

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Idris Habib, a prisoner at HMP Swaleside, on 20 November 2018

A report by the Prisons and Probation Ombudsman

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 Idris Habib was found hanged in his cell at HMP Swaleside on 20 November 2018. He was 22 years old. I offer my condolences to Mr Habib's family and friends.

Mr Habib had only been at Swaleside for five days before he died. He repeatedly said that he was under threat from other prisoners. I am satisfied that staff responded promptly and appropriately by taking his fears at face value and moving him to the vulnerable prisoner unit while his concerns were investigated. The evidence of staff and other prisoners suggests that Mr Habib's fears were unfounded and that he was developing a paranoid state, but this had not been established before he died and there had not, therefore, been time to refer him for a mental health assessment.

I am concerned, however, that staff did not consider monitoring Mr Habib under suicide and self-harm monitoring procedures (known as ACCT) after he deliberately set fire to his cell and said that he wanted to kill himself four days before he took his life. I cannot say whether this would have altered the outcome for Mr Habib, but it might have done.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2021

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	11

Summary

Events

1. On 21 January 2017, Mr Idris Habib was remanded to HMP Thameside after being charged with grievous bodily harm. In December 2017, he received an extended sentence of 11 years.
2. On 24 February 2017, he was transferred to HMP Pentonville. There are numerous reports about his drug use, bullying, fighting and general disregard for prison rules at Pentonville. He initially engaged with drug support services but in July 2018, he refused further contact. He had no history of self-harm and was not monitored under suicide and self-harm monitoring.
3. Mr Habib often told staff he was under threat from other prisoners but no evidence was found to support this. He told his offender supervisor that he became paranoid when he was using drugs.
4. On 9 November 2018, Mr Habib climbed onto the netting that separated the floors on the wing. Staff intervened and Mr Habib agreed to come off the netting. He was taken to the segregation unit where he stayed until 15 November, when he was transferred to HMP Swaleside. Mr Habib gave no reason for his actions.
5. Mr Habib reported no immediate concerns when he arrived at Swaleside on 15 November. The next day, 16 November, a nurse was called after he cut his hand in what he said was an accident. An hour later he deliberately set fire to his cell. He told staff that he had started the fire because he was under threat on the wing and that he wanted to kill himself. He was moved to the vulnerable prisoner unit on 17 November. Mr Habib later denied that he had said that he wanted to kill himself. Staff found no evidence that Mr Habib was under threat from other prisoners and were concerned that he was showing signs of paranoia.
6. On 20 November, the officer who completed the morning roll check at 7.00am said that he saw Mr Habib standing at the back of his cell, but that he did not speak to him.
7. At 10.57am, two prisoners told an officer that there was a problem in Mr Habib's cell. The officer ran to the cell and saw Mr Habib suspended by a ligature at the back of the cell.
8. The officer radioed a medical emergency code and attempted to open the cell door, but Mr Habib had barricaded the door. Prisoners helped the officer to open the door and one of the prisoners slipped into the cell through a small gap. The officer passed his anti-ligature knife to the prisoner and told him to cut the ligature, before gaining entry himself.
9. Staff started cardiopulmonary resuscitation (CPR) until the paramedics arrived at 11.18am. After they assessed Mr Habib, CPR was stopped and at 11.20am it was confirmed that Mr Habib had died.

Findings

Assessment, Care in Custody and Teamwork (ACCT)

10. When Mr Habib said he was under threat from other prisoners, staff responded appropriately by moving him promptly to the vulnerable prisoner unit for his own protection while they investigated whether his fears were grounded in reality. This was good practice.
11. However, we are concerned that staff did not start suicide and self-harm monitoring procedures on 16 November when Mr Habib deliberately set fire to his cell and told staff that he wanted to kill himself.

Allegations of bullying

12. Mr Habib's claims that he was under threat were still being investigated at the time of his death. As he had only been at Swaleside for five days when he died, we do not consider this was unreasonable.

