

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Hanif Shakeri-Jahromi, a prisoner at HMP Peterborough, on 27 January 2022**

**A report by the Prisons and Probation Ombudsman**

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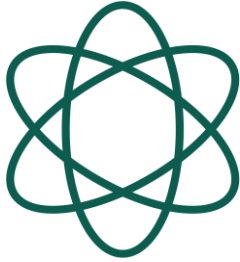
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## Our vision

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

**OGL**

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## Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Hanif Shakeri-Jahromi died of bilateral pulmonary thromboembolus (a life-threatening condition which causes the heart and lungs to stop working), on 27 January 2022 at Peterborough City Hospital, while a prisoner at HMP Peterborough. He was 34 years old. I offer my condolences to Mr Shakeri-Jahromi's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Shakeri-Jahromi received at Peterborough was equivalent to that which he could have expected to receive in the community. She was satisfied that Mr Shakeri-Jahromi's health concerns were appropriately assessed by healthcare in the weeks leading up to his death. She was also content that the emergency response was in line with national guidelines. However, she identified concerns regarding the healthcare response to Mr Shakeri-Jahromi's disclosure of suicidal thoughts.
5. We too are concerned that healthcare staff did not open ACCT procedures for prisoners at risk of suicide and self-harm when Mr Shakeri-Jahromi said he was feeling suicidal. A referral was made for mental health support, but this took eight days to follow up. This practice could have resulted in avoidable serious harm or death and we have made a recommendation accordingly.
6. The clinical reviewer makes a recommendation regarding reception screening that is not directly related to Mr Shakeri-Jahromi's death, but that the Head of Healthcare will need to address.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff are aware of their responsibility to start ACCT procedures whenever they are concerned about a prisoner's risk of suicide or self-harm, and that they clearly document their decision making.

## The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Shakeri-Jahromi's clinical care at HMP Peterborough.
8. The PPO investigator has investigated non-clinical issues, including Mr Shakeri-Jahromi's location, the prison's emergency response process and liaison with his family. She attended Peterborough on 16 March 2022 to interview two staff with the clinical reviewer. The clinical reviewer attended via video link.
9. The PPO family liaison officer wrote to Mr Shakeri-Jahromi's family and next of kin, to explain the investigation. They had questions about the healthcare response regarding his leg and foot pain. This has been addressed in our report and the clinical review.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
11. Mr Shakeri-Jahromi's family received a copy of the draft report. They did not make any comments

## Assessment, Care in Custody and Teamwork

12. ACCT is the care planning system HMPPS 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 made at irregular intervals to prevent the prisoner anticipating when they will occur.
13. Part of the ACCT process involves assessing immediate needs and drawing up a care map 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 care map are completed. 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).

## Previous deaths at HMP Peterborough

14. In the two years before Mr Shakeri-Jahromi's death, there were four deaths at Peterborough. Two of the deaths were from natural causes (one of which was related to COVID-19), one was self-inflicted and one classified as non-natural. There has since been one further suspected natural cause death. There were no similarities between our findings across these investigations.

## Key Events

15. On 2 December 2021, Mr Hanif Shakeri-Jahromi was remanded at HMP Peterborough whilst awaiting sentence for assault charges.
16. On arrival, it was noted that Mr Shakeri-Jahromi had several pre-existing mental health concerns. These included anxiety (persistent feeling of worry and nervousness), depression (persistent feeling of low mood) and post-traumatic stress disorder (PTSD). No physical health conditions were identified at reception.
17. On 15 December 2021, Mr Shakeri-Jahromi was seen by a prison GP. Mr Shakeri-Jahromi told the GP that he was feeling suicidal but did not want to hurt himself. The GP sent a referral to the prison Mental Health Team to complete an assessment. There is no evidence that an Assessment Care in Custody and Teamwork (ACCT) document was considered or opened at this time, to manage the risk of suicide and self-harm.
18. On 23 December, eight days after the mental health referral, Mr Shakeri-Jahromi had a telephone appointment with a nurse from the mental health team. He said that he was not feeling suicidal, and a review appointment was set for two weeks later.
19. On 25 January, Mr Shakeri-Jahromi attended an appointment with a prison GP, after reporting that his left knee was swollen and painful. She recorded that the pain was due to a varicose vein behind his knee that was inflamed. The clinical reviewer found that the GP had appropriately diagnosed Phlebitis. (Phlebitis is an inflammation of a vein, which is near the surface of the skin.) The GP told Mr Shakeri-Jahromi to use Paracetamol and Ibuprofen for pain management and said that she would review him in a weeks' time if his leg had not improved.
20. On 27 January at 8.05am, a prison custody officer (PCO) was in the wing office and heard a door rattling on the lower landing. He went immediately to Mr Shakeri-Jahromi's cell and was told by his cell mate that Mr Shakeri-Jahromi was "not alright". He opened the cell door and saw Mr Shakeri-Jahromi lying unresponsive on the bottom bunk with his eyes open. He radioed a Code Blue call (an emergency code indicating that a prisoner is not breathing or is having difficulty breathing).
21. The PCO commenced cardiopulmonary resuscitation (CPR) whilst he waited for support from healthcare staff to arrive. Approximately two minutes later a nurse arrived, having heard the radio call for assistance. When he arrived and took over CPR with his colleague, he asked the PCO to bring an emergency bag to the cell.
22. The ambulance arrived at 8.22am and paramedics took over treatment. Mr Shakeri-Jahromi was transferred to Peterborough City hospital by blue light ambulance. Further treatment was unsuccessful, and he died in hospital at 10.48am.

## **Post-mortem report**

23. The Coroner concluded in the post-mortem that Mr Shakeri-Jahromi died of Bilateral Pulmonary Thromboembolus (a life-threatening condition which causes the heart and lungs to stop working) caused by deep vein thrombosis.

## **Clinical Findings**

24. The independent clinical reviewer concluded that the clinical care that Mr Shakeri-Jahromi received was equivalent to that which he could have expected to receive in the community. The clinical reviewer had no concerns about the emergency response. However, she identified concerns about the healthcare response when Mr Shakeri-Jahromi said that he was feeling suicidal.

**Tallulah Frankland**  
**Assistant Ombudsman**

**December 2022**

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