Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Syed Rahman, a prisoner at HMP Forest Bank, on 8 June 2021

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

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 Syed Rahman was found on his cell floor at HMP Forest Bank on 6 June 2021 with a plastic bag over his head. He was resuscitated but subsequently died from hypoxic ischaemic brain damage on 8 June, having never regained consciousness. He was 38 years old. I offer my condolences to Mr Rahman's family and friends.

Mr Rahman was remanded to Forest Bank on 14 May and his probation officer emailed the prison expressing concerns for his safety. Mr Rahman was seen with a ligature around his neck two days later and staff started suicide and self-harm prevention procedures (known as ACCT). A few days later, Mr Rahman fractured his heels after jumping from one landing to the landing below.

I am concerned that ACCT procedures were not started when Mr Rahman first arrived at Forest Bank. I am also concerned that his level of risk was not reviewed in response to his erratic behaviour on 5 and 6 June. I am especially concerned that he was left alone with an unperforated plastic clinical waste bag which he used to harm himself.

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 **January 2023**

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Summary

Events

1. On 14 May 2021, Mr Syed Rahman was remanded to HMP Forest Bank, charged with assault. Before his arrival, Mr Rahman's probation officer emailed the prison, attaching a copy of a mental health assessment made while Mr Rahman was in police custody and asking for him to be monitored closely for his mental health needs and risk of self-harm.

2. A nurse completed an initial health assessment but did not see the probation officer's email. She noted that Mr Rahman had no present thoughts of suicide or self-harm and that he appeared in a good mood. She did not start suicide and self-harm prevention procedures (known as ACCT).

3. On 16 May, Mr Rahman was seen with a ligature around his neck. He said that he had heard voices telling him to take his life. Staff started ACCT procedures.

4. On 21 May, Mr Rahman jumped from a prison landing to the landing below. He was sent to hospital, where he was found to have fractured both of his heels. He remained in hospital until the evening of 25 May when he returned to Forest Bank and was moved to the prison's healthcare unit.

5. At an ACCT review on 26 May, Mr Rahman's risk of suicide or self-harm was deemed to be low, and his observations were set at one an hour. The next day, his day-time observations were reduced to one every two hours.

6. On 5 June, Mr Rahman began behaving in an erratic manner, including shouting, and smashing a Zimmer frame against his cell door. When an officer went into his cell, Mr Rahman wrapped his arms around the officer's legs and the officer had to prise off his arms.

7. On the morning of 6 June, Mr Rahman began making squeaking noises and he rubbed faeces on his body. No adjustment was made to his level of observations, although CCTV footage shows that the officer on duty made more frequent checks on him than the scheduled number. In the early afternoon, Mr Rahman apologised and asked for cleaning materials. The officer gave him some cleaning materials, including a clinical waste bag. At 4.55pm, the officer gave Mr Rahman another clinical waste bag because he had also soiled his bedding.

8. When the officer checked Mr Rahman again at 5.38pm, she saw him lying on the cell floor, with the clinical waste bag over his head. The officer radioed a medical emergency code and went into the cell. The officer began cardiopulmonary resuscitation (CPR). Nurses arrived and took over his care. Paramedics arrived at 5.57pm and established a pulse. Mr Rahman was taken to hospital and placed in intensive care. He died in hospital on 8 June.

9. Mr Rahman's cause of death was given as hypoxic ischaemic brain damage.

Findings

10. We consider that there was sufficient information available, particularly the concerns expressed by Mr Rahman's probation officer, for staff to have started ACCT procedures on 14 May.