Clinical care

13. The clinical reviewer was satisfied that the care Mr Habib received during the brief period he was at Swaleside was of a good standard and was equivalent to that which he could have expected to receive in the community.
14. Staff and prisoners thought that Mr Habib seemed paranoid but he was not referred for a mental health assessment. We agree with the clinical reviewer that, although there were indications that Mr Habib was developing a paranoid state with persecutory delusions, it was too early for staff to have established whether his fears were real or imagined by the time he died. It was, therefore, too early for a mental health referral to have been made.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that an ACCT is opened following all acts of self-harm (which should include deliberately setting fire to a cell).
- The Governor should ensure that staff completing roll checks are aware of their responsibilities and that they must satisfy themselves all prisoners are present and correctly accounted for, that they have not escaped, and are not obviously ill or dead.

The Investigation Process

15. 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. One prisoner responded.
16. The investigator obtained copies of relevant extracts from Mr Habib's prison and medical records.
17. The investigator interviewed six members of staff and two prisoners at Swaleside on 13 February 2019.
18. NHS England commissioned an independent clinical reviewer to review Mr Habib's clinical care at the prison. The clinical reviewer attended interviews with the investigator.
19. We informed HM Coroner for Kent and Medway of the investigation. The coroner gave us the results of the post-mortem and toxicology examinations. We have sent the coroner a copy of this report.
20. We contacted Mr Habib's next of kin to explain the investigation and ask if there were any matters the family wanted the investigation to consider. A family representative said that they wished to raise some concerns about events leading up to Mr Habib's death and would do so in a written statement once they had had the opportunity to discuss with family members.
21. We asked for any issues to be shared with us by 14 January 2019. We have had no further contact from Mr Habib's family or representatives. The family said that they would like to receive a copy of our investigation report, which we have provided.
22. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified some factual inaccuracies and we have amended our report accordingly. HMPPS provided an action plan which is annexed to this report.

Background Information

HMP Swaleside

23. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. Minster Medical Group provides GP cover on weekdays on Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of Swaleside was in December 2018. Inspectors found that Swaleside was safer and more respectful than at the previous inspection in 2016, but that progress was very lopsided, with work to help rehabilitate prisoners and reduce individual risk actually getting worse. Violence had risen considerably since the last inspection and reducing violence remained a key task.
25. Inspectors found that levels of self-harm were lower than at comparable prisons, but that there had been five self-inflicted deaths since the last inspection. Work to embed the PPO's recommendations following fatal incident investigations was weak and local policies to reduce self-harm were limited. Self-harm incidents were not investigated and the case management support for many of those in crisis was mixed. Despite this, many prisoners said they felt well cared for and work to help reduce self-harm among prisoners with complex needs was impressive, with some elements constituting good practice.

Independent Monitoring Board

26. 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 April 2018, the IMB said that their greatest concern, also expressed the previous year, was the violence in the prison and the assaults on both staff and prisoners. The IMB said that, although a reduction in violence had been noted from time to time during the year, and the figures showed improvement, the problem remained unacceptable and the efforts put into reducing violence by the staff had not yielded consistent results. Attempts to prevent the smuggling in of weapons and drugs had had a great deal of success and had yielded remarkable results. Nevertheless, the problem remained and continued to occupy much of the Senior Management Team's time.

Previous deaths at HMP Swaleside

27. Mr Habib's death was fifth apparently self-inflicted death at Swaleside since January 2016. This investigation has found no similarities those deaths.

Psychoactive Substances (PS)

28. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a genuine problem across the prison estate. They are difficult

to detect and can affect people in several ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

29. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
30. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Assessment, Care in Custody and Teamwork (ACCT)

31. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 risk and how best to monitor and supervise the prisoner. 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 multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.
32. 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).

