

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ahsan Hassan, a prisoner at HMP Highpoint, on 20 February 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100



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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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 Ahsan Hassan was found hanging in his cell at HMP Highpoint on 20 February 2022. He was 33 years old. I offer my condolences to Mr Hassan's family and friends.

Mr Hassan had a history of self-harm. Between June and October 2021, he was supported by Prison Service suicide and self-harm prevention procedures (known as ACCT). However, by the time Mr Hassan was moved to Highpoint in November 2021, he seemed more settled and during his three months there, gave staff no indication that he was at risk of suicide or self-harm. I am satisfied that staff at Highpoint could not have prevented Mr Hassan's death.

I am concerned about the delay in going into Mr Hassan's cell on the evening he was found hanging. Staff did not respond appropriately when they found that Mr Hassan had covered his observation panel which resulted in a five-minute delay before they entered the cell. We cannot say whether the delay affected the outcome for Mr Hassan, but we know that in a medical emergency, a delay of a few minutes may be critical.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

September 2022

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Summary

Events

1. Mr Ahsan Hassan was sentenced to life imprisonment for murder in April 2017.
2. During 2021, Mr Hassan harmed himself by cutting. Between June and October 2021, he was supported using suicide and self-harm prevention procedures (known as ACCT). He was also assessed by a psychiatrist, but they diagnosed no enduring mental illness.
3. Mr Hassan was moved to HMP Highpoint on 25 November 2021. He seemed more settled and there were no incidents of self-harm.
4. On the morning of 20 February 2022, Mr Hassan telephoned his partner three times. He spoke about dying and said it would be the last time he spoke to her. (Although all calls are recorded, calls are not routinely monitored so staff were unaware of the content of these conversations until after Mr Hassan's death.)
5. At 8.18pm, during the evening roll check, an operational support grade (OSG) saw that Mr Hassan had covered the observation panel on his cell door. The OSG knocked on the door and shouted to Mr Hassan but got no response. He carried on checking around 30 other cells before telling an officer, who went to Mr Hassan's cell. After also getting no response, the officer collected the inundation point key from the office and opened the inundation point on Mr Hassan's cell door. He saw that Mr Hassan was hanging and called a medical emergency code at 8.23pm.
6. The officer and OSG entered the cell, cut Mr Hassan down and started CPR. Other staff responded to the code and assisted with resuscitation attempts. Ambulance paramedics arrived at Mr Hassan's cell at 8.43pm but resuscitation attempts were unsuccessful, and they pronounced his death at 9.06pm.

Findings

7. Mr Hassan gave no indication to staff at Highpoint that he was at risk of suicide or self-harm. We are satisfied that they could not have prevented his death.
8. The clinical reviewer found that Mr Hassan's clinical care was equivalent to that which he could have expected to receive in the community.
9. The OSG should have reported the covered observation panel straightaway once he failed to get any response from Mr Hassan. There was an unacceptable delay in entering Mr Hassan's cell. We cannot say whether the delay affected the outcome for Mr Hassan but we know that in a medical emergency, a delay of a few minutes may be critical.

Recommendations

- The Governor should ensure that staff are aware of, and follow, the Local Security Instructions for Security at Night, and immediately report covered cell door observation panels.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Highpoint informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Hassan's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Hassan's clinical care at the prison.
13. The investigator and clinical reviewer jointly interviewed nine members of staff on 22, 23 and 28 March. Due to coronavirus restrictions, the interviews were conducted by telephone or video.
14. We informed HM Coroner for Suffolk of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Hassan's next of kin, to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond. They have not been sent a copy of the initial or final report.

Background Information

HMP Highpoint

16. HMP Highpoint is a Category C prison in Suffolk, holding up to 1,319 men across two sites (North and South). Health Practice Plus Group, Health and Rehabilitation Services have been providing general and mental health services at Highpoint since October 2021.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Highpoint was in August 2019. Inspectors reported excellent staff and prisoner relationships and decent living conditions. Inspectors noted self-harm had increased among prisoners but it was still lower than other Category C prisons. Inspectors noted that the quality of mental health care was good for prisoners in crisis.
18. Inspectors noted that there had been three deaths since their last inspection. They said that the Prisons and Probation Ombudsman's recommendations were taken seriously, and the prison had ensured lessons were learned.

Independent Monitoring Board

19. 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 December 2021, the IMB reported a decrease in self-harm and suicide monitoring. They noted that the prison tried to maintain support systems for vulnerable prisoners, despite COVID-19 restrictions.
20. Some prisoners had become frustrated because of restrictions that COVID-19 put on their regime but the Governor had kept all prisoners fully informed and updated.

