

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Imran Khan, a prisoner at HMP Isle of Wight, on 5 December 2020**

**A report by the Prisons and Probation Ombudsman**

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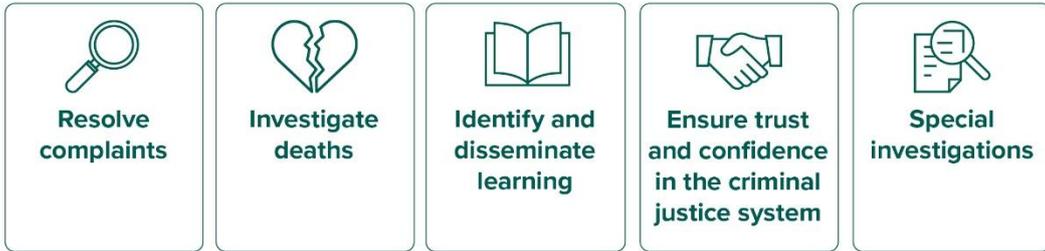
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## OUR VISION

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

## WHAT WE DO



## WHAT WE VALUE



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

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

Mr Imran Khan died in hospital on 5 December 2020 after being found hanging in his cell at HMP Isle of Wight three days earlier. He was 43 years old. I offer my condolences to Mr Khan's family and friends.

Mr Khan had only been at Isle of Wight for seven days when he was found hanging. He had been diagnosed with bi-polar disorder and dissocial personality disorder and had been managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) on a number of occasions during his seven years in custody, following periods of low mood.

We are satisfied that ACCT procedures were appropriately opened on 1 December, after concerns were raised about his low mood. However, we are concerned that the initial ACCT assessment, the first ACCT case review and a mental health assessment were all combined, contrary to policy, and that, as a result, the assessment of Mr Khan's risk to himself fell short of what was required.

We are satisfied that the frequency of checks on Mr Khan was appropriately increased on the evening of 1 December, although checks were carried out at regular intervals which meant they were predictable. We have also identified concerns about the training of new staff.

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

**Sue McAllister, CB**  
**Prisons and Probation Ombudsman**

**December 2021**

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## Summary

### Events

1. Mr Imran Khan had been in custody since October 2013, serving a 12-year sentence for sexual offences.
2. Mr Khan had a history of self-harm including threats to take his own life. He had Type 2 diabetes and had also been diagnosed with bi-polar disorder and dissocial personality disorder. He was prescribed medication for these conditions but did not always take it.
3. Mr Khan transferred to HMP Isle of Wight on 25 November 2020. On 1 December, he was placed on Prison Service suicide and self-harm monitoring procedures (known as ACCT), as staff were concerned, he was in a low mood. An assessment with prison staff and a mental health nurse took place later that day and Mr Khan said that he was feeling low as he had moved around a lot during his sentence and was a long way from his home in Lancashire. It was agreed that he should be observed hourly.
4. On the evening of 1 December, Mr Khan told a prison officer, "I don't want to live this life anymore". The officer reported Mr Khan's comments to the night orderly officer, who increased the frequency of observations to two irregular checks per hour. Mr Khan continued to be observed for the remainder of the night, and no further concerns were raised.
5. At around 7.00am on 2 December, an officer checked on Mr Khan and recorded that he was asleep in bed. When the officer checked again at approximately 7.30am, he recorded that Mr Khan was out of bed and standing behind the door. The officer did not speak to Mr Khan, but said he had no concerns about him.
6. At around 8.00am, an officer began unlocking prisoners on the house unit to use the showers and toilets. When she arrived at Mr Khan's cell, she saw him slumped on the bed, with a ligature around his neck. She immediately shouted for staff assistance, and another officer radioed to relay a medical emergency code blue. The control room called an emergency ambulance.
7. Officers entered the cell and cut the ligature from Mr Khan and immediately began doing chest compressions. Nurses arrived and continued resuscitation attempts.
8. Paramedics arrived at 8.11am and took over. Paramedics obtained an output from Mr Khan, although he remained unconscious, and took him to hospital. Mr Khan never regained consciousness and was pronounced dead on 5 December, with his family at his bedside.

### Findings

#### Assessment and management of Mr Khan's risk

9. Mr Khan had some risk factors for suicide or self-harm when he arrived at Isle of Wight on 25 November. We consider that staff should have recorded whether they

considered opening ACCT procedures and why they decided that it was not necessary.

10. We are satisfied that ACCT procedures were appropriately opened on 1 December in response to Mr Khan's perceived low mood. However, we are concerned that the ACCT assessment interview and the first ACCT case review were combined, contrary to the requirements of PSI 64/2011.
11. We are also concerned that Mr Khan's mental health assessment was conducted during the ACCT assessment/interview. We consider this to be poor practice.
12. There was no definite arrangement at the end of the ACCT review for Mr Khan to be seen again by anyone from the mental health team, although Nurse A told the investigator that this would have happened in the next week.
13. The ACCT case manager's writing on the ACCT document is illegible. This is not acceptable.
14. Although Mr Khan was subject to hourly checks, there is no evidence that any ACCT observations were carried out between 7.00pm and 8.45pm on 1 December.
15. There was a delay of around 40 minutes before the night orderly officer was told that Mr Khan had said he did not want to live any more. This did not affect the outcome for Mr Khan, but such a delay could be critical in other cases. The officer responsible had only been in the Prison Service for three weeks and had not received ACCT training.
16. The night orderly officer appropriately decided that Mr Khan should be subject to irregular half hourly checks. However, in practice the checks were conducted at regular intervals on the hour and half hour, which meant they were predictable.

## **Clinical care**

17. The clinical reviewer concluded that the physical and mental healthcare received by Mr Khan was of a good standard and was equivalent to that which would have been received in the wider community.

