Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Moustafa Melouha a prisoner at HMP Manchester on 15 January 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

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 Moustafa Melouha was found hanged in his cell at HMP Manchester on 15 January 2016. He was 27 years old. I offer my condolences to Mr Melouha's family and friends.

Although he claimed to be Syrian, Mr Melouha was Egyptian and spoke Arabic and French, but knew little English. When he first arrived at the prison, I am concerned that staff did not use an interpreter during his initial assessments at the prison to help identify whether he was at risk of suicide or self-harm. Staff also missed an opportunity to assess his risk when he returned to the prison from court after his conviction on 6 January. I am also concerned that staff did not follow the correct procedures for calling an ambulance in an emergency and that instructions to staff do not fully reflect national policy.

Despite these concerns, I recognise that there was little to indicate that Mr Melouha was at high or imminent risk of suicide immediately before his death and it would have been difficult to have 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 **September 2016**

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Summary

Events

1. On 16 November 2015, Mr Moustafa Melouha (then known as Mr Mustafa Al-Halak) was remanded to HMP Manchester, charged with theft. It was his first time in prison. Mr Melouha had claimed to be Syrian but, after his death, prison staff discovered that he was Egyptian. He spoke only limited English.

2. Staff assessed Mr Melouha without using an interpreter or the telephone interpretation service. He reported no physical or mental health problems but said that he had once cut himself while under the influence of ‘Spice’, a new psychoactive substance. Staff did not refer him to the substance misuse service.

3. On 14 December, Mr Melouha appeared to be under the influence of an illicit drug, possibly a new psychoactive substance. A nurse monitored him, but he needed no treatment. On 19 December, Mr Melouha said he had been subject to an unprovoked assault, but prison staff could not determine exactly what had happened.

4. On 6 January 2016, Mr Melouha was convicted and sentenced to four months 19 days imprisonment. As he had already served time on remand, he was due to be released on 22 January. On 14 January, police officers interviewed Mr Melouha about possible further offences, using an interpreter. They did not charge him.

5. On the afternoon of Friday 15 January, Mr Melouha’s cellmate moved to share with another prisoner, leaving Mr Melouha on his own in the cell. Around 6.00pm, officers locked prisoners in their cells for the night. At 8.15pm, a night patrol officer could not see Mr Melouha when she looked through the observation panel of his cell during a routine check. She and another officer obtained permission from the night manager to open the cell and found Mr Melouha hanged. No one called an ambulance until at least eight minutes later. Attempts at resuscitation were unsucceful and, at 9.14pm, paramedics recorded that Mr Melouha had died.

Findings

6. Mr Melouha had limited understanding of English, yet only the officer who assessed his risk for cell sharing risk used an interpreter when he arrived at the prison. All the written information he received was in English. Although Mr Melouha had some risk factors for suicide, we recognise there was little to suggest he was at raised risk and needed monitoring when he arrived at the prison. However, without the use of interpretation services, we cannot be assured that staff fully assessed his risk. No one reviewed his risk after his conviction in early January or after he had been questioned by police the day before he died. There was little to indicate that Mr Melouha was at high or imminent risk of suicide immediately before his death, and we do not consider that staff could have predicted or prevented his actions.

7. There was a delay in calling an ambulance, while control room staff double checked details of the incident. A recently issued staff instruction about handling medical emergencies did not reflect the requirement of the national instruction to call an ambulance immediately.

Recommendations

- The Governor and Head of Healthcare should ensure that professional interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor, particularly in health assessments and when assessing prisoners' risk of suicide and self-harm.

- The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health issues or risk of suicide and self-harm, after events which could involve a change in status, including court appearances and being questioned by the police.

- The Governor should ensure that the prison's local emergency protocol meets the requirements of PSI 3/2013, and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for further information.

The Investigation Process

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

9. The investigator visited HMP Manchester on 20 January 2016. She obtained copies of relevant extracts from Mr Melouha's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Melouha's clinical care at the prison. In her review, she has made a recommendation about clinical record keeping, which the Head of Healthcare will need to address.

11. The investigator interviewed staff and prisoners at Manchester in February 2016. She and the clinical reviewer interviewed healthcare staff together.

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

13. One of the Ombudsman's family liaison officers contacted Mr Melouha's cousin to explain the investigation. He had no specific matters for the investigation to consider, but asked for a copy of the report in Arabic, which we have provided.