Key Events

HMP Thameside / HMP Pentonville

33. On 21 January 2017, Mr Idris Habib was remanded to HMP Thameside after being charged with grievous bodily harm. No concerns were recorded about Mr Habib's mental or physical health at his reception screening.
34. While at Thameside, Mr Habib was involved in a fight with another prisoner and was warned for being verbally abusive towards staff.
35. On 24 February, Mr Habib was transferred to HMP Pentonville. A health screen was completed and no concerns about his physical and mental health were recorded.
36. In April, Mr Habib asked to be placed on a restricted regime because he believed that he was under threat. There was no intelligence to support his concerns, however, and staff recorded that Mr Habib was the perpetrator of bullying, rather than the victim.
37. Between June and October, Mr Habib was placed on the basic regime and placed in segregation for fighting and barricading his cell. He was also placed on report for inciting other prisoners to riot and was found to be stealing items from other prisoners, which led to him being assaulted. Following a search of his cell, Mr Habib was found to be in possession of a number of unauthorised items including two homemade weapons and cannabis. Mr Habib's poor behaviour continued and staff recorded that he appeared oblivious to prison rules and had a poor attitude.
38. On 1 December, Mr Habib received an extended sentence of 11 years, with a custodial term of nine years and an additional two years to be served on licence. This was Mr Habib's first adult sentence, although he had previously served sentences as a young offender. Mr Habib told staff that he intended to appeal against his extended sentence.
39. On 7 February 2018, Mr Habib's Offender Supervisor (OS) introduced herself to him. Mr Habib initially engaged with the substance misuse team, but his OS said that in July 2018, she observed a deterioration in his level of self-care and in-cell hygiene and officers told her that they believed Mr Habib was using drugs. Around the same time that Mr Habib was told that his appeal against his extended sentence had been rejected.
40. On 23 July, Mr Habib said that he was drug free and signed a disclaimer saying that he did not want to engage with the substance misuse service any further.
41. On 1 November, Mr Habib told his OS that he had placed himself on a restricted regime because he was in fear for his life. Mr Habib said that his concerns were linked to issues related to his extended family members in the community and were nothing to do with him personally. Mr Habib told his OS he felt he was a target in Pentonville and was concerned for his safety.
42. On 7 November, Mr Habib's OS recorded that Mr Habib seemed better and no longer under the influence of drugs. He told her that he experienced feelings of

anxiety and paranoia at times, linked to his substance misuse, and that, when he was feeling paranoid, he believed his uncle (who he was sharing a cell with) was going to assault him.

43. Intelligence reports submitted at Pentonville recorded that Mr Habib was suspected of using drugs daily, fighting, bullying and was involved in trafficking into Pentonville. Mr Habib also continued to tell staff that he believed that he was in fear of his life and was concerned for his safety. However, staff found no evidence of this and Mr Habib continued to associate with other prisoners on the wing.
44. On 9 November, Mr Habib jumped on the netting between floors. Staff negotiated with Mr Habib and he agreed to come off the netting. He was then taken to the segregation unit, where he remained until he was transferred to HMP Swaleside. Mr Habib gave no reason for his actions. (Climbing on the netting is a recognised way for prisoners who feel under threat for some reason to get themselves moved to segregation unit where they feel safer.)

