and July 2025. Inspectors reported that Pentonville had failed to address the considerable backlog in sentence calculation, which prevented effective sentence or release planning. Some prisoners reported that they had been sentenced weeks or months earlier but had not received their sentence calculation dates.

17. HMIP issued an Urgent Notification following this inspection. (An Urgent Notification is the process HMIP uses to alert the Secretary of State for Justice about significant concerns about a prison's performance.) HMIP found that Pentonville achieved the lowest healthy prison assessment scores for safety, purposeful activity and preparation for release. Pentonville provided an action plan stating that as of August 2025, additional resource had been secured to clear the sentence calculation backlog, training had been provided to Offender Management Unit (OMU) staff to improve their capability and competence, and a rota had been introduced to ensure appropriate cover of the mailbox to improve timely responses to court outcomes.

Deaths following release from prison

18. Since September 2021 to the end of January 2026, the PPO has started investigations into nearly 300 deaths of people who die within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health and substance use issues and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from Pentonville

19. Mr Hailemichel was the second of three men to die within 14 days of release from Pentonville since October 2023, and the first of two to take his own life. Although we made no recommendations in our investigation report into the self-inflicted death

which took place four months after Mr Hailemichel's death, that person was also released without a referral to community mental health services. Pentonville told us that they had put in place a process to ensure that the mental health team is told of the scheduled release date for a prison leaver before his release.

Key Events

Background

20. On 29 January 2025, Mr Moses Hailemichel, an Eritrean national, was remanded to HMP Pentonville, charged with possession of a knife in a public place. A nurse completed his initial health screen in reception and noted that he said he had no suicidal thoughts or mental health problems. She recorded that he needed an interpreter but there is no evidence that one was arranged.

First release from HMP Pentonville

21. On 5 February, the healthcare team received Mr Hailemichel's community medical records which noted that he had a mental and behavioural disorder due to his use of cannabinoids. They asked the mental health team to review him.

22. On 6 February, Mr Hailemichel was sentenced to four weeks in prison for malicious wounding and other similar offences. Based on his offence type, Mr Hailemichel had been assessed as posing a medium risk of serious harm to others.

23. On 8 February, a mental health nurse, saw Mr Hailemichel for his mental health review. He recorded that Mr Hailemichel's community records indicated that he was prescribed mental health medication and had been diagnosed with a mental and behavioural disorder but he had not been willing to engage with the community mental health team. When the nurse visited Mr Hailemichel in his cell, he made it clear that he did not want to be seen. The nurse offered to come back another time, but Mr Hailemichel was adamant that he did not want to see him. The nurse left the cell and recorded that the mental health team would nonetheless try again in due course.

24. On 9 February, an officer was allocated as Mr Hailemichel's Community Offender Manager (COM). The COM told us that he did not make contact as Mr Hailemichel was being released the following day and he expected him to attend his probation induction appointment in the community.

25. On 10 February, a nurse who was the Early Days in Custody Mental Health Lead, made a second attempt to complete a mental health review with Mr Hailemichel. Mr Hailemichel shouted at her, told her to get out and was verbally aggressive and intimidating. The nurse recorded that she was unable to complete the full assessment due to Mr Hailemichel's aggressive behaviour and that he may benefit from a psychiatric review.

26. Later that day, Mr Hailemichel was released from Pentonville. He did not attend his initial appointment with the Probation Service.

27. Mr Hailemichel was a care leaver and had a care-leaving placement arranged by the local authority in accommodation providing semi-independent living. On 11 February, the COM telephoned Mr Hailemichel's social worker. The social worker told the COM that he had seen Mr Hailemichel that day and he had not mentioned an appointment with the Probation Service. The social worker said that Mr Hailemichel's English was limited, and he had a history of mental health problems.

28. The nurse emailed the COM to report concerns about Mr Hailemichel's mental health and that a full mental health assessment had not been completed in prison due to his behaviour. The nurse asked the COM to consider referring Mr Hailemichel to the community Crisis team (who provide urgent help for those in mental health crisis) if he presented with acute mental health and behavioural concerns.

Recall to HMP Pentonville

29. On 14 February, Mr Hailemichel was recalled to Pentonville for failing to attend his initial appointment with the Probation Service. During his first night interview with a member of the Safer Custody Team, Mr Hailemichel confirmed that he would speak to staff if he felt low or had concerns and he reported no mental health concerns. A nurse tried to complete his initial health screen in reception but Mr Hailemichel said he did not want to be assessed. There is no indication in the medical records that Mr Hailemichel's need for an interpreter was identified during this admission to Pentonville.