## **Contact with Mr Khan's family**

18. We are satisfied that the bedwatch officers behaved correctly in telling Mr Khan's family that they could not use their mobile phones to video Mr Khan or be left alone with him in hospital. We cannot say whether or not they showed appropriate sensitivity to the family.
19. We are satisfied that the prison's Family Liaison Officer (FLO) communicated appropriately with Mr Khan's family.

## **Recommendations**

- The Governor should ensure that:

- ACCT assessment interviews and the first ACCT case review are conducted separately, in line with PSI 64/2011;
- ACCT reviews determine the required frequency of conversations with the prisoner, as well as the required frequency of observations; and
- ACCT case managers are reminded of the importance of completing the ACCT documentation legibly.
  
- The Governor should share this report with CM A and arrange for a senior manager to discuss the Ombudsman's findings with him.
  
- The Head of Healthcare should ensure that mental health assessments are carried out separately from ACCT case reviews.
  
- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.
  
- The Governor should ensure that:
  - when staff carry out ACCT checks they vary the times of the checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked; and
  - ACCT training is provided to all new staff prior to them taking up a role where they have responsibility for monitoring prisoners, such as night shifts.
  
- The Governor should:
  - review the bedwatch log for the day of Mr Khan's death (5 December); and
  - remind bedwatch officers of the importance of showing respect and sensitivity to prisoners' families.

## The Investigation Process

20. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
21. The investigator obtained copies of relevant extracts from Mr Khan's prison and medical records.
22. NHS England commissioned a clinical reviewer to review Mr Khan's clinical care while in custody. The investigator and clinical reviewer interviewed six members of staff at HMP Isle of Wight between 16 February and 18 April 2021. Another investigator then took over the investigation and conducted two further interviews on 14 July. All the interviews were conducted by telephone because of the COVID-19 restrictions.
23. We informed HM Coroner for Isle of Wight of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
24. We wrote to Mr Khan's next of kin, to explain the investigation and to ask if they had any matters that they wanted the investigation to consider. Mr Khan's family wanted to know:
  - what support did Mr Khan receive for his mental health issues;
  - why was he transferred to a prison so far from his family and why was he not told in advance that he would be moving;
  - what medication was he prescribed and was he taking it;
  - who last saw and spoke to him;
  - why were the family not allowed to spend time in private with Mr Khan when he was in hospital and unconscious, and why were their mobile phones confiscated?
  - They also said that they considered the bedwatch staff were insensitive to the family's religious needs and that the prison Family Liaison Officer was ineffective and insensitive and did not communicate with them well
25. We have addressed the family's comments and questions in this report and in the clinical review.
26. Mr Khan's family received a copy of the initial report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
27. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

28. An inquest into Mr Khan's death was concluded on 12 January 2026. A jury concluded that:

- Mr Imran KHAN killed himself by suicide. We believe from the evidence that has been presented to us, that a range of contributing factors led to Mr KHAN's death. Underlying Mental Health conditions, including Bipolar Disorder and Dissocial Personality Disorder. Worsened by acute physical health conditions: severe oral thrush, constipation, abdominal discomfort that coincided with an unwanted move to HMP Isle of Wight from HMP Dovegate.

## Background Information

### HMP Isle of Wight

29. HMP Isle of Wight is a Category B male training prison occupying two separate sites with a central administration. It holds approximately 1,000 men, most of whom have been convicted of sexual offences. Around 40% of the population are aged 50 or over. Practice Plus Group provide mental and physical healthcare and substance misuse services.

### HM Inspectorate of Prisons

30. The most recent full inspection of HMP Isle of Wight was in May 2019. Inspectors found that the prison was a respectful place with good relationships between staff and prisoners. Healthcare was very good but stronger links with the local authority were needed to support prisoners with social care needs. However, inspectors found that outcomes were not sufficiently good in relation to safety. Levels of self-harm were high and there had been three self-inflicted deaths since the last inspection and inspectors were concerned that some of the Prisons and Probation Ombudsman's recommendations had not been implemented. Managers needed to use data better to understand the causes and reduce the frequency of self-harm.
31. Inspectors also noted that many prisoners were held a long way from home, and they considered that more could be done to support prisoners to establish and maintain contact with friends and family.
32. In January 2020, HMIP conducted an Independent Review of Progress at the prison. They concluded that local managers had made good progress against many of the recommendations from the 2019 inspection. They noted that managers had ensured that staff understood their roles and responsibilities in the event of a medical emergency and that an ambulance was called promptly when a medical emergency code was used.

### Independent Monitoring Board

33. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2020, the IMB reported that during the pandemic, significant action had been taken to assist prisoners with the lengthy periods of confinement. The Board noted that there had been a total of 728 incidents of self-harm during 2020, which was a decrease of 2% on the previous year. Many of these incidents of self-harm resulted from just seven individuals. The Board commented that the top three triggers for acts of self-harm appeared to be location, regime and family contact.

### Previous deaths at HMP Isle of Wight

34. Mr Khan was the 14th prisoner to die at Isle of Wight since November 2018. Of the previous deaths, eight were from natural causes, and five were self-inflicted. We

have previously made recommendations about assessing levels of risk and ensuring that welfare and roll checks are completed correctly.

