

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aktar Uddin, a prisoner at HMP Wandsworth, on 25 December 2021

A report by the Prisons and Probation Ombudsman

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.

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 Aktar Uddin was found hanged in his cell on 25 December 2021 at HMP Wandsworth. He was 35 years old. I offer my condolences to Mr Uddin's family and friends.

My investigation found that prison staff appropriately considered Mr Uddin's risk and there were no indications that should have prompted Prison Service suicide and self-harm monitoring procedures (known as ACCT) in the period leading to his death.

The officer who discovered Mr Uddin hanged did not call an emergency code as he should have done, although this did not affect the outcome for Mr Uddin.

The clinical reviewer concluded that the healthcare Mr Uddin received at HMP Wandsworth was equivalent to that which he could have expected to receive in the community.

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

May 2023

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Summary

Events

1. In January 2020, Mr Uddin was convicted of terrorism offences and was sent to HMP Wandsworth. He had been in prison several times before. In 2016, Mr Uddin was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT).
2. Mr Uddin was previously diagnosed with dissocial personality disorder and was known to have suicidal feelings. It was considered that Mr Uddin did not have an enduring mental illness. He also had a history of substance misuse which impacted on his behaviour. During his time at Wandsworth, Mr Uddin received support from the substance misuse team.
3. At around 4.20am on 25 December, a member of prison staff conducted a routine check and found that Mr Uddin's observation panel was covered. He called for assistance. Other prison staff attended the cell and opened the inundation port (an extra viewing access point on the door). They saw Mr Uddin hanging in his cell. Staff attempted to gain entry to the cell, but Mr Uddin had barricaded the door with furniture. Staff did not call a medical emergency code.
4. Officers called healthcare staff while they retrieved Allen keys to open the cell door and entered Mr Uddin's cell. One officer cut him down, while the others supported his body and carried him to the landing. Officers and healthcare staff gave Mr Uddin emergency first aid until paramedics arrived. Paramedics confirmed that Mr Uddin had died.

Findings

5. Although Mr Uddin had some risk factors for suicide and self-harm, including his upcoming release, previously reported suicidal feelings and a history of drug use, we found that there was little to indicate he was at heightened or imminent risk in the period before his death. We consider that it would have been difficult for staff at Wandsworth to have foreseen his actions on 25 December.
6. It is unclear when a code blue was called. While it is unlikely to have affected the outcome for Mr Uddin, this might not be the case in other emergencies. After Mr Uddin died, the Governor issued notices reminding staff of the need to use an emergency code.
7. The clinical reviewer concluded that the healthcare Mr Uddin received at Wandsworth was equivalent to that which he could have expected to receive in the community.
8. The clinical reviewer noted there were some shortcomings in the emergency response, namely that some staff failed to systematically follow the ABCDE ILS (Airway, Breathing, Circulation, Disability, Exposure Immediate Life Support) approach. The clinical reviewer was satisfied that the shortcomings had already been robustly addressed by the primary healthcare lead and resuscitation and practice development nurse, through training and support for staff.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Uddin's prison and medical records. There was a significant delay in obtaining CCTV evidence from the prison.
11. The investigator, and another PPO investigator, interviewed eight members of staff remotely over a number of months.
12. NHS England commissioned an independent clinical reviewer to review Mr Uddin's clinical care at the prison. She attended all interviews.
13. We informed HM Coroner for Inner West London of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Uddin's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. The family representative asked for a number of points to be addressed, some of which were outside the remit of the PPO. Among the points raised which could be addressed were:
 - Where was Mr Uddin located at the time of death?
 - Was Mr Uddin on an ACCT?
 - When was the last roll check done, was Mr Uddin's cell bell on and when was he found?
 - Why was there a delay in informing the family of Mr Uddin's death?
15. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.
16. We sent a copy of our initial report to Mr Uddin's family's representative. They did not notify us of any factual inaccuracies.

Background Information

HMP Wandsworth

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

HM Inspectorate of Prisons

18. The most recent inspection of Wandsworth was in September 2021. Inspectors reported the rate of self-harm had more than doubled during the year but remained comparatively low for the type of prison. The prison had taken action to address levels of self-harm, underpinned by daily reviews of incidents and scrutiny of data. There was no published overall safety strategy and supporting action plan to make the prison safer. The quality of Assessment, Care in Custody and Teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm varied too widely across the prison. The large team of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) was well supported and available on a rota to those needing them.
19. Inspectors noted the pressures on staff in relation to ACCT processes and that there was evidence of ACCTs being kept open unnecessarily. The prison had taken actions to address self-harm levels. These had included improvements to early days provision, ACCT case coordinator training, a wide review of data, daily reviews of incidents and the introduction of a specific ACCT handover document that identified the key staff responsible for the support of prisoners subject to ACCT each period. However, it still lacked an overall up-to-date safety strategy and supporting action plan to inform the wider staff group and to make the prison safer.

