Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammed Emamy-Foroushani a prisoner at HMP Winchester on 2 September 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

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We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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 Mohammed Emamy-Foroushani was found hanged in his cell at HMP Winchester on 2 September 2015. He was 40 years old. I offer my condolences to Mr Emamy-Foroushani's family and friends.

The investigation identified some shortcomings in Mr Emamy-Foroushani's mental and physical health care which the prison will need to address. However, at the time of his death, I consider that it would have been difficult for prison staff to have identified that he was at imminent or high risk of suicide and I do not believe they could have foreseen or prevented his actions.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2016**

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Summary

Events

1. On 24 December 2013, Mr Mohammed Emamy-Foroushani was remanded to HMP Bristol, charged with possession of a firearm and a racially aggravated assault. This was his first time in prison. Mr Emamy-Foroushani was a heavy cannabis user and had been admitted to psychiatric hospitals in the past but had no history of suicide attempts or self-harm.

2. On 14 January 2014, Mr Emamy-Foroushani was transferred to HMP Winchester. A nurse assessed him and found no signs of mental illness. Mr Emamy-Foroushani said that some people thought he was mentally ill because he was unconventional, but he did not think he was. In April 2014, a psychiatrist completed a court ordered assessment and found no symptoms of mental illness. She recommended Mr Emamy-Foroushani should receive support for substance misuse problems but he declined.

3. Mr Emamy-Foroushani suffered chronic back pain, predating his remand to prison, and sought treatment and advice at Winchester. He also often complained of ongoing tooth pain and had two teeth removed.

4. From 13 March 2015, Mr Emamy-Foroushani was monitored under Prison Service suicide and self harm prevention procedures, known as ACCT, because he said he had problems with his family and was thinking of suicide. On 20 March, staff constantly supervised him when he said he had tried to strangle himself. He later told a mental health nurse that this was due to severe tooth pain, which had been resolved. On 31 March, staff ended the ACCT procedures.

5. On 30 March, a doctor prescribed Mr Emamy-Foroushani antidepressants. However, between 3 July 2015 and 2 September, Mr Emamy-Foroushani took his medication only four times, the last on 12 August 2015.

6. In July, Mr Emamy-Foroushani told his substance misuse worker and a doctor that he was worried about his trial, which was due to start on 7 September. A mental health nurse assessed him on 19 August. She did not consider that he was at risk of suicide and self-harm but recommended that he should continue to take his antidepressant medication. Neither she nor the doctor knew that Mr Emamy-Foroushani was not taking his medication regularly.

7. On 1 September, Mr Emamy-Foroushani saw his substance misuse worker and talked about his trial and his plans for further substance misuse groupwork afterwards. On the morning of 2 September, Mr Emamy-Foroushani tried to call his brother 11 times, but got no reply. He was locked in his cell shortly before midday and a prisoner said he saw him asleep on his bed, shortly after 2.00pm. At 4.30pm, an officer doing routine cell checks saw Mr Emamy-Foroushani hanging from the window with a torn sheet around his neck. Attempts to resuscitate Mr Emamy-Foroushani were unsuccessful and, at 5.08pm, a doctor recorded that he had died.

Findings

8. Mr Emamy-Foroushani had some risk factors for suicide, including a history of substance misuse, possible mental health problems, chronic physical conditions which caused him pain and an imminent court appearance. However, he had not been regarded as at risk of suicide since March 2015. A mental health assessment on 19 August did not identify any further risk. We are satisfied that staff had no reason to consider Mr Emamy-Foroushani's risk of suicide had substantially increased in the days before his death or that he needed to be managed under ACCT procedures again. We do not consider that staff could reasonably have foreseen or prevented Mr Emamy-Foroushani's actions on 2 September.

