Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamal Hussein formerly a prisoner at HMP Manchester on 13 September 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 Jamal Hussein was found hanged in his cell in at HMP Manchester on 2 September 2016. He was resuscitated and taken to hospital. On 13 September, a Crown Court granted Mr Hussein bail. He died later the same day, having never regained consciousness. He was 32 years old. I offer my condolences to Mr Hussein's family and friends.

Mr Hussein was a vulnerable man who had a mental illness and a history of self-harm. The mental health team assessed Mr Hussein the day after he arrived and supported him throughout his time at Manchester. However, in other respects, support for Mr Hussein was inadequate.

I consider that on arrival reception staff placed too much reliance on Mr Hussein's presentation rather than his underlying risk of suicide and self-harm. I am also concerned that Mr Hussein was not allocated a personal officer during his time in Manchester and that staff did not instigate violence reduction measures following an alleged assault just a few days before he was found hanged. Information about the alleged assault was not recorded on his prison record.

Finally, as in previous investigations at Manchester, I am concerned that there were deficiencies in the emergency response. The Governor needs to ensure the prison fully implements national guidance.

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 **May 2017**

Contents

Summary 1
The Investigation Process 4
Background Information 5
Key Events 7

Summary

Events

1. On 14 July 2016, Mr Hussein was charged with assault by beating and burglary and remanded to HMP Manchester. (The alleged victim was his father.) Mr Hussein had been in custody before.

2. In 2004, Mr Hussein was diagnosed with paranoid schizophrenia. This was managed with medication, although he spent periods in hospital under Mental Health Act powers, most recently from June 2015 until his discharge on 9 May 2016. Mr Hussein had a history of self-harm (by cutting) and on reception an officer recorded Mr Hussein had old scars on both arms. Reception officers did not consider information that arrived with Mr Hussein, and recorded incorrect information on his prison record.

3. On 15 July, the mental health team obtained Mr Hussein's full community mental health records. A community psychiatric nurse (CPN) assessed Mr Hussein and did not identify any immediate concerns or an increase in his risk. Mr Hussein was prescribed his anti-psychotic medication, as well as medication to control his diabetes. The CPN communicated with Mr Hussein's care co-ordinator and support worker throughout his time at Manchester. When the CPN identified that Mr Hussein had not routinely been taking his medication, it was removed from his possession so nurses could monitor his compliance.

4. No personal officer was ever appointed for Mr Hussein, and there is no evidence in his prison record that officers had any meaningful interaction with him. In late July, Mr Hussein was suspected of being under the influence of "Spice" a New Psychoactive Substance (NPS). On 28 August, officers conducting a random cell search found two containers of homemade alcohol in his cell and Mr Hussein handed officers an improvised bladed weapon. Mr Hussein told staff these items were not his, but would not say to whom they belonged.

5. Mr Hussein did not tell staff he was being bullied. However, on 1 September, a prisoner told an officer that another prisoner had assaulted Mr Hussein because staff had discovered the contraband items in his cell. The officer did not speak to Mr Hussein, or record this information in prison records. Mr Hussein's family contacted his solicitor and community support worker to inform them he had been assaulted and raised their concerns directly with the prison on the day he hanged himself.

6. On Friday 2 September, the CPN spoke to Mr Hussein's community support worker and went to see Mr Hussein in the afternoon to check on his well-being. Mr Hussein indicated that he had been punched, but would not say any more. The CPN did not assess Mr Hussein as being at an increased risk of suicide or self-harm, and did not pass this information on to prison staff. At 6.00pm, a prison officer found Mr Hussein hanged in his cell. Staff and paramedics were able to resuscitate him and he was transferred to hospital. The Crown Court granted bail on 13 September, but Mr Hussein never fully regained consciousness and died at around 5.00pm the same day.

Findings

Assessment risk of suicide and self-harm

7. The investigation found that staff failed to give sufficient weight to Mr Hussein's level of risk when he arrived at Manchester on 14 July and, in the circumstances, we believe staff should have fully considered starting ACCT procedures. While Mr Hussein gave no direct indication to staff or other prisoners that he had thoughts of suicide or self-harm, staff were too reliant on his presentation in making an assessment.

Support for prisoners, management of violence and anti-social behaviour

8. Mr Hussein did not receive the support from staff he could have expected. He was never allocated a personal officer who could have provided greater engagement and opportunities to identify any underlying concerns.