11. Staff should have formally reviewed Mr Rahman's level of risk on 5 and 6 June when he began displaying unusual behaviour, but they did not do so.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, and in particular that reception staff should:
  - be provided with all information about a prisoner's risk factors, including any information sent to the prison by external partners such as probation staff;
  - have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm;
  - examine all relevant information that arrives with a prisoner;
  - identify a prisoner's risk factors and assess their risk based on their risk factors and not solely their personal presentation; and
  - document the risk information considered and the reasons for not starting ACCT procedures.
- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national and local instructions, including that:
  - staff review a prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk; and
  - all staff are aware of the local instruction on the issue to prisoners of unperforated plastic bags.
- The Head of Healthcare should ensure that staff complete an appropriate risk assessment following significant events of self-harm or other incidents of unusual and concerning behaviour.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Rahman's prison and medical records. She watched CCTV footage from 1.03pm on 5 June to 6.28pm on 6 June. She interviewed seven members of staff in September 2021. The interviews were conducted by video-link and telephone due to the COVID-19 pandemic. The investigation was subsequently transferred to one of the investigator's colleagues. He interviewed two further witnesses by telephone.

14. NHS England commissioned a clinical reviewer to review Mr Rahman's clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical staff.

15. We informed HM Coroner for Greater Manchester West District of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Rahman's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Rahman's brother asked:

    - Why was his brother sent to prison when he had clear mental health problems?
    - What did the prison know about his mental health problems and what assessments were made to safeguard him?
    - Was his brother on suicide watch?
    - How often was his brother being checked?
    - Why was he left alone for half-an-hour with a plastic bag?
    - Is there any CCTV footage?
    - Why was the family not informed until 7 June that his brother had been sent to hospital?
    - Why was the severity of his brother's condition not made clear to him when he spoke to the prison's family liaison officer on 7 June and what did the prison do to verify his identity?
    - Why did the prison FLO use insensitive language when communicating with the family?

    We have answered Mr Rahman's brother's questions in this report and in separate correspondence.

Background Information

HMP Forest Bank

17. HMP Forest Bank is a local prison in Salford, serving courts in north-west England. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services, who also provide primary health care services and psychosocial substance misuse care.

18. In August 2021, the Ministry of Justice issued Forest Bank a 45-day improvement notice for immediate actions needed to address safety concerns at the prison. None of the concerns were directly relevant to the circumstances of Mr Rahman's death.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) most recently inspected Forest Bank in February 2022. HMIP noted that HM Prison and Probation Service (HMPPS) had issued the prison a formal rectification notice in late 2021 due to concerns for safety and living conditions for prisoners highlighted by HMIP following their previous inspection in 2019. HMIP noted that Sodexo, who manage Forest Bank, had responded quickly and positively to the rectification notice. HMIP noted that the recorded level of self-harm had reduced by 20% since the 2019 inspection and levels were then similar to other comparable prisons. HMIP noted that 71% of prisoners responding to the prisoner survey said staff treated them with respect, although HMIP noted that there were not always enough officers on the units to interact with prisoners or to challenge poor behaviour. HMIP noted that the revised ACCT process for managing prisoners at risk or suicide or self-harm was not well managed: staff did not have easy access to ACCT folders and care maps were weak. HMIP noted that 66% of prisoners reported that they had mental health problems. HMIP found that mental health provision overall was reasonable, despite lengthy delays before prisoners received their initial mental health assessment. HMIP noted that the mental health team had devised a bespoke three-hour training programme for new officers.

Independent Monitoring Board

20. 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 October 2021, the IMB noted that the ongoing effect of the COVID-19 pandemic had continued to affect the prison and efforts to address and control spread of the virus might have concentrated resources away from other areas.

Previous deaths at HMP Forest Bank

21. Mr Rahman was the seventh prisoner to die at Forest Bank since April 2019. Of the previous deaths, one was self-inflicted, three were from natural causes, one was drug-related, and one cause of death was unascertained.

22. In our investigation into a self-inflicted death at Forest Bank in September 2019, we found that staff did not take account of all the information about the prisoner's risk of suicide or self-harm but placed too much emphasis on his presentation. In the same case, we found that staff did not immediately request an ambulance when an emergency code was called. The prison is in the process of responding to our concerns.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. On 14 May 2021, Mr Syed Rahman was remanded to HMP Forest Bank, charged with robbery. He had previously been released from Forest Bank on 30 December 2020, after serving a six-week sentence for assault and harassment of his wife. During his previous sentence, Mr Rahman had been supported through Prison Service suicide and self-harm monitoring procedures (known as ACCT).