9. The clinical reviewer identified some inadequacies in the standard of healthcare at Winchester, particularly relating to managing back pain, although we do not consider this was directly related to his death. There was no follow-up, as there should have been, when Mr Emamy-Foroushani stopped taking antidepressant medication. There is also a need to improve the management of mental health referrals. Although we found no evidence of effective personal officer work, Mr Emamy-Foroushani had some good support from a substance misuse worker.

Recommendations

- The Head of Healthcare should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach.
- The Head of Healthcare should ensure that there are appropriate referrals to the mental health team, particularly when prisoners are assessed as high risk of suicide, and that all referrals are actioned promptly and managed effectively.

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr Emamy-Foroushani's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Emamy-Foroushani's clinical care at the prison.

13. The investigator interviewed four members of staff jointly with the clinical reviewer on 19 October 2015. She interviewed three further members of staff on 26 October 2015, and one by telephone on 19 January 2016.

14. We informed HM Coroner for Winchester of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers wrote to Mr Emamy-Foroushani's brother to explain the investigation. Mr Emamy-Foroushani's brother had no specific matters he wanted the investigation to consider.

16. Mr Emamy-Foroushani's brother was informed the initial report was available, but did not wish to receive a copy or make any comment.

Background Information

HMP Winchester

17. HMP Winchester is an adult male local prison which can hold 685 men. Central and North West London Foundation Trust provide all healthcare services, including primary care, substance misuse services, and mental health services. There is 24-hour nursing cover.

HM Inspectorate of Prisons

18. The most recent inspection of Winchester was in February 2014. Inspectors found that prisoners subject to suicide and self-harm prevention procedures were well cared for. There was generally good attendance at reviews and appropriate care plans. Most staff had not had any mental health awareness training. Inspectors recommended that prisoners should have timely access to a full range of interventions for mild and moderate mental health problems, including counselling, clinical psychology and group therapies. The personal officer scheme had been re-launched but was not effective. Most prisoners said that they rarely, if ever met their personal officer.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent published report for the year to May 2015 the IMB were also critical of the personal officer scheme and reported that most prisoners had had no contact with their personal officer. They found that suicide and self-harm prevention procedures were well managed, with a multidisciplinary approach to helping prisoners with their problems.

Previous deaths at HMP Winchester

20. Before Mr Emamy-Foroushani's death, there had been five self-inflicted deaths and seven natural cause or unclassified deaths at Winchester since 2014. We have previously identified concerns about the mental health referral process, medicines management and the personal officer scheme.

Assessment, Care in Custody and Teamwork (ACCT)

21. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. On 24 December 2013, Mr Emamy-Foroushani was remanded to HMP Bristol for possession of a firearm and a racially aggravated assault. This was his first time in prison. At an initial health screen he told a nurse that he had been detained under the Mental Health Act in a psychiatric hospital about six years previously but had never harmed himself. The nurse referred him for a mental health assessment because he appeared agitated and because of his previous psychiatric history. The assessment was due to take place on 17 January 2014. In the meantime, staff recorded no particular concerns about him.

23. On 14 January 2014, Mr Emamy-Foroushani was transferred to HMP Winchester, before he had had the mental health assessment at Bristol. At an initial health screen, a nurse referred him to the mental health team as he was concerned about his mental state and apparent delusional thoughts. He asked healthcare administrators to request Mr Emamy-Foroushani's community GP records, but no one did. Staff assessed Mr Emamy-Foroushani as unsuitable to share a cell and he had a single cell throughout his time at Winchester.

24. On 23 January, a mental health nurse assessed Mr Emamy-Foroushani. She told the investigator that Mr Emamy-Foroushani was very angry about being in prison and told her that people made assumptions about him due to his wild hair style and because he did not wear shoes. He said that he was happy to participate in psychiatric assessments for court, which would confirm that he had no mental illness.

25. The nurse discussed Mr Emamy-Foroushani at the mental health team's referral meeting later that day and the team decided not to take him onto their caseload because they did not think he had a mental illness and wing staff had reported no specific concerns. They noted that they would liaise with the psychiatrist preparing the court report and tell wing staff to re-refer Mr Emamy-Foroushani if they were concerned about him.