9. There were a number of missed opportunities to help Mr Hussein following an alleged assault. His family raised their concerns about bullying through various channels. Another prisoner made an officer aware that Mr Hussein had been bullied the day before he was discovered hanged in his cell. On the day Mr Hussein was found, the officer spoke to him and despite seeing a bruise on his face did not investigate further or begin violence reduction measures. The CPN also spoke to Mr Hussein a few hours before he was discovered and, although he told her that somebody had punched him in the face, she did not inform prison staff.

Clinical care

10. The care Mr Hussein received from healthcare staff was equivalent to the care he would have received in the community. The clinical reviewer concluded that Mr Hussein's mental health care was well-managed and informed by his community records.

Emergency response

11. When staff discovered Mr Hussein they responded quickly but no one used the required medical emergency code. This meant there was a short delay in calling and despatching an ambulance at a time when any delay can be critical. A recently issued Manchester staff instruction about handling medical emergencies does not reflect the requirement of the national instruction to call an ambulance immediately.

Recommendations

- The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:

  - Have a clear understanding of their responsibilities and the need to share all relevant information about risk;
  - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources;
  - Document the information considered and the decision whether or not to open an ACCT.

- The Governor should ensure the personal officer scheme is effectively implemented on all residential wings and managers ensure compliance.

- The Governor should ensure that all prison staff are made aware of and understand the local violence reduction protocol and their responsibilities after an act of violence which:

  - Ensures staff efficiently and effectively communicate the nature of the act of violence;
  - Ensures staff support and protect victims;
  - Ensures staff take appropriate measures against perpetrators to address violent or anti-social behaviour.

- The Head of Healthcare should ensure that Person Escort Records are fully completed and that physical and mental health issues are accurately recorded.

- The Governor should ensure that the prison's local emergency protocol meets the requirements of PSI 03/2013, *Medical Emergency Response Codes*, and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for further confirmation.

The Investigation Process

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

13. The investigator visited Manchester on 20 September and obtained copies of relevant extracts from Mr Hussein's prison and medical records. She spoke to several prisoners and staff on D Wing.

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

15. Another investigator and the clinical reviewer interviewed seven members of staff at Manchester in November. Three prisoners refused to be interviewed as part of the investigation. The first investigator also interviewed two prison officers at Manchester and Mr Hussein's solicitor by telephone in January 2017.

16. We informed HM Coroner for City of Manchester District of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Hussein's family to explain the investigation. At a meeting on 15 November, Mr Hussein's family raised a number of questions and concerns about his care in prison. Family members wanted to know whether the prison had obtained Mr Hussein's community mental health records, whether the prison acted on the family's concerns for Mr Hussein's safety, whether he had been bullied and details of the events leading up to his actions on 2 September.

18. Mr Hussein's family received a copy of the initial report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

19. The prison also received a copy of the report and identified no factual inaccuracies.

Background Information

HMP Manchester

20. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester operates a personal officer scheme (personal officers should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress). Manchester Mental Health and Social Care Trust provide 24 hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Manchester was conducted in November 2014. Inspectors reported good relationships between staff and prisoners. Inspectors found that Manchester focused on preventing self-inflicted deaths and learned lessons from each incident. Levels of self-harm were comparatively low and care for those at risk was good. Vulnerable prisoners generally felt safe, however support for victims of violent incidents needed to be improved. Health provision was generally good, however too few prison staff had mental health awareness training. Inspectors noted that there was a high incidence of mental health and substance misuse problems.

Independent Monitoring Board

22. 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 29 February 2016, the IMB reported that the health and welfare of prisoners was given a high priority. The IMB commented that the main challenges for the prison have been mobile phones, drugs and offence weapons.

Previous deaths at HMP Manchester

23. Mr Hussein's death was the third self-inflicted death at Manchester since January 2016. Four weeks after Mr Hussein's death there was a further self inflicted death. Previous investigations have identified deficiencies in the emergency response.

Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

26. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm, to self, to others and from others (Safer Custody)*.

Incentives and Earned Privileges Scheme (IEP)

27. Each prison has an incentives and earned privileges (IEP) 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 wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

28. In 2004, Mr Hussein, who had a significant history of mental illness, was diagnosed with paranoid schizophrenia. Before arriving at HMP Manchester, he had been sectioned under the Mental Health Act on seven separate occasions. Most recently, he had been detained at Bramley Street, an inpatient rehabilitation facility, between 5 June 2015 and 9 May 2016. Mr Hussein was released on a Community Treatment Order (CTO which provides supervised treatment in the community and facilitates readmission to hospital if required), together with a support package monitored under the Care Programme Approach (CPA, a system for coordinating care for people with major mental illness).