25. Mr Rahman's probation officer emailed Forest Bank before his arrival to ask for an ACCT to be opened and for Mr Rahman to be monitored very closely because of his mental health and risk of self-harm. She included in her email information from a mental health assessment following Mr Rahman's arrest, including that he had spoken of fleeting thoughts of suicide and that he had had such thoughts for a number of years. The assessment also recorded that Mr Rahman had been diagnosed with Emotionally Unstable Personality Disorder although he had presented in a calm manner when assessed in police custody on 13 May, and that he had denied any present thoughts of suicide or self-harm. Mr Rahman's Person Escort Record (PER) contained a warning that he had taken an overdose on 1 April. (A PER is used to convey relevant information when a person is transferred from one custodial setting to another.)

26. When he arrived at Forest Bank, a nurse saw Mr Rahman for his reception health screen. She noted that he had harmed himself in the past and that she had received a telephone call from the court Liaison and Diversion nurse to say that an ACCT document should be opened for him. She also noted that Mr Rahman had had a mental health assessment the previous day and had been deemed fit for detention. In her own assessment, she noted that while Mr Rahman had harmed himself or attempted suicide in the previous 12 months, he had no current thoughts of suicide or self-harm. She noted that he was in a happy mood and was dancing in the reception area. She did not start ACCT monitoring for Mr Rahman. She told the investigator that it was common for the court Liaison and Diversion nurse to contact the reception nurse with concerns so it would not be routine to start ACCT procedures based only on the receipt of such a call. She also said that reception nurses did not usually have the time to read previous entries in a prisoner's medical record, so she had not seen the email from Mr Rahman's probation officer.

27. Mr Rahman was prescribed aripiprazole (for symptoms of psychosis), epilim chrono (for epilepsy and mood fluctuations) and propranolol (a beta blocker used for symptoms of anxiety).

28. In the late morning of 16 May, staff opened an ACCT document for Mr Rahman because they saw him in his cell with a ligature around his neck, which he had made from shoelaces. Mr Rahman said that he heard voices in his head telling him to take his life.

29. A Prison Custody Officer (PCO) saw Mr Rahman for an ACCT assessment interview. Mr Rahman repeated what he had said earlier about hearing voices and said that it was now too much for him, he was confused, and he wanted to die. He said that he had a long history of self-harm and had a strained relationship with his family. The PCO noted that Mr Rahman walked in and out of the interview several times.

30. At 1.30pm, a Senior Prison Custody Officer (SPCO), the first SPCO, chaired an ACCT case review. Mr Rahman, a PCO and a mental health nurse also attended the review. The SPCO noted that Mr Rahman did not engage well and twice walked out of the room. She assessed that Mr Rahman's level of risk was raised and that he should be observed three times an hour. She arranged for him to have another ACCT case review the following day.

31. On 17 May, a different SPCO, the second SPCO, chaired the ACCT case review and noted that Mr Rahman's presentation was much improved. She noted that he engaged well and that he said he felt better and had recovered from the previous day's "episode". He said that he had no current plans of suicide or self-harm. A mental health nurse who attended the review noted that Mr Rahman said that he had a diagnosis of bipolar disorder and that he regularly heard voices, but the strength of the voices varied. The second SPCO reduced Mr Rahman's observations to two each hour.

32. At just after 10.00am on 19 May, Mr Rahman collapsed on the exercise yard. Officers radioed a code blue medical emergency (indicating a prisoner is unconscious or has breathing difficulties) and a nurse responded. Mr Rahman told her that he had not collapsed and that he wanted his afternoon medication early. She told Mr Rahman that he could not have his medication early. She also noted that his clinical observations were normal and that he did not need any treatment.

