Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Halo Hama-Rashid, a prisoner at HMP Pentonville, on 28 August 2019

A report by the Prisons and Probation Ombudsman

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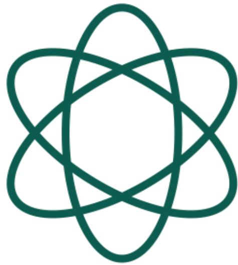
Our vision

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 Halo Hama-Rashid died in hospital on 28 August 2019, after being found hanging in his cell at HMP Pentonville a week earlier. He was 34 years old. I offer my condolences to his family and friends.

This is a troubling case. Mr Hama-Rashid had a number of significant risk factors for suicide and self-harm. Although he was being managed under suicide and self-harm support procedures (known as ACCT) when he hanged himself, I am concerned that staff under-estimated his risk to himself and that the ACCT procedures were poorly managed.

I am very concerned that staff did not hold an ACCT review when they found Mr Hama-Rashid with an aerial around his neck and with superficial cuts to his arms the day before he hanged himself.

The clinical review into Mr Hama-Rashid's death concluded that Mr Hama-Rashid's care was not equivalent to that he might have expected to receive in the community. Despite staff concerns about his deteriorating mental health and his own repeated requests for help with his anxiety and depression, he was not seen by a prison GP or assessed by the mental health team during the six weeks he spent at Pentonville. I share the clinical reviewer's concerns about prisoners' access to GPs and prison officers' inability to contact the mental health team.

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
Acting Prisons and Probation Ombudsman **November 2020**

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Summary

Events

1. On 10 July 2019, Mr Halo Hama-Rashid was remanded to HMP Pentonville, charged with supplying drugs. It was his first time in prison.

2. Over the next three weeks, staff noted that Mr Hama-Rashid was very stressed about being in prison. He said he was feeling anxious and unwell and was worried about his trial. He also complained that he was being threatened and that his cellmate was bullying him. On 2 August, he was moved to share with a different cellmate.

3. On the morning of 5 August, staff opened suicide and self-harm monitoring procedures (known as ACCT) after Mr Hama-Rashid said he felt suicidal. He told a psychologist that he was being threatened by gang members, was worried about his court appearance on 7 August, and was very depressed. Later that evening he was moved to a different cell after fighting with his cellmate who he said had threatened him with a razor. On 6 August, the ACCT was closed after Mr Hama-Rashid said he had no thoughts of suicide or self-harm.

4. He appeared in court on 7 August and his case was adjourned until November.

5. The prison's health and wellbeing team discussed him and noted that he was anxious and depressed and had been referred to the prison GP and was on the waiting list for the anxiety support group.

6. On 15 August, another ACCT was opened after he was found crying in his cell and said he had not eaten for several days and wanted to die. It was agreed he would be checked once an hour by staff.

7. Over the following week, Mr Hama-Rashid's mental health appeared to deteriorate. He said he was hearing voices, was distressed about traumatic events that had happened in Iraq, and was not eating or sleeping. He said he thought he was going crazy. He asked repeatedly to be referred to the prison GP and mental health team. Prison staff tried to get him seen urgently by the mental health team but were told he had an appointment for 22 August.

8. On 20 August, he became very distressed after learning that his flat had been burgled. He was moved to a single cell as he was not getting on with his cellmate. He was later found with a ligature around his neck and superficial cuts to his arms, and he told a nurse that he wanted to die. Staff started a food refusal log.

9. On the morning of 21 August, the health and wellbeing team discussed him and agreed he would have a mental health assessment the following day. At 1.00pm an officer carrying out an ACCT check found Mr Hama-Rashid in his cell with a ligature tied around his neck. He immediately called a medical emergency code. Officers and healthcare staff responded promptly.

10. Hospital paramedics arrived and resuscitated him. Mr Hama-Rashid was taken to hospital, where he died on 28 August.

Findings

11. Mr Hama-Rashid had a number of known risk factors for suicide and self-harm, and his mental health appeared to deteriorate, particularly in the week before he hanged himself.

12. We are concerned that Mr Hama-Rashid's risk to himself was under-estimated and that the ACCT procedures were poorly managed and did little to support him or address his risks.

13. Although ACCT procedures were appropriately opened on 5 August, we consider that the ACCT was closed prematurely the following day and that no healthcare staff participated in this decision.

14. We are concerned that staff did not start ACCT procedures again when Mr Hama-Rashid returned from court on 7 August with a suicide and self-harm warning form, and relied too heavily on what he said and did not give sufficient attention to his risk factors. We are also concerned that healthcare staff did not assess him, as they should have done.

15. The paperwork for the ACCT opened on 15 August was only partially completed, the ACCT assessments and ACCT reviews were not completed within 24 hours of the start of ACCT procedures, and the caremap was not completed.

16. Although Mr Hama-Rashid told staff that he wanted to die and harmed himself on 20 August, staff failed to review his risk and to identify that he was at an increased risk of suicide or self-harm.

17. Both the PPO and HMIP have previously raised similar concerns about the assessment and management of risk at Pentonville.

18. Pentonville had no formal process in place to support victims and did not address Mr Hama-Rashid's fears that he was under threat effectively.

19. We are concerned that Mr Hama- Rashid was placed in a cell in poor condition the day before he hanged himself.

20. The clinical reviewer concluded that Mr Hama-Rashid's care was not fully equivalent to that which he could have expected to receive in the community, and that healthcare staff did not manage his mood and possible depression in line with NHS guidance. Healthcare staff did not request his community GP records until he had been in prison for five weeks. He was never seen by a GP or assessed by the mental health team. There were no clear channels by which officers could express concerns about a prisoner's mental health, and the prison's health and wellbeing team was not effective in expediting a GP appointment or mental health assessment.

21. We are concerned that the safer custody team did not respond promptly to a telephone call from Mr Hama-Rashid's ex-partner on 23 August and that she was, therefore, not identified as his next of kin until the day of his death.

