

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

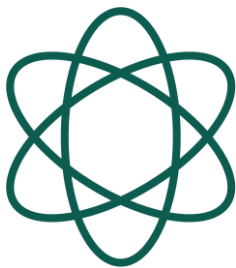
# **Independent investigation into the death of Mr Vahid Kabiri, a prisoner at HMP Doncaster, on 1 July 2022**

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



## Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



## Our values

**We are:**

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity

**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 Vahid Kabiri died after he was found hanged in his cell on 1 July 2022 at HMP Doncaster. He was 43 years old. I offer my condolences to Mr Kabiri's family and friends.

Mr Kabiri was on remand for the murder of his wife, and it was his first time in prison. He had been at Doncaster for less than one month when he died. I am concerned that the nurse who assessed Mr Kabiri on arrival did not have access to information on his suicide and self-harm risk factors. A referral should have been made to the mental health team, but this was not submitted.

Despite several known risk factors, staff did not identify Mr Kabiri as at risk of suicide. I am concerned that opportunities to make a holistic assessment of the risk he posed were missed. Because Mr Kabiri presented as someone settling well into prison life and making plans for the future, staff did not consider monitoring him under suicide prevention procedures. The investigation identified a disappointing lack of professional curiosity about Mr Kabiri's circumstances by staff at Doncaster.

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**

**May 2023**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings .....	13

# Summary

## Events

1. On 6 June, Mr Vahid Kabiri was arrested and charged with the murder of his wife. He appeared at court, was remanded to custody and taken to HMP Doncaster. It was his first time in prison.
2. During his initial interviews, Mr Kabiri said he had no thoughts of suicide or self-harm. The nurse who completed his first health screen did not record any risk factors or concerns about his wellbeing.
3. Mr Kabiri had three key worker sessions with three different Prison Custody Officers (PCOs) during his time at Doncaster. He told all of them that he felt safe and had no concerns. Mr Kabiri also said he had regular contact with his family despite him not being able to speak to his children.
4. On 28 June, Mr Kabiri moved into a cell with another prisoner. They told us that Mr Kabiri was worried about how long he would spend in prison and his children's welfare. The prisoner said that Mr Kabiri said that he would kill himself if he received a life sentence.
5. On 1 July, a PCO was unlocking prisoners for exercise but could not open Mr Kabiri's door. When they looked through the observation panel, they could see him hanging from his top bunk. They called to another PCO on the wing and ran to tell them. Both PCOs returned to the cell within 30 seconds. They opened the door, radioed an emergency code and cut the ligature. As staff were bringing Mr Kabiri out of the cell so that they had more room to treat him, other prisoners were obstructive and kicked Mr Kabiri.
6. More staff arrived, moved the other prisoners away and started resuscitation. Paramedics arrived and took over Mr Kabiri's care. At 2.33pm, paramedics pronounced Mr Kabiri had died. Police found a note in his cell in which he referred to the alleged offence and indicated he did not want to live if he could not be with his children.

## Findings

7. Mr Kabiri had several recognised significant risk factors for suicide and self-harm, including a history of depression, previous suicide attempts, a lack of family support, being in prison for the first time, the alleged murder of a close family member and the likelihood of a long sentence.
8. During the short period Mr Kabiri spent at Doncaster, he was worried about forgiveness from God, his children's future and a lack of financial support. He told different members of staff about some of his concerns, including the prison Imam and his probation officer. However, Mr Kabiri also appeared to build a good support network in prison, engaged with staff, was apparently planning for the future and consistently said he had no thoughts of suicide and self-harm.

9. Mr Kabiri had three key worker sessions at Doncaster. However, staff completing them did not know that he had been charged with murdering his wife (a well-known risk factor for suicide) or that he was not allowed contact with his sons. Three different officers delivered key work to Mr Kabiri in the three and a half weeks he lived at Doncaster, so there was no opportunity for a meaningful contact and trust to develop that might have enabled Mr Kabiri to share his concerns.
10. When the police directed that Mr Kabiri should not have contact with his children, the news was delivered to him by letter and it seems that neither wing staff nor his key worker was told, despite this being likely to cause him significant distress.
11. The clinical reviewer concluded that Mr Kabiri's care was only partially equivalent to that which he could have expected to receive in the community. His physical healthcare and the emergency response were satisfactory. However, the nurse who completed Mr Kabiri's reception health screen did not have access to his Person Escort Record (PER – for documenting key information on individual needs when a person is transported from police to prison custody), which contained information about his previous suicide attempt. She did not refer Mr Kabiri to the mental health team, which should have been automatic based on the nature of his offence.