29. On 14 July 2016, Mr Hussein was remanded to Manchester charged with assault by beating (the alleged victim was his father) and burglary. Mr Hussein had been in prison before, in 2006, for an offence of conspiracy to defraud.

30. On arrival at Manchester, Mr Hussein's person escort record (PER), a document which accompanies all prisoners when they move between police stations, courts and prisons, noted that he had schizophrenia and diabetes, and had self-harmed in December 2012.

31. At an initial health screen, a nurse recorded that Mr Hussein told her he was diagnosed with paranoid schizophrenia and diabetes, had no history of using drugs or alcohol, and had no history of self-harm or suicidal thoughts. Mr Hussein also told her he had never been in a psychiatric hospital, which was untrue. She noted that Mr Hussein did not appear confused or mentally unwell. She recorded that he was prescribed olanzapine (an anti-psychotic) and metformin (for diabetes). Mr Hussein gave consent for healthcare staff to obtain his community GP records, and she referred Mr Hussein to the prison doctor and the mental health team.

32. A prison GP assessed Mr Hussein in reception. He examined Mr Hussein and recorded that he looked well and had no thoughts of suicide or self harm. He prescribed Mr Hussein's medication for him to have in his possession. Ideally, prisoners should be responsible for managing their own medication and have the autonomy they would have in the community. Allowing prisoners to keep stocks of medication in their possession can lead to bullying and intimidation or trading in medication and other misuse. The risks and benefits therefore need to be carefully assessed.

33. An officer completed a Basic Custody Screening (an assessment of immediate risks and needs) and incorrectly recorded that this was Mr Hussein's first time in prison. He also recorded the wrong offence and was unaware of the context of the offence - that Mr Hussein's father was the alleged victim. In interview, the officer told the investigator that he relied on information provided by Mr Hussein, and did not check the documents received from court, which were kept together in a tray. He said that typically most prisoners gave honest answers to the questions in the assessment. He recorded that Mr Hussein had old self-harm scars on both arms, but had no current thoughts of suicide or self-harm. He recorded that the nurse was aware of the scars. He described Mr Hussein as confident and engaged in the assessment, with good eye contact.

34. An officer completed reception induction documentation with Mr Hussein, including the cell sharing risk assessment (CSRA) which is designed to assess the risk of violence a prisoner poses. He noted Mr Hussein as high risk as his previous convictions were not available, he had no suicide or self-harm issues, was a smoker and he was happy to share a cell. A nurse completed the health assessment and noted 'no increased risk'; there was no comment about Mr Hussein's mental health or history of self-harm. An officer authorised the CSRA, but on the prison record Mr Hussein's CSRA was revised to standard, although it is unclear from the records when or who made the decision. (Again, when the CSRA was revised to high risk on 21 July, it is unclear who updated the form, and the prison record was not updated fully, although there is a comment on the case notes by an officer). An officer noted that Mr Hussein tried to make a telephone call, but received no reply. Neither officers nor the nurse considered that Mr Hussein was at an increased risk of suicide or self-harm.

35. An officer allocated Mr Hussein to a shared cell on I Wing, usually a wing for those with substance misuse issues. He could not remember why Mr Hussein did not go to A Wing, the induction unit, but said it was probably because there were no spaces and I Wing was often used as an overspill for new receptions. On 15 July, Mr Hussein moved to A Wing, into a shared cell. Mr Hussein was not allocated a personal officer. Personal officers are expected to know the prisoners for whom they are responsible, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about prisoners' progress. Mr Hussein lived on A Wing for around a month but there are no entries on his prison record.

36. A member of the mental health team read Mr Hussein's community mental health records then assessed Mr Hussein's mental health on 15 July. She recorded that, in 2004, Mr Hussein was diagnosed with paranoid schizophrenia, which was exacerbated by his use of khat (a class C drug chewed for its stimulant properties). She recorded that his community records noted a history of self-harm (by cutting) but that no dates were documented. She recorded that Mr Hussein appeared to be in a positive mood, and noted the early warning signs which might indicate a relapse in his psychotic symptoms (irritation, aggression, changes in sleep patterns, persecutory ideas, and neglecting to eat and drink). She informed Mr Hussein that she would be his allocated mental health worker. She would liaise with his community care co-ordinator and his community support worker to ensure the CPA requirements were followed. She produced a mental health care plan.