33. Around 20 minutes later, officers saw that Mr Rahman had used a pen to make a wound to his wrist. The nurse saw him again. She noted that he had a superficial puncture wound, which was not bleeding. She washed the wound but there was no need for a dressing. The second SPCO noted that Mr Rahman was already being supported by ACCT procedures and that there was no need to adjust his level of observations from two each hour.

34. At 9.00am on 20 May, the second SPCO chaired Mr Rahman's next ACCT case review and a nurse attended. The second SPCO noted that Mr Rahman engaged well at the beginning of the review but became upset when they told him that he would remain in prison on remand until 11 June: Mr Rahman seemed to believe that he was due to be released from prison on 20 May. She noted that Mr Rahman's level of risk remained raised, and she kept his observations at two an hour. She scheduled a further ACCT case review for 21 May.

35. At around 10.30am, Mr Rahman harmed himself by cutting his forearm. A nurse examined him and noted that it was a small superficial cut. Mr Rahman said that he wanted a vape and the nurse advised him that cutting himself was not the correct way to get things he might want. The nurse sent a task for Mr Rahman to be reviewed by the prison's mental health team who arranged to assess him the following day.

36. In the afternoon, Mr Rahman smashed his television and said that he had hit it on his head. A nurse noted that he had no head wound, although he did have a red mark on his forehead.

37. On the morning of 21 May, Mr Rahman jumped from the second landing to the floor below. CCTV footage showed that Mr Rahman landed on his feet and rolled onto his side. A nurse responded and noted that while he was alert, she was unable to take clinical observations because he was writhing in pain. He told her that he had

heard voices telling him to harm himself. Mr Rahman was sent to hospital, where he was found to have fractured both of his heels.

38. Mr Rahman returned to Forest Bank in the early evening of 25 May and was moved to the observation cell in the prison's healthcare unit. The observation cell had two large Perspex windows. It was also fitted with two cameras so that the prisoner in the cell could be monitored from the wing office several feet away. Mr Rahman's observations were set at two an hour.

39. Mr Rahman's next ACCT case review was on the morning of 26 May. A third SPCO chaired the review and Mr Rahman, a nurse and the duty manager also attended. The third SPCO noted that Mr Rahman was very calm and talkative. He said that he still heard voices telling him to do things. He also noted that Mr Rahman was evasive when the nurse challenged him about his symptoms and why he had jumped off the prison landing. The third SPCO assessed that Mr Rahman's risk was low and he reduced his observations to one an hour although he also decided that he should remain in the observation cell. He arranged for Mr Rahman to have another ACCT case review the following day.

40. The nurse made an entry in Mr Rahman's medical record to say that he denied having suicidal ideation or current plans to harm himself and that he was displaying no evidence of hopelessness. He also noted that that when Mr Rahman was questioned about the nature of the voices he was hearing, he became evasive, asked to end the review, and put his head beneath his pillow.

41. The nurse told the investigator that it was clear from Mr Rahman's first ACCT case review on 16 May that he was going to be difficult to assess. He said that whenever Mr Rahman was pushed for clarification of his symptoms and of the voices he was hearing, he would say that it was too stressful, and he would leave the room. However, on returning to the room ten or so minutes later, he would pick up the conversation exactly where he had left it. He said that this was a constant pattern at Mr Rahman's ACCT case reviews. He said that he did not consider Mr Rahman to be cognitively impaired and did not believe that Mr Rahman was hearing voices or was mentally distracted during ACCT reviews.

42. On 27 May, the third SPCO chaired the next ACCT case review and Mr Rahman and a nurse also attended. The third SPCO noted that Mr Rahman apologised for "his recent irritable behaviour". He said that he had no plans of suicide or self-harm and he asked to return to his previous prison wing. The third SPCO told Mr Rahman that he would need to remain in the healthcare unit until his health stabilised. He noted that Mr Rahman's level of risk was low, and he reduced observations to one every two hours, with hourly observations overnight. He scheduled the next ACCT review for 3 June.