### **Assessment, Care in Custody and Teamwork**

35. 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.
36. An immediate action plan must be completed within an hour of the ACCT being opened, and an initial assessment of the prisoner's main concerns must be completed within 24 hours. The first ACCT review, which should ideally take place immediately after the assessment, will then set the required levels of supervision and interactions according to the perceived risk of harm. As part of the process, a caremap (plan of care, support and intervention) is put in place. There should be regular multi-disciplinary review meetings involving the prisoner. The ACCT should not be closed until all the actions on the caremap have been completed.
37. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **Keyworker Scheme**

38. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Under the scheme all prisoners in the male closed estate must be allocated a key worker who is responsible for engaging, motivating and supporting them through the custodial period, and who is expected to spend an average of 45 minutes per prisoner per week on the key worker role, including individual time with each prisoner.
39. The key worker scheme was suspended during the pandemic, although prisons were expected to put regular welfare checks in place for vulnerable prisoners.

## Key Events

40. In October 2013, Mr Imran Khan was remanded into custody charged with sexual offences. He was subsequently sentenced to 12 years in prison. He had been in prison before and had also spent time in psychiatric units.
41. Mr Khan had been diagnosed with bi-polar and dissociative personality disorder for which he was prescribed anti-psychotic drugs. He also had Type 2 diabetes. He had a history of threatened suicide and self-harm and had been managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) on numerous occasions since 2013 following threats to harm himself.
42. In addition, he had a history of threatening behaviour toward both staff and other prisoners and had been placed on disciplinary charges 29 times for poor behaviour, including verbal and physical abuse of staff and fighting with other prisoners. He also had a history of drug misuse.

## HMP Dovegate

43. Mr Khan spent time in a number of prisons. In November 2019, he moved to HMP Dovegate.
44. Mr Khan's physical and mental health needs were regularly reviewed at Dovegate. He was prescribed medication for his physical and mental health needs (although he sometimes chose not to take it) and was regularly reviewed by a psychiatrist.
45. Prior to the pandemic, Mr Khan had regular key worker meetings with the same officer. From March 2020 onwards, this was replaced by safer custody welfare checks carried out weekly by different officers.
46. Mr Khan admitted that he used illicit drugs at Dovegate, particularly cannabis, and was referred to the substance misuse service (SMS). He only sporadically engaged with this service. However, he was regularly reviewed by the SMS team, although this became more limited during the COVID-19 pandemic. He started to engage with the SMS towards the end of his time in Dovegate and a substance misuse Care Plan was created in October 2020.
47. In July, Mr Khan told a psychiatrist that he no longer wanted to take his anti-psychotic drugs as he felt they "slowed him down". The psychiatrist suggested a gradual withdrawal, but Mr Khan was adamant he wanted to stop completely. From 11 August, Mr Khan was managed under ACCT procedures after he said he felt suicidal and had a plan to cut his throat. He said his "head was gone" because his mother was ill, and a cousin had died of COVID-19. He also said his anti-psychotic drugs were not working as he had not been taking them. His anti-psychotic was re-prescribed. When asked if he had thoughts of suicide or self-harm a few days later, he said he had had such thoughts for a long time but managed them himself as he had "family to get out to". The ACCT was closed on 10 September when Mr Khan appeared to be more stable.
48. Throughout 2020, Mr Khan sometimes refused to have his insulin injection (for his diabetes) or to have his blood glucose levels checked. He was judged to have capacity to make this decision. The implications of not having his insulin injections

were explained to him and he sometimes agreed to take oral diabetes medication instead (although insulin injections were preferable). In early November, Mr Khan refused to see the mental health nurse for a review.

49. During 2020, Mr Khan spent several periods in segregation for threats and assaults on staff. In September, he was segregated again after he bit a female officer.
50. On 21 November, an officer completed a safer custody welfare check on Mr Khan, who was still in the segregation unit. (It is not clear from her entry on Mr Khan's prison record whether she spoke to Mr Khan or just to unit staff.) She recorded that Mr Khan had recently been unhappy with how he felt he had been treated by staff and had requested a transfer to HMP Swaleside in Kent. Mr Khan had said he was sorry for biting the officer, but that he had been angry at the time. She also recorded that Mr Khan had contact with his family, although he did not discuss this with staff. Staff said that Mr Khan was complying with the regime in the segregation unit, and although he could be anxious and rude at times, he was mostly polite.

## **HMP Isle of Wight**

51. On 25 November, Mr Khan moved to HMP Isle of Wight as a routine prison transfer, to enable him to address his offending behaviour. (Isle of Wight is a specialist prison for those serving long sentences for sexual offences.) As with all prison transfers, Mr Khan would not have been informed of the move until shortly beforehand for security reasons.
52. Due to the distance from Dovegate, Mr Khan spent one night at HMP High Down en route. He was seen by healthcare staff there, who recorded that he was calm, relaxed and co-operative, and engaged appropriately, with normal tone of voice, and maintained good eye contact. He did not display any abnormal thoughts or perceptions and said he had no thoughts of suicide or self-harm.
53. When Mr Khan arrived at Isle of Wight, an officer in Reception explained the prison rules and the process he would follow on the residential unit once he had completed the reception procedures. The officer noted that due to Mr Khan's ACCT history and the fact he had transferred some distance, he spoke with him about how he was feeling (although he did not record the detail of this conversation). He recorded that Mr Khan reported no immediate concerns.
54. Mr Khan was also seen in Reception by a nurse, who completed a health screen. The nurse confirmed Mr Khan's physical and mental health history and noted the medications he was prescribed. Mr Khan was given an insulin injection. Mr Khan denied having any problems with illicit drugs. The nurse noted that Mr Khan had been managed under ACCT procedures on 24 occasions, most recently from 11 August to 10 September.
55. The nurse noted that Mr Khan made good eye contact, was well kempt and had normal speech. He recorded that Mr Khan said he had "pervasive low mood" and was "feeling low with fleeting thoughts of suicide" due to the length of his sentence, but that he had control of his thoughts and had no plans or intentions to harm himself and knew how to access support in prison if he needed it, and also had support from his mother.