Previous deaths at HMP Highpoint

21. Mr Hassan was the third prisoner to die at Highpoint since February 2020. The previous two deaths were from natural causes. There are no similarities between Mr Hassan's death and the previous deaths.

Assessment, Care in Custody and Teamwork

22. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. In April 2017, Mr Ahsan Hassan was sentenced to life imprisonment for murder, with a tariff of 24 years.
24. On 19 June 2021, while at HMP The Mount, Mr Hassan cut his wrists. He told staff he had been bullied by other prisoners. Staff started suicide and self-harm monitoring (known as ACCT) which they continued until 12 July.
25. On 11 September, staff started ACCT monitoring again because Mr Hassan threatened to cut his throat. He was anxious that a transfer to another prison had been delayed due to COVID-19 restrictions. Mr Hassan was also upset that he was sharing a cell and that it had affected his prayers, which helped to calm him. Mr Hassan asked to be transferred to HMP Highpoint, HMP Coldingley or HMP Huntercombe. Mr Hassan was moved to a single cell and put on a transfer waiting list.
26. Mr Hassan was moved to Coldingley on 20 September, while still subject to ACCT monitoring. On 25 September, Mr Hassan scored the name of his deceased partner (the victim of his offence) into his arm. He told staff he struggled during the day when he was not busy and would think about her. He said he wanted to move to Highpoint as it would be easier for his new partner to visit him there.
27. There were several further incidents of Mr Hassan harming himself with razor blades and he continued to be supported under ACCT procedures until 28 October.
28. Mr Hassan was referred to the mental health team at Coldingley and he had a psychiatric assessment on 6 October. The psychiatrist found no evidence of enduring mental illness and diagnosed mild depression in the context of possible personality disorder. Healthcare staff offered Mr Hassan a low dose of antidepressants but he declined. He was discharged from the mental health team but remained under the care of psychology services.

HMP Highpoint

29. Mr Hassan was moved to HMP Highpoint on 25 November. The next day, a nurse referred him to the mental health team.
30. A nurse saw Mr Hassan in his cell the next day. He complained of shoulder and knuckle pain and asked for pain relief. The nurse referred him to the prison's physiotherapist and the GP clinic.
31. A nurse met Mr Hassan on 8 December, following his mental health referral. The nurse noted in Mr Hassan's medical record that he was at low risk of self-harm and needed no mental health input at this stage but was advised how to access help if he needed it. Mr Hassan said that although his partner could visit him, he was unhappy with the restricted COVID-19 regime at the prison and did not want to be at Highpoint, despite applying to move there.
32. On 17 December, a prison GP examined Mr Hassan. He diagnosed rotator cuff syndrome (injury to the muscles and tendons that surround the shoulder joint) and

suggested that Mr Hassan should have a steroid injection, which he accepted. Mr Hassan asked for co-codamol painkillers. The prison GP told him that this was unnecessary and prescribed paracetamol.

33. A prison paramedic saw Mr Hassan on 2 January 2022, as he had complained of chest pain. The prison paramedic carried out a full set of observations and an ECG (a test to check the heart's rhythm). The ECG was normal, and Mr Hassan showed no signs of having had a heart attack, although he seemed a little anxious. Mr Hassan told the prison paramedic that he was worried about needing another steroid injection in his shoulder, which he did not want. He gave Mr Hassan some paracetamol and ibuprofen.
34. Mr Hassan tested positive for COVID-19 on 12 January and was put in isolation. On 5 February, he was moved to a single cell on Unit 14.
35. Mr Hassan's last recorded interaction with a member of healthcare staff was on 11 February. Mr Hassan complained of dry skin on his right foot and asked about being referred to the hospital for his neck and shoulder problems. He said a prison GP had recommended a steroid injection but he did not want one.
36. On 13 February, an officer noted in Mr Hassan's prison record that he had settled in well on Unit 14, got on well with staff and prisoners but was not employed at that point. On 14 February, Mr Hassan was granted a one-pound emergency telephone credit, as his had run out.

Events of 20 February

37. Mr Hassan made three telephone calls to his partner on 20 February, at 4.47am, 5.32am and 6.15am, which lasted 48 minutes in total. Mr Hassan told his partner that it would be the last time he would speak to her and that he had to leave this life as he was not a good person. He said he was not eating or sleeping and was suffering. He told his partner that he loved her and would take her love with him. Mr Hassan said that he was tired of their arguments and did not want to live anymore, not because they had broken up, but because he had "never wanted to live". Neither Mr Hassan nor his partner passed on this information to anyone at Highpoint.
38. An officer carried out a roll check at approximately 5.30pm, after prisoners had collected their meals and been locked in their cells for the night. She checked each prisoner was in their cell and reported no issues.
39. An Operational Support Grade (OSG) started his night shift at around 8.15pm. After a handover from day staff, the OSG started his roll check. CCTV footage shows that the OSG reached Mr Hassan's cell at 8.18pm. Mr Hassan had covered the observation panel on his cell door. The OSG knocked and shouted through the door but could not get a response from Mr Hassan.
40. The OSG checked approximately 30 more cells before he told an officer that he had been unable to get a response from Mr Hassan. CCTV footage shows that the officer arrived at Mr Hassan's cell at 8.22pm. He got no response, so collected the cell inundation key from the office and removed the door's inundation point. The officer looked through and saw that Mr Hassan was hanging from a light fitting.