Recommendations

- **The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with PSI 64/2011, including that:**
    - **the ACCT assessment interview and first ACCT case review are completed within 24 hours of the start of ACCT procedures;**
    - **first ACCT case reviews are multidisciplinary and always include a member of healthcare staff;**
    - **staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews;**
    - **ACCT case reviews assess and record the level of risk, considering all risk factors;**
    - **a multi-disciplinary review is held when there is evidence of a significant change in risk;**
    - **case managers complete caremaps at the first ACCT case review, set specific and meaningful caremap actions, identify who is responsible for them and review progress at each review;**
    - **the frequency of observations reflects the prisoner's risk and is adjusted when that risk changes;**
    - **ACCT procedures are not closed at the first case review, unless all issues identified at the assessment interview and in the caremap have been resolved; and**
    - **there are procedures in place to check the quality of ACCT procedures, identify poor practice, learn lessons and, where appropriate, provide staff with refresher training.**
- **The Governor and Head of Healthcare should ensure that:**
    - **staff do not rely solely on a prisoner's presentation and denial of thoughts of suicide and self-harm;**
    - **reception staff consider all risk factors of newly arrived prisoners, particularly those with a suicide and self-harm warning form; and**
    - **a healthcare professional assesses all prisoners who arrive in reception with a suicide and self-harm warning form.**
- **The Prison Group Director for London should write to the Ombudsman setting out what she is doing to satisfy herself that effective action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.**
- **The Governor should ensure that:**

- **information about bullying and intimidation is fully and promptly investigated;**
- **alleged perpetrators are appropriately challenged;**
- **victims are effectively supported and the possible impact on their risk of suicide and self-harm properly considered and addressed; and**
- **HMPPS's Challenge Support Intervention Plan is fully implemented.**

- **The Governor should ensure that staff check that cells are fit to be occupied before placing prisoners in them.**
- **The Head of Healthcare should ensure that healthcare staff request full GP records for newly arrived prisoners.**
- **The Head of Healthcare should ensure that:**
  - **there is a clear procedure for prison staff to contact the mental health team, including a system for escalating concerns promptly when the mental health team is unavailable; and**
  - **there is a clear escalation procedure in place when a prisoner is repeatedly referred to the health and wellbeing team and their risk of suicide has increased.**
- **The Head of Healthcare should ensure that healthcare staff review completed PHQ9 and GAD7 forms within twenty-four hours of receipt and address concerns raised promptly and appropriately.**
- **The Head of Healthcare should ensure that:**
  - **there is sufficient GP availability to meet the demand for urgent appointments; and**
  - **the health and wellbeing team can directly and promptly refer a prisoner to a GP.**
- **The Governor should ensure that safer custody staff respond promptly to telephone calls about prisoners' wellbeing and share information with wing staff or FLOs.**
- **The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

The Investigation Process

22. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him.

23. The investigator visited Pentonville on 29 August 2019. He obtained copies of relevant extracts from Mr Hama-Rashid's prison and medical records.

24. NHS England commissioned a clinical review to review Mr Hama-Rashid's clinical care at the prison. The review was completed by a clinical reviewer.

25. The investigator interviewed 21 members of staff and one prisoner, some jointly with the clinical reviewer. The investigator also arranged to speak to Mr Hama-Rashid's cellmate. However, on the day of the interview, the prisoner declined to do so.

26. We informed HM Coroner for London Inner North of the investigation. She gave us a copy of the post-mortem results for Mr Hama-Rashid. We have sent the Coroner a copy of this report.

27. We contacted Mr Hama-Rashid's ex-partner in the UK and his parents in Iraq (using an interpreter). His ex-partner asked how often Mr Hama-Rashid was monitored before his death, if he was appropriately located in the prison and if he had been diagnosed with a mental health condition. Mr Hama-Rashid's family had no specific questions but asked if his death was really suicide, and said they thought it might be "mafia" (gang) related and linked to the burglary of his flat.

28. Mr Hama-Rashid's family and ex-partner received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Pentonville

29. HMP Pentonville is a local prison in London that holds around 1,200 prisoners. The prison primarily serves the courts of north and east London. Care UK, in partnership with Enfield and Haringey Mental Health Trust, provides healthcare services at the prison.

HM Inspectorate of Prisons

30. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Pentonville in April 2019. Inspectors said that ACCT support processes remained weak and were generally poorly managed. They reported that many ACCT caremaps were inadequate, that there was no continuity of case ownership and that there was limited multidisciplinary involvement in case reviews.

31. Inspectors reported that about a third of prisoners said they felt unsafe and that levels of violence were high. Inspectors found that investigations were currently not being completed and the Prison Service's new case management approach to managing perpetrators of violence and supporting victims (CSIP) had not yet been introduced. Inspectors reported that the prison suffered from under-investment, was in a generally poor physical state and much of the accommodation was in poor condition.

32. Inspectors reported that there was sound governance of healthcare, that staffing levels and skills mix were sufficient, that there had been demonstrable learning from deaths in custody and regular sharing of health information between specialist teams at the health and wellbeing referral meetings.

33. Reporting on previous deaths at the prison, inspectors raised concerns that while PPO recommendations about healthcare had been met, most of the other PPO recommendations had not been achieved.

Independent Monitoring Board

34. 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 March 2019, the IMB reported that incidents of self-harm had risen over the reporting year. The number of prisoners monitored under ACCT procedures had also risen, but they found that monitoring was often stopped within a day once immediate concerns had been addressed.

35. The IMB noted that the poor physical environment at Pentonville was incompatible with maintaining prisoners' humanity and dignity but that many staff were doing their best to treat prisoners humanely.

36. The IMB reported that healthcare at the prison delivered a high-grade professional service and that in mental healthcare, staffing levels were very good, with a rich mix of skills.

Previous deaths at HMP Pentonville

37. Mr Hama-Rashid's death was the sixth at Pentonville since August 2017. Of the previous deaths, three were self-inflicted and two were from natural causes. Since Mr Hama-Rashid's death, there have been three further deaths: one self-inflicted, one from natural causes, and one where the cause of death is currently unascertained. (We are still investigating these three deaths.)

38. In our previous investigations into self-inflicted deaths at Pentonville, we have identified concerns about risk assessment, the quality of ACCT procedures, timely referrals to mental health services and delays in requesting GP records. In July 2019, the prison said that it was taking action in response to our recommendations for improvements.

Assessment, Care in Custody and Teamwork (ACCT)

39. 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. 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, *Safer Custody.*

Key Events

40. Mr Halo Hama-Rashid was born in Iraqi Kurdistan and lived there before coming to the United Kingdom at the age of 17. He became a British citizen in 2009.