14. Mr Melouha's cousin received a translated copy of the initial report. He did not point out any factual inaccuracies and thanked the office for the report.

Background Information

HMP Manchester

15. HMP Manchester operates as both a high security and a local prison, serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester Mental Health and Social Care Trust provides 24-hour nursing care and the healthcare centre includes an inpatient unit

HM Inspectorate of Prisons

16. The most recent inspection of HMP Manchester was in October and November 2014. Inspectors reported that levels of self-harm were lower than at similar prisons. Staff provided good support for those at risk of suicide and self-harm and actively identified future risks. There was a high level of substance misuse and, although drug services were reasonable, some had deteriorated or stopped. Inspectors considered that the prison was committed to equality and diversity and provided adequate support for most foreign national prisoners. However, there was little provision or support for those with limited English and some felt isolated. Induction information for foreign national prisoners was poorly presented.

Independent Monitoring Board

17. 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 February 2016, the IMB reported that the number of foreign national prisoners varied between 10% and 13% of the total prison population, with 133 prisoners of 45 different nationalities at the end of February 2016. Weekly foreign national surgeries for prisoners to see immigration officials were held, but attendance was low. Security arrangements had improved, including testing for ‘Spice’, a new psychoactive substance (NPS) and taking action against prisoners found in possession of such substances.

Previous deaths at HMP Manchester

18. There have been seven deaths at Manchester since the beginning of 2015, three of which were self-inflicted. There were no significant similarities with the circumstances of those we have already investigated.

Assessment, Care in Custody and Teamwork

19. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. 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.

New psychoactive substances (NPS)

20. NPS are an increasing problem across the prison estate and can be difficult to detect. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. In July 2015, we published a Learning Lesson Bulletin, which identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Incentives and Earned Privileges (IEP) Scheme

21. Each prison has an Incentives and Earned Privileges scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

22. On 16 November 2015, Mr Moustafa Melouha was remanded to HMP Manchester, charged with theft. It was his first time in prison. Mr Melouha's Person Escort Record, which accompanied him from court to the prison, noted that he had self-harmed by cutting two years before. No other details of this were recorded. While he was in prison, Mr Melouha was known as Mr Mustafa Al-Halak and said he was Syrian. After his death, his true identity was discovered. His nationality was Egyptian.

23. At an initial health screen, a nurse noted that Mr Melouha had no physical or mental health problems and had not registered with a GP in the community. He smoked 20 cigarettes a day and drank 20 units of alcohol a week. He recorded that Mr Melouha had 'scratched' his arm while under the influence of new psychoactive substances, but had never attempted suicide and had no current thoughts of suicide or self-harm. He noted that his mood was normal and he was fit to work and live on a residential wing, in any type of cell. He assessed him as not suitable to keep his medication in his cell because of his previous self-harm and drug use, but did not refer him to the substance misuse team.

24. During the assessment, the nurse had ticked 'yes' to indicate that Mr Melouha had a significant language or communication problem. However, he told the investigator he did not use the interpreter service, as he was able to communicate with him using basic English and hand gestures.

25. An officer interviewed Mr Melouha in reception using a telephone interpreting service. She noted that he spoke French and Arabic, but only a little English. He told her that he had cut his wrists in the past, but felt fine and had no current thoughts of suicide or self-harm. She explained the support networks available. A risk assessment concluded that Mr Melouha was standard risk and could be allocated to a shared cell.

26. An officer saw Mr Melouha's for a first night interview and induction but did not use an interpreter. He ticked a box to indicate that Mr Melouha had been in prison before, although this was not the case. He also ticked to say that Mr Melouha was "not at all" concerned about being in prison and did not feel at risk of harming himself. He gave Mr Melouha numerous policy documents and Mr Melouha signed several agreements to say that he had understood and would comply with the prison's rules. All the documents were written in English and did not include anything about provision for foreign national prisoners. He noted in Mr Melouha's records that he had raised no issues and was aware of how to seek help and support.

27. On 17 November, a mental health nurse saw Mr Melouha for a more detailed secondary health assessment, but did not use an interpreting service. He recorded that Mr Melouha had said he had no thoughts of deliberate self-harm. He noted that Mr Melouha said that he had never smoked, which was contrary to what he had said the previous day. He said that Mr Melouha's English was not very good, but he thought he understood the questions; otherwise he would have used the telephone interpreting service.

