Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Abdus Sabit a prisoner at HMP Swaleside on 9 August 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

Our Vision

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

Our Values

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Abdus Sabit died on 9 August 2016 at HMP Swaleside after he was found hanged in his cell. I offer my condolences to Mr Sabit's family and friends.

Mr Sabit was serving a long sentence and had been in prison for a number of years. He had no history of attempted suicide or self-harm, and although had previously had depression, he was not diagnosed with a mental illness. Over a number of years, Mr Sabit believed he was being bullied. There was little evidence to support this, and staff could not reasonably have determined in the days before his death that Mr Sabit was in crisis or intended to take his own life.

There were deficiencies in the emergency response, including a delay in cutting the ligature from Mr Sabit's neck, checking for signs of life and in opening the prison gates for the ambulance. While these shortcomings might not have changed the outcome for Mr Sabit, in another emergency it might be critical to saving a prisoner's life.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **April 2017**

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Summary

Events

1. On 1 December 2009, Mr Abdus Sabit was sentenced to life in prison for murdering his wife. He had been at HMP Swaleside since 7 September 2012. He had no history of attempted suicide, self-harm or substance misuse.

2. Overall, prison staff noted that Mr Sabit was a polite man. He worked well in the prison workshops and attended education classes. No one recorded any concerns about Mr Sabit's mental health or risk of suicide or self-harm.

3. In September 2013, Mr Sabit told staff that prisoners were bullying him. Staff investigated his allegation and Mr Sabit was moved to another wing at his request. Over the following months, he settled again and staff noted he worked hard, was compliant and polite.

4. During 2015, Mr Sabit complained to staff a number of times about prisoners bullying him. Staff investigated Mr Sabit's allegations but found no evidence to support them. During the investigation, staff and prisoners said they believed Mr Sabit was paranoid and might need mental health support. The mental health team saw Mr Sabit but noted that he had no mental health issues.

5. From March to June 2016, Mr Sabit again told staff that prisoners and staff were bullying him. Staff investigated his complaint but found no evidence to support his allegation. Evidence suggested staff and prisoners thought Mr Sabit was paranoid.

6. On 4 August, staff informed Mr Sabit that his request to transfer to HMP Parc had been refused because he did not meet their criteria.

7. At 8.24am, on the morning of Tuesday 9 August, a prison officer found Mr Sabit hanged during the morning unlock. He radioed a medical emergency code and left the cell to get further help. Staff responded quickly and cardiopulmonary resuscitation began. A nurse could not find any signs of life. At 8.53am, paramedics arrived and recorded that Mr Sabit had died.

Findings

8. Mr Sabit had been in prison for eight years having committed a very serious offence. Overall, he was a polite and compliant prisoner who used his time in prison constructively, working and attending education classes. Although Mr Sabit complained about bullying a number of times, staff investigated but found no evidence that this was the case. The mental health team assessed Mr Sabit but found no evidence that he had a mental health issue. Mr Sabit said he had no mental health issues, did not have depression and had no thoughts or suicide or self-harm.

9. We are satisfied that there was little to indicate that Mr Sabit was in crisis or intended to take his life. It would have been difficult for Swaleside to have identified that he was at imminent or high risk of suicide and self-harm.

10. There were deficiencies in the emergency response. There was a delay in cutting the ligature from Mr Sabit's neck, checking for signs of life and starting cardiopulmonary resuscitation. There was also a delay in paramedics arriving at Mr Sabit's cell, which ambulance records indicated was because staff delayed in opening the prison gates. It is unlikely however that these failings were material for Mr Sabit.

Recommendations

- **The Governor and Head of Healthcare should ensure that:**
  - **Staff are aware of the requirements of PSI 03/2013 on medical emergency codes.**
  - **Staff understand their responsibilities during medical emergencies.**
  - **Staff ensure there are no delays to calling, directing or discharging ambulances.**

The Investigation Process

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

12. The investigator visited Swaleside on 11 August 2016. He obtained copies of relevant extracts from Mr Sabit's prison and medical records.

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

14. The investigator interviewed seven members of staff and a prisoner at Swaleside in October 2016.

15. We informed HM Coroner for Mid-Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Sabit's cousin to explain the investigation. Mr Sabit's cousin wanted to know if Mr Sabit had complained to the prison or asked for a transfer to another prison. He wanted to know when Mr Sabit was last seen alive, and how and when he was discovered.