## Recommendations

- The Director should ensure that key work is delivered by a consistent member of staff and that officers have sufficient time to meaningfully engage with prisoners, in line with the HMPPS key worker scheme.
- The Director should ensure that where the Public Protection Unit is responsible for delivering potentially distressing information to prisoners:
  - they ensure that relevant staff responsible for supporting the prisoner are made aware, and
  - consider whether the information would be better delivered in person as well as, or instead of, by letter.
- The Director and Head of Healthcare should ensure that Person Escort Records (PERs) are available to and referenced by healthcare staff completing reception screenings, to ensure that care planning is informed by individual risks.
- The Head of Healthcare should ensure that all staff refer prisoners who have been charged with murder to a GP and the Mental Health Team within 24 hours of their arrival at Doncaster, in accordance with the local operating procedure.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her. No one responded. She obtained copies of relevant extracts from Mr Kabiri's prison and medical records.
13. The investigator interviewed seven members of staff and three prisoners, some in person at Doncaster and some via telephone in July and August.
14. NHS England commissioned a clinical reviewer to review Mr Kabiri's clinical care at the prison. The clinical reviewer conducted joint interviews with Mrs Stolworthy.
15. We informed HM Coroner for South Yorkshire East District of the investigation. The coroner provided us with a copy of the post-mortem report. We have sent the coroner a copy of this report.
16. The Ombudsman's family liaison officer contacted Mr Kabiri's nephew to explain the investigation and to ask if he had any matters he wanted us to consider. We did not receive a response.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

## Background Information

### HMP Doncaster

18. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 remanded or convicted male prisoners. Practice Plus Group provides clinical services. The prison directly employs qualified paramedics as part of the healthcare team, and they respond to emergency calls in the prison.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Doncaster was in February and March 2022. Inspectors reported that the prison was very well run, with proactive and supportive staff. They noted that good arrangements were in place for new prisoners and most said they were treated well and properly inducted on arrival. Instances of violence, the number of disciplinary proceedings, use of segregation and use of force were reducing, and fewer prisoners said they felt unsafe since the previous inspection, although recorded incidents of self-harm had remained constant. Despite this, inspectors concluded that the work undertaken to support those in crisis seemed to be useful and effective.
20. Inspectors noted that prisoners' time out of their cell was still limited as the prison moved on from COVID-19 restrictions.
21. Inspectors observed positive relationships between staff and prisoners. They noted that key worker sessions had continued throughout the pandemic and were recorded regularly, with 80% of prisoners receiving a key worker session every two weeks. They also found that although the sessions were supportive, the content was limited, often formulaic and did not discuss the prisoner's rehabilitation or sentence plan. Prisoners did not always see the same key worker each time, which affected their ability to build a rapport.
22. There had been eight self-inflicted deaths since the previous inspection and recommendations from our investigations into these deaths had been implemented and were regularly reviewed.
23. Foreign national prisoners were well provided for with access to a full-time dedicated officer for this group.

### Independent Monitoring Board

24. 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. There is no recent IMB report for HMP Doncaster.

### Previous deaths at HMP Doncaster

25. Mr Kabiri was the eighteenth prisoner to die at Doncaster since July 2020. Three of these previous deaths were self-inflicted, eleven were due to natural causes and three were due to drugs. Previous investigations have recommended that prisoners

are given the opportunity to have meaningful contact with staff and that prisoners are referred to the mental health team if initial screenings suggest this is necessary. There have been two further deaths due to natural causes since that of Mr Kabiri which we are currently investigating. At the time of writing, there are no direct similarities in our findings in these investigations and that of Mr Kabiri's death.