28. The mental health nurse is a trained ACCT assessor and said he would have recorded any unusual behaviour or signs of agitation and started ACCT procedures if he had considered it necessary. Mr Melouha agreed to a general health check for sexually transmitted diseases, but did not attend the appointment he booked for the following day. (It is possible that he had not understood about the appointment.) Little was recorded about Mr Melouha in the next few weeks.

29. On the afternoon of 14 December, Mr Melouha and a friend were in the exercise yard and asked an officer if they could go back to their cells, but the officer told them that all the prisoners would be going back inside shortly. Both men started to act strangely and he thought they might be under the influence of drugs. A nurse examined Mr Melouha. She said that Mr Melouha and his friend were laughing hysterically and hugging each other and told her they had taken Spice. Mr Melouha was slightly drowsy, but coherent and said he felt sick. She recorded suspected use of an NPS or another illicit substance. His clinical observations were stable and no treatment was necessary. She observed him in the treatment room for 20 minutes until he was no longer drowsy, and he went back to his wing unaided. She told the investigator that Mr Melouha did not have a large English vocabulary and usually had a friend with him who would interpret. No one referred him to the substance misuse service after this incident.

30. The next day, due to Mr Melouha's suspected use of NPS, staff downgraded him to the basic regime level under the prison's incentives and earned privileges (IEP) scheme. This meant that he had fewer social visits, reduced access to the goods he could buy from the prison shop and the television was removed from his cell. The records noted he should not use 'unknown substances' and he was placed on closed visits. (Closed visits means the prisoner and his visitor have a glass partition between them and cannot make physical contact.) Mr Melouha refused to sign the form recording the decision.

31. On 18 December, an immigration officer had a routine interview with Mr Melouha, held with all new foreign national prisoners, to try establish their nationality, identity and immigration status, and whether they want to transfer to their home country if sentenced. She told us that Mr Melouha was an illegal entrant and failed asylum seeker and his case was complex. There was no intention to deport him to Syria (where they believed he was from at the time) as his nationality was unclear and the policy was not to return people to war zones. She said that the local immigration team would probably continue to monitor him after he was released. She said she did not use an interpreter, as she knew that Mr Melouha had been in the UK for three years and assumed he understood English. She had no concerns about his wellbeing when she saw him.

32. On 19 December, Mr Melouha told an officer that two prisoners had attacked him in his cell and had cut him with a razor. A nurse examined him and cleaned his wounds, which she described as long scratches on his left forearm and a one inch cut near his right eyebrow. Mr Melouha told her that the attack had been unprovoked. She booked an appointment to review his wound the next week, but he did not attend. The reasons were not recorded. She told the investigator that Mr Melouha had seemed shocked and agitated, but she did not find this unusual for someone who had been involved in a fight. She said she had seen

Mr Melouha a few times and had always found him pleasant and in good spirits. She was surprised that he had taken his own life and saw no sign that he was at risk.

33. When the nurse had previously treated Mr Melouha, she had noted in his medical record that there was a language barrier, but his English was reasonable. She told the investigator that when speaking to Mr Melouha, they would both rephrase their questions and answers to make themselves understood.

34. On 21 December, the violence reduction officer spoke to Mr Melouha about the alleged assault. Mr Melouha said that some Albanian prisoners had been standing at his cell door and making cut throat gestures. Later, when his cell was unlocked, a prisoner had assaulted him. He interviewed the prisoner Mr Melouha had accused of the assault and found that his clothes had been ripped and he had marks on his body. As there were no witnesses to the incident and the CCTV footage was unclear, staff took no further action, apart from reviewing the other prisoner's regime level.

35. On 27 December, staff reviewed Mr Melouha's behaviour and reinstated him to the standard IEP regime level. On 30 December, Mr Melouha asked an officer if he could have a prison job. The officer forwarded his name to the activity allocations team.

36. On 4 January 2016, an officer asked the prison chaplain if he would telephone Mr Melouha's partner. Mr Melouha had run out of phone credit and wanted to check whether his partner intended to visit him the next day, as they had planned. He spoke to Mr Melouha's partner, who confirmed that she would visit as planned.

37. On 6 January, Mr Melouha was convicted and sentenced to four months, 19 days imprisonment. (He was due to be released on 22 January, a week after his death.) When he came back to the prison from court his status had changed from a remand to a convicted and sentenced prisoner. Prisoners are considered to be more vulnerable after court appearances, or a change of status. Before he left the prison, a nurse had assessed that Mr Melouha was fit to attend court, but there is nothing in his records to show that a nurse assessed his health or risk of suicide or self-harm in reception when he got back.