43. After the review, staff gave Mr Rahman a radio, but the nurse noted that he returned the radio to staff within an hour because of "the voices".

44. On 1 June, staff moved Mr Rahman from the observation cell to a standard healthcare cell.

45. On the morning of 3 June, a prison psychiatrist went to see Mr Rahman. The psychiatrist noted that Mr Rahman reported hearing voices which dated back to 2014 when he said that he had been kidnapped. Mr Rahman said that the voices

compelled him to follow instructions, including an instruction to eat his own excrement. He also said that he had been told that he had special powers. The psychiatrist noted that there was evidence that Mr Rahman's reports were not psychotically driven but instead appeared to have an emotional basis that needed exploration. He noted that he needed to discuss Mr Rahman's treatment with the prison's mental health team the following week. Healthcare staff recorded a separate entry in Mr Rahman's clinical record and noted that the mental health team would continue to review him.

46. On the afternoon of 3 June, the third SPCO chaired Mr Rahman's ACCT case review and a nurse also attended. The third SPCO noted that Mr Rahman was calm and relaxed, and he said he was happy to be in the healthcare unit. He said that he still had thoughts of self-harm but had had no such thoughts that day. The third SPCO assessed Mr Rahman's risk as low and kept the observations at one every two hours. He scheduled the next ACCT case review for 10 June.

47. The third SPCO told the investigator that he did not work on weekends, and he was shocked when he heard on the following Sunday that Mr Rahman had seriously harmed himself. He said that if he had had concerns about Mr Rahman's risk, he would have raised his level of observations.

Events of 5 June (Saturday)

48. A mental health nurse told the investigator that she visited Mr Rahman on the morning of 5 June when he said that he needed to see a nurse and needed extra medication for his mental health needs. He then turned to his side and began talking in a language she did not understand. He turned back to her and spoke in English and then repeated this behaviour several times. In her medical record entry, the nurse wrote that Mr Rahman was talking to unknown stimuli but at interview with the investigator, she said that Mr Rahman did not present in a way that suggested he was being disturbed by psychotic phenomena as he seemed very controlled.

49. A PCO told the investigator that he found it difficult to describe Mr Rahman because one minute he would be aggressive, and soon afterwards, he would say that he could not remember what he had done earlier but felt that he needed to apologise. However, Mr Rahman was consistent in saying that he did not believe that he should be in prison and that he needed to go home. The PCO said that there had also been times when staff found him lying on his cell floor, covered by his mattress.

50. At around 3.45pm, the PCO responded to a banging noise and found that Mr Rahman was hitting his cell door observation panel with the Zimmer frame he had been given to help him move around. He was shouting that he wanted to go home. The PCO went into the cell and removed the Zimmer frame. A nurse had also responded to the sound of banging, and she had stood at the cell door while the PCO dealt with Mr Rahman. Mr Rahman then jumped at him, wrapped his arms around his legs and would not let go. The PCO said that Mr Rahman was not trying to assault him, so he first tried speaking to him and had then prised Mr Rahman's arms off his legs. He moved Mr Rahman to his bed and Mr Rahman tried to grab hold of his key chain. The nurse asked the PCO if she should call for response officers, but he said that that was not necessary. The PCO told Mr Rahman to stay

on his bed as otherwise, he would have to use force. He had then walked backwards out of the cell and relocked the door.

51. The PCO raised Mr Rahman's security risk for two officers to be present whenever his cell was unlocked. He said that Mr Rahman later apologised for what he had done. There were no further issues with him that day.

Events of 6 June (Sunday)

52. On 6 June, a PCO (the first PCO) went to see Mr Rahman after the visiting the chaplain told her that he was lying on his cell floor and playing with the water in his toilet bowl. Mr Rahman said that he wanted to use the shower, but she told him that she was the only officer on duty in the healthcare unit that day and as his cell could only be unlocked if two officers were present, she would have to try to arrange for another officer to help later that day. She made entries in Mr Rahman's ACCT document at 9.30am and 11.00am about Mr Rahman's requests for a shower.