41. On 9 July 2019, Mr Hama-Rashid was arrested on suspicion of supplying controlled drugs and obstructing a police officer. While in police custody, it was noted that he was very emotional but he denied having a history of, or thoughts of, suicide or self-harm.

42. On 10 July, Mr Hama-Rashid was remanded to HMP Pentonville. He was identified as at risk because it was his first time in prison. An officer completed a first night safer custody interview and assessed his risk. Mr Hama-Rashid told him that he had no history of or thoughts of suicide or self-harm and the officer considered that he could share a cell with another prisoner.

43. A nurse completed an initial health screen. The nurse noted that Mr Hama-Rashid appeared stressed. He told her that he had no mental health or substance misuse issues and denied thoughts of suicide or self-harm. He gave consent for Pentonville to access his community GP records.

44. On 11 July, a nurse completed a secondary health screen. Mr Hama-Rashid told her that he was "feeling stressed". She referred him to the prison's health and wellbeing team (a multi-professional team, including mental health nurses and therapists, which meets from Monday to Friday and reviews referrals and plans for substance misuse, mental health and occupational health support).

45. On 15 July, a nurse assessed Mr Hama-Rashid's wellbeing, feelings and needs. Mr Hama-Rashid said that he had had no previous contact with mental health services but was stressed about being in prison and was worried about his dog and forthcoming court appearance. He said that prison officers were unhelpful but that he would feel better with some sleep. The nurse noted that Mr Hama-Rashid was guarded and suspicious but showed no symptoms of psychotic behaviour and denied thoughts of suicide or self-harm.

46. Mr Hama-Rashid asked the nurse if he could see a prison GP because he could not sleep well and had a persistent headache. He said he felt stressed and the nurse noted that he had hinted at being involved with a gang, which had led to a previous head injury. Mr Hama-Rashid said that he was concerned that he was being watched, that he would be in trouble for "snitching" and that "they" would send someone to the prison to get him, but said that he felt safe and had no issues with his cellmate. He refused to be referred to Catch 22, a charity working with prisoners on resettlement and gang issues. The nurse suggested that he should take part in psycho-educational groups to support his anxiety.

47. On 16 July, the health and wellbeing team added Mr Hama-Rashid to the GP waiting list and sent him a self-referral letter, together with details of support groups. They also sent him a patient health questionnaire (PHQ-9, used to measure depression and anxiety) and a self-referral tool (GAD-7, used to measure symptoms of anxiety and post-traumatic stress disorder) for him to complete so that he could be directed to the appropriate psychological support.

48. On 24 July, Mr Hama-Rashid told an officer that he was being bullied and threatened by his cellmate, and that he felt unsafe and wanted to move. The officer asked Mr Hama-Rashid if he had formally asked to move. Mr Hama-Rashid told the officer that he would do so the next day.

49. On 25 July, a nurse assessed Mr Hama-Rashid after he complained of feeling unwell. The nurse noted that he was very tense and did not relax. Mr Hama-Rashid agreed with the nurse that he may be anxious about his upcoming court appearance. Mr Hama-Rashid then calmed down and said that he felt much better.

50. On 2 August, an officer moved Mr Hama-Rashid to another cell and introduced him to his new cellmate.

ACCT – 5 to 6 August

51. At 9.00am on 5 August, Mr Hama-Rashid told staff that he felt suicidal and an officer started suicide and self-harm monitoring and support procedures (known as ACCT). The officer noted Mr Hama-Rashid's unusual behaviour and "low mood" and that Mr Hama-Rashid was concerned about his safety on the wing and in prison. He said Mr Hama-Rashid seemed very quiet and did not cause any trouble. An immediate action plan was completed. It noted that Mr Hama-Rashid needed no medical intervention, and he had access to the telephone and Listeners (a confidential service run by prisoner volunteers to offer support to prisoners who are struggling to cope).

52. On the same day, a trainee forensic psychologist completed a risk assessment for Mr Hama-Rashid after he completed the PHQ-9 and GAD-7 questionnaires. (The investigator was unable to establish when Mr Hama-Rashid had completed the forms.) Mr Hama-Rashid had written on the forms, "I cannot cope anymore. I need help, I'm afraid," and "I'm going to end my life," which he had subsequently crossed out. Mr Hama-Rashid had also said in response to the questionnaires that he was depressed, feared other people in the prison and might need antidepressants.

53. The trainee forensic psychologist noted in Mr Hama-Rashid's ACCT ongoing record that he said he was anxious about his forthcoming court hearing and because he was being bullied and had received threats. She noted that he hoped to move to the vulnerable prisoners' wing for his own safety. She noted that Mr Hama-Rashid was malodorous and unkempt and that although he denied thoughts of self-harm, he said "he did not know what will happen". She noted in the ACCT ongoing record that she would refer him to the prison GP and wellbeing team. (Mr Hama-Rashid had still not seen a GP since he arrived.)

54. The trainee forensic psychologist also noted her contact with Mr Hama-Rashid in his medical record. She recorded that he refused to answer questions about whether he had thoughts of suicide or self-harm, but that he told her he did not want to die. He also said he was being targeted in prison by known gang members but he did not elaborate. She recorded that she had referred him to the prison GP, and she noted that his risk could be managed under ACCT procedures and that he was already on the waiting list for health and wellbeing groups.

55. Late that evening, an officer answered a cell bell from Mr Hama-Rashid's cell and found him fighting with his cellmate. He was moved to a cell in the prison's

reception wing for his own safety. A nurse saw him the following day and noted that he had no injuries. Mr Hama-Rashid later claimed that his cellmate had threatened him with a razor. His cellmate denied it.

56. At 10.50am on 6 August, an officer completed the ACCT assessment. Mr Hama-Rashid told him he thought other prisoners would see him as a "snitch", was concerned about his safety and thought there would be repercussions if other prisoners found out about his case. He denied thoughts of suicide or self-harm. The officer noted marks on Mr Hama-Rashid's neck, which he said had been caused when his cellmate assaulted him the previous evening. He noted Mr Hama-Rashid was sharing a new cell, was going to court the next day, had support in the community and denied thoughts of self-harm.

57. At 11.00am, a Supervising Officer (SO) chaired Mr Hama-Rashid's first ACCT review with the officer. No other staff were present. The SO noted that Mr Hama-Rashid "quickly told me he has no thought of self-harm and has never harmed himself before". Mr Hama-Rashid told the officer he was going to court the next day and was worried he would be put in with another cellmate who might attack him. He said he was not involved with a gang.