37. The same day, as part of the induction process, a member of the chaplaincy team met Mr Hussein. He recorded on Mr Hussein's prison record that this was his first time in prison but that he had no thoughts of self harm. Mr Hussein said he was a Muslim and that he was aware of how to access help from the chaplaincy.

38. On 21 July, a nurse reviewed Mr Hussein's mental health. Mr Hussein had been sleeping on the floor, wore dirty clothes and smelled of body odour. He did not explain why he had slept on the floor, although his CPA co-ordinator had told her this was not uncommon for him. Mr Hussein told the nurse he found it hard to cope and wanted to be back in the community, although did not have any

thoughts of harming himself and did not feel unsafe or at risk. She checked Mr Hussein's medication to ensure he was compliant - which he was - and told Mr Hussein that his CPA co-ordinator would visit him on 26 July. After this meeting she arranged with a Supervising Officer (SO) on A Wing to raise Mr Hussein's CSRA to high risk, so he would be moved to a single cell. Mr Hussein moved cells shortly afterwards. Later the same day, a nurse recorded that Mr Hussein was suspected to be under the influence of a new psychoactive substance (NPS), often known as Spice, but that no medical intervention was necessary. Mr Hussein told her he just needed to rest.

39. On 26 July, Mr Hussein failed to attend his appointment with his CPA co-ordinator and the mental health nurse. The nurse went to see Mr Hussein to find out why he had not attended and he told her that he "could not be bothered". Mr Hussein told her he had no problems on the wing, and felt better living in a single cell. She had no specific concerns about Mr Hussein's mental health and told him he had an appointment with the prison psychiatrist on 1 August.

40. On 29 July, Mr Hussein requested to see a member of the chaplaincy and spoke to a chaplain. Mr Hussein asked him contact his family and ask them to drop the charges against him. The chaplain told Mr Hussein that such a request was inappropriate and he placed an entry on Mr Hussein's prison record.

41. That afternoon, the mental health nurse spoke to Mr Hussein to tell him that his community support worker would visit him on 4 August. (In the event, Mr Hussein did not attend this appointment as there were insufficient prison officers to escort him to healthcare.) The nurse checked Mr Hussein's medication and found he had not taken it as prescribed. She, in consultation with a psychiatrist, changed Mr Hussein's medication to 'not in possession', in order to allow nurses to monitor his compliance.

42. On 1 August, the visiting consultant forensic psychiatrist met Mr Hussein. He recorded that Mr Hussein did not appear to be acutely psychotic and that he did not need to review him again unless his mental health deteriorated. However, Mr Hussein should continue to be monitored by the mental health nurse from the mental health team.

43. On 15 August, Mr Hussein appeared at Crown Court and was again remanded in custody until his next court appearance on 29 September. The healthcare section of the PER was completed by a nurse. She recorded that Mr Hussein had received his medication and was fit to attend court. However, no information was recorded about his diagnoses of schizophrenia or diabetes.

44. The same day, the mental health nurse spoke to the community support worker and agreed to help Mr Hussein book a visit for his sister. Mr Hussein received a standard letter to say that his medication would be stopped if he continued to be non-compliant. (On 12 August, he had attempted to hide his olanzapine under his tongue.) However, she assured the investigator during interview that the letter had been sent automatically, and that Mr Hussein's anti-psychotic medication would not have been stopped.

45. On 16 August, Mr Hussein moved from the induction wing to D Wing, a standard residential wing. Again, a personal officer was not allocated as should have

been the case and nobody was tasked with making routine entries on his prison record. The next day, a nurse completed a diabetic review with Mr Hussein, and the mental health nurse helped him to complete visiting orders for his brother and sister.

46. On 19 August, the mental health nurse reviewed Mr Hussein's mental health. She reminded him of the importance of taking his medication, which continued to be a concern, and he assured her he would take it. Mr Hussein asked her to contact his community support worker to request his family to send him money (which she did). She also helped him complete another visitor form as his brother and sister had not yet been added to his visitors list. That evening, a nurse recorded that Mr Hussein refused to take his medication.