HMP Swaleside

45. On 15 November, Mr Habib was transferred to Swaleside. A nurse completed a health screen with Mr Habib. Mr Habib said that he was not using drugs, was not being bullied and that he had no thoughts or intent of suicide or self-harm. The nurse recorded that Mr Habib was not receiving any prescribed medication, and had no ongoing physical or mental health concerns, so no referrals were deemed necessary.
46. Mr Habib was located in a single cell on D wing. He raised no concerns or issues with staff. No concerns were raised by staff about Mr Habib using illicit drugs during his time at Swaleside.
47. On the afternoon of 16 November, the duty chaplain went to see Mr Habib for an introductory visit. He recorded that Mr Habib refused to let him into his cell and instead whispered to him through the door that he should not be on the induction wing. The duty chaplain reported this conversation to staff.
48. At approximately 7.00pm that day, Mr Habib pressed his cell bell. An officer responded and Mr Habib told him that he had accidentally cut his hand on some plastic cutlery. The officer called a nurse to come and see Mr Habib and while he was being treated, the officer asked Mr Habib why he was messing around with his cutlery. Mr Habib said that he had been making a weapon because he had problems on the wing and wanted to protect himself if the door was opened. The officer told Mr Habib that staff were now aware of his situation and reassured him that no one would be opening his door unnecessarily. Staff found no evidence that Mr Habib was having problems on the wing or that he was under threat by other prisoners.
49. At 8.00pm, Mr Habib started a fire in his cell. Staff dealt with the fire and removed Mr Habib from the cell. Mr Habib told staff that he wanted to 'kill himself' but once removed from the cell, he denied that he had said this. Mr Habib told a Supervising Officer (SO) that he believed that staff were going to open his door the following morning and let prisoners into his cell. The SO

reassured Mr Habib that this was not the case. Mr Habib also said that he was getting bullied and he felt threatened on the landing. Staff did not consider starting ACCT procedures but did explore Mr Habib's allegations of threats by other prisoners and found no evidence to support his concerns.

50. Mr Habib was moved to A wing temporarily and the SO reassured him that he would look into moving him to the vulnerable prisoner unit on B wing the following morning. The SO said Mr Habib told him that he had made an application to be located on B wing. The SO told Mr Habib that he would go back and look at the application and see what could be done. He asked Mr Habib for names of the prisoners who were threatening him but Mr Habib would not give any names. The SO recorded that he did not get the impression that Mr Habib was under the influence of illicit drugs when he was speaking with him but felt that Mr Habib seemed paranoid. The SO also said that after he had spoken to Mr Habib, he took him back to his cell, and there were no more problems for the remainder of the night.
51. The following day, 17 November, Mr Habib was moved to the vulnerable prisoner unit. The SO said that Mr Habib was 'a bit panicky' and was unsure with everything, so he reassured Mr Habib and said that if he had any problems, he should tell an officer and he or another SO would come and talk to him. The SO said that Mr Habib knew a couple of people on the wing, which made him feel a bit more relaxed.
52. A Custodial Manager (CM) and an officer also spoke to Mr Habib. The CM told the investigator that Mr Habib seemed anxious, but he reassured Mr Habib that they were just there to talk to him. Mr Habib told them that people he had transferred with from Pentonville were bullying him and that he was under threat from his previous establishment. The CM said that he could not determine whether Mr Habib's concerns were paranoid or true without investigating his concerns further and establishing the facts.
53. The CM asked Mr Habib if he had any issues on B wing and Mr Habib said that he did not. He said that he knew two prisoners who knew his family and were both mentors on B wing. The CM said that the more he talked to Mr Habib, the more he seemed to relax. He said that it was normal for prisoners to be locked up during the morning on that day, but because Mr Habib was new on the wing, he allowed his cell to stay unlocked so that Mr Habib could associate with the two prisoners that he knew. The CM said that he had no concerns about Mr Habib's well-being.
54. The concerns raised by Mr Habib were referred to the prison security department, but they did not find any evidence to support Mr Habib's belief that he was at risk.
55. Two prisoners told the investigator that they knew Mr Habib. One said that he had known Mr Habib since he was 11 years old. They said that Mr Habib was 'paranoid' but that they had reassured him that he was now on a good wing and nothing was going to happen to him. They said that for the first couple of days, Mr Habib appeared to be alright, he was calm and they were looking out for him.
56. One of the prisoners told the investigator that in his role as wing representative, he went to D wing where Mr Habib had said he had been under threat and asked

the prisoners what they knew about Mr Habib, but the prisoners did not know who he was talking about. He said that Mr Habib told him that he thought officers were going to go into his cell and 'beat him up' but he tried to reassure him.