58. The SO noted that Mr Hama-Rashid was to be moved to G wing for a fresh start, and that ACCT monitoring would stop because no self-harm issues were raised.

59. There is no evidence that the SO considered the concerns the trainee forensic psychologist had noted on the ACCT ongoing record the previous day. The trainee forensic psychologist told the investigator she was "incredibly surprised and disappointed" that the ACCT was closed the following day because there had not been time to see if Mr Hama-Rashid's state of mind had improved and he had not been assessed by the mental health team.

60. The health and wellbeing team discussed Mr Hama-Rashid as the trainee forensic psychologist had emailed them a summary of her meeting with Mr Hama-Rashid. They noted that he had presented as extremely anxious, was preoccupied with his court case, and wanted to attend an anxiety support group and see a prison GP. They noted that he had written on 5 August that he was quite depressed and thought he needed antidepressants, and that he was worried other people would be malicious towards him, although he acknowledged that this may be paranoia. The meeting concluded that Mr Hama-Rashid had already been referred to the prison GP and was on the waiting list to attend the anxiety support group.

7 – 14 August

61. On 7 August, Mr Hama-Rashid appeared at Wood Green Crown Court. His prisoner escort record noted that he was a victim of bullying, that ACCT monitoring had ended and that a post-closure review was due that day. (This was an error as the review was not due until 13 August.) Mr Hama-Rashid's case was adjourned until 11 November.

62. When he was at court, a court officer completed a suicide and self-harm warning form because Mr Hama-Rashid had told the judge that "he would self-harm if not given more time". There are no further details to explain what Mr Hama-Rashid meant.

63. When Mr Hama-Rashid returned to Pentonville, a SO completed a suicide and self-harm form, and noted that Mr Hama-Rashid said he had back pain but that he said he had no thoughts of self-harm denied telling the judge that he would self-harm. She told the investigator that she did not start ACCT procedures because Mr Hama-Rashid did not express thoughts of self-harm.

64. A nurse should have signed the suicide and self-harm form but there is no evidence that a nurse saw Mr Hama-Rashid.

65. On 13 August, Mr Hama-Rashid told a SO at the ACCT post-closure review that he could not understand why he had been assessed under ACCT procedures in the first place. The SO noted that Mr Hama-Rashid was okay, had never harmed himself but had issues with the noise in the prison as he was not used to the environment as it was his first time in prison.

66. On 14 August, an officer said he saw Mr Hama-Rashid sitting on the floor of his cell, with his knees drawn up, crying while talking to his cellmate. He said Mr Hama-Rashid told him that he was okay and he thought it looked as though his cellmate had been trying to comfort him.

ACCT – 15 August onwards

67. At 9.00pm on 15 August, an officer started ACCT procedures after Mr Hama-Rashid, who was still crying in his cell, said he had not eaten for several days and wanted to die. Mr Hama-Rashid was to be checked hourly but no one completed an ACCT immediate action plan.

16 August

68. On 16 August, at the ACCT assessment, Mr Hama-Rashid told an officer that he felt very depressed. He said it was his first time in prison and he had no family in the UK but had some telephone contact with his family in Iraq. He said he had not eaten properly for several days, was sleeping poorly, was hearing voices, felt he was going crazy and had nightmares about the wars in his home country. He said attending mosque helped. He asked the officer to refer him to the mental health team. She noted that Mr Hama-Rashid looked as if he had not slept much for some time.

69. That afternoon, a SO chaired Mr Hama-Rashid's first ACCT case review with two prison staff and an assistant psychologist. The SO noted that Mr Hama-Rashid appeared clean but slightly dishevelled. He said he had no thoughts of suicide or self-harm but appeared to be traumatised as he said he had seen family members killed in Iraq under the regime of Saddam Hussein.

70. The SO told the investigator that it became clear during the review that the "noise" Mr Hama-Rashid referred to was in fact "voices"' he was hearing and not the noise of the prison environment. Mr Hama-Rashid said that he had good support from his cellmate and he found solace in prayer.

71. The assistant psychologist told the investigator that Mr Hama-Rashid appeared to be "overwhelmed at being in prison". She agreed to refer him to the health and

wellbeing team to address his sleep and depression issues. These issues were identified in the ACCT caremap. Mr Hama-Rashid's risk to himself was considered low and staff agreed that he should continue to be monitored hourly. She later noted in Mr Hama-Rashid's medical record that he had said he felt he was going crazy. She recommended that his trauma level should be assessed so that he could be referred to the prison GP for medication.

72. Later that afternoon, Mr Hama-Rashid left his cell to collect his evening meal

17 August

73. On the morning of 17 August, an officer found Mr Hama-Rashid sitting on the floor of the landing instead of going outside for exercise. She told the investigator she had seen Mr Hama-Rashid leaving his cell several times and then sinking to the landing floor, with his knees curled to his chest, mumbling and not talking to anyone. He said he had not eaten for four days and wanted to die.

74. The officer tried unsuccessfully to contact the mental health team by telephone and then emailed a mental health manager about her concerns and asked for someone from the team to see Mr Hama-Rashid that day. (On 19 August, a mental health manager forwarded the email to the mental health team and the officer was told that Mr Hama-Rashid was waiting for a health and wellbeing assessment.)

18 August

75. On 18 August, Mr Hama-Rashid's keyworker met him and noted that he kept repeating under his breath, "I hate this life". Mr Hama-Rashid told his keyworker about his traumatic experiences in Iraq and said that he had faith in God. The keyworker told him that "every man would account to God for his life and that he should think of that before doing anything that is not wise". Mr Hama-Rashid said he had not eaten for several days and complained of hearing voices. The keyworker told him that "not eating just weakened his ability to block the voices out and make them over powering".

76. Mr Hama-Rashid said that he wanted to see the mental health team, so the keyworker emailed them. He also emailed the keyworker team, setting out his concerns about Mr Hama-Rashid and asking them to contact the mental health team as he would not be at work for several days.

77. At lunchtime, Mr Hama-Rashid collected his food and returned to his cell. A little later, an officer saw him lying on the floor of his cell. She told the investigator that Mr Hama-Rashid was "writhing around" and did not respond to her. That afternoon, Mr Hama-Rashid asked her for some strong medication as he had "stressful images" in his head and just wanted to die. She told him that the mental health team had been contacted.