Independent Monitoring Board

20. 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 May 2021, the IMB reported that self-harm was reported and monitored on a daily basis and staff were able to focus on the prisoners who accounted for a significant portion of the self-harm incidents.

Previous deaths at HMP Wandsworth

21. Mr Uddin was the fourteenth prisoner to die at Wandsworth since December 2019. Of the previous deaths nine were self-inflicted.
22. In our previous investigations into the death of three prisoners at Wandsworth, we found issues with staff calling an emergency code and we made recommendations about staff understanding the importance of emergency codes, their use, and responsibilities. The prison accepted our recommendations and told us that they

had issued notices to staff reminding them of the importance of emergency medical codes, and the communications team issued reminder cards for all staff.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (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.
24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

Key Events

25. In January 2020, Mr Aktar Uddin was convicted of terrorism related (TACT) offences and sent to HMP Wandsworth to await sentencing. He had been in prison on several occasions previously, most recently in 2019. Mr Uddin was last managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) in 2016.
26. In February 2020, Mr Uddin was sentenced to two years imprisonment.
27. During his previous sentences, Mr Uddin was in contact with the Counter Terrorism Unit (CTU). They told us that he had engaged well with them but, from January 2020, he had disengaged because he said that he did not want to be seen as a terror related offender. As a result, CTU had no direct contact with Mr Uddin and used wing staff to check on him during his time at Wandsworth. CTU said that being convicted of TACT offences was not specifically considered a risk factor, and they never considered Mr Uddin to be at risk of suicide or self-harm.
28. From June 2021, Mr Uddin was open with staff and told them when he did not want to leave his cell. Staff consistently noted his reasons and recorded whether they had any concerns. This pattern of behaviour was not constant, and Mr Uddin would leave his cell on other days.
29. In July 2014, July 2019 and February 2021, Mr Uddin underwent psychological assessments due to concerns around his disruptive behaviour and the nature of his offending. The assessments concluded that Mr Uddin may have a personality disorder, but it did not diagnose any ongoing mental illness. The report written in 2021, noted that Mr Uddin had reported previous suicidal feelings but was not considered at risk at that time or as having depression or anxiety.
30. A psychiatrist told us that when Mr Uddin was referred to him in February 2021, there was a focus on offering more support to prisoners who were exhibiting challenging behaviours, without having evidence of a treatable mental illness. He said that CTU referred Mr Uddin to the mental health team as they were concerned that he had stopped engaging with them. During the assessment, Mr Uddin told the psychiatrist that he found it ironic that he had been labelled an Islamic terrorist, as he did not consider himself particularly religious. The psychiatrist said that there was no evidence that Mr Uddin had psychosis or severe depression, and he was not added to the Mental Health Team caseload.
31. On 27 May 2021, Mr Uddin was referred to substance support services 'Change Grow Live' (CGL). During his assessment, Mr Uddin said that he had previously had issues with heroin, crack cocaine, cannabis and alcohol. Mr Uddin received monthly support sessions for his substance misuse issues.

November – December 2021

32. On 1 November 2021, an officer rang Mr Uddin for a keyworker session on his in cell telephone, and he hung up straightaway. She recorded on his electronic prison record (NOMIS) that she assumed Mr Uddin did not want a keyworker session. This

was during a period of heightened COVID-19 restrictions when prisoners were let out of their cells for an hour a day.