47. On 25 August, the CPA co-ordinator, accompanied by the mental health nurse, met Mr Hussein in order to discuss and make a referral for supported accommodation for his release from custody. Mr Hussein was happy for the CPA co-ordinator to progress this on his behalf. However, Mr Hussein became verbally aggressive and expressed paranoid thoughts about his family (that they stole from him and followed him all the time, even in prison). However, he was never directly aggressive towards them. The CPA co-ordinator noted this was the most open Mr Hussein had been about his psychosis and delusional beliefs and that, through his solicitor, a psychiatric report would be requested before his next court appearance.

48. There were no further entries by wing officers on Mr Hussein's prison record until 28 August. At around 2.10pm, two officers conducted a routine, randomly-selected search of Mr Hussein's cell. Before the officers searched his cell, Mr Hussein gave them an improvised bladed weapon, which he took out of his bin. Mr Hussein said he found the weapon on his bed and it was not his. When the officers searched his cell they discovered two bottles of 'hooch' (homemade alcohol). Mr Hussein said that the bottles were not his, but would not say to whom they belonged. The items were confiscated and Mr Hussein was put on report. One officer told the investigator that although she could not be certain, she did not think the hooch belonged to Mr Hussein.

49. On 30 August, the Head of Operations held an adjudication meeting with Mr Hussein. There were two separate charges; both were for possessing unauthorised items (an offensive weapon and the hooch). Mr Hussein told him that he was not guilty. He adjourned the adjudication hearing to obtain a mental health report, and to refer the matter to the police. In line with the violence reduction strategy, if a weapon is discovered, Manchester automatically refers the matter to the police. The police did not manage to consider the referral before Mr Hussein died a fortnight later. An officer recorded in Mr Hussein's prison record that he was on the basic IEP regime, presumably as a consequence of the events of 28 August.

50. On 31 August, Mr Hussein's family visited him. They told the investigator that Mr Hussein had been assaulted, and that he had a bruised eye. Mr Hussein did not report this to any of the staff. Mr Hussein's family said they contacted his solicitor and community support worker about the injury, but did not contact the prison directly.

51. The investigator saw a letter dated 1 September, sent to Manchester Security Department (sic) by a solicitor. This noted information had been received from Mr Hussein's family on 31 August, that he had been assaulted, had visible injuries and requested he was moved to a different wing. The solicitor told the investigator that he did not email the prison as he was not confident anyone would take responsibility and believed a letter was more appropriate. He did not recall whether the letter was posted second class (which is typical) or first class (when more urgent).

52. On 3 September (after Mr Hussein had been found hanging), an officer made a retrospective entry on Mr Hussein's prison record and submitted a security intelligence report. He recorded that on 1 September he had been made aware by another prisoner that Mr Hussein had been bullied and assaulted by another prisoner, because the hooch had been discovered in his cell. There is no evidence that, at that time, the officer had considered violence reduction measures, discussed these with the wing manager or spoken directly to Mr Hussein about the allegation.

Friday 2 September

53. On 2 September, at 9.54am, the mental health nurse recorded that she read an email from the community support worker that he had sent the previous day. It stated that Mr Hussein's sister had contacted the community support worker to say that her brother had been targeted and physically abused by another prisoner. The nurse contacted the wing to ask whether there had been any incidents concerning Mr Hussein. An officer told her that Mr Hussein was on the basic IEP regime as hooch and a weapon had been found in his cell, but there was no report of any violence towards him. She left a telephone message for the community support worker to say she would see Mr Hussein later that afternoon.

54. At 2.46pm, the mental health nurse recorded that she had been to see Mr Hussein on the wing. Mr Hussein's cell could not be unlocked, as there were no available staff, so she had spoken to him through the observation panel. When asked, Mr Hussein said he had been punched and pointed to his cheek. She told the investigator she saw no obvious injury and had no concerns about a decline in his mental health. Mr Hussein said he would not tell staff the name of the prisoner that punched him, but he maintained that the hooch and weapon did not belong to him. She told Mr Hussein she would visit him again the following week, and contacted his community support worker to let him know she had spoke to Mr Hussein. She did not complete a security intelligence report or speak to wing staff.

55. A Supervising Officer (SO) spoke to Mr Hussein's family, who had telephoned the prison. They said that he had been bullied and assaulted on the wing. The investigator was unable to establish the time of the telephone call and the SO could not remember. However, a security intelligence report completed by the Control Room recorded that the call was received at 5.42pm. They said that they contacted the SO and emailed the safer custody team. The SO told the investigator that, due to the time of the call and because he did not want Mr Hussein to talk in front of other prisoners, he planned to speak to Mr Hussein

after the evening roll check. This was around 6.00pm, once all prisoners had been locked in their cells.