30. On 17 February, a multidisciplinary team meeting took place to discuss Mr Hailemichel. It was noted that he had been diagnosed with a mental and behaviour disorder and that there were no suicide or self-harm concerns. A nurse tried to see Mr Hailemichel for an assessment but staff were taking him to the shower at the time. Prison staff told her that Mr Hailemichel's behaviour had been challenging for the last few days, and it was unlikely that he would engage.

31. A Senior Probation Officer (SPO) told us that a sentence calculation for Mr Hailemichel (to calculate when he should be released) took place on 18 February. (Mr Hailemichel was to be released on 25 February.) The SPO said that there was a delay in the sentence calculation as Pentonville was managing a backlog of cases. He told us that following this, Mr Hailemichel should have been allocated a Prison Offender Manager (POM). However, Pentonville have a locally agreed five working day timescale to allocate POMs following sentence calculation and Mr Hailemichel was to be released before this took place. A mental health team meeting took place, and it was decided that Mr Hailemichel would be referred for inpatient admission on the healthcare unit.

32. On 19 February, the COM responded to a nurse's email. He said he would refer Mr Hailemichel to Crisis after he had attended his first probation appointment after release. The COM did not inform the nurse of Mr Hailemichel's release address or that he was under the care of social services in his response. The COM told us that he did not contact Mr Hailemichel as he was only recalled to prison for a brief period and he had received background information from the prison about Mr Hailemichel.

33. On 20 February, a nurse visited Mr Hailemichel to review his need for inpatient admission. Mr Hailemichel was very angry, tried to attack a nurse and prison officers had to block him. The nurse recorded that due to Mr Hailemichel's paranoid and guarded presentation, he needed planned intervention to reduce the risk of harm to himself and others.

34. On 22 February, when a nurse visited him, Mr Hailemichel did not engage but shouted at her. Although medical records state that he was awaiting inpatient

admission, there is no indication that Mr Hailemichel was transferred to the inpatient unit before his release.

Second release from HMP Pentonville

35. On 25 February, Mr Hailemichel was released from Pentonville to accommodation provided by the local authority for those leaving care. He refused to take his medication when he left the prison. He also refused to sign his licence paperwork. The London Prisons Mental Health Service Lead told us that healthcare staff were not aware that Mr Hailemichel was being released until they saw him in reception. Release planning and onward referrals were therefore not completed before his release.

36. A mental health practitioner who was the Release and Transfer Mental Health Lead at Pentonville, emailed the COM to ask for Mr Hailemichel's release address so that he could be referred to community mental health services. Another probation practitioner responded, providing Mr Hailemichel's address as the COM was on annual leave.

37. A nurse referred Mr Hailemichel to the community mental health team by email. An automated out-of-office message was emailed in response which instructed that contact should be made by telephone if the matter was urgent. This did not happen. The community mental health team subsequently picked up the email and triaged Mr Hailemichel's case, with a plan to see him within two weeks. (He died before they saw him.)

38. Mr Hailemichel did not attend his initial appointment with the Probation Service. A letter was issued, asking for evidence of the reasons for his non-attendance and informing him of his next appointment on 4 March. It warned that he was in breach of his licence conditions.

Circumstances of Mr Hailemichel's death

39. On 3 March, a resident at Mr Hailemichel's accommodation initiated a police welfare check as they had not heard from him for some time and were unable to contact him. When they went into his room, the police found Mr Hailemichel hanged in the corner of the room.

40. On 6 March, the COM received an email from Mr Hailemichel's social worker, saying that another resident felt unsafe as the police had come and left with a body in a bag. Mr Hailemichel's key worker visited the home and found no evidence of police having been in Mr Hailemichel's room. There was no other information to confirm the resident's account. Mr Hailemichel's social worker said they would contact the COM if they received further information.

41. On 17 March, the social worker emailed the COM and informed him that Mr Hailemichel had apparently taken his own life. This email was not uploaded to the Probation Service's case management system and we do not know whether the COM saw it.

42. Between 18 March and 24 April, the COM sent two letters to Mr Hailemichel's address to say that he was in breach of his licence conditions, initiating recall

procedures and requesting a summons to court as Mr Hailemichel had failed to attend multiple appointments.