## **Assessment, Care in Custody and Teamwork (ACCT)**

26. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.
27. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

## **Key worker scheme**

28. The key worker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversation with each of their allocated prisoners.
29. The key worker scheme was suspended across the estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, such as those who were at risk of suicide or self-harm, the Prison Service introduced the Exceptional Delivery Model for keywork in May 2020. This provided for officers to have a weekly conversation with prisoners identified as vulnerable. The model was withdrawn in May 2022, and prisons are now expected to be delivering the full scheme again.

# Key Events

## Background

30. Mr Kabiri's community medical record notes that he had post-traumatic stress disorder (PTSD) after his experiences in Afghanistan where he had been imprisoned and tortured. He sought asylum in Britain in 2002 and had subsequently been granted British citizenship. Mr Kabiri spoke good English. This has been confirmed from his records, our interviews and listening to telephone calls that he made.
31. Mr Kabiri took overdoses in 2002 and 2004 and cut his wrists in 2002. Notes from 2018 indicate that he had a history of depression and anxiety but was not prescribed any medication for this. In 2019, Mr Kabiri was diagnosed with ischaemic heart disease (heart problems caused by narrowed arteries).
32. On 6 June 2022, Mr Kabiri was arrested and charged with the murder of his wife. While in police custody, NHS England's Liaison and Diversion Service completed an assessment of Mr Kabiri's mental health. (The Liaison and Diversion service identifies people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system and provides additional support and health and social care referrals to divert them from it.) The Liaison and Diversion Service mental health assessment was not provided to Doncaster by the police, and despite several requests, we were not issued with a copy during our investigation.
33. Mr Kabiri appeared at South Yorkshire Magistrates Court and was remanded to custody, with his next appearance at Sheffield Crown Court on 8 June. He was taken to HMP Doncaster. It was his first time in prison. Mr Kabiri's Person Escort Record (PER) noted he had been charged with murder and that Mr Kabiri was a risk of suicide and self-harm. The PER noted that he was being observed every 30 minutes at court and during the transfer to prison. Staff noted on the form that the concerns related to the nature of the charge against Mr Kabiri and that he said he had self-harmed and attempted suicide in 2003.

## Reception into HMP Doncaster

34. When he arrived at HMP Doncaster, Mr Kabiri told a Prison Custody Officer (PCO) that he had no thoughts of suicide or self-harm and got support from his two sons. He rated his mood as six out of ten.
35. A nurse completed Mr Kabiri's initial health screen. Mr Kabiri said he had no mental health issues or thoughts of suicide or self-harm. He said that he was prescribed medication for stomach acid and heart disease which he had brought with him (in fact it seems that he had not been prescribed any heart medication since 2021). A GP prescribed him esomeprazole (used to treat conditions causing too much stomach acid), but he never collected this medication. The Deputy Head of Healthcare told the investigator that Mr Kabiri would have been told about the process for collecting medication when it was prescribed.

36. The nurse sent an electronic request for an appointment with the GP for a heart review. This was later scheduled for 18 July. The nurse told the investigator that Mr Kabiri did not seem distressed and was “matter of fact” when he told her that he had been charged with killing his wife. However, she then recorded “no” in answer to the question whether Mr Kabiri had been charged with murder or had a life changing event. In interview, she told us that because Mr Kabiri had not been convicted of the offence, she did not consider that he had experienced a life changing event. She had no concerns that Mr Kabiri was a risk to himself. She did not have access to Mr Kabiri’s previous medical record or his PER when completing her assessment. She said that she had stopped receiving PERs in reception around May 2022. The Head of Healthcare told us that she was not aware of this and expected staff to receive them.
37. A PCO had an introductory key worker session with Mr Kabiri. She explained the purpose of the key worker scheme. Mr Kabiri said that he had no concerns in prison or the community. He said that he had no thoughts of suicide or self-harm. She told Mr Kabiri that he would have weekly key worker sessions. Mr Kabiri said that he had no family support. He said he had heart issues but was not on any medication and had no substance misuse issues. It seems that she did not know that Mr Kabiri had been charged with his wife’s murder.