53. In the early afternoon, the first PCO noted that Mr Rahman was smearing faeces on his body and was making strange noises. A nurse came to speak to him.

54. A CCTV recording shows that the nurse spoke to Mr Rahman at 1.38pm and was also at or near his door from 1.55pm to 2.01pm. She made an entry in his medical record to say that he had been rolling on his cell floor and had rubbed faeces on his face and chest and had also made it appear that he was eating his faeces. He had also hidden beneath his mattress while speaking in a squeak-like voice but then resumed speaking in a normal manner. He said he needed more medication and needed to be admitted to hospital. She told him that the psychiatrist would make those decisions. She told the investigator that Mr Rahman made good eye contact and spoke to her without distraction. She noted that he said he had no recollection of his earlier behaviour and when she told him that he had been playing with faeces, he "sounded unconvincingly shocked".

55. The first PCO told the investigator that during the afternoon, Mr Rahman rang his cell bell and he apologised and said that he wanted to clean himself. She told him that he would have to clean himself in his cell and she passed him soap, shampoo, clean clothing and a plastic bag for his soiled clothes. She then realised that the soiled clothing would have to go into a clinical waste bag (also plastic) so she gave him one of those too. At 3.54pm, Mr Rahman gave her a bag with his soiled clothing. CCTV footage shows that she gave Mr Rahman another plastic clinical waste bag at 4.55pm because he needed an extra bag for his bedding.

56. At 5.38pm, the first PCO checked Mr Rahman during a roll check and saw him on his cell floor. She called his name several times, but he did not respond. She went into the cell and saw that Mr Rahman had placed a clinical waste bag over his head. She removed the bag, radioed a medical emergency code blue and began CPR.

57. A nurse responded and noted that the fist PCO was performing CPR. She checked on Mr Rahman and noted that he had no pulse, although he was warm. She took over CPR and other nurses arrived. The nurses gave Mr Rahman oxygen and continued giving CPR. They also checked him with a defibrillator which advised that no electric shock should be given.

58. At around 5.57pm, ambulance paramedics arrived and gave Mr Rahman adrenalin. At around 6.10pm, the paramedics establish a pulse and Mr Rahman was taken to hospital. He was not restrained

59. Mr Rahman remained in intensive care in hospital until he died at just after 6.00am on 8 June.

Contact with Mr Rahman's family

60. Forest Bank appointed a family liaison officer (FLO). The FLO had finished work for the day by the time that Mr Rahman had been sent to hospital on 6 June. The FO on duty was asked to make immediate contact with the family. He noted that Mr Rahman was restricted from contacting his wife, but he sourced a mobile telephone number for Mr Rahman's mother. At 8.17pm, he noted that he had made numerous unanswered calls to Mr Rahman's mother and had left voicemail messages for the family to contact him. He also noted that it sounded as though his calls were being transferred overseas.

61. On the morning of 7 June, the appointed FLO resumed efforts to contact Mr Rahman's family. She made an unanswered call to Mr Rahman's mother and left a voicemail message. She also made unsuccessful calls to two numbers that were supposed to belong to Mr Rahman's sister. She than telephoned a friend of Mr Rahman, who told her that Mr Rahman's mother had moved to Bangladesh and that he could not help with any other family contacts. She then obtained another possible number for Mr Rahman's sister and again left a voicemail message.

62. At just before midday on 7 June, the FLO received a call from a person who said that he was Mr Rahman's brother. She asked the caller if he could provide proof of his identity and that she would take advice from her manager on what information she could disclose. She then telephoned the caller, who was subsequently established to be Rahman's brother, to ask if he could come into the prison with proof of identity. Mr Rahman's brother said that he was in London but would come to the prison the next day in the late afternoon.