26. On 31 January, Mr Emamy-Foroushani complained of back pain after using the gym and was referred to the GP, who prescribed ibuprofen on 5 February. Two days later, a nurse went to see Mr Emamy-Foroushani on the wing to discuss his back pain, but he was at the gym. On 10 February, a prison GP examined Mr Emamy-Foroushani and prescribed nefopam (a strong opioid painkiller). On 17 March, a dentist treated Mr Emamy-Foroushani for a chronic tooth infection. On 14 April, the dentist removed the tooth.

27. On 28 April, a psychiatrist assessed Mr Emamy-Foroushani for the court psychiatric report. She noted that Mr Emamy-Foroushani had previously been detained under the Mental Health Act, after concerns that he was suffering drug-induced psychosis, but assessments found no mental disorder. She said that Mr Emamy-Foroushani had slightly pressured speech (fast and frenzied, which can be a sign of mental illness), but had spoken to his brother, who said that this was how he normally spoke. Mr Emamy-Foroushani told her that he was a heavy cannabis user, and also used other hallucinogenic drugs. He said that he had used drugs to help alleviate his chronic back pain.

28. After the assessment, the psychiatrist told the mental health nurse that she did not think Mr Emamy-Foroushani needed ongoing support from the prison's mental health team but that he might benefit from substance misuse treatment. The nurse referred Mr Emamy-Foroushani to the drug treatment service but he told a substance misuse worker that he did not want to engage with the service.

29. On 30 April, a nurse reviewed Mr Emamy-Foroushani's back pain. Mr Emamy-Foroushani told the nurse that he had injured his back some years earlier and that a hospital scan had showed a fractured lower vertebra. Mr Emamy-Foroushani said that nothing had been done to follow this up since he had been remanded to prison.

30. On 12 May, a prison GP saw Mr Emamy-Foroushani to review his back pain and requested his community GP notes, but no one asked for them until 25 June. The prison healthcare department received the records on 10 July.

31. On 28 May, Mr Emamy-Foroushani tested positive for cannabis after a random drug test. Again he said that he did not want to engage with drug treatment services, but on 3 July, he referred himself to them.

32. On 8 July, Mr Emamy-Foroushani told the substance misuse worker that he was using cannabis daily. The substance misuse worker drew up a drug treatment care plan, which included doing reflective work on cannabis use and group treatment sessions. He told the investigator that when he first met Mr Emamy-Foroushani he found him difficult to understand as his thinking patterns and speech were erratic and hard to follow. He was worried about Mr Emamy-Foroushani's mental state and noted in his file that he intended to refer him to the mental health team, but he did not actually make a referral.

33. The substance misuse worker told the investigator that he had frequent contact with Mr Emamy-Foroushani, initially focused on his drug use but then providing more general support when Mr Emamy-Foroushani told him about the stressful experiences he had had. He said that Mr Emamy-Foroushani rarely left his cell and so he would try to check on him when he was on the wing. (Mr Emamy-Foroushani had no allocated activity during his time at Winchester. He said he could not work because of back pain and spent most of the time locked in his cell.)

34. In July and August 2014, Mr Emamy-Foroushani complained a number of times to healthcare staff about his back and tooth pain. On 16 July, a nurse assessed him and requested his hospital records. The hospital records were received on 24 July, but no one reviewed them at the time.

35. On 6 August, a prison dentist found a suspected cyst in Mr Emamy-Foroushani's jaw and referred him to the GP for a course of antibiotics. On 3 September, another dentist referred Mr Emamy-Foroushani to maxillofacial surgeons at the local hospital because the lump was still present.