19 August

78. On the morning of 19 August, an officer noted that Mr Hama-Rashid had refused to leave his cell to mix with the other prisoners and was not communicating with staff.

79. The health and wellbeing team discussed Mr Hama-Rashid that morning, including the assistant psychologist's comments that Mr Hama-Rashid was struggling to eat, sleep and cope, that she was concerned about his history of trauma and current level of distress, that he was on the waiting list for anxiety sessions and that he wanted antidepressants. (There is no evidence that they discussed the keyworker's concerns about Mr Hama-Rashid from the previous day.) The health and wellbeing team made an appointment for them to assess Mr Hama-Rashid on 22 August, and they wrote to him to let him know. Healthcare staff also requested his community GP medical records.

80. That afternoon, an officer noted that Mr Hama-Rashid shook his head and looked "blankly" when he tried to speak to him and did not answer when asked why he had not collected his dinner.

81. At 7.00pm, an officer noted that Mr Hama-Rashid was lying on the floor of his cell with a blanket round him. He told the officer that he believed people wanted to kill him. The officer encouraged him to speak to his cellmate.

82. At 11.00pm, an officer noted that Mr Hama-Rashid was crying and had asked to talk to the police. The officer told the prison's night manager and noted that Mr Hama-Rashid spent the night sleeping on the floor and frequently rang his cell bell asking to speak to the police.

20 August

83. On 20 August, Mr Hama-Rashid told a SO that his house had been burgled. (He said that knew this because he had called a friend on his cellmate's illegally held mobile phone.) The SO allowed Mr Hama-Rashid to call his solicitor. Mr Hama-Rashid asked to move to another cell after he told the SO about his cellmate's mobile phone. Later that morning, the SO noted that Mr Hama-Rashid had refused to move cells after asking to be moved.

84. Mr Hama-Rashid spoke to a friend on the prison telephone about the burglary. He asked her to make sure that his flat was secure. Later that afternoon, he left a telephone message asking her to contact the police and, again, to check that the flat was secure.

85. An officer said that he decided to move Mr Hama-Rashid because he was not happy sharing with his cellmate, who he described as "not a good man". A SO authorised the move and an empty cell was found on the ground floor of the wing near the wing office where staff could keep an eye on him. The officer told the investigator that he removed some items from the cell and that the cell had had a fresh coat of paint.

86. An officer said that at around 10.15am, as Mr Hama-Rashid was moving cells, she saw him sitting on the landing floor, with a bag of his belongings. She said he looked distressed and she allowed him to call his solicitor.

87. At around 11.30am, an offender resettlement worker spoke to Mr Hama-Rashid because she noted that he was very stressed. She said that he burst into tears. He told her that his house had been burgled, he was afraid that the burglars would kill

him when he was released from prison, that he would kill himself if the issue with his flat was not resolved and that he had not eaten for six days.

88. An officer noted that after he moved cells, Mr Hama-Rashid had refused to take his lunch and was lying on the floor of his cell, looking upset.

89. At 1.00pm, an officer completed an ACCT check and found Mr Hama-Rashid "very distressed", with his television aerial around his neck. She told the investigator that Mr Hama-Rashid was rambling and that it was difficult to understand him but he gave her the aerial when she asked for it. She said that his actions were "like a cry for help". He told her he wanted to see someone from the mental health team. She said that she told officers on the wing about Mr Hama-Rashid at lunchtime, and told them to keep an eye on him.

90. At 2.00pm, it was noted that Mr Hama-Rashid was lying on the floor of his cell. At 3.00pm, Mr Hama-Rashid told an officer that he was not happy and wanted to die. The officer removed some clothes and "some strings hanging" from his cell "for safety purposes". He spoke to the mental health team and was told that Mr Hama-Rashid had been booked for an assessment on 22 August.

91. At around 3.50pm, Mr Hama-Rashid told a nurse that he wanted to end his life. She noticed superficial cuts to his wrists and later noted in his medical record that he had appeared dishevelled and said, "My mind is gone and I cannot control it," and that he was planning to "end his life anytime". He also said that he missed his son, that he had not been eating or sleeping, and that he was depressed and wanted to see someone from the mental health team for medication. The nurse said Mr Hama-Rashid was happy when she told him that she would refer him to the health and wellbeing team. She later emailed the health and wellbeing team to ask them to discuss Mr Hama-Rashid at their next meeting.

92. The nurse told two officers about her concerns. She said the officers told her that Mr Hama-Rashid was already getting support, had moved cells and been allowed to make two welfare telephone calls. She said that she told them about Mr Hama-Rashid's superficial cuts, which they saw. She told them to keep a closer watch on him. She said the cuts were quite fresh although the blood had dried and could have been made earlier that day. Neither the officers nor the nurse completed a self-harm injury form for Mr Hama-Rashid.

93. The nurse told the investigator that when she returned to the healthcare unit, she checked whether there was a GP available to see Mr Hama-Rashid, but there was no one there. She said that she discussed her concerns about Mr Hama-Rashid with her line manager, who was a clinical psychologist. They concluded that Mr Hama-Rashid was being adequately managed as he was being supported through ACCT procedures and he had a mental health review scheduled for the next day.

94. At 4.00pm, an officer noted that Mr Hama-Rashid was lying on the floor of his cell. At around 5.00pm, the officer allowed Mr Hama-Rashid to call his cousin to say that his home had been burgled. At 5.30pm, Mr Hama-Rashid did not take his evening meal but collected his breakfast pack for the morning.

95. At 5.41pm, a nurse noted that a SO had told him that Mr Hama-Rashid had refused food for several days. He noted that the healthcare team had not been aware of

this. (There is no evidence that the assistant psychologist's comment of 19 August about Mr Hama-Rashid struggling to eat had been shared with primary care nurses to ensure they were involved in his care.) The nurse noted that Mr Hama-Rashid was being monitored under ACCT procedures and had made cuts to his wrist which appeared untreated. The nurse arranged for the healthcare team to check on Mr Hama-Rashid daily and updated the GP referral to include the food refusal issue.

96. At 5.43pm, a member of the mental health team responded to the officer email of 18 August. She confirmed that the mental health team would see Mr Hama-Rashid on 22 August, and that the healthcare team was aware that another officer had started a food refusal log.