17. Mr Sabit's cousin received a copy of the initial report and chose not to comment or provide feedback.

Background Information

HMP Swaleside

18. HMP Swaleside, HMP Elmley and HMP Standford Hill form a group of prisons in the Isle of Sheppey. Swaleside holds life-sentenced prisoners and those serving determinate sentences. The prison houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17 bed inpatient unit. Minster Medical Group provides GP cover from 9.00am to 5.00pm on Monday to Friday, while Medoc provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

19. The report of the most recent inspection of Swaleside was in April 2016. The inspectorate said Swaleside had been a struggling prison for some time, and the population had become more challenging. The Inspectorate described the mental health provision as very good. The prison had started to improve ACCT monitoring for prisoners at risk of suicide or self-harm. Prisoners were positive about the care they received,

20. Each prison in England and Wales 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 recently published annual report for the year ending April 2016, the IMB was concerned about the continuing shortage of experienced prison officers at Swaleside. In the Board's view, this was the major reason that the preceding year had been a very difficult one for the prison. It also highlighted that Swaleside could not be considered to be a safe prison and noted there had been continued bullying by prisoners often along racial/religious lines. Swaleside's Safer Custody team had undergone some radical changes due to restructuring. From this, they had revised the processes to ensure that there was a central knowledge of all ACCT cases to ensure the timely and multi-disciplinary ACCT assessments and reviews.

Previous deaths at HMP Swaleside

21. Mr Sabit's death was the second prisoner to take his life at Swaleside since December 2014. After two deaths at Swaleside in 2012, we made recommendations to improve the emergency response procedures, and we identified similar issues in this investigation.

Key Events

December 2009 – October 2015

22. Mr Abdus Sabit was born in Bangladesh and spoke English well. On 1 December 2009, Mr Sabit received a life sentence for the murder of his wife. He spent time at HMP Belmarsh and HMP Whitemoor before he was transferred to HMP Swaleside on 7 September 2012.

23. Mr Sabit was an ex-smoker, had no history of drug or alcohol use and no history of attempted suicide or self-harm. He was prescribed medication for some physical health issues. He had been diagnosed with depression some years earlier, but had no current symptoms and did not take medication.

24. Over the next year, officers noted in Mr Sabit's prison records that he worked well in the prison workshops and was polite. Staff noted no concerns about Mr Sabit, his mental health or risk of suicide or self-harm.

25. In September 2013, Mr Sabit told staff that other prisoners were bullying him. Staff investigated his allegation and although they found no evidence that he was being bullied, moved him to a different wing at his request. Over the following months, Mr Sabit seemed settled and staff reported no concerns about him.

26. In October 2014, Mr Sabit told staff that another prisoner was dealing drugs in the workshop. The security team investigated but were concerned that the alleged perpetrator knew that Mr Sabit had reported him and might seek revenge. They discussed this with Mr Sabit, who was adamant that staff should investigate no matter the consequences. There is no recorded evidence to suggest that Mr Sabit or staff had any concerns for his safety after the investigation.

2015 onwards

27. In April 2015, Mr Sabit complained a number of times that he was being bullied by different prisoners in the workshop. Staff investigated the allegations and spoke to the prisoners whom Mr Sabit said had bullied him. Although they found no evidence of bullying, they arranged a mediation meeting between Mr Sabit and the alleged bullies to try to resolve any problems and moved Mr Sabit to different workshops. Staff recorded that Mr Sabit appeared paranoid at times and believed that everyone was out to get him. Despite the steps taken to resolve the problems, Mr Sabit continued to make allegations against prisoners. Staff were concerned that Mr Sabit might have mental health problems. They referred him to the mental health team, who saw him that month.

28. By 20 May, Mr Sabit had stopped working in the workshop due to physical ill health.

29. On 26 May, a mental health care support worker saw Mr Sabit in his cell because staff were concerned that he had been acting out of character. Wing officers told the nurse that Mr Sabit continued to claim he was being bullied in workshops and on the wing, despite staff arranging for him to move cells. The staff said that they were worried that Mr Sabit's continued allegations of bullying were making other prisoners angry and that someone might retaliate. She recorded in Mr Sabit's

medical record that he had politely declined a mental health assessment and had said that he did not have any past or current mental health issues. She noted that Mr Sabit's personal hygiene was good, that he interacted in an appropriate and coherent manner and displayed no overt signs of a severe and enduring mental illness.