63. While the FLO was on her way to work at 6.35am on 8 June, she received a message to say that Mr Rahman had died. She telephoned Mr Rahman's brother, but he said that he had already heard the news from the hospital and he was unhappy that that was how he had found out.

64. The prison contributed to the cost of Mr Rahman's funeral in line with national instructions.

Support for prisoners and staff

65. A member of the care team offered support to the staff involved in the response when Mr Rahman was discovered. Support was later offered to the officers who were with Mr Rahman when he died.

66. The prison posted notices informing other prisoners of Mr Rahman's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Rahman's death.

Post-mortem report

67. The pathologist gave Mr Rahman's cause of death as hypoxic ischaemic brain damage.

68. Mr Rahman's toxicology report only detected the drugs that he was prescribed or were used in his treatment.

Findings

Initial assessment of risk

69. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* sets out the procedures for identifying and supporting prisoners at risk of suicide and self-harm. PSI 64/2011 sets out a list of risks and triggers that can increase the risk of suicide and self-harm. It also sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as at risk.

70. Mr Rahman's PER recorded that he had taken an overdose on 1 April. More significantly, his probation officer emailed Forest Bank to ask for an ACCT to be opened and she included a mental health assessment that had been made on 13 May.

71. A nurse noted that she had received a telephone call from the court Liaison and Diversion nurse about the concerns for Mr Rahman but, having noted Mr Rahman's denial of current thoughts of suicide or self-harm and also noting his jovial presentation, she did not start ACCT procedures. She told the investigator that she did not see the earlier entry in Mr Rahman's medical record containing the probation officer's email.

72. In February 2016, we published a Learning Lessons Bulletin which examined self-inflicted deaths of prisoners within the first month of custody. We found that in many instances staff based their assessments on the prisoner's presentation and their statements that they had no thoughts of suicide or self-harm. We noted that known risk factors, such as a history of suicidal behaviour, were often overlooked.

73. We consider that there were sufficient risk factors for staff to start ACCT procedures on Mr Rahman's arrival at Forest Bank on 14 May: his probation officer had emailed her concerns, as had the court Liaison and Diversion nurse and his PER form noted that he had taken an overdose on 1 April. In addition, he had a history of self-harm and had been supported through ACCT during his last time at Forest Bank. Moreover, while Mr Rahman's jovial demeanour on 14 May might have appeared a positive factor, it could also be viewed as potentially concerning for a prisoner to be jovial at prison reception, particularly coupled with the fact that he was dancing in the reception area. We also note that a nurse said that she did not see the probation officer's email as it was not routine practice for reception nurses to read through previous entries in a prisoner's medical record: it would have been helpful had that information been highlighted to her before she met Mr Rahman. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, and in particular that reception staff should:

- **be provided with all information about a prisoner's risk factors, including any information sent to the prison by external partners, such as probation staff;**
- **have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm;**

- **examine all relevant information that arrives with a prisoner;**
- **identify a prisoner's risk factors and assess their risk based on their risk factors and not solely their personal presentation; and**
- **document the risk information considered and the reasons for not starting ACCT procedures.**

Subsequent assessment of risk

74. At Mr Rahman's first ACCT assessment on 17 May his level of risk was deemed to be raised and his observations were set at two per hour. The same judgements were made at the next ACCT review on 20 May.

75. On 21 May, Mr Rahman jumped from the second landing and was sent to hospital for treatment. He returned to Forest Bank on 25 May and at his next ACCT review on 26 May his level of risk was deemed low, and his observations set at one per hour. Mr Rahman continued to be deemed low risk from that time onwards and from 27 May onwards his observations were reduced to once every two hours.

76. While we acknowledge that judgements on a prisoner's level of risk, and the level of observations needed to mitigate that risk, are for the staff directly involved in dealing with the prisoner, we are not confident that Mr Rahman should have been deemed low risk at his first ACCT assessment after his return from hospital.