56. An officer told the investigator that he had seen Mr Hussein twice in the 20-30 minutes before the roll check. He said that Mr Hussein was seated on his chair watching television. He noticed a bruise on Mr Hussein's face, but when he asked him about it, Mr Hussein smiled and said he was alright.

57. At 6.00pm, an officer began the evening roll check of all prisoners on the wing. When he reached Mr Hussein's cell, he looked through the observation panel. He saw him at the end of his bed, hanging by a ligature, made from bedding, attached to the bed frame. (CCTV was not available to the investigator as there was a technical issue downloading the footage. However, Greater Manchester Police viewed CCTV at Manchester and confirmed the time of the roll check.)

58. The officer shouted for assistance and immediately entered the cell. Another officer, who was a short distance away, responded immediately. The officers cut the sheet and lowered Mr Hussein to the floor and started cardiopulmonary resuscitation (CPR). Other staff arrived and a SO used his radio to call a Priority 1 message to summon urgent medical assistance.

59. Three nurses responded to the Priority 1 message and took over CPR until paramedics arrived.

60. According to the Control Room records, the Priority 1 message was radioed at 6.04pm, and at 6.06pm, an ambulance was requested. North West Ambulance Service records confirm they received a request for an emergency ambulance at 6.05pm. Paramedics arrived at Manchester at 6.11pm, and were able to resuscitate Mr Hussein. Paramedics took him to hospital at 7.05pm. Mr Hussein remained in hospital, in intensive care. Although officers escorted Mr Hussein to hospital, he was never physically restrained.

61. On 6 September, at 10.29am, the solicitor emailed Manchester Prison Custody Office. The email reflected the same information contained in the letter dated 1 September. He sent another email at 2.59pm the same day, directly to the Management Co-ordinator reiterating the information in the earlier email, but adding that he was now aware that Mr Hussein was in hospital. Manchester responded to this email at 3.45pm, explaining that Mr Hussein had been admitted to hospital and providing a brief outline of events.

62. On 13 September, the Crown Court granted Mr Hussein bail, and prison staff were withdrawn from the hospital. Later the same day, hospital staff pronounced Mr Hussein dead.

Contact with Mr Hussein's family

63. On 2 September at 7.45pm, the duty governor contacted Mr Hussein's family to inform them that he had been admitted to hospital. At 9.00pm, the prison imam and a prison family liaison officer arrived at the hospital and met Mr Hussein's family. Manchester maintained contact with Mr Hussein's family and contributed towards the costs of Mr Hussein's funeral, in line with national instructions.

Support for prisoners and staff

64. After Mr Hussein's death, the duty governor debriefed the staff involved in the emergency response. He offered his support and that of the staff care team.

65. The prison posted notices informing other prisoners of Mr Hussein's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Hussein's death.

Post-mortem report

66. A pathologist concluded that Mr Hussein had died from pneumonia and hypoxic brain damage (lack of oxygen) as a result of hanging.

Findings

Assessment risk of suicide and self-harm

67. PSI 07/2015, *Early Days in Custody*, states that it is a mandatory requirement for staff to manage prisoners who arrive with an indication that they might be at risk of suicide and self-harm appropriately. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody*), states that, after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision as to 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. These include a history of self harm, mental illness and charged with an offence against a family member, all of which applied to Mr Hussein. Although we do not know whether this would have affected the outcome for Mr Hussein, the failure to fully consider or open an ACCT meant that he did not receive structured, ongoing support, something which became progressively important during Mr Hussein's time in custody.

68. In our thematic report about risk factors in self-inflicted deaths published in April 2014, we identified that, too often, assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Information entered on the Basic Custody Screening was inaccurate, despite the PER and previous convictions being available. A SO told the investigator that he relied on Mr Hussein giving honest and open answers. He said that documents containing potentially significant information were routinely not considered as they were left in a tray in reception to avoid their being misplaced. A nurse did not record Mr Hussein's history of self-harm and also relied on his presentation. All decisions regarding risk and subsequent actions should be defensible and fully recorded. We make the following recommendation:

    The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:

    - **Have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
    - **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources;**
    - **Document the information considered and the decision whether or not to open an ACCT.**

Support for prisoners, management of violence and anti-social behaviour

69. It is clear from the investigation that the prison did not support Mr Hussein as they should have. Mr Hussein was never allocated a personal officer at Manchester, and there are no meaningful entries in his prison record until the cell search on 28 August when illicit items were found. An officer told the investigator

that, on balance, she did not think the hooch and weapon belonged to Mr Hussein, yet there was no follow up to assess whether this was the case or whether he was being bullied.