56. The nurse also recorded that Mr Khan appeared “obsessive” about physical ailments which he wanted investigated. These included pain in his chest, abdomen and teeth, a burning sensation when passing urine, feeling thirsty a lot, a sore tongue and blurred vision in one eye. The nurse recorded that Mr Khan’s concerns could have been appropriate, as he did not have a prescribed insulin pen when he arrived at the prison, despite saying he had one. On examination, Mr Khan’s clinical observations were all within the normal ranges. Due to his mental health history, the nurse made a routine referral for him to be followed up by the mental health team. A follow-up appointment was also booked for Mr Khan to be seen by the prison GP about his physical health concerns and diabetes.
57. Mr Khan also had a first night risk assessment and was asked if he had previously self-harmed. He said that he had previously made cuts to his arms because he had not committed an offence and should not be in prison, and also when his father died. The interviewing officer ticked the box to indicate that Mr Khan was a low risk of suicide or self-harm and did not need to be on an ACCT.
58. Mr Khan arrived at Isle of Wight during the COVID-19 pandemic and was therefore required to isolate from the general prison population for 14 days. This meant that he was able to leave his cell but would not be able to leave the house block during this period, other than for exercise.
59. When he arrived on the house block from reception, staff explained the regime to Mr Khan and gave him a first night telephone call to his mother. He was observed hourly during the first night and no concerns were recorded. In the morning, staff noted that Mr Khan had not worked out how to use the in-call phone and would benefit from being shown again by the day staff. The prison imam also visited Mr Khan that day.
60. Because he was isolating, Mr Khan’s medications, including his insulin injections were administered at his cell, and he was seen at least twice a day by nursing staff. A nurse told us that she saw Mr Khan a couple of times to give him medication and that he was pleasant and polite and interacted normally.
61. At 6.30am on 28 November, an officer called an emergency medical code blue (which indicates a prisoner has breathing difficulties is unconscious or not breathing) after Mr Khan complained of chest pains. Healthcare staff were alerted, and an ambulance was requested. However, when nursing staff arrived and assessed Mr Khan, they stood the ambulance down as Mr Khan’s clinical observations were normal. Mr Khan told nursing staff that he was not in pain, but his bowels felt ‘a bit burnie’ and that he had a dry mouth. Mr Khan was advised to see the doctor about his back pain and to contact healthcare urgently if he felt worse or experienced breathlessness.
62. On the morning of 30 November, an officer recorded that Mr Khan was constantly asking to see a doctor and had been told that he must submit an application to healthcare for this.
63. Also, on 30 November, a prison GP reviewed Mr Khan’s medical records and noted his mental health issues and his poor diabetes control (although the latter was improving). A formal and comprehensive follow up of his physical health was scheduled for after he had completed the mandatory 14 days of isolation.

64. A prisoner who worked as an induction orderly, provided a statement saying that, on 30 November, he had helped Mr Khan complete healthcare applications. He said that Officer A warned him in advance that Mr Khan was “a bit of a hypochondriac”. He said he helped Mr Khan fill out applications to see a doctor, an optician and a dentist, as well as an application to see the mental health team about paranoia, anxiety and stress which Mr Khan said had got significantly worse since he had arrived at Isle of Wight. The prisoner also said that Mr Khan said, “Sometimes I think I am going to hurt myself, sometimes worse”. He said he reported this to Officer A and Officer B.

## **1 December: ACCT procedures**

65. At midday on 1 December, Officer B opened ACCT procedures because Mr Khan appeared to very low in mood and seemed “to have become paranoid, believing that people may harm or attack him, including staff”. The officer also recorded that Mr Khan kept repeating, “I don’t know what’s going on” and that during the morning he had become fixated with his tongue, believing that something was happening to it. The officer was aware that a referral for Mr Khan to be seen by the mental health team had already been submitted at Reception, but he contacted them again and arranged for someone to see Mr Khan that afternoon.
66. Officer C was tasked with carrying out the ACCT assessment.
67. Temporary Custodial Manager (CM) A was asked in his role as a duty manager to complete an ACCT review with Mr Khan. The CM said that he did not know Mr Khan, but he had spoken with wing staff before seeing Mr Khan and they had updated him on the concerns that had led to the ACCT being opened. He said that he and Officer C initially started the ACCT assessment in Mr Khan’s cell, but he then decided to move to the unit office for more privacy.
68. Officer C led the assessment and recorded that Mr Khan said that he did not know what was going on and had felt unwell for some time; that he “did not want to live this life any more” (although he did not say why); that he was not eating at all; that he had a long history of anxiety and paranoia and was living in permanent fear of everything; and that he felt his family had given up on him (although he was in regular contact with his mother and brother).
69. CM A told us that the ACCT review was strange in that Mr Khan alternated between periods of lucidity when he made eye contact and engaged normally, and periods when he did not respond to questions and kept saying, “My head is ‘cabbaged’, I don’t want to be here” (which the CM took to mean he wanted to leave the review and go back to his cell).
70. About 10-15 minutes into the review, Nurse A, a mental health nurse, arrived to assess Mr Khan, following the call made earlier by Officer B. She took part in the ACCT review. At interview, she said that someone from the mental health team would have gone to see Mr Khan on 1 December in any case as it had been five working days since his arrival and initial referral.
71. Nurse A recorded that Mr Khan presented as worried and concerned that “someone” may hurt him. She discussed his recent moves between prisons with him and how having a routine disrupted can make people anxious. She also told him that she thought he would feel better once he was out of isolation. She noted

that he had been taking his mental health medications and that he gave her no indication that he was having thoughts of suicide or self-harm. She also noted that, although he said he wanted to be in prison closer to his home, he was in contact with his family.