33. On 5 November, an officer visited Mr Uddin and told him that he would be starting the frequent drug testing programme again and said that he would be back later to take him for a drug test. The officer said that Mr Uddin said he felt under the weather and did not want to come. He told Mr Uddin that if he did not provide a sample he would be placed on report. Mr Uddin declined again and was placed on report.
34. On 9 November, an officer conducted a keyworker session with Mr Uddin over the phone. She recorded that he said he had no issues and was in contact with people at home. Keyworker sessions took place roughly every two weeks. We contacted the officer for an interview, but she did not respond to our request.
35. Mr Uddin's offender manager said she had her last contact with him on 26 November. Mr Uddin asked for his parole hearing, which was scheduled for 3 December, not to go ahead and told her that he had discussed it with his legal representatives. He said that the parole hearing did not matter because he was going to be released on his sentence expiry date in January. She told him that he may wish to discuss this again because his hearing was a week away. She said that Mr Uddin discussed how he was doing, and he raised no concerns.
36. On 2 December, Mr Uddin told a worker from substance support services that he no longer wished to have drug support sessions as he no longer needed them. The worker asked whether he wanted to be referred to community drug support services and he declined. The worker said that he had no concerns about Mr Uddin's risk of suicide and self-harm.
37. On 3 December, Mr Uddin was scheduled to attend his parole hearing. A Probation worker told us that she had arranged the hearing by video link, and had made referrals to London housing organisations in preparation for Mr Uddin's release.
38. On 4 December, an officer noted that Mr Uddin had left his cell to get clean clothes and bedding and had spent time cleaning his cell. The officer also noted Mr Uddin was in a good mood. The next day, an officer recorded on NOMIS that Mr Uddin did not get out of bed that morning because he was tired and cold, but she had no concerns about him.
39. On 8 December, an officer conducted a welfare check after Mr Uddin did not attend his parole hearing. Mr Uddin told her that his non-attendance had been on the agreement of both parties, and he was going to be released three weeks later. She recorded that Mr Uddin thanked her for coming to see him.
40. On 13 December, an officer recorded that Mr Uddin refused his hot meal in the evening and did not want to leave his cell. However, throughout December, officers conducted welfare checks on Mr Uddin and noted no concerns.
41. On 22 December, an officer conducted a key worker session with Mr Uddin. She recorded that the Probation Service had been in contact with him about accommodation in preparation for his upcoming release. She also noted that he said that he was happy to raise any concerns with wing staff.

42. At approximately 7.00pm on 24 December, an officer provided Mr Uddin with some coffee sachets from other prisoners and noted nothing of concern. At around 9.00pm, an Operational Support Grade (OSG) conducted a roll check (a count to ensure all prisoners are locked in their cells) and did not note any concerns about Mr Uddin.

Events of 25 December

43. At 4.00am, the OSG conducted the early morning roll check. When he got to Mr Uddin's cell approximately 20 minutes later, he noticed that the observation panel was blocked. He knocked on Mr Uddin's cell door a few times to see if he could get a response, but he did not. He then he radioed the control room for more staff to attend the cell. Records showed that Mr Uddin's cell bell had not been activated during the night.
44. At 4.22am, the control room log showed staff were made aware of the blocked observation panel in Mr Uddin's cell. Officer A made his way to the cell and arrived approximately two minutes later with other officers. Staff then retrieved the inundation key, which allows another view into the cell and opened the inundation port. Officer A saw Mr Uddin hanging over the side of the bed with a green bedsheet tied around his neck. Staff unlocked the door, but officers could not enter because Mr Uddin had barricaded the door with furniture. CCTV shows Officer A radioed for help and officers tried to force entry into cell. No one called a code blue.
45. At 4.24am, Officer B said he was made aware by radio that a prisoner had blocked his observation panel and assistance was needed at the cell. He said that he recalled a code blue being called, but evidence from other officers suggests that this was not the case. Two more officers also responded. Officer B said he arrived at the cell and found the two officers and the OSG trying to gain access. CCTV showed Officer B arrived a minute after Officer A radioed for help. He said that he tried to force the door open with his shoulder, but it would not move. At this point he noticed that the door was barricaded with a cupboard which was wedged between the bed and the door.
46. Officer B and other officers tried to force the door open again. Another officer retrieved the Allen keys needed to open the door outwards which took around 30 seconds. Officer B said it took them around 45 seconds to detach the door. A nurse and other healthcare staff arrived at the cell 30 seconds after the officer. The control room incident log showed that an ambulance was called at 4.26am. CCTV showed officers entered the cell approximately six minutes after the OSG had first noticed the blocked observation panel.
47. Officer B was the first to enter the cell. He said that Mr Uddin was hanging over the edge of the bunk bed, with a sheet twisted into a rope around his neck. He took out his cut down tool, climbed onto the top bunk and cut the sheet. Officer A and Officer C supported Mr Uddin's body, and Officer B assisted them in carrying Mr Uddin to the landing outside the cell.
48. Officer A, Officer B and the nurses started chest compressions. Officer A said that Mr Uddin felt cold. Officer C said Mr Uddin was blue and his tongue was swollen, but he did not believe rigor mortis had set in.