36. On 5 November, Mr Emamy-Foroushani told a prison GP that he was frustrated that the prison had not yet received information from the hospital about his back pain. The GP noted that Mr Emamy-Foroushani was in pain, agitated and anxious. The GP found that the hospital records had been in the prison some

time, reviewed the hospital X-ray results and referred Mr Emamy-Foroushani to orthopaedic surgeons. This referral was sent on 13 November. On 27 November, a maxillofacial surgeon examined Mr Emamy-Foroushani and advised a further tooth extraction.

37. On 29 December, was angry about some of the information in the psychiatric report. The mental health team discussed Mr Emamy-Foroushani's concerns and advised him to speak to his solicitor. The team agreed that Mr Emamy-Foroushani did not need to be taken onto their caseload as he did not have a mental illness.

38. In January and February 2015, Mr Emamy-Foroushani had a number of doctor and dental appointments for his back and tooth pain.

39. On 13 March, an officer began ACCT suicide and self-harm prevention procedures after Mr Emamy-Foroushani said that he had family problems and had thoughts of suicide. Later that morning, a custodial manager assessed Mr Emamy-Foroushani as part of the ACCT process. Mr Emamy-Foroushani said that he had experimented twice with strangulation by using his television aerial cable. He said he was frustrated about being in prison, was locked in his cell for much of the time, and had argued with his family.

40. The next day, 14 March, a Supervising Officer (SO) chaired the first ACCT case review. The custodial manager was present but there was no member of healthcare staff at the review, contrary to ACCT procedures. They discussed how they could keep Mr Emamy-Foroushani busy and noted on the ACCT caremap that he should see a doctor about using the gym and should attend the Muslim service. They did not record anything about dealing with his family problems. The review assessed Mr Emamy-Foroushani as at a raised risk of suicide and self-harm (from options of low, raised and high). Staff were required to check him once an hour.

41. On 19 March, Mr Emamy-Foroushani had a tooth removed in hospital. On 20 March, he told an officer that he had recently tried to strangle himself and a SO held an interim ACCT case review with a mental health nurse. The nurse told the investigator that Mr Emamy-Foroushani said that strangling himself had helped to relieve his back pain and toothache. He said that after having his tooth out he was no longer in pain, and would not try to strangle himself again. She told the investigator that she thought this was an extreme reaction to a toothache and wondered whether there was more to it.

42. The SO and nurse decided that Mr Emamy-Foroushani needed to be constantly supervised because he had no insight into the dangerousness of his actions. They moved him to the prison inpatient unit and the nurse noted that she would discuss him at the mental health referrals meeting the next week. The SO updated the caremap with details of the constant supervision. He did not include any further actions to address Mr Emamy-Foroushani's problems and help reduce his risk.

43. On 21 March, the custodial manager held an ACCT case review. As Mr Emamy-Foroushani was being constantly supervised, the duty governor attended but there was no member of healthcare staff present as should happen for prisoners

on constant supervision. Mr Emamy-Foroushani said that he did not want to die and he had strangled himself to alleviate his toothache and back pain. The staff assessed him as at a low risk of suicide. They decided to end the constant supervision and that staff should check him once an hour. Mr Emamy-Foroushani returned to a single cell on D Wing later that day. There was no record that the mental health referrals meeting discussed Mr Emamy-Foroushani after he was discharged from the inpatient unit and no one referred him for a mental health assessment.

44. On 27 March, Mr Emamy-Foroushani had an initial appointment at the orthopaedic clinic and was referred for a scan. On 30 March, a prison GP discussed his future treatment options with him. The GP prescribed citalopram (an antidepressant) to improve his low mood.

45. On 31 March, Mr Emamy-Foroushani told staff that he was not suicidal and they ended ACCT monitoring. On 8 April, at an ACCT post-closure review, Mr Emamy-Foroushani said that he was happy with the support he had in the prison. He did not mention any further toothache or back pain but said he still had family problems.

46. On 13 April, the prison GP changed Mr Emamy-Foroushani's antidepressant medication to fluoxetine, because he said he was having bad dreams. She advised him to see the dentist about his ongoing dental problems. Mr Emamy-Foroushani's had an MRI scan on 1 June.