43. On 24 April, the case administrator for London Service Centre (part of the Probation Service) emailed the COM and told him that Mr Hailemichel had died.

Post-mortem report

44. The post-mortem report concluded that Mr Hailemichel died from suspension by ligature.

Findings

Risk of suicide

45. Mr Hailemichel took his own life six days after he was released from prison. He had a history of mental health problems. During his two brief periods in custody, he did not engage much with prison or healthcare staff and his behaviour was sometimes challenging. While there were concerns for his mental health, he did not harm himself or express thoughts of suicide. Other than his poor mental health, there was little to indicate that he was at an increased risk of suicide or that he should have been monitored under suicide and self-harm prevention procedures in prison.

Clinical findings

46. The clinical reviewer concluded that the care that Mr Hailemichel received in the lead up to his release from Pentonville was partially of the standard reasonably expected and was therefore equivalent to that which he could have expected to receive in the wider community. She noted that while it was difficult to consider pre-release planning in the context of equivalence because it is a prison-specific process, the pre-release planning for Mr Hailemichel was not equivalent to the expectation in comparable prison settings nationally. There was some evidence of equivalent care, including the contact Mr Hailemichael had with the integrated mental health hub in prison, and it is likely that he received more timely and regular input than he could have initially expected in the community. However, the clinical reviewer concluded that there was a breakdown of communication between community services, healthcare and prison teams which impacted on Mr Hailemichel's continuity of care, release planning and the safety of his release.

Pre-release planning

47. A nurse emailed the community mental health team on 25 February. This triggered an automated out-of-office response which instructed that the team should be contacted by telephone if the matter was urgent. This did not happen. Although the community mental health team subsequently picked up the message and triaged Mr Hailemichel's case, with a plan to see him within two weeks, he died before this happened. The clinical reviewer concluded that the Release and Transfer Team should have telephoned the community mental health service on receipt of the automated out-of-office email, given the urgency indicated by Mr Hailemichel's presentation in prison and the need for a referral to Crisis for immediate support.

48. Neither healthcare nor prison staff were aware that Mr Hailemichel was a care leaver and had an allocated community social worker as he had not disclosed this information. Had they known, a multidisciplinary team (MDT) meeting could have been held with social services before Mr Hailemichel's release, and this would likely have provided better release planning and continuity of care.

49. Both of Mr Hailemichel's periods in prison were brief. Practice Plus Group have a number of processes in place to support release and transfer processes but these focus on a pre-release planning period of twelve weeks. While the London Prisons Mental Health Service Lead, told us that the Offender Management Unit (OMU) give the healthcare team a daily paper list of prisoners being released over the following

few days, the clinical reviewer found that there was no collaborative policy in place to support pre-release planning for shorter sentences.

50. For both periods in custody, the Release and Transfer Team within the healthcare department were not aware that Mr Hailemichel was being released until the day of his release. Since Mr Hailemichel's death, all healthcare staff involved in the release and transfer process have been given access to prison records so that they can regularly check release dates to better support prison leavers.

51. We make the following recommendations:

The Head of Healthcare, Release and Transfer Mental Health Lead for Pentonville and the London Prisons Mental Health Service Lead should:

- **work with the Offender Management Unit (OMU) at Pentonville to ensure there is a collaborative policy in place to support pre-release planning for short-term sentences (of less than twelve weeks); and**
- **ensure that when there are urgent concerns about a prison leaver, onward referrals are completed by telephone, where possible, so that a full handover and context can be provided to community services.**

Use of an interpreter

52. During Mr Hailemichel's first period in custody, it was recorded in his medical records that he needed an interpreter as his first language was not English. However, this was not arranged for him. During his second period of custody, there is no indication that this need was identified. This likely affected Mr Hailemichel's ability and willingness to engage and an interpreter would have ensured that he understood and was able to communicate more effectively with staff. We make the following recommendation:

The Head of Healthcare should ensure that interpreters are arranged for patients who have an alert on their medical records to indicate that they need interpretation services.

Allocation of a Prison Offender Manager

53. In line with HMPPS' Offender Management in Custody (OMiC) Model, all sentenced individuals should be allocated a Prison Offender Manager (POM) to undertake offender management activities (which includes pre-release planning). The OMiC Delivery Manager, told us that there was no specific timeframe for a case to be allocated to a POM but there was an expectation that all cases are allocated as soon as possible to avoid delays in risk assessment and sentence planning. The OMiC process map indicates that as soon as sentence calculations have been completed and reviewed for accuracy, the case should be allocated to a POM.