72. Nurse A told the investigator that while Mr Khan was clearly anxious, he was not as bad as she had been expecting. She said that she had read his notes and was fully aware of his mental health history. She said that his eye contact was good, and he was able to hold a conversation, he was not manic, and he explained to her what was happening. She said he told her that he felt the way he did because he had moved a lot between prisons and had now moved a long way from his family in Lancashire. She said she concluded that Mr Khan was feeling stressed because of his recent prison move. She said he gave her no indication that he was going to take his own life, and that from his notes, attempted suicide “was not a norm for him”. She said she was shocked when she heard he had hanged himself because she had not expected that, and she thought something must have happened after she saw him which had led him to do so.
73. Nurse A also said that Mr Khan would have been followed up by a secondary care practitioner once he was out of isolation, although no appointment had been made at the time of his death.
74. CM A told the investigator that Mr Khan said he was scared because he had been assaulted by other prisoners in the past, and that he tried to reassure him that he would be safe at Isle of Wight and that he would feel differently once he had completed his initial period of isolation. He said that Nurse A said that Mr Khan had a history of becoming stressed and anxious as a coping mechanism when faced with change or something he did not like and that he [the CM] was reassured to hear this.
75. CM A said that Mr Khan said that he had only been able to speak to his brother since arriving at the prison and had not spoken to any other family members. He therefore noted as an action on Mr Khan’s care plan that his access to the PIN phone should be sorted as soon as possible and, in the meantime, Mr Khan was offered the opportunity to make a telephone call from the unit office. The other action on the care map was for Mr Khan to engage with the mental health team and to take his anti-psychotic medication.
76. CM A assessed Mr Khan’s risk to himself as ‘raised’ and set the frequency of observations at hourly. He said that, although Mr Khan had not engaged very well during the review, he had not come across as someone who was in “massive crisis” or who was going to harm himself and he felt quite confident that he was not going to hurt himself. He said Mr Khan had not self-harmed since the ACCT was opened at midday and his only issue seemed to be contact with his family, where they had put things in place to help him. He therefore considered hourly observations to be adequate.
77. Nurse A also noted that during the review, it became clear that Mr Khan was suffering from severe oral thrush, which would have accounted for his concerns about his tongue and his inability to eat. After the review, she spoke to another nurse and arranged for medication to be prescribed to alleviate the symptoms.

78. Staff continued to observe Mr Khan hourly for the remainder of the afternoon and early evening. Officer C spoke to Mr Khan at about 7.00pm before he went off shift and recorded that Mr Khan said he was feeling better than he had earlier and had managed to eat his evening meal.
79. No further ACCT checks took place until 8.45pm, when Officer D, the night officer, recorded that Mr Khan told him that he "did not want to live this life anymore". The officer recorded that he advised Mr Khan to make a drink and try to settle. He told a Senior Officer (SO), the night orderly officer, what Mr Khan had said when he made a routine visit to the house unit at about 9.25pm.
80. The SO told the investigator that although he was assured by Officer D that Mr Khan was settled and not distressed, he decided to increase the frequency of observation to two irregular checks an hour for the rest of the night. He also updated a document used by staff to record when ACCT reviews were due, to show that Mr Khan required a full review on 2 December. No further issues with Mr Khan were recorded for the remainder of the night.

## Events of 2 December

81. Officer E came on duty just before 7.00am and received a handover from Officer D. Officer E said that Officer D told him what Mr Khan had said the previous evening, and that his observations had been increased to two an hour. After receiving the handover, Officer E went to check on those subject to ACCT monitoring and begin a welfare check on all prisoners on the wing.
82. At about 7.00am, he checked Mr Khan and said that when he looked in via the observation panel, Mr Khan was in bed but looked up and acknowledged him with a 'thumbs up'. At 7.30am, Officer E checked on Mr Khan again. He said that when he looked into the cell on this occasion, he was expecting to see Mr Khan still in his bed but was taken by surprise as Mr Khan was standing directly behind the door. He said that they did not speak to each other, but he had no concerns and was happy that he had seen Mr Khan up and about. He then continued with other tasks.
83. At around 8.00am, Officer F, began unlocking prisoners to use the showers and toilets. She said that when she arrived at Mr Khan's cell, she looked in via the observation panel and could see him slumped to one side on the bed with a ligature tied around his neck (made from the waist cord of his trousers), attached to a screw in the wall above.
84. Officer F said that she immediately shouted for staff assistance, and as she was opening the door also shouted, "Code blue". Officer E, who was now running towards the cell, called the code blue via his radio, which was timed at 8.02am.
85. Officer E entered the cell with Officer F and cut the ligature using his cut down tool, before laying Mr Khan on the bed. Another officer who had been alerted by the code blue, arrived at the cell and said that she immediately began doing chest compressions on Mr Khan. Nurses arrived shortly afterwards and advised the officers to move Mr Khan onto the floor just outside the cell, to provide more room for the medical staff to work.
86. The nurses continued to attempt resuscitation, and a defibrillator was attached to Mr Khan, which advised no shockable rhythm. Resuscitation continued until

paramedics arrived at 8.11am, with a second ambulance arriving at 8.13am. Paramedics obtained an output from Mr Khan although he remained unconscious, and took him to St Mary's Hospital, Isle of Wight, where he was placed on life support in the Intensive Therapy Unit (ITU).

87. Mr Khan never regained consciousness and was pronounced dead on the evening of 5 December, with his family by his bedside.