47. On 3 June, Mr Emamy-Foroushani told the prison GP that he had only taken one or two doses of his antidepressant because he was worried about the side effects. He said he had tried other prisoners' medications and found mirtazapine (an antidepressant with sedative properties) helpful. She agreed to prescribe mirtazapine. Later that day, Mr Emamy-Foroushani saw the dentist and said he was no longer in pain.

48. On 9 June, the substance misuse worker saw Mr Emamy-Foroushani and thought that he seemed down. Mr Emamy-Foroushani said that he was having trouble speaking to his family and that his back pain was worse. However, he said he had no thoughts of suicide or self-harm. On 17 June, Mr Emamy-Foroushani asked him to contact his brother on his behalf as he was having trouble getting in touch. The substance misuse worker asked a prison family support worker if she could encourage Mr Emamy-Foroushani's brother to get in contact, but she thought that it would be inappropriate to pressurise family members in this way.

49. On 1 July, a prison GP asked healthcare administrators to chase up the MRI scan results. She agreed to increase the mirtazapine dose and arranged to review Mr Emamy-Foroushani in two weeks. Mr Emamy-Foroushani did not attend his GP review on 15 July.

50. On 16 July, the orthopaedic clinic wrote to Mr Emamy-Foroushani informing him that the surgeon had advised non-surgical treatment for his back pain and that they would send him an appointment to discuss alternative treatments.

51. On 23 July, the substance misuse worker saw Mr Emamy-Foroushani and noted that he was beginning to worry about his trial, which was starting on 7 September.

52. On 27 July, a prison GP saw Mr Emamy-Foroushani and explained his MRI scan results. The GP also noted that he was anxious about his court case and referred him to the mental health team. The referral was not logged until 16 August. Between 1 and 27 July, Mr Emamy-Foroushani had taken only one dose of mirtazapine but the GP did not know that.

53. On 19 August, a nurse assessed Mr Emamy-Foroushani's mental health. She told the investigator that Mr Emamy-Foroushani was anxious about the trial. She decided that he should keep taking the antidepressant medication and that they would reassess his situation after his trial. She did not know that Mr Emamy-Foroushani had not been taking his mirtazapine. She said that he told her he had no thoughts of harming himself.

54. On 21 August, a prison GP saw Mr Emamy-Foroushani and agreed to refer him to the gym for exercises to help his back pain. The GP said that Mr Emamy-Foroushani seemed calm and did not mention any concerns about his mental health.

55. On 1 September, the substance misuse worker saw Mr Emamy-Foroushani in his cell to review some course work. He told the investigator that he was with him for around ten minutes and that he looked well. He said that Mr Emamy-Foroushani was preoccupied about his upcoming trial and that they discussed what would happen if he were released or if he got a longer sentence than anticipated. He said that Mr Emamy-Foroushani talked about attending further group work sessions and seemed to be planning for the future. He did not appear to be in any pain.

Wednesday 2 September

56. A SO told the investigator that, on the morning of 2 September, Mr Emamy-Foroushani appeared to be frantically trying to make a phone call. At 9.26am, Mr Emamy-Foroushani spoke to his solicitor for 10 minutes. We do not know what they talked about because the solicitor declined to participate in the investigation because of client confidentiality. Mr Emamy-Foroushani also tried to call his brother ten times between 9.45am and 10.47am, but never got through to speak to him. The SO locked Mr Emamy-Foroushani in his cell at 11.56am. He was not due to be unlocked again until later that afternoon.

57. At 2.11pm, CCTV footage shows that a prisoner, who had been unlocked from his cell to go to work, looked into Mr Emamy-Foroushani's cell and then walked away. The prisoner said that Mr Emamy-Foroushani was asleep on his bed at the time, so he did not disturb him. During the afternoon, Officer A made routine cell checks. At 4.29pm, he reached Mr Emamy-Foroushani's cell. When he opened the door, he saw Mr Emamy-Foroushani hanging from the window bars with a piece of torn sheet around his neck.