30. The nurse reviewed Mr Sabit's medical record and found no evidence of mental illness. She saw that Mr Sabit had a history of depression and had been prescribed citalopram, an antidepressant, twice in the past but not since 2014. On both occasions, Mr Sabit had decided to stop taking the medication as he no longer felt depressed. She saw that during this period Mr Sabit had alleged that other prisoners were putting medication in his food that made him drowsy and had said he sometimes heard voices.

31. On 27 May, a nurse from the mental health team visited Mr Sabit on the wing. Mr Sabit told her that he did not need the mental health team's support. The mental health team discussed Mr Sabit and agreed to try to engage with him.

32. On 29 June, another mental health nurse visited Mr Sabit on the wing. He said he felt good and did not need mental health support. The nurse spoke to wing staff who were still concerned about his apparent paranoia and continued allegations of bullying.

33. The mental health team decided to keep Mr Sabit in their caseload. They discussed him at their multi-disciplinary team meetings in July and August and noted that wing staff remained concerned about him. At the meeting on 30 September, wing staff reported no concerns about Mr Sabit's mental health and said that he had not recently expressed any paranoid beliefs that others were bullying him.

34. On 9 October, Mr Sabit started work in the kitchens and moved to B Wing. Although he had one altercation with another prisoner, the catering manager recorded that he had settled in well and she had no concerns about him. Mr Sabit remained settled over the next few months and staff made few entries in his prison record.

35. On 22 March 2016, Mr Sabit submitted a complaint that he was being bullied at work in the kitchens. The safer custody and security teams investigated but found no evidence to support his allegation.

36. On 31 March, Mr Sabit referred himself to the mental health team.

37. On 5 April, Mr Sabit submitted another complaint alleging that others, including prisoners in the kitchen and staff, were bullying him and trying to make him go crazy. Mr Sabit said people were playing games with him.

38. The catering manager reviewed and discussed Mr Sabit's complaint with him. She tried to reassure him that neither staff nor prisoners in the kitchens were bullying him. The Head of Safer Prisons and Equalities also spoke to Mr Sabit about his complaint of bullying and, having done so, believed he would benefit from the mental health team's support.

39. On 13 April, a mental health nurse spoke to Mr Sabit. Mr Sabit told her that other prisoners were bullying him and he had submitted complaints about this. He said that, as English was not his first language, he sometimes struggled to understand when others were making jokes. He knew that staff were worried about his mental health, and although he said his mood was low, he said he had no mental health problems or thoughts of suicide and self-harm. She told Mr Sabit that the mental health team would discuss what support they could offer and she would see him again in four weeks.

40. On 11 May, staff issued Mr Sabit with a written warning because his attendance at work had been sporadic since 26 April. Mr Sabit was still attending the art education class twice a week. The art teacher told the investigator that Mr Sabit was a quiet man who was highly religious and spoke English well. She said that he was a good worker, who focused on his artwork and did not get involved in any prison banter with the other prisoners. She said Mr Sabit had never told her that he was being bullied, but had said he was struggling in the kitchens because of an old arm injury, which sometimes made it difficult to pick things up.

41. On 23 May, a nurse spoke to Mr Sabit on the wing landing. Once again, he told her that he believed others were playing games with him and said he had made a written complaint about this. Mr Sabit said he had experienced the same problems for around two and a half years. She noted that she suspected that Mr Sabit got confused when prisoners and staff made jokes, as this was what he seemed to describe. She told Mr Sabit that he should always ask for an explanation if he did not understand what was being said to him. Mr Sabit said he was “one hundred per cent” okay and had not felt depressed for years. She reminded Mr Sabit that he could contact the mental health team if he needed supported. She passed this information on to the rest of the mental health team.

42. ON 27 May, the catering manager told the investigator that Mr Sabit approached her in the kitchen. Mr Sabit said another kitchen worker, whom he named, was bullying him by calling him unpleasant names. She spoke to both prisoners together in her office to try to get to the root of the problem. The other prisoner denied the allegation and both prisoners agreed to stay away from each other. She noted Mr Sabit was his usual self, polite and hard working.