### **Contact with Mr Khan's family**

88. The prison Governor contacted Mr Khan's next of kin by telephone on 2 December to inform them that Mr Khan had attempted to take his own life and had been taken to hospital, where he remained in a critical condition. An officer was appointed as the prison's Family Liaison Officer (FLO).
89. The FLO remained in contact with the family, updating them on any changes to Mr Khan's condition, and arranging for them to contact the hospital directly. The prison imam visited Mr Khan in the afternoon and offered the family his support via the FLO. The prison's managing chaplain also visited Mr Khan on 3 December, and the imam visited again on the morning of 5 December.
90. The family travelled to the Isle of Wight on 4 December. Family members were only able to sit by Mr Khan's bed in pairs due to social distancing restrictions in place in the hospital, but they took it in turns. At one point the family asked to use their mobile phones to video Mr Khan for other family members, but the bedwatch officers told them this could not be allowed for security reasons.
91. Mr Khan's family were by his side when treatment was withdrawn and when he was pronounced dead. The FLO made contact with the family the following day, to provide advice and support on the process that would follow. The prison contributed to the cost of Mr Khan's funeral in line with national guidance.

### **Support for prisoners and staff**

92. A hot debrief was held immediately after the emergency response on 2 December, with a Trauma Risk Management (TRiM) assessment offered to staff the following day. The staff care team also offered support.
93. The prison posted notices informing other prisoners of Mr Khan's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm on 2 December, in case they had been adversely affected by Mr Khan's actions.

### **Information received from prisoners**

94. After Mr Khan was taken to hospital on 2 December, a chaplain and a prison manager spoke to prisoners on Mr Khan's wing. One prisoner said he had known Mr Khan from a previous prison and that he had been concerned about him since his arrival at Isle of Wight. He said that he and Mr Khan had been telling officers for six days that he was "not right". He also said that Mr Khan had asked to see mental health services more than once and was not eating and that he had talked about

sending his belongings back to his family. Other prisoners present were less vocal and emotional than Mr Walker but agreed, "You could tell he was not right".

95. Another prisoner, who worked as a Listener (a prisoner trained by the Samaritans to support other prisoners), wrote to the investigator saying that he had also been told by other prisoners on the wing that it had been obvious that Mr Khan was "not right" before he died. He also said that prisoners who had arrived at Isle of Wight with Mr Khan had found the numbers on their PIN phones were not working, and that one had been told, incorrectly, that they could not speak to a Listener while they were in isolation.

## **Postmortem**

96. The pathologist concluded that Mr Khan died from the delayed effects of ligature suspension (hanging). The toxicology report did not detect any illicit substances in Mr Khan's system.

## Findings

### Management of Mr Khan's risk of suicide and self-harm

97. Mr Khan was found hanging a week after he arrived at Isle of Wight. We have considered whether staff appropriately assessed and managed his risk of suicide or self-harm.

### Reception

98. When Mr Khan arrived at Isle of Wight, both prison and healthcare staff identified that he had a diagnosis of bi-polar disorder and a personality disorder and a history of being managed under ACCT procedures, and the nurse noted that he was "obsessive" about his physical health issues (which may have been genuine concerns or may have been an indication of anxiety). In addition, Mr Khan had had a long journey to a prison a long way from his home area, including spending a night at another prison en route. These were all risk factors. In these circumstances, we consider that staff should have recorded whether they considered opening ACCT procedures and why they decided that it was not necessary.

### The induction unit

99. Once he was in the induction unit, Mr Khan was seen at least twice a day by nursing staff. However, given Mr Khan's risk factors, and the fact that he was spending long periods in his cell because of the restricted regime during the pandemic, we are concerned that there is no evidence that prison staff had any meaningful conversations with Mr Khan during his first few days to check on his welfare.
100. An officer's entry in Mr Khan's record on 30 November and a prisoner's statement that Officer A described Mr Khan as a hypochondriac, suggest that some prison staff were dismissive of Mr Khan's concerns about his physical health. We are concerned that they did not recognise that they could be signs of mental anxiety.
101. However, we are satisfied that ACCT procedures were appropriately opened on 1 December in response to Mr Khan's perceived low mood. It may be that the concerns other prisoners say they had raised with staff about Mr Khan played a part in the decision to open an ACCT, but there would be nothing wrong if this were the case. Prisoners may open up to fellow prisoners more than they do to staff and it is therefore important that staff listen to concerns raised by other prisoners.
102. We do, however, have concerns about the way the ACCT procedures were managed.

### ACCT assessment and first case review

103. PSI 64/2011 makes it clear that the ACCT assessment interview and the first ACCT case review are separate procedures. In Mr Khan's case, CM A decided to combine them. When asked if this was normal at Isle of Wight, he said:

“It’s each to their own. It’s not set in stone that [the assessment and case review have] to be done on their own. As I said, in our establishment we like to be there [at the assessment interview]. So, if we do it at the same time then it gives us more information. I wouldn’t necessarily put an input into the assessment, I would just be sat in the corner, listening to what the assessment takes place.”