41. The officer radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) at 8.23pm, and then he and the OSG went into the cell. Mr Hassan had barricaded the door with furniture and clothes, hindering their entry until 8.24pm. Once inside the cell, the OSG lifted Mr Hassan to relieve the pressure on him, and the officer cut the ligature (a bedsheet). The cell was covered in blood as Mr Hassan had cut his wrists. Once Mr Hassan was laid on the floor, the OSG started chest compressions. The officer radioed that he needed an ambulance and a Custodial Manager (CM), the Night Orderly Officer, said that the communications room was on the telephone to them.
42. Two other officers heard the code blue call and went to Unit 14 immediately to assist the officer and the OSG. CCTV footage showed this at 8.24pm and 8.25pm respectively. An officer took over chest compressions from the OSG. An officer touched Mr Hassan's hands and forehead and noted that he felt slightly warm. She attached a defibrillator to Mr Hassan's chest, which instructed to continue chest compressions. The officer continued administering chest compressions. Ambulance staff were on the telephone to the communications room who relayed that someone should start mouth-to-mouth rescue breaths. The officer started these and continued until paramedics arrived at Mr Hassan's cell at 8.43pm. Paramedics pronounced Mr Hassan's death at 9.06pm.
43. Police recovered a disposable razor blade from Mr Hassan's cell. The blades had been removed and were found in a pool of blood.
44. Mr Hassan left some notes in his cell: one entitled "Last suicide note", another dated 20 February, and an unsent letter to his friend.

Contact with Mr Hassan's family

45. An officer was appointed as family liaison officer. She telephoned Mr Hassan's nominated next of kin, his partner, in the early hours of 21 February, but got no answer. She telephoned again at 7.55am and broke the news of Mr Hassan's death. The next of kin subsequently asked for another friend to be appointed as Mr Hassan's next of kin.
46. The prison contributed to the cost of Mr Hassan's funeral, in line with national instructions.

Support for prisoners and staff

47. After Mr Hassan's death, a CM 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.
48. The prison posted notices informing other prisoners of Mr Hassan'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 Hassan's death.

Post-mortem report

49. Mr Hassan's post-mortem report concluded that he died from hanging.

Findings

Assessment of Mr Hassan's risk of suicide and self-harm

50. Mr Hassan harmed himself by cutting while he was at The Mount and at Coldingley and during June/July 2021 and September/October 2021, staff supported him using ACCT procedures. However, Mr Hassan appeared more settled by the time he was moved to Highpoint in November and during his three months there, he gave staff no indication that he was at risk of suicide or self-harm.
51. Staff were unaware of the contents of Mr Hassan's telephone conversations on the morning of 20 February as they had no reason to monitor his calls. We are satisfied that staff at Highpoint could not have reasonably prevented Mr Hassan's death in the circumstances.

Clinical care

52. The clinical reviewer concluded that the mental and physical health care that Mr Hassan received at Highpoint was equivalent to that which he could have expected to receive in the community.

Emergency response Inquest

53. Highpoint has Local Security Instructions for Security at Night, dated March 2021, which say, "Where observation panels are covered, the NOO [Night Orderly Officer] should be informed immediately and staff deployed to the cell". The OSG who carried out the evening roll check on 20 February, did not inform the Night Orderly Officer when he found that Mr Hassan had covered his observation panel. He carried on with his checks before telling an officer. When interviewed, he told the investigator that he finished the roll check in case another prisoner had also blocked their observation panel and they could be dealt with together. We consider that this was not in line with Highpoint's policy.
54. There was a delay of over five minutes before staff entered Mr Hassan's cell. We cannot say whether the delay affected the outcome for Mr Hassan but we know that in a medical emergency, a delay of a few minutes may be critical. It is important that staff follow the correct procedures when they find a prisoner has covered their observation panel and they are unable to get a response. We recommend:
55. **The Governor should ensure that staff are aware of, and follow, the Local Security Instructions for Security at Night, and immediately report covered cell door observation panels**

Inquest

56. The inquest into Mr Hassan's death concluded he died by suicide.

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