## **7 – 30 June**

38. On 7 June, a case administrator in the Offender Management Unit at Doncaster completed Mr Kabiri’s basic custody screening with him. He noted that before he was arrested, Mr Kabiri lived with his two sons, but had no accommodation to be released to. His sons were being cared for by social services. Mr Kabiri said that he could read English but struggled with writing it.
39. Later that day, a PCO met Mr Kabiri as part of his induction to see how he was feeling. Mr Kabiri replied that he felt “good” and got on with his cellmate really well. Mr Kabiri said that he last self-harmed in 2005 but had no active thoughts of harming himself now. Mr Kabiri said that he wanted to learn to write English while in prison and get a job. He said that he would maintain contact with his friends and family via the telephone once the numbers had been added to his account.
40. In the evening, staff completed Mr Kabiri’s first night checks (a standard procedure for all new arrivals). Since it was his first time in prison, he was offered additional support from staff and other prisoners. Mr Kabiri said he had good support from his family (contrary to what he said to a PCO).
41. On 8 June, Mr Kabiri attended the videolink centre for a court appearance. He raised no concerns and declined to see healthcare staff afterwards.
42. On 14 June, a Probation Service Officer completed part two of Mr Kabiri’s basic custody screening, which should be completed within five days of the initial screen. She told the investigator that usually this would involve speaking to Mr Kabiri in person, but that wing staff had not been able to unlock him, and the in-cell telephones were not working at the time. She therefore completed the screening without his input and based it on the information from the first screening meeting. She emailed the Job Centre, who confirmed that Mr Kabiri’s rent would continue to be paid while he was on remand. She had been unable to contact him to inform

him of this at the time. She also sent a letter asking him to contact the community integration team if he required support with his finances or accommodation.

43. On 17 June, Mr Kabiri called the Prisoner Assist Line (PAL). The call went to voicemail, and he did not leave a message. PAL is a free service run by prisoners at Doncaster and overseen by the prison librarian. The service is available to assist with general queries and is open 8.30am to 3.30pm. When Mr Kabiri called, the line was closed over the lunch period. There is also an answerphone which can be accessed 24 hours a day to leave a message.
44. On 18 June, a PCO held a key worker session with Mr Kabiri. He told her that he was happy and felt safe in prison, having settled onto the wing and developed a good relationship with his cellmate. Mr Kabiri also said that he had family contact mainly via telephone and letter (this was not factually accurate) and had no financial difficulties or thoughts of self-harm to report. She noted that Mr Kabiri participated in the regime and played pool. He said that his health was good, and he took regular medication.
45. On 23 June, there is a note on Mr Kabiri's record that the police had instructed the prison that he must not have contact with his sons because they had been witnesses to the alleged offence. The Public Protection Unit (PPU) sent Mr Kabiri a notice in Kurdish, indicating that he must not try to contact his sons by telephone or letter. There is no evidence to suggest that the PPU informed either wing staff or Mr Kabiri's key worker of the development.
46. On the morning of 24 June, Mr Kabiri called the PAL and asked for help with his community finances and getting a job in prison. The PAL operator explained to Mr Kabiri that he could not get a job until he had been in prison for 28 days. They said that staff could help with his finances, and they would refer him to Nacro (who work with disadvantaged adults) for assistance, which they did. Mr Kabiri asked for social services' telephone number and the PAL operator said they would find it and give to him. He said that he did not know where his children were and was worried about them.
47. Later on, Mr Kabiri attended Friday prayers. As he was leaving, he asked the Imam if he would come see him on the wing, and the Imam agreed. Mr Kabiri called the PAL that evening, but it went through to voicemail. He did not leave a message.
48. On 26 June, a PCO held a key worker session with Mr Kabiri. PCO A told the investigator that he had been allocated as Mr Kabiri's key worker that week. He said that due to time constraints, he was not able to visit Mr Kabiri on the wing, so he telephoned the staff wing office to speak to him. PCO B answered the telephone and spoke to Mr Kabiri, who did not seem to want to engage. PCO A therefore asked Mr Kabiri some questions via PCO B. Mr Kabiri said he felt safe at Doncaster and had no concerns in prison or the community. He said he got on well with his peers, enjoyed life on the wing and was forming a good rapport with staff. Mr Kabiri said that he had regular contact with his sons via letters. PCO A did not question this as he was unaware that Mr Kabiri was not allowed contact with his children. He also did not know the nature of the offence Mr Kabiri had been charged with. In interview, PCO A told us that PCOs had two or three minutes to catch up with a prisoner each