Events of 20 November 2018

57. At around 7.00am on 20 November, an officer started the morning roll check. He told the investigator that he remembered checking Mr Habib's cell and that Mr Habib was standing at the back of his cell by the window. The officer said that he did not speak to Mr Habib or check that he was alright but moved on to the next cell.
58. Prisoners are not unlocked during the morning unless they are employed or work as cleaners on the wing. Mr Habib's cell was not unlocked.
59. One of the prisoners who knew Mr Habib said that just before 11.00am, he and the other prisoner who knew him, went to see Mr Habib in his cell because plans were in place for Mr Habib to move onto their landing so that he would be closer to them. One of them said that he looked into Mr Habib's cell through the observation panel and for the first few seconds he thought Mr Habib was standing by the window at the back of the cell. He then realised that Mr Habib was hanging and immediately called for staff assistance.
60. An officer said that at approximately 10.57am, he heard a shout and saw a prisoner beckoning him to follow him, and he ran down the landing. When the officer arrived at Mr Habib's cell he looked in through the observation panel and saw Mr Habib suspended by a ligature at the back of the cell.
61. The officer called a medical emergency code blue over his radio and attempted to open the door, but it had been barricaded. The emergency call was logged in the control room at 10.58am. The officer said that, with the help of the two prisoners, they forced the door open which allowed one of the prisoners to squeeze through the gap in the door. The officer said that he passed his anti-ligature knife to him and told him to cut the ligature. The officer then managed to get into the cell and helped him lower Mr Habib to the ground. They immediately started CPR. The officer said that Mr Habib felt cold. Other staff arrived and took over resuscitation attempts.
62. A nurse arrived at around 11.00am, bringing an emergency medical bag with her. The nurse said that when she arrived at the cell she saw Mr Habib lying on the floor and three officers were doing CPR. She said that she checked for signs of life and CPR continued.
63. The nurse said that her impressions were that Mr Habib had been hanging for some time because he was cold to touch and his airway was swollen and she thought that she would struggle to insert or maintain an airway. A defibrillator was attached but indicated that CPR should continue.
64. A prison GP arrived and assessed Mr Habib. He observed that Mr Habib was cold, stiff and swollen around the neck. The GP said that although Mr Habib's presentation was not good, CPR had already been started before he arrived and, given Mr Habib's age, he wanted to make sure that they had done everything they could to attempt resuscitation. However, when he assessed Mr Habib he

concluded that Mr Habib was showing signs of rigor mortis and he said he was about to call a halt to the resuscitation when the paramedics arrived.

65. Paramedics arrived at the cell at approximately 11.18am, and completed their own assessment, before consulting with the GP and the nurses present, who all agreed that CPR should be stopped.
66. At 11.20am, the GP confirmed that Mr Habib had died.

Contact with Mr Habib's family

67. The prison appointed a CM as the prison's family liaison officer (FLO). At 3.00pm, the CM, the Deputy Governor and the prison Imam visited Mr Habib's parents at their home to inform them of Mr Habib's death. The FLO remained in contact with the family to offer support and arrange for Mr Habib's property to be returned.
68. The prison contributed to the cost of the funeral in line with national guidance.

Support for prisoners and staff

69. After Mr Habib's death, the duty manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
70. The prison posted notices informing other prisoners of Mr Habib'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 Habib's death.

Post-mortem report

71. The Coroner provided both post-mortem and toxicology reports. The cause of Mr Habib's death has been given as hanging.
72. The toxicology tests showed that no illicit substances were present in Mr Habib's system at the time of his death.