43. Another prisoner told the investigator that Mr Sabit was a good friend, and that they shared Muslim beliefs and talked often. He said he started to notice that Mr Sabit appeared depressed, and he would often walk around the prison exercise yard by himself. Mr Sabit told him that he believed people were talking about him in the workshops. He thought Mr Sabit was paranoid as he had not witnessed this.

44. By 27 June, Mr Sabit had again stopped attending work in the kitchens, and an officer told him his employment had been terminated. Mr Sabit said he was now attending art and maths education classes twice a week and hoped to increase these to full time. He knew that Mr Sabit had complained about problems in the kitchens and that staff had investigated and found no evidence to support his allegations. He noted that as Mr Sabit no longer worked in the kitchens, his issues might be resolved.

45. On 12 July 2016, Mr Sabit asked to transfer to HMP Parc in Wales. He said that Parc was closer to his family, which would enable them to visit him more often. On 4 August, staff informed Mr Sabit that Parc had a refused his transfer because he did not meet their criteria of having a short period of his sentence left to serve.

46. The prisoner said he began to notice that sometimes, Mr Sabit behaved strangely, and continued to think others were bullying, torturing and playing mind games with him. He said that Mr Sabit had once accused him of playing mind games with him without any cause and despite their friendship. He thought Mr Sabit was paranoid and said he had never seen anything to suggest that other prisoners were bullying Mr Sabit. He said that on 7 August, he attended the Arabic education class with Mr Sabit and had no concerns about him. No one else recorded any concerns about Mr Sabit over the next couple of days.

9 August 2016

47. At 7.25am on 9 August, an officer started his duty on B Wing and received a handover from the night patrol officer, who raised no concerns. At about 7.35am, he began a routine check of all prisoners on the wing, including Mr Sabit. He could not remember checking Mr Sabit's cell but told the investigator that he must not have had any concerns about him.

48. At about 8.20am, two officers started unlocking all of the cells on B Wing. When Officer A unlocked Mr Sabit's cell, he found him hanged with a sheet tied around his neck and to the notice board on the wall. He alerted Officer B, who was only yards away, and both officers went into the cell. Officer B supported Mr Sabit's body while Officer A untied the sheet from the notice board and the officers placed Mr Sabit on the bed. They did not remove the ligature from Mr Sabit's neck, check for signs of life or try to resuscitate him.

49. The control room log noted that Officer B radioed a code blue emergency at 8.24am. (A code blue indicates a life-threatening medical emergency such as when a person is found hanging, unconscious or not breathing.) Staff in the control room immediately called an ambulance.

50. Officer B was not sure whether other staff had heard his emergency radio call because of the high volume of messages being broadcasted on the radio network at the time. He saw that Officer A was visibly shaken and so they both left the cell and he ran to alert other staff. Officer A stood outside Mr Sabit's cell to ensure no one went in.

51. A prison manager had heard the emergency code blue alarm and responded immediately. He arrived at Mr Sabit's cell within around 15 seconds and at the same time as a SO.

52. The SO opened Mr Sabit's cell door and saw him lying on his bed, with the ligature still around his neck. He cut the ligature from around Mr Sabit's neck.

53. A nurse responded to the code blue, immediately collected the medical emergency bag and went to B Wing. She arrived as the SO removed the ligature from Mr Sabit's neck. She examined Mr Sabit, who was cold, lifeless and showed no signs of life. As the ligature was removed, she started

cardiopulmonary resuscitation by conducting chest compressions. As other prison and healthcare staff arrived at the cell, they took it in turns to deliver chest compressions. She tried to insert an airway into Mr Sabit's mouth to give him oxygen, but was unable to as his jaw was stiff.

54. The ambulance records show that paramedics arrived at the prison front gate at 8.43am, and that their entry was delayed because they had to wait for staff to open the gates. They did not reach Mr Sabit's cell until 8.53am. The prison manager told the investigator that the delay was likely to have occurred because of staff shortages at that time and also the distance to B Wing from the prison entrance.

55. The paramedics examined Mr Sabit and at 8.56am, recorded that he had died.

56. Mr Sabit left four letters in his cell in which he clearly stated his intention to take his life. In the letters he said some staff and prisoners had continually bullied and tortured him, were playing games and trying to make him go crazy.