97. During the ACCT checks that night, staff noted that Mr Hama-Rashid slept on the floor of his cell.

21 August

98. On the morning of 21 August, Mr Hama-Rashid made three unsuccessful attempts to call his friend on the prison telephone.

99. At 11.00am, an officer noted during an ACCT check that Mr Hama-Rashid was on his bed crying but did not speak to explain why.

100. At 11.30am, a nurse arranged for Mr Hama-Rashid to go to the healthcare unit for a review about his reported food refusal. At 12.00pm, an officer noted in the ACCT document that Mr Hama-Rashid had refused go and said that healthcare staff would have to see him on the wing. The officer was the last person to see Mr Hama-Rashid alive.

101. Later that morning, the health and wellbeing team again discussed Mr Hama-Rashid. They decided that his care plan should remain the same and that he would be assessed on 22 August. They considered the nurse's contact but did not comment on his food refusal or discuss whether the concerns should be escalated before the assessment the next day.

102. At approximately 1.00pm, an officer went to Mr Hama-Rashid's cell to check on him. He looked through the observation panel and saw Mr Hama-Rashid apparently sitting on the bottom bunk of his bed with a towel tied to the bunk and around his neck. He went straight into the cell and called a medical emergency code blue (used when a prisoner is not breathing and triggers an automatic request for an ambulance and for healthcare staff to attend).

103. An officer, who was nearby, responded immediately and helped her colleague remove the ligature from Mr Hama-Rashid's neck. The Deputy Head of Healthcare arrived and helped to lay Mr Hama-Rashid on the floor.

104. A nurse responded to the code blue. He said Mr Hama-Rashid was pale but warm to touch. He assessed him and immediately started cardiopulmonary resuscitation (CPR), with the help of the Deputy Head of Healthcare and another nurse, who arrived soon after.

105. An ambulance was called at 1.02pm and the first paramedic arrived on the scene at 1.15pm. The paramedics succeeded in resuscitating Mr Hama-Rashid and took him to hospital, where he was placed in an induced coma in the intensive care unit.

106. On 22 August, hospital doctors told the prison that Mr Hama-Rashid's prognosis was poor and asked them to contact family or friends.

107. On 23 August, Mr Hama-Rashid's ex-partner telephoned the prison's safer custody team as she was concerned that she had not heard from Mr Hama-Rashid for some time. There is no evidence that Pentonville took any action.

108. Mr Hama-Rashid died in hospital at 4.40am on 28 August.

Contact with Mr Hama-Rashid's family

109. On 21 August, after Mr Hama-Rashid had been taken to hospital, a family liaison officer was appointed. As Mr Hama-Rashid had not identified a next of kin and had left no details, the family liaison officer asked the police and his solicitor to identify one, but they were not able to do so.

110. On the evening of 27 August, an officer from the safer custody team emailed the family liaison officer her to tell her that Mr Hama-Rashid's ex-partner had called the prison on 23 August.

111. The family liaison officer and a custodial manager visited Mr Hama-Rashid's ex-partner on the afternoon of 28 August, after checking her identity, and broke the news of Mr Hama-Rashid's death. The family liaison officer continued to provide her with support and advice.

112. On 2 September, the family liaison officer also made contact with Mr Hama-Rashid's brother in Iraq, with an Imam from Pentonville acting as translator. The prison paid for Mr Hama-Rashid's body to be repatriated to Iraq in line with Prison Service policy.

Support for prisoners and staff

113. After Mr Hama-Rashid's death, a custodial 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.

114. The prison posted notices informing other prisoners of Mr Hama-Rashid'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 the death.

Events after Mr Hama-Rashid's death

115. After Mr Hama-Rashid's death, his ex-partner said that he had told her by telephone on 19 or 20 August that he wanted to take his life. She said that she encouraged him not to do so. She had not told anyone because she did not believe he would go through with it.

116. At the beginning of our investigation, the PPO investigator visited Mr Hama-Rashid's cell. He noted that the cell window had been painted over with a light-coloured paint which restricted natural light and made it impossible to see out of the window; the walls were covered in what appeared to be gang-related graffiti; and the cell had little furniture in a poor state of repair and was in a very poor state of cleanliness.

117. A prisoner wrote to the investigator to say that he had briefly known Mr Hama-Rashid. He said he had cried a lot and was deeply distressed by a break-in at his flat. He said that Mr Hama-Rashid's ex-cellmate was to blame as he had bullied and teased Mr Hama-Rashid.

Post-mortem report

118. No post-mortem report was available at the time of issuing this report.

119. Post-mortem toxicology tests showed no traces of drugs in Mr Hama-Rashid's system, although test results taken from a strand of his hair indicated that he had used cocaine sometime in the last six months of his life.

Findings

Management of risk of suicide and self-harm

120. PSI 64/2011 on safer custody says that staff must identify prisoners at risk of self-harm and suicide. It provides a non-exhaustive list of risk factors that might increase a prisoner's risk and requires staff to start ACCT procedures when they receive information about a prisoner which may indicate that he is at risk of suicide or self-harm.

121. Mr Hama-Rashid had a number of significant risk factors, including first time in prison, previous trauma (in Iraq), fears of being bullied, apparent mental health issues (including increasing anxiety and depression and hearing voices), repeated expressions of suicidal intent, and self-harm on the day before he hanged himself.

122. We are concerned that staff under-estimated his risk of suicide and self-harm. Although he was managed under ACCT procedures on two occasions, we are concerned that the ACCT procedures were poorly managed and did very little to support Mr Hama-Rashid or address his underlying risks.

ACCT 5 to 6 August

123. ACCT procedures were appropriately started on 5 August after Mr Hama-Rashid expressed thoughts of ending his life. A SO ended ACCT monitoring just over 24 hours later because Mr Hama-Rashid said he had no thoughts of self-harm.

124. PSI 64/2011 requires case reviews to be multidisciplinary, where possible, and for the ACCT assessor and a member of the healthcare team to attend at least the first case review. There were no healthcare staff at Mr Hama-Rashid's first case review and the SO held the review with just the assessor present. We are particularly concerned that no one from healthcare was present given the psychologist's entry in the ACCT document.

125. Guidance in the ACCT document says that staff can end ACCT procedures at the first case review if it is safe to do so and if all issues identified in the assessment have been resolved.