77. However, we are more concerned about the apparent absence of meaningful reassessment of his risk during 5 and 6 June. Mr Rahman's behaviour on these days included aggressive behaviour, making strange noises, and rolling on his cell floor and smearing himself with faeces. Despite these strange behaviours, no formal adjustment was made to Mr Rahman's set level of observations, although we note that the first PCO made more checks on Mr Rahman during 6 June than were actually required according to his ACCT plan.

78. During the afternoon of 6 June, Mr Rahman apologised to the first PCO for his earlier behaviour and said that he wanted to clean himself. She gave Mr Rahman soap, shampoo and clean clothing. She also gave him a plastic bag for his soiled clothing. She left him alone with the bag which he subsequently filled and returned to her. At 4.55pm, she gave Mr Rahman another plastic bag, which he said he needed for his soiled bedding, but he used it to suffocate himself.

79. Forest Bank had a protocol in place that ensured plastic bags for prisoners' property and prison shop (canteen) purchases were perforated to reduce the risk of suicide and self-harm. However, clinical waste bags were not perforated. Following Mr Rahman's death, Forest Bank introduced a policy specifically advising staff of the need to be mindful of the risks when giving unperforated clinical waste bags to prisoners instructing that prisoners must be supervised until the bag is returned. The policy stresses that the instruction is particularly important in the case of prisoners being managed through ACCT or where an ACCT document has been closed recently.

80. As Mr Rahman was on an open ACCT, we consider that he should not have been left alone when given the clinical waste bags. However, as Forest Bank did not have a policy in place at the time, warning staff of the dangers potentially associated with unperforated plastic bags, our criticism is more directed to the prison, rather than to the first PCO. We make the following recommendation:

The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national and local instructions, including that:

- **staff review a prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk.**
- **all staff are aware of the local instruction on the issue to prisoners of unperforated plastic bags.**

Family liaison

81. Mr Rahman's brother was upset that the severity of his brother's condition was not made clear to him when he contacted Forest Bank on 7 June. He said that he was travelling to London but would not have gone had he realised that his brother was so seriously ill, and he was still in London when he learned that his brother had died. He also complained that the prison FLO had been cold and insensitive in her language.

82. The prison FLO had made extensive efforts to contact Mr Rahman's mother, but when Mr Rahman's brother had contacted her on 7 June, she sought advice from her manager and explained that he would need to come into the prison with proof of identification before she could give him any information.

83. It is not possible for us to determine the specific words used in the two telephone conversations between the FLO and Mr Rahman's brother nor the tone of the conversations. However, the FLO was correct in saying that he would need to provide proof of his identity before she could give him any information. It is unfortunate that the conversations coincided with Mr Rahman's brother's visit to London which meant that he was unable to visit his brother before he died.

Clinical care

84. The clinical reviewer concluded that the healthcare that Mr Rahman received at Forest Bank was not equivalent to that which he could have expected to receive in the community.

85. The clinical reviewer found that Mr Rahman's medical records did not reflect a clear formulation of his risk even after the incident when he jumped from the landing. The clinical reviewer considered that this event demonstrated a clear degree of unpredictability in Mr Rahman and that a Mental Health Act Assessment would have been indicated following such an incident in the community. The prison's failure to make such as assessment was a missed opportunity to intervene before matters escalated further.

86. The clinical reviewer also found that there did not appear to have been a clear risk assessment in place when Mr Rahman began behaving with very unusual and concerning behaviour on 6 June. He considered that if an appropriate safety assessment had been made, it was unlikely that it would have been deemed safe to allow Mr Rahman to keep items such as a plastic bag, with which he could harm himself, in his cell. We make the following recommendation:

The Head of Healthcare should ensure that staff complete an appropriate risk assessment following significant events of self-harm or other incidents of unusual and concerning behaviour.

Inquest

87. The inquest, held on 22 June 2023, concluded that Mr Rahman died as a result of misadventure.

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