58. The officer called out to colleagues who were nearby, and they all went into the cell. An officer cut the ligature from around Mr Emamy-Foroushani's neck and moved him onto the floor. According to prison logs, at 4.30pm, Officer A radioed

an emergency code blue (which indicates circumstances such as when a prisoner is unconscious or not breathing). Staff in the control room called an ambulance immediately. Officer A told the investigator that he did not hear a response to his first radio message and had radioed a second call for assistance and blew his whistle. He began chest compressions and told the investigator that Mr Emamy-Foroushani was still warm.

59. A nurse arrived at the cell shortly after hearing the code blue and took over CPR. Ambulance records indicate that a first paramedic arrived at the prison at 4.31pm and a second paramedic arrived at 4.43pm. CCTV shows the first paramedic arrived at Mr Emamy-Foroushani's cell at 4.37pm. The paramedics and staff continued emergency treatment but at 5.08pm, an emergency doctor arrived and recorded that Mr Emamy-Foroushani had died.

Contact with Mr Emamy-Foroushani's family

60. An operational manager was the prison's family liaison officer. At 8.00pm, she arrived at Mr Emamy-Foroushani's brother's house to inform him that Mr Emamy-Foroushani had died. He was not at home so she phoned him and discovered he was abroad. She explained what had happened. She visited Mr Emamy-Foroushani's brother the next day, when he had arrived home, and offered condolences and support. The prison contributed towards funeral costs in line with national guidance.

Support for staff and prisoners

61. After Mr Emamy-Foroushani's death the Governor, debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

62. The prison posted notices informing other prisoners of Mr Emamy-Foroushani's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Emamy-Foroushani's death.

Post-mortem report

63. The post-mortem examination found that Mr Emamy-Foroushani died as a result of suspension by ligature around his neck. The toxicology examination found no drugs or alcohol in Mr Emamy-Foroushani's body.

Findings

Identification and management of the risk of suicide

64. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include a number of factors which applied to Mr Emamy-Foroushani, such as a physical illness, especially chronic conditions and those related to pain, a history of substance misuse, a history of mental health problems, lack of social support and court appearances.

65. On 13 March 2015, staff began ACCT suicide and self-harm prevention procedures as Mr Emamy-Foroushani said that he had tried to strangle himself with the cable of his television aerial. At first, he said that he was having family problems, was frustrated about being in prison and felt suicidal. At a later ACCT review, he said he had strangled himself to relieve his back and tooth pain. Mr Emamy-Foroushani was constantly supervised for two days. Staff ended ACCT monitoring on 31 March, when Mr Emamy-Foroushani said he no longer had any thoughts of suicide and they considered his risk had reduced.

66. The investigation identified some procedural failings in ACCT procedures, particularly the lack of healthcare and other multidisciplinary involvement in case reviews. As this was some months before his death we do not consider this contributed to his death. We have recently made a recommendation to Winchester about ACCT procedures, covering similar issues, so we do not repeat that recommendation here.

67. Mr Emamy-Foroushani continued to experience back pain and dental problems (which we discuss later). He told the substance misuse worker that he was having problems contacting his brother. The substance misuse worker and other staff also noticed that Mr Emamy-Foroushani was becoming more preoccupied with his trial, which was due to begin on 7 September, five days after Mr Emamy-Foroushani died. However, Mr Emamy-Foroushani said that he had no thoughts of suicide and no one identified significant concerns about his state of mind to consider beginning ACCT procedures again. A mental health nurse assessed him on 19 August and had no concerns that he was at risk of suicide. We consider that, despite Mr Emamy-Foroushani's ongoing risk factors, there was little to indicate that he was at imminent and raised risk of suicide and it would have been difficult for staff to have foreseen his actions on 2 September.