126. We are concerned that the SO failed to recognise Mr Hama-Rashid's continued risk and ended ACCT monitoring prematurely before Mr Hama-Rashid's issues had been fully addressed. We consider that the issues raised by the assessor, and the psychologist's concerns and subsequent actions, should have been discussed at the ACCT review and recorded on the ACCT caremap, and that the ACCT document should have remained open until the issues had properly been resolved. These included his concern for his safety and fear of being bullied, his worries his court appearance the next day and that fact that his referral to the health and wellbeing team remained unknown.

Return from court with suicide and self-harm warning form – 7 August

127. When Mr Hama-Rashid returned from court on 7 August, he arrived with a suicide and self-harm warning form as he had told court staff that he would harm himself. He was seen in reception by a SO, who completed a suicide and self-harm form. He told her that he had no thoughts of suicide or self-harm and that he had not said at court that he would harm himself. She therefore concluded that Mr Hama-Rashid did not need ACCT monitoring as he had not expressed thoughts of self-harm.

128. The SO told the investigator that she did not start ACCT monitoring because "we can only go by what they tell us". We are concerned that this statement shows a fundamental misunderstanding of risk assessment. We have said repeatedly over many years that staff often place too much weight on how a prisoner presents and what he says, and do not give sufficient weight to the prisoner's risk factors. It is crucial that all information is considered to ensure that a prisoner's level of risk is judged holistically.

129. In this case, the SO knew that Mr Hama-Rashid had recently been on an ACCT and was reported to have said at court that he would self-harm (even though he denied it) and she also knew that court appearances are stressful and can increase a prisoner's risk to himself. We consider that she relied too heavily on what Mr Hama-Rashid said and that she should have considered re-opening the ACCT.

130. We are also concerned that although Mr Hama-Rashid arrived back at the prison with a suicide and self-harm warning form, he was not seen by a nurse, who should have reviewed him and completed the healthcare sections of the form. If a nurse had seen him and read his healthcare records, it seems likely that ACCT procedures would have been started again. The clinical reviewer concluded that this was a missed opportunity for healthcare staff to address Mr Hama-Rashid's expressions of despair through an effective clinical assessment.

ACCT 15 August onwards

131. An officer appropriately opened an ACCT on the evening of 15 August after he found Mr Hama-Rashid crying in his cell, saying he had not eaten for several days and that he wanted to die.

132. Over the next few days, Mr Hama-Rashid's risk factors increased. He was seen on numerous occasions in a highly agitated state; told his keyworker he "hated his life"; periodically told staff he was not eating and could "hear voices" and had "stressful images" in his head; was seen sleeping on the floor of his cell; was found with an aerial cable around his neck; and made superficial cuts to his wrists. He said he thought he was going crazy and repeatedly asked to see the mental health team and to be given medication.

133. Officers tried to contact the mental health team about their concerns about Mr Hama-Rashid behalf on 17, 18 and 20 August, and he was referred to the health and wellbeing team on 16 and 20 August.

134. PSI 64/2011 says that in addition to planned ACCT case reviews, a case review must be held where an ACCT trigger is activated or there are other concerns. We are concerned that when Mr Hama-Rashid told staff he wanted to die, and when an

officer found him with a cable around his neck and a nurse reported to staff that he had made superficial cuts to his wrists on 20 August, staff did not hold an ad hoc case review to re-assess his risk. We are concerned that they therefore missed opportunities to identify if Mr Hama-Rashid's risk was increasing, and to consider protective measures, such as increasing the frequency of his observations, considering if a single cell was appropriate and arranging for an urgent mental health review. We do not consider that the frequency of observations on the day he hanged himself adequately reflect his changing level of risk.

135. We are also concerned that the two ACCT documents opened for Mr Hama-Rashid were poorly completed: the front page of the document and the immediate action plan had not been completed on one, and the second was only partially completed, the ACCT assessments and ACCT reviews were not completed within 24 hours of the start of ACCT procedures and the caremap was not completed.

136. We are concerned that many of the deficiencies we have raised in this report about the quality of ACCT procedures were also identified by HMIP in their last inspection report in April 2019. We make the following recommendations:

- **The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with PSI 64/2011, including that:**
    - **the ACCT assessment interview and first ACCT case review are completed within 24 hours of the start of ACCT procedures;**
    - **first ACCT case reviews are multidisciplinary and always include a member of healthcare staff;**
    - **staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews;**
    - **ACCT case reviews assess and record the level of risk, considering all risk factors;**
    - **a multi-disciplinary review is held when there is evidence of a significant change in risk;**
    - **case managers complete caremaps at the first ACCT case review, set specific and meaningful caremap actions, identify who is responsible for them and review progress at each review;**
    - **the frequency of observations should reflect the prisoner's risk and be adjusted when that risk changes;**
    - **ACCT procedures are not closed at the first case review, unless all issues identified at the assessment interview and in the caremap have been resolved; and**
    - **there are procedures in place to check the quality of ACCT procedures, identify poor practice, learn lessons and, where appropriate, provide staff with refresher training.**

- **The Governor and Head of Healthcare should ensure that:**
  - **staff do not rely solely on a prisoner's presentation and denial of thoughts of suicide and self-harm;**
  - **reception staff consider all risk factors of newly arrived prisoners, particularly those with a suicide and self-harm warning form; and**
  - **a healthcare professional assesses all prisoners who arrive in reception with a suicide and self-harm warning form.**

137. We are concerned that we are having to repeat our previous recommendations to Pentonville about the need to improve the quality of ACCT procedures. Although they agreed to implement our previous recommendations in July 2019, it is clear from the failings in this case that more needs to be done to embed the necessary learning. We make the following recommendation:

The Prison Group Director for London should write to the Ombudsman setting out what she is doing to satisfy herself that effective action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.

Managing violence and bullying

138. Mr Hama-Rashid often told staff that he felt threatened and feared for his safety. We do not know if his fears had any foundation in reality. His fears for his safety in prison were highlighted as a reason for him being monitored under ACCT, but there is no evidence that staff took any meaningful action to investigate and address his concerns.

139. At the time of Mr Hama-Rashid's death, Pentonville had violence reduction officers working as part of the safer custody team. A supervising officer told the investigator that when bullying allegations arose, individuals were challenged and concerns highlighted with other staff. However, the prison did not have any formal violence reduction or victim support policy or procedures in place and had not at that point introduced HMPPS's Challenge Support Intervention Plan (CSIP, a multi-disciplinary approach which focuses on prisoners who pose a raised risk of being violent, and works to change their behaviour).