38. On 14 January, two police officers interviewed Mr Melouha at the prison about offences of dealing cannabis, allegedly committed in October 2015, before he had gone to prison. They used an interpreter and Mr Melouha's solicitor was also present. The officers said that Mr Melouha had denied the allegations and seemed to be in good spirits at the end of the interview. They did not charge him with any offences. That day, Mr Melouha was reinstated to normal visits.

Events on 15 January

39. At approximately 4.30pm on 15 January, Mr Melouha's cellmate moved out to share a cell with another prisoner who was a good friend of his. He said that before they were locked up for the night Mr Melouha had seemed fine and had asked other prisoners for a cigarette. He told the investigator that Mr Melouha did not speak much English, so he had helped him to learn more words by singing songs and using flash cards.

40. Although he did not generally talk about his problems, Mr Melouha had told his cellmate that he was very angry with his solicitor. He denied committing the offence for which he had been convicted and said his solicitor had advised him that if he pleaded guilty he would not be sent to prison. He was therefore upset about getting a prison sentence. The cellmate said that Mr Melouha had told him that he had not committed the offences that the police had questioned him about that day before and he was not bothered if they charged him, as he did not consider them to be serious. He said there was nothing about Mr Melouha, which had caused him any concern. He did not know why he had killed himself and was very surprised that he had. He wondered whether someone had given Mr Melouha a cigarette containing Spice that evening.

41. A previous cellmate said that he had seen Mr Melouha during the day on 15 January. He said Mr Melouha had gone to Friday prayers and seemed particularly happy afterwards, but he did not know why. They had spoken about his release date, which Mr Melouha thought was the next Friday, 22 January. The cellmate was very shocked about Mr Melouha's actions, particularly as his release was so imminent. He said that Mr Melouha had told him that he sometimes had flashbacks to the car explosion that had killed his parent, under the influence of Spice. (Mr Melouha appears to have invented this story of his parent's death as part of his pretence to be Syrian.)

42. A Listener (a prisoner trained by the Samaritans to support other prisoners) said that Mr Melouha had some concerns about his immigration status and the possibility of deportation. However, he had told him that he was Syrian, so deportation was unlikely because of the conflict. He said that although Mr Melouha's English was poor, they were able to communicate. He said he had seen no sign at any time that he would take his own life and that everyone had been shocked by his death.

43. Prisoners were locked up for the night at approximately 6.00pm. The officer who locked Mr Melouha in his cell that evening said he seemed his usual self and there was nothing out of the ordinary.

44. Shortly after starting duty at 8.15pm, the night patrol officer did a routine check that all the prisoners on the wing were in their cells and accounted for. When she reached Mr Melouha's cell, she could not see him through the observation panel. She thought he might have been in the separate toilet area at the time, so she carried on checking other prisoners and then went back to Mr Melouha's cell. She knocked and kicked the door to get his attention, but Mr Melouha did not respond. She then went to the wing office and asked an officer for help. Neither

of them could see Mr Melouha in the cell, so at 8.25pm, they telephoned the night manager, who gave them permission to open the cell.

45. When they went into the cell, they found Mr Melouha suspended by a sheet attached to the bars of the toilet window. At 8.28pm, the night patrol officer pressed the nearby general alarm bell. The night manager and several other staff arrived about a minute later. They cut the sheet, with some difficulty as it had been tightly rolled, lowered Mr Melouha to the floor and began cardiopulmonary resuscitation. At 8.31pm, another night patrol officer radioed a priority 1 call for the duty nurse to attend.

46. A nurse was on his way to the wing after hearing the general alarm. He said that when he heard the priority 1 call, he radioed to ask another nurse to bring the emergency bags and a defibrillator. When he arrived he asked for someone to call an ambulance. At 8.34pm, the night patrol officer radioed the control room to ask them to call an ambulance. The Supervising Officer (SO), who was working in the control room, asked her to phone with further details, which he said the Ambulance Service would require such as the prisoner's name, age, physical condition and whether he was taking any medication. At 8.36pm, after receiving the information, the SO called an ambulance.

47. An ambulance crew arrived at the prison at 8.44pm, followed shortly afterwards by two paramedics and a doctor. The first crew reached the cell at around 8.50pm and took over Mr Melouha's care. At 9.14pm, an advanced paramedic, in consultation with the doctor, recorded that Mr Melouha had died.