Contact with Mr Sabit's family

57. Mr Sabit's next of kin was his cousin, who lived over one hundred miles away. At 10.15am, the SO was appointed as the prison's family liaison officer. The prison manager and the SO Blake visited Mr Sabit's cousin, and arrived at 3.50pm. They explained the circumstances of Mr Sabit's death and offered their condolences. The prison contributed to the cost of funeral expenses in line with national instructions.

Support for prisoners and staff

58. After Mr Sabit's death a prison manager debriefed the staff involved in the emergency response to discuss any issues arising and to offer support. The staff care team also offered support.

59. The prison posted notices informing other prisoners of Mr Sabit's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Sabit's death. A memorial service was later held for Mr Sabit.

Post-mortem report

60. A post-mortem examination established the cause of death as suspension. The toxicology report did not identify alcohol or drugs in Mr Sabit's body.

Findings

Identifying and managing risk of suicide and self-harm

61. Mr Sabit had been in prison for a number of years and had no history of suicide or self-harm. Swaleside identified and addressed his physical and mental health issues. Based on the available evidence, we are satisfied that staff could not reasonably have known that Mr Sabit was at risk of suicide and self-harm before his death.

Bullying

62. Swaleside's local violence reduction strategy sets out measures to support victims of bullying, threats and intimidation and keep them safe. It says that reports and incidents of victimisation should be promptly and thoroughly investigated by unit staff and the safer custody team.

63. Mr Sabit told staff that other prisoners (and sometimes staff) had bullied him a number of times, and a suicide note found in his cell said that he had been bullied and tortured by "everyone" for three to four years and this had turned him into a "lunatic". Yet, no one, including the security department, managers and the Head of Safer Prisons and Equalities, identified bullying as an issue for Mr Sabit. Staff felt that Mr Sabit displayed symptoms of paranoia about being bullied.

64. We saw no evidence to suggest that Mr Sabit was bullied or that he felt threatened or unsafe in the weeks before his death. Staff responded appropriately to his concerns by investigating the issue.

Mental health

65. Prison staff questioned many times whether Mr Sabit had mental health issues because of his apparent paranoid behaviour. During May 2015 and April 2016, the mental health team had discussed Mr Sabit's mental health 17 times at multidisciplinary meetings. They saw Mr Sabit a number of times and monitored the situation with wing staff. Mr Sabit repeatedly said he had no mental health problems, and the mental health team concluded the same. They found Mr Sabit had no symptoms of depression or psychosis. Mr Sabit showed no symptoms of being in crisis and did not express thoughts of suicide or self-harm. The clinical reviewer concluded that Mr Sabit received healthcare that was at least as good as that he could have expected to receive in the community.

Emergency response

66. An officer could not recall checking Mr Sabit's cell but told the investigator that he must not have had any concerns about him. In the absence of CCTV or other evidence, we cannot know what happened, or conclude whether he carried out the morning roll check appropriately.

67. All prison staff receive entry level training guidance on what to do if they find a prisoner hanged. This includes asking for immediate medical assistance and an ambulance, removing the ligature, checking for signs of life, and if the prisoner is not breathing, trying to resuscitate him.

68. While we recognise that Officer A was shaken, Officer B and he should have promptly cut the ligature from Mr Sabit's neck, checked for signs of life and started cardiopulmonary resuscitation. Instead, there was a short delay before a code blue was called and before other prison staff arrived and removed the ligature from Mr Sabit's neck, checked for signs of life and began emergency first aid. This is unacceptable.

69. PSI 03/2013 on medical emergency response codes contains mandatory instructions that all prison staff must understand their responsibilities during medical emergencies. It says that prison staff should prevent unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison (with or without the patient).

70. The first ambulance arrived at the prison at 8.43am but could not get through the prison because the prison's gates were locked. They did not arrive at Mr Sabit's cell until ten minutes later. The prison manager told the investigator that the delay was likely to have been caused by staff shortages and the distance from the prison entrance to B Wing. While the delay is unlikely to have affected the outcome for Mr Sabit, such a delay might be critical in other circumstances. We make the following recommendations:

The Governor and Head of Healthcare should ensure that:

- **Staff are aware of the requirements of PSI 03/2013 on medical emergency codes.**
- **Staff understand their responsibilities during medical emergencies.**
- **Staff ensure there are no delays to calling, directing or discharging ambulances.**

Prisons &
Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141