49. The nurse said because the door was barricaded, and it took a few minutes to gain access to the cell, he had time to set up equipment on the landing. He said once officers had brought Mr Uddin onto the landing, he checked for a pulse but could not find one and assisted with CPR.
50. Officer B assisted the nurses in getting the oxygen tubes into Mr Uddin's throat and said Mr Uddin's jaw was stiff. They attached a defibrillator which told them to continue CPR.
51. At 4.41am, a fast response paramedic arrived and reached Mr Uddin's cell four minutes later.
52. At 5.10am, the paramedics confirmed that Mr Uddin had died.

Contact with Mr Uddin's family

53. A governor telephoned Mr Uddin's sister to tell her he had died. The FLO (family liaison officer) log noted there was a delay as due to intelligence checks because Mr Uddin was a TACT offender. Mr Uddin's sister expressed concern that there was a nine hour delay in the FLO contacting the family following the governor's call. The prison said they had difficulty appointing a FLO on Christmas Day.
54. An officer was appointed as FLO on 25 December. She met Mr Uddin's sister on 27 December. She arranged for the family to visit Mr Uddin's cell and kept in contact with Mr Uddin's sister via email.
55. The prison offered to pay toward the cost of the funeral in line with national guidance.

Support for prisoners and staff

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

Post-mortem report

58. The post-mortem report gave Mr Uddin's cause of death as hanging. Mr Uddin did not have any drugs in his system at the time of death.

Findings

Assessment of risk

59. Prison Service Instruction (PSI) 64/2011 lists a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. Mr Uddin had some of these risk factors, including that he was coming up to his release date, had felt suicidal in the past and had a history of drug use. He was last monitored under ACCT procedures eight years previously.
60. From June 2021, Mr Uddin was open with staff and told them when he did not want to leave his cell for exercise or food. Staff always noted whether they had concerns and what Mr Uddin had said. However, this behaviour was not constant, and staff regularly checked on him. In December, Mr Uddin appeared to be displaying his usual behaviour. We have not seen any evidence that staff could have reasonably considered Mr Uddin was at significantly increased or imminent risk of suicide before he died. We do not therefore consider that staff could reasonably have predicted his actions.

Emergency response

61. Prison Service Instruction (PSI) 03/2013 requires that the Governor must have a medical emergency response code protocol in place which ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.
62. Witness evidence suggests a code blue was called at some point during the incident, however it is unclear when it was called and there is no record on the control room log. We cannot say that this affected the outcome for Mr Uddin, but it might be critical in other circumstances. We have made a number of recommendations to Wandsworth about this issue, and it is disappointing to repeat our concerns again. However, immediately after Mr Uddin's death the Governor published notices to staff reminding them of the need to call medical emergency codes. On that basis, we make no recommendation.
63. HMPPS Safety Bulletin on Observation Panels (February 2018) says if a prisoner does not comply with instructions to remove a blockage, staff must take immediate action to remove the obstruction and check the prisoner's welfare. Staff acted quickly to open the inundation point to look into Mr Uddin's cell. Mr Uddin's barricade meant that they needed specific tools to open the door outwards. CCTV showed that access was only gained with some difficulty and that there were no unnecessary delays in gaining entry to the cell. We make no recommendation.

Clinical care

64. The clinical reviewer concluded that the clinical care Mr Uddin received at Wandsworth was of a good standard and equivalent to that which he could have expected to receive in the community.
65. The clinical review did, however, identify some shortcomings in the emergency response, namely that some staff failed to systematically follow the ABCDE ILS (Airway, Breathing, Circulation, Disability, Exposure Immediate Life Support) approach. The clinical reviewer was satisfied that the shortcomings had already been comprehensively and robustly addressed by the primary healthcare lead and resuscitation and practice development nurse, who implemented training and support for staff on this issue to prevent recurrence.

Inquest

66. At the inquest, held from 28 September to 5 October 2026, the jury found:

“We are satisfied that Aktar Uddin died as a result of hanging on 25/12/21 at HMP Wandsworth. We are satisfied that the imposition of the original TPIM [Terrorism Prevention and Investigation Measures – restrictions applied to individuals suspected of terrorism-related activities] and its unusually restrictive nature, had a substantial impact on the mental state of Aktar Uddin. We are satisfied that the fear of a likely reimposition of such a restrictive TPIM and its possibly never-ending nature had a significant impact on the mental state of Aktar in prison. We are satisfied as a result of the consistent evidence that prison services were not aware of TPIM restrictions and their likely effect on Akthar, there was a failure to provide support most suitably targeted to Aktar's specific needs and situation.”
67. The jury concluded:

“Applied a ligature to his neck and suspended himself. It is not possible to determine whether he intended the outcome to be his death.”

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