54. Mr Hailemichel was not allocated a POM during his initial admission to Pentonville or when he was recalled. A POM might have enabled collaborative communication between the prison, healthcare services and the COM to plan for Mr Hailemichel's release. This might have resulted in healthcare staff being aware of Mr Hailemichel's release date and address earlier. It would also have given the COM a

designated contact in the prison to discuss Mr Hailemichel's identified risks and needs.

55. The SPO told us that Mr Hailemichel was not allocated a POM because there was a delay in his sentence calculation due to a backlog, as referenced in HMIP's recent Urgent Notification. The Head of Offender Management Services told us that the backlog had been cleared and that although there were a number of measures in place to try to prevent it happening again, they were still experiencing an ongoing backlog of more recent cases which they were working to address. He said that they had recruited ten additional members of staff in the Offender Management Unit (OMU).

56. Although there is no written local policy, the SPO told us that Pentonville had agreed locally that POMs should be allocated within five working days following sentence calculation. For both his releases, Mr Hailemichel was released within five days of his sentence calculation and had not been allocated a POM.

57. While the delay in Mr Hailemichel's sentence calculation resulted in him not being allocated a POM, we recognise that Pentonville are addressing this issue.

58. We draw to the Governor's attention that the five-day timescale to allocate a POM may cause further delay in completing meaningful pre-release work, particularly for those serving short sentences, and could result in more prison leavers not being allocated a POM.

Information sharing

59. A senior probation officer told us that COMs routinely make safeguarding enquiries to determine whether an individual is known to social care services. The COM contacted Mr Hailemichel's social worker on 11 February and gathered this information.

60. When Mr Hailemichel was recalled, there is no indication that the prison or healthcare team were aware that he was under the care of social services and was being released to accommodation for those leaving care. In addition, social services were not aware that Mr Hailemichel was in prison.

61. The mental health team emailed the COM on 19 February and asked him to refer Mr Hailemichel to Crisis on release as they were concerned about his mental health. The SPO told us that he would have expected the COM to have informed the mental health team at this point that Mr Hailemichel was under the care of social services. This would have enabled the healthcare team and social services to work collaboratively to arrange appropriate support for Mr Hailemichel's release. Additionally, when probation staff responded to the mental health team's email about Mr Hailemichel's address on 25 February, the email did not indicate that Mr Hailemichel had a leaving care placement or that he had an allocated social worker.

62. As Mr Hailemichel did not have a POM, the COM did not have a designated contact at the prison. However, this made it even more important for the COM to inform the healthcare team of this information when they contacted him. We make the following recommendation:

The Head of Redbridge and Waltham Forest Probation Delivery Unit should ensure that probation practitioners share with relevant prison and healthcare staff safeguarding information, including whether a prisoner is known to social services.

Head of Redbridge and Waltham Forest Probation Delivery Unit to note:

63. The COM was not aware that Mr Hailemichel had accommodation for those leaving care until the day after his initial release from prison. Despite this, he had not completed any accommodation referrals. It is fortunate that Mr Hailemichel had other arrangements in place and was not released homeless. Taking into account that the lack of referral in this case did not impact on Mr Hailemichel and that the COM was not allocated as Mr Hailemichel's COM until the day before his initial release, we do not make a recommendation about his.

64. The COM received an email from Mr Hailemichel's social worker on 17 March 2025 to let him know that Mr Hailemichel had died. This email was not uploaded to the Probation Service's case management system and we do not know whether or not The COM saw the email. (Although we interviewed the COM, this issue was identified subsequently by which time he was on long-term sick leave and we were unable to confirm the position with him.) He told us at interview that the London Service Centre notified him of Mr Hailemichel's death on 24 April 2025, which is when he started the process to record and review the death under supervision. This process was delayed by over a month after Mr Hailemichel's death, during which time the COM issued two letters to Mr Hailemichel's address, initiating a recall to prison and asking for a court summons for Mr Hailemichel for breaching his licence conditions. It is possible that he missed the email of 17 March due to human error or oversight. On receipt of the email, the COM should have contacted the police or the Coroner or sought advice from his line manager promptly.

Inquest

65. At an inquest held on 25 August 2026, the Coroner determined the medical cause of death to be suspension by ligature. The jury returned a narrative conclusion, stating that Mr Hailemichel died as a result of suicide.

Adrian Usher **April 2026**
Prisons and Probation Ombudsman

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