Contact with Mr Melouha's family

48. When Mr Melouha arrived at HMP Manchester, he had said that he had no next of kin and had no fixed address. After his death, prison staff checked his prison telephone and visits records and found details of his partner. A prison Imam and an officer acted as the prison's family liaison officers. The police offered to notify Mr Melouha's partner of his death.

49. The following day, the Imam and the officer went to see Mr Melouha's partner offered their condolences and explained what had happened. His partner told them that he was Egyptian, not Syrian, and that Spice had been a big problem for him in the community and in prison. He had no immediate family in this country, but she and another friend had informed his relatives and they wanted his body to be repatriated to Egypt. Mr Melouha's partner said that he had been happy and cheerful when she had last seen and talked to him. She showed them a letter she had received on either 12 or 13 January, in which he had been very positive and said he looked forward to being with her after he was released.

50. On 18 January, Mr Melouha's cousin and two friends went to the prison. They showed staff a photograph of Mr Melouha's passport on a phone, which revealed his true identity and nationality

51. In line with national policy, the prison contributed to the costs of the funeral and repatriation of Mr Melouha's body to Egypt.

Support for prisoners and staff

52. Due to the time of night, the prison said it was impractical to hold a collective debrief immediately after Mr Melouha's death. However, a SO debriefed some of the staff involved in the emergency response individually and offered his support and that of the staff care team. A further debrief meeting was held on 18 January.

53. The prison posted notices informing other prisoners of Mr Melouha'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 Melouha's death.

Post-mortem report

54. A post-mortem examination found that Mr Melouha died from hanging. The pathologist said there was no evidence of recent use of new psychoactive substances, but due to their continually changing nature and the number of variants, it was not possible to exclude this completely.

Findings

Assessment of Mr Melouha's risk of suicide

55. When he arrived at Manchester in November 2015, Mr Melouha's escort record noted that he had deliberately cut himself two years before. He told prison reception staff that he had cut his arm while under the influence of Spice, a new psychoactive substance. Mr Melouha said he had no current thoughts of self-harm or suicide.

56. Prison Service Instruction (PSI) 07/2015, about early days in custody, states that it is a mandatory requirement for staff to manage appropriately prisoners who arrive with an indication that they might be at risk of suicide and self-harm. PSI 64/2011 (Safer Custody) says that, after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision about whether a prisoner poses a risk to himself. Both instructions list a number of risk factors and triggers that might increase prisoners' risk of suicide or self-harm. Several of these applied to Mr Melouha, including previous self-harm, first time in prison, early days in custody, substance misuse, being an asylum seeker and, subsequently, a change in status from remand to convicted and sentenced. No one identified Mr Melouha as at risk of suicide or self-harm when he arrived at the prison or later.

57. The healthcare manager said that at Manchester, when a newly prisoner indicates they have had previous mental health problems or self-harm, this triggers an automatic referral to the mental health team and they have to be seen within 24 hours. The mental health nurse, who assessed Mr Melouha the day after he arrived at Manchester, was both a mental health nurse and a trained ACCT assessor. He said he was alert to signs of distress and did not think that Mr Melouha was at immediate risk of suicide or self-harm. Although, we have concerns about how well staff were able to communicate with Mr Melouha, which we outline below, we are satisfied that. as an experienced assessor, the nurse was mindful that beginning ACCT procedures was an option, but did not consider Mr Melouha's risk was such that he needed monitoring.

58. Prison Service Order 3050 (PSO) Continuity of Healthcare indicates that events such as attending court, sentencing at court and being questioned by the police are factors that might increase an individual's risk of suicide and self-harm. It says that for prisoners passing though reception, prisons must have protocols to screen them for any potential healthcare, suicide or self-harm issues. There is nothing in Mr Melouha's records to show that a nurse assessed him in reception when he returned from court after his conviction on 6 January, or that any member of staff assessed his mood after he was interviewed by the police on 14 January.

59. Accounts of Mr Melouha's proficiency in English varied. Most staff believed that he generally understood what was said to him, but it was evident that his proficiency in English was not good. Only one officer used the telephone interpreting service to communicate with Mr Melouha, during the reception and induction processes. No one had assessed Mr Melouha's comprehension and we are concerned that there was insufficient shared understanding of the

questions and responses during interviews, to carry out effective assessments of his risk, wellbeing, mental state and general health. We cannot be certain that he fully understood what was said to him, prison processes and how to access support.