We recognise the difficulty in investigating a prisoner's unspecified fears that he is under threat. However, we are concerned that more was not done in response Mr Hama-Rashid's repeated expressions of fear for his safety. We make the following recommendation:

The Governor should ensure that:

- **information about bullying and intimidation is fully and promptly investigated;**
- **alleged perpetrators are appropriately challenged;**

- **victims are effectively supported and the possible impact on their risk of suicide and self-harm properly considered and addressed; and**
- **HMPPS's Challenge Support Intervention Plan is fully implemented.**

Cell location

140. Mr Hama-Rashid asked to move to a single cell because he felt threatened by his cellmate and unsafe in the prison. We therefore consider it reasonable and appropriate that staff moved him to a cell near the wing office where he could be more closely monitored. However, the cell he moved to had restricted daylight, was covered in graffiti and was in a poor standard of cleanliness.

141. We accept that accommodation at Pentonville is stretched. However, we consider that this cell was not fit for habitation by prisoners generally, and was a particularly unsuitable environment for someone vulnerable and at risk of suicide or self-harm. We make the following recommendation:

     The Governor should ensure that staff check that cells are fit to be occupied before placing prisoners in them.

Clinical care

142. The clinical reviewer noted that a judgment of clinical equivalence was difficult as many of Mr Hama-Rashid's concerns were a result of his imprisonment. However, she concluded that, overall, his care was not equivalent to that which he could have expected in the community.

GP records

143. The clinical reviewer was concerned that healthcare staff did not request Mr Hama-Rashid's community GP records until 16 August, over five weeks after he arrived at Pentonville. She noted that this meant that they knew nothing of his previous medical history and staff relied only their own observations without additional clinical information. We recommend that:

     The Head of Healthcare should ensure that healthcare staff request full GP records for newly arrived prisoners.

Health and wellbeing team

144. The clinical reviewer noted that, despite the increasing concerns staff had about Mr Hama-Rashid's mental health, he was not seen by a GP or the mental health team during the six weeks he spent at Pentonville. She considered that senior clinicians should have seen Mr Hama-Rashid urgently on 20 and 21 August to assess his mental state and his risk of suicide and self-harm. She was concerned that there was no clear process for officers to contact the mental health team with their concerns about Mr Hama-Rashid's mental health and no standard procedure for officers to contact the primary healthcare team if the mental health team could not be reached.

145. The clinical reviewer also found that although the health and wellbeing team were closely involved with Mr Hama-Rashid and included staff from the mental health in-reach team, they were not effective in providing him with a prompt GP or mental health review. We make the following recommendation:

The Head of Healthcare should ensure that:

- **there is a clear procedure for prison staff to contact the mental health team, including a system for escalating concerns promptly when the mental health team is unavailable; and**
- **there is a clear escalation procedure in place when a prisoner is repeatedly referred to the health and wellbeing team and their risk of suicide has increased.**

Mental health self-referral tools

146. The clinical reviewer found that although healthcare staff sent Mr Hama-Rashid questionnaires (PHQ9 and GAD 7) designed to identify the severity of depression and anxiety on 16 July, the health and wellbeing team did not read the completed forms until 5 August and even then, staff did not refer Mr Hama-Rashid for a GP or other clinical review. She said that while the health and wellbeing team had a risk assessment tool to help them identify patients at risk of suicide, it was unclear if it provided sufficient guidance to assess prisoners consistently.

147. The clinical reviewer concluded that the management of Mr Hama-Rashid's mood disturbance and possible depression did not comply with guidance from the National Institute for Health and Care Excellence (NICE). She found that the clinical assessment of Mr Hama-Rashid, a man who was in prison for the first time and who clearly stated he was struggling to cope, was insufficient to meet his needs and address his risks. We make the following recommendation:

The Head of the Health and Wellbeing Team and the Head of Healthcare should ensure that healthcare staff review completed PHQ9 and GAD7 forms within twenty-four hours of receipt and address concerns raised promptly and appropriately.

Access to a prison GP

148. Mr Hama-Rashid repeatedly asked to see a doctor and the clinical reviewer considered that his presentation indicated that he should have been seen. She noted that at Pentonville a primary care nurse must first assess whether a referral to a GP is appropriate, and that this delays appointments. Although the clinical reviewer was unable to establish the waiting time for a GP referral triage, she established that the average waiting time for a routine GP appointment at Pentonville was three and a half weeks. We are concerned that the health and wellbeing team were not able to refer Mr Hama-Rashid directly to a GP at their daily meetings. We make the following recommendation:

The Head of Healthcare should ensure that:

- **there is sufficient GP availability to meet the demand for urgent appointments; and**

- **that the health and wellbeing team can directly and promptly refer a prisoner to a GP.**

Family liaison

149. On 21 August, after Mr Hama-Rashid had been taken to hospital, a family liaison officer was appointed. As Mr Hama-Rashid had provided no next of kin details, she made efforts through the police and his solicitor to identify one. These attempts were unsuccessful.

150. On 23 August, two days after Mr Hama-Rashid had been admitted to hospital, his ex-partner telephoned the safer custody department to say she was concerned about him because she had not heard from him for a few days. We are concerned that safer custody staff did not follow this up. We were told that this was an administrative error which the prison had already identified.

151. The family liaison officer did not learn about this call until 28 August. As a result, she was not able to make contact with Mr Hama-Rashid's ex-partner until after his death, and she was, therefore, unable to visit him in hospital before he died.

152. While we appreciate that Mr Hama-Rashid had not identified a next of kin, we are concerned that it took five days for his ex-partner to be identified, given her telephone call to safer custody. We recommend:

    The Governor should ensure that safer custody staff respond promptly to calls about prisoners' wellbeing and share information with wing staff or FLOs.

Learning lessons

153. We have identified a significant number of concerns in this report. We consider it is important that staff learn from our findings. We recommend:

    The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest Verdict

154. The Inquest hearing into the death of Mr Hama-Rashid concluded on 17 April 2023. It confirmed that the medical cause of Mr Hama-Rashid's death was partial suspension. It concluded, in a narrative verdict, that Mr Hama-Rashid's death was as a result of suicide, following a number of causative failures and other contributory factors where the impact was less clear.

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