70. On 3 September, the day after Mr Hussein had been taken to hospital, an officer made an entry in Mr Hussein's prison record. This related to information he had received on 1 September from another prisoner that Mr Hussein had been assaulted because of the discovery of the hooch and weapon. The officer should have recorded Mr Hussein's alleged assault on 1 September and instigated violence reduction procedures immediately. There was a further missed opportunity to engage Mr Hussein in discussion, a few hours before he was discovered. The mental health nurse should have submitted a security intelligence report after she noticed Mr Hussein's injury on the afternoon of 2 September. She should also have alerted wing staff that Mr Hussein had indicated he had been assaulted.

71. Guidance on the effective management of violent prisoners is contained in PSI 64/2011. The national instruction states "Every verbal or physical act of violence must be challenged. Appropriate sanctions for perpetrators must be applied robustly, in a fair and consistent manner. Victims must be supported and protected". Manchester has a local protocol for violence reduction and anti-social behaviour which sets out the steps staff are required to follow to support victims of violence, and the actions to be taken to address a perpetrator's behaviour.

72. We consider that Mr Hussein did not receive the level of support from staff that he could have expected, in particular following the alleged assault and make the following recommendations:

The Governor should ensure the personal officer scheme is effectively implemented on all residential wings and managers ensure compliance.

The Governor should ensure that all prison staff are made aware of and understand the local violence reduction protocol and their responsibilities after an act of violence which:

- **Ensures staff efficiently and effectively communicate the nature of the act of violence;**
- **Ensures staff support and protect victims;**
- **Ensures staff take appropriate measures against perpetrators to address violent or anti-social behaviour.**

Clinical care

Mental Health

73. The clinical reviewer judged that, overall, the mental health care that Mr Hussein received from healthcare staff at HMP Manchester was equivalent to the care he would have received in the community. He comments that Mr Hussein's mental health care was well-managed; his mental health community records were obtained the day after he arrived at the prison and the mental health team liaised with his community care co-ordinator and support workers. There was

recognition that Mr Hussein's schizophrenia required assertive management, together with the likelihood that he would disengage from services. The mental health team took appropriate action to ensure that Mr Hussein was compliant in taking his prescribed medication.

74. The clinical reviewer has made a recommendation about revising standard letters that the Head of Healthcare will need to address.

Person Escort Record

75. On 15 August, Mr Hussein appeared at court. All prisoners attending court have a PER completed which provides a summary of any risks relating to that prisoner, including a summary of any healthcare issues. A nurse stated that Mr Hussein had received his medication and that he was fit to attend court. However no information was included regarding his schizophrenia or diabetes.

76. The nurse told the investigator that on any one day she could be required to complete around 20 PERs and relied upon the prisoner declaring any healthcare issues. No reference is made to the medical record at the time of completing the PER, although an entry is made on the medical record once the PER is completed. She told the investigator that as she is not a psychiatric nurse she did not feel it was appropriate to comment on a prisoner's mental state.

77. Mr Hussein returned to Manchester on 15 August. However, prisoners do not always return to the same prison when they appear in court (or when transferred) and it is crucial that all known risk factors are fully recorded.

The Head of Healthcare should ensure that Person Escort Records are fully completed and that physical and mental health issues are accurately recorded.

Emergency response

78. PSI 03/2013, *Medical Emergency Response Codes,* issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.

79. On 2 April 2016, the prison issued an updated Governor's Order about medical emergencies in response to a previous death. 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.

80. On 2 September, there was a delay of two minutes between the Priority 1 message being relayed and an ambulance being called. Staff responded very quickly to the emergency and an ambulance arrived promptly. However, in other cases, any delay could be critical.

81. In our reports into two other self-inflicted deaths at Manchester in 2016, we found the same issue regarding the emergency response and made a recommendation for change. We urge the Governor to take action to ensure the medical emergency response is in line with national guidance and make the following, repeated, recommendation:

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

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