60. PSI 64/2011 states that 'all members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process'. PSI 07/2015 says that prisons should provide induction information in a range of languages, but the material and compacts Mr Melouha signed were all in English. Mr Melouha gave some apparently contradictory answers during assessments and it is possible that he had misunderstood some of the questions. We note that the police used an interpreter when interviewing Mr Melouha about further possible offences.

61. Although we have some concerns about the initial assessment of risk when staff did not use interpreting services and the failure to assess Mr Melouha's risk when he returned from court and from police questioning, we recognise that immediately before his death, there was little to indicate that Mr Melouha was at high or imminent risk of suicide. Staff and prisoners were all shocked and surprised by his death and had seen no indication that he had any intention of kill himself or that his mood was low. He was only seven days away from release and his partner and friends thought he seemed happy at the prospect. He did not leave a note to explain his actions. There were no obvious signs that Mr Melouha was at high or imminent risk of suicide and we do not consider that staff could have foreseen his actions. We make the following recommendations:

The Governor and Head of Healthcare should ensure that professional interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor, particularly in health assessments and when assessing prisoners' risk of suicide and self-harm.

The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health issues or risk of suicide and self-harm, after events which could involve a change in status, including court appearances and being questioned by the police.

New psychoactive substances

62. During his initial health screen, Mr Melouha admitted that he had used NPS in the community. It is not clear how far staff explored the extent of his use. In December 2015, staff suspected he had used NPS. Healthcare staff monitored him until the symptoms wore off but no one referred him to drug services. After his death, his partner told the prison's family liaison officers that Mr Melouha had a problem with using Spice before and during his time at the prison. Other prisoners speculated that Mr Melouha's death might have been related to his use of Spice, as they could not identify any other reason. However, toxicology tests found no evidence that Mr Melouha had used illicit substances in the period before his death.

63. We are concerned about the prevalence of NPS in prisons and the effect it has on the behaviours and health of those taking it. In July 2015, we published a learning lessons bulletin about deaths in which NPS was thought to be a factor. We highlighted several lessons to be learned, including giving staff information about NPS to help them identify when prisoners are using it and having an effective drug supply reduction and violence reduction strategy. A few days after Mr Melouha's death, the Governor issued a notice instructing staff to refer prisoners known to be using illicit substances to the drug and alcohol service. We therefore make no recommendation.

Emergency response

64. PSI 3/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that when a medical emergency is called over the radio network, an ambulance must be called immediately and local procedures should ensure this. There should be no requirement for control room staff to check with managers, healthcare staff or others at the scene before calling an ambulance, but they should wait for updates and keep the ambulance service informed. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.

65. The night patrol officer and an officer found Mr Melouha hanged just before 8.25pm. As the night patrol officer did not have a radio, she pressed the general alarm, at 8.28pm. (She was due to receive the officer's radio a few minutes later when he went off duty.) Another officer radioed a priority 1 call at 8.31pm asking for the duty nurse, who went to Mr Melouha's cell and then requested an ambulance. The supervising officer in the control room called for an ambulance at 8.36pm, after first checking the details of the incident with staff. We do not know whether this affected the outcome for Mr Melouha but a delay of eight minutes after the staff found Mr Melouha hanged was too long and such a delay could be critical.

66. The emergency response protocol in place at the time of Mr Melouha's death clearly stated that an ambulance should be called immediately when a priority 1 call was made. On 2 April 2016, the prison issued an updated Governor's Order about medical emergencies. However, we are concerned that it does not reflect the instructions in PSI 3/2013 and could lead to further delays. It stated, "ECR [the control room] automatically calls an ambulance only where it is certain one is needed. In all other cases Hotel One [emergency response nurse] will make that decision". We are concerned that the new instruction qualifies the need to call an ambulance automatically after a priority 1 call, rather than asserting that it should be called immediately and automatically without waiting for further information. We make the following recommendation:

The Governor should ensure that the prison's local emergency protocol meets the requirements of PSI 3/2013, and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for further confirmation.

Clinical care

67. When Mr Melouha arrived at Manchester, he was physically well and reported no mental health problems. As noted, healthcare staff did not use an interpreter to get a full picture of his health or refer him to the substance misuse service, as they should have done. The clinical reviewer concluded that Mr Melouha's care was largely equivalent to that he would have received in the community, with the exception of these omissions.

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