Findings

Assessment, Care in Custody and Teamwork (ACCT)

73. Mr Habib had no history of self-harm (apart from one minor incident of superficial cutting during a previous sentence in July 2016). He was not assessed as a risk of suicide and self-harm while at Pentonville.
74. However, on 16 November, the day after he arrived at Swaleside, he cut his hand in what he said was an accident, and an hour later he set fire to his cell and initially said that he wanted to kill himself, although he later denied this. There is no evidence that staff explored Mr Habib's comments further or considered opening an ACCT.
75. Mr Habib had only been at Swaleside for one day and staff had not had time to get to know him, which should have made them more cautious. Deliberately setting fire to a cell while inside should generally be considered as an act of self-harm. In this case Mr Habib had also possibly self-harmed shortly before and had been expressing what staff thought were paranoid ideas about them letting people into his cell. Although we recognise that staff reacted promptly to Mr Habib's concerns by moving him to the vulnerable prisoner wing, we consider that an ACCT should have been opened to provide Mr Habib with support and the safeguard of regular observations by staff until they had established whether his fears were grounded in reality.
76. The SO told the investigator that he thought that an ACCT had been opened following the incident, but the investigation has found no evidence of this. The ACCT process would have been an opportunity for Mr Habib to express any concerns he had had and for staff to consider referring him to the mental health team given their concerns about his apparent paranoia.
77. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that an ACCT is opened following all acts of self-harm, including deliberately setting fire to a cell.

Allegations of bullying

78. Mr Habib told staff at Swaleside on several occasions that he felt under threat by other prisoners. As a result, Mr Habib was moved to the VPU and staff reassured him that he would be safe. Staff asked for the names of the prisoners who were threatening him but Mr Habib would not give any names.
79. If Mr Habib's fears were grounded in reality, he should have been offered support under Swaleside's local violence reduction strategy. However, his concerns were still being investigated at the time of his death and, given the very short time he had been at Swaleside, we do not consider that this was unreasonable. We make no recommendations.

Roll checks

80. An officer completed the roll check at about 7.00am on 20 November. He told the investigator that when he got to Mr Habib's cell, he saw him standing by the window at the back of the cell but did not attempt get a response from him before moving onto the next cell. When a prisoner looked into the cell at about 11.00am, he also thought at first that Mr Habib was standing at the back of the cell by the window, but then realised that Mr Habib was hanging. It is, therefore, possible that Mr Habib was in fact hanging when the officer looked into his cell four hours earlier.
81. Rigor mortis had set in when Mr Habib was found and this suggests he had probably been dead for at least four hours. It is, therefore, possible that he was already dead at the time of the roll check, although this cannot be known for certain.
82. We make the following recommendation:

The Governor should ensure that staff completing roll checks are aware of their responsibilities and that they must satisfy themselves all prisoners are present and correctly accounted for, that they have not escaped, and are not obviously ill or dead.

Clinical care

83. The clinical reviewer concluded that the overall care Mr Habib received during the brief period he was at Swaleside was of a good standard and was equivalent to that which he could have expected to receive in the community.
84. Prison staff and Mr Habib's friends said that Mr Habib seemed paranoid before he died, but Mr Habib was not referred for a mental health assessment during the few days he spent at Swaleside.
85. The CM said that, without further enquiry, they did not know whether Mr Habib's fears were real or the product of paranoia, but that they had to take his concerns at face value until they had had investigated them. The CM said that if it they had confirmed that there were no grounds for his fears, they would have referred Mr Habib for a mental health assessment. The prison's security department but they did not find any evidence to support Mr Habib's belief that he was at risk – although this had not been confirmed by the time he died.
86. The clinical reviewer considers that there were indications that Mr Habib was developing a paranoid state with persecutory delusions ideas in the last three weeks of his life, but says this would have been difficult to distinguish from reality without corroborating evidence that his perception of being under threat by other prisoners was unfounded. Mr Habib did not present with any signs of depression or other psychotic features which might have indicated a clearer mental health condition and prompted further assessment.
87. We are satisfied that staff took Mr Habib's fears seriously and responded appropriately by moving him promptly to the vulnerable prisoner unit. Efforts were being made to identify his underlying issues and the pieces of the jigsaw were coming together. We agree with the clinical reviewer that the indications

are that this would have resulted in Mr Habib getting the intervention he required and it was misfortune rather than lack of judgement that prevented this happening before he took his own life.

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