Mental health care

68. Mr Emamy-Foroushani showed some symptoms suggestive of mental illness but he did not consider that he was mentally ill. At several points during his time in prison, clinicians assessed his mental health. This included a psychiatric assessment in April 2014. The psychiatrist and the mental health nurses who assessed him subsequently did not identify any significant mental illness and did not consider he needed ongoing support from the prison mental health team. A nurse assessed his mental health on 19 August 2015, just two weeks before he died, but did not have any serious concerns about his mental health.

69. On 30 March 2015, a prison GP prescribed antidepressants to improve his low mood. She changed the medication twice and also increased the dose. The clinical reviewer noted that between 3 July and 2 September, Mr Emamy-Foroushani collected his medication only four times, the last time on 12 August. The GP did not know that Mr Emamy-Foroushani was not taking his medication when she saw him on 27 July. On 19 August, a nurse completed a mental health assessment but she was also unaware that Mr Emamy-Foroushani was not taking the antidepressant. It appears that Mr Emamy-Foroushani did not disclose this, even when the nurse advised him to continue taking the medication.

70. Winchester has a local policy (Prevention of Omitted Doses, dated June 2014), which says that nurses should take action if patients do not attend for medication. No one followed up with Mr Emamy-Foroushani when he did not collect his medication. The clinical reviewer found that the policy for missed medication was not being followed reliably. We make the following recommendation:

The Head of Healthcare should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach

71. Mr Emamy-Foroushani was assessed as at high risk of suicide and constantly supervised in March 2015, but no one referred him for a mental health assessment at the time, although a nurse wondered about his motivation for harming himself. On 27 July, a prison GP referred Mr Emamy-Foroushani to the mental health team for assessment, as he was anxious about his court case. This referral was not logged until 16 August and a nurse saw Mr Emamy-Foroushani on 19 August. Although she did not consider that Mr Emamy-Foroushani needed additional support when she saw him, the clinical reviewer considered that the delay of over three weeks for a mental heath assessment was too long. We make the following recommendation:

The Head of Healthcare should ensure that there are appropriate referrals to the mental health team, particularly when prisoners are assessed as high risk of suicide, and that all referrals are actioned promptly and managed effectively.

Management of Mr Emamy-Foroushani's physical health problems

72. Mr Emamy-Foroushani had a long history of back pain, predating his remand to prison. Throughout his time at Winchester, he complained of ongoing pain and had a number of GP appointments. As noted above, on 21 March, Mr Emamy-Foroushani linked his attempts to strangle himself with his back pain and also dental pain.

73. The clinical reviewer concluded that the management of Mr Emamy-Foroushani's back pain was not equivalent to the standard of care that he could have expected to receive in the community. He noted there were significant delays in referrals for specialist opinion, missed hospital appointments, a failure to obtain Mr Emamy-Foroushani's GP and hospital records promptly and a general lack of impetus in managing his condition. He was satisfied that Mr Emamy-Foroushani received effective dental care.

74. We do not consider that Mr Emamy-Foroushani's physical health conditions were directly related to the circumstances of his death so make no formal recommendations in this report. However, the clinical reviewer has made a number of recommendations in his clinical review, about improvement in the delivery of health services at Winchester, which the Head of Healthcare will need to address.

Personal officer support

75. Winchester re-launched its personal officer scheme in January 2014. According to the policy, all prisoners should have a personal officer who should make two entries in the prisoner's record each month. Mr Emamy-Foroushani's personal officer made only one entry in his record, on 6 June 2015. There were two management checks on 16 February and 12 July 2015, which noted the lack of personal officer entries in Mr Emamy-Foroushani's record, apparently without effect. We draw this omission to the attention of the Governor, as the support of an individual member of staff can be very important to isolated prisoners. However, the substance misuse use worker appears to have got to know Mr Emamy-Foroushani well and given him good support. We therefore do not make a formal recommendation.

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