104. We consider that the assessment and the first ACCT review serve different purposes and that it is important that staff follow the PSI and conduct them separately.
105. The assessment is an opportunity to have a one-to-one discussion with the prisoner to explore his concerns and his risks, triggers and protective factors. Prisoners may feel more comfortable discussing their concerns on a one-to-one basis rather than in a bigger group. CM A said that he liked to sit in on assessments because he could not necessarily rely on the assessor to pass all the key information to him. However, assessors should capture all the necessary information on the assessment form which must highlight any areas of risk discussed as part of the assessment, and any protective or mitigating factors that would be helpful to mitigate the risk. The assessor should also attend the first case review wherever possible, so, again, communication should not be an issue.
106. While the role of the assessment interview is to identify and record the prisoner’s risks, the role of the first case review is to use that information to assess the seriousness of the prisoner’s risk to himself, to put support actions in place to mitigate and lower risk, and to set appropriate levels of observations. If the two are combined there may be a tendency to move too quickly to trying to identify ‘solutions’ rather than really paying attention to the prisoner’s risk factors.
107. It is not clear from the paperwork whether Nurse A had been asked to attend the first ACCT review, as she should have been, or whether she came to the houseblock to carry out a mental health assessment of Mr Khan which was due that day. Either way, we are concerned that Mr Khan’s mental health assessment took place during the ACCT case review. We consider that this is poor practice. Prisoners should be able to speak to a medical professional in private for an assessment and may feel able to be more open in those circumstances than in a room with prison staff present.
108. In addition, because Nurse A was concerned that the office where the ACCT was taking place was too small to permit social distancing, she initially stood in the doorway to talk to Mr Khan and then sat on the desk. We do not consider that this is an appropriate way to conduct something as sensitive as a mental health assessment.
109. We are concerned that the confusion between these different elements that should have been kept separate may have contributed to a poor assessment of Mr Khan’s risk. Nurse A told the investigator that Mr Khan gave no indication that he was going to take his life, and CM A said that Mr Khan never said at any point that he no longer wanted to live. However, Officer C had recorded on the assessment form that Mr Khan had said “he does not want to live any more” and “he no longer wants to live this life”. These appear to be clear statements of suicidal thoughts and we are not satisfied that CM A paid them sufficient attention when he set the level of observations. Nurse A may not have been aware of Mr Khan’s statements because

she joined the ACCT assessment/ review 10-15 minutes after it started, but there is no record that she spoke to him about whether he had suicidal thoughts.

110. We are also concerned that there was no definite arrangement at the end of the ACCT review for Mr Khan to be seen again by anyone from the mental health team, although Nurse A told the investigator that this would have happened in the next week.
111. Although CM A recorded that Mr Khan was to be observed hourly, he did not set any requirement for staff to have conversations with him. PSI 64/2011 says that while observations are important, prisoners can find them intrusive and that conversations are generally more supportive and helpful. Having meaningful conversations also enables staff to judge whether a prisoner's risk to himself may be increasing or decreasing.
112. We also note that CM A's writing on the ACCT document is effectively illegible. This is not acceptable. The summary of the case review and the ACCT ongoing record both contain important information that needs to be easily available to other staff who have responsibility for monitoring the prisoner. If it cannot be read, it is useless.
113. We recommend:

The Governor should ensure that:

- ACCT assessment interviews and the first ACCT case review are conducted separately, in line with PSI 64/2011;
- ACCT reviews determine the required frequency of conversations with the prisoner, as well as the required frequency of observations; and
- ACCT case managers are reminded of the importance of completing the ACCT documentation legibly.
- The Governor should share this report with CM A and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Head of Healthcare should ensure that mental health assessments are carried out separately from ACCT case reviews.
- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

113. HMPPS accepted this recommendation and have said:

- The implementation of ACCT Version 6 (v6) commenced in July 2021 and the updated training has now been delivered to all staff. All Managers and Supervising Officers are also trained in ACCT case management and have access to the new Case Co-ordinator training for ACCT v6. The training reinforces the requirement that the initial case reviews and assessments are two separate processes and should not be combined.
- The training also reminded staff of the need to determine the appropriate frequency of conversations and observations with the prisoner during all ACCT reviews and that these should be discussed, agreed and clearly documented in the ACCT records during each review.

- A staff notice was sent to all Case Co-ordinators to reinforce the ACCT requirements and to highlight the learning points from this report. The Case Co-ordinators were then asked to return a signed copy to the Safer Custody team in November 2021 to show that the requirements were read and understood.
- Monthly ACCT Quality Assurance processes will be maintained by the Senior Managers to identify any deviation from national policy and to provide feedback and further training for staff where required.
- The Head of Residence discussed this report and the Ombudsman's findings in a formal meeting with this named member of staff in November 2021 which addressed all of the relevant learning points. All actions following this meeting were also reported to the Deputy Governor.
- The Head of Healthcare instructed all staff in October 2021 that primary mental health assessments should be undertaken separately from ACCT case reviews. This will be monitored by the Clinical Lead for Mental Health.
- This report was shared with the staff member in October 2021 during a meeting with the Clinical Lead for Mental Health and the Head of Healthcare.

### **The evening of 1 December**

114. Although Mr Khan was subject to hourly checks, there is no evidence that any ACCT observations were carried out between 7.00pm and 8.45pm. We do not know the reason for this. The house block where Mr Khan lived does not have in-cell sanitation and prisoners who want to use the toilet overnight have to press a bell to be let out of their cell and the door is then opened electronically. Staff are not permitted to enter the landings on their own while a prisoner is out using the toilet. Nurse A said she thought that this might make it difficult for staff to conduct ACCT observations as frequently as they should.
115. When Mr Khan told Officer D at 8.45pm that he “did not want to live this life anymore”, the SO, the night orderly officer, said that he would have expected to be notified straight away. We agree. In fact, the SO was not told what Mr Khan had said until he made a routine visit to the house block at 9.22pm. We are satisfied that he appropriately increased Mr Khan's observations to two checks an hour for the remainder of the night and scheduled a full multidisciplinary review for the next morning.
116. Officer D had only joined the Prison Service as an officer three weeks before 1 December and had been unable to attend the initial officer training because it had been suspended during the COVID-19 pandemic. He was, therefore, being employed to cover the role of an Operational Support Grade (OSG). He said that he had not had ACCT training but that the ACCT document had been explained to him. In the event, the fact that 40 minutes elapsed before he told the SO what Mr Khan had said did not affect the outcome for Mr Khan, who did not hang himself until nearly 12 hours later. However, such a delay could be critical in other cases. We consider that all new staff should receive training in key parts of their role.
117. PSI 64/2011 says that ACCT observations should be at unpredictable times, meaning that a prisoner should not be checked at the same time every hour or half

hour. This is to ensure that a prisoner who may be contemplating suicide cannot predict when he will next be checked.

118. We are concerned that although the SO recorded on the ACCT ongoing record that the half hourly observations should be irregular, both Officer D and Officer E, who took over from him, carried out their checks at exactly half hourly intervals.

119. We recommend:

The Governor should ensure that:

- when staff carry out ACCT checks they vary the times of the checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked; and
- ACCT training is provided to all new staff prior to them taking up a role where they have responsibility for monitoring prisoners, such as night shifts.

120. HMPPS accepted this recommendation and have said:

- ACCT Version 6 (v6) awareness training sessions were introduced in July 2021 which all staff have now received. These are being added to the Suicide and Self-Harm (SASH) training package and will be delivered annually as refresher training.
- ACCT Quality Assurance checks will continue to be undertaken by Senior Managers to ensure that all observations are carried out at irregular intervals and to identify where any further training for staff may be required.
- A Notice to Staff (NTS) was published in October 2021 to further reinforce the learning from this report and to ensure that all staff are aware of the procedures for observation checks including that they must be at varied times. All staff were asked to acknowledge that they read and understood the NTS, and the Safer Custody team collated these responses.

## Clinical care

121. The clinical reviewer was satisfied that the care Mr Khan received was of a good standard and was equivalent to that which would have been received in the community.

122. The clinical reviewer found that Mr Khan's long-term physical health issues were all reviewed regularly and appropriately at Dovegate (although he noted that no formal care plans were in place). He found that Mr Khan's physical care at Isle of Wight was limited during the week before his death owing to restrictions in place due to the COVID-19 pandemic. Mr Khan's diabetes was not well controlled, although the GP noted it was improving. The clinical reviewer said that Mr Khan's intermittent refusal of his diabetic medication contributed to this poor control. The clinical reviewer was satisfied that a full review of Mr Khan's physical healthcare needs was planned after he had completed his isolation, but that he died before this could happen.

123. The clinical reviewer found that Mr Khan was regularly reviewed by the substance misuse team at Dovegate and started to engage with them by the end of his time

there, but that this history was not identified when he arrived at Isle of Wight. However, this had no impact on his death.

124. With regard to Mr Khan's mental health, the clinical reviewer considered that this was managed appropriately at both Dovegate and Isle of Wight. Mr Khan was regularly reviewed by a psychiatrist at Dovegate, although he was not always compliant with his anti-psychotic medication. The clinical reviewer considered that Mr Khan's mental health was appropriately assessed by the mental health team at Isle of Wight within the required time frame. Although Mr Khan hanged himself the following day, the clinical reviewer said that he did not disclose any such intent during Nurse A's detailed mental state evaluation and did not display any symptoms or signs that might have caused concerns.
125. The clinical reviewer also said that clinical staff responded quickly to the code blue and began efficient and appropriate CPR.

### Contact with Mr Khan's family

126. Mr Khan's brother complained that the bed watch officers would not allow them to play verses from the Koran on their mobile phones and then took their phones away and would not allow them to film Mr Khan as he was dying. He considered that this showed a lack of religious sensitivity. He also complained that the family were not allowed to be alone with Mr Khan.
127. While he was in hospital, Mr Khan remained a prisoner and was therefore still subject to the same rules that he would have been in prison. This meant that he could not be filmed. The officers were also instructed to remain in sight and hearing of Mr Khan at all times to ensure that prison rules were followed. We are, therefore, satisfied that the bed watch staff followed the correct procedures.
128. We would obviously expect bed watch staff to recognise that family members will be distressed when a loved one is seriously ill or dying and that they will not be familiar with prison procedures. Families also need to understand that prison staff have to follow their instructions. Emotions can run high in these circumstances and the relationship between bed watch staff and family members can sometimes be a difficult one. We cannot say how sensitive or otherwise the bed watch officers were in this case. We recommend:

The Governor should:

- review the bed watch log for the day of Mr Khan's death (5 December); and
  - remind bed watch officers of the importance of showing respect and sensitivity to prisoners' families.
129. HMPPS accepted this recommendation and have said:
- An investigation was initiated in December 2020 by a Senior Manager following the events of the 5 December 2020, which included a review of the bed watch log, which is now completed.
  - All staff were briefed in January 2021 on the requirements of external escorts and of bed watch duties. Staff were reminded to ensure that they are aware

of what is required of them during the external escort and of the professional standards expected whilst on escort duties.

- An aide-memoir for all bed watch and escorting officers was produced in October 2021 to serve as a reference guide for staff that are undertaking external escort duties in hospitals. This included the protocols for communication with the next of kin and guidance on the correct escorting process.
130. Mr Khan's brother also complained that the prison FLO did not provide the family with support with the logistics of getting Mr Khan's body back to Lancashire so that religious rites could be performed before the funeral. He said that the FLO was ineffective and insensitive, and that his communication with the family was poor.
131. There is nothing in the FLO log to suggest that the FLO was anything other than helpful or that he did not communicate well with the family. He had telephone contact with different family members, and he arranged a password with the hospital so Mr Khan's family could obtain confidential updates about his condition before they were able to travel to the hospital. He also provided them with advice on ferry services. On the morning of 6 December, the day after Mr Khan's death, the FLO recorded that he had explained that Mr Khan's body was in the care of the coroner, who would decide when it could be released, and that he would refer the family's request to visit Mr Khan's cell to the Governor.
132. However, the FLO log we have been provided with ends there so we cannot say what help was given in returning Mr Khan's body to Lancashire. It may be that this was something the family needed to arrange with the Coroner's office and not with the prison FLO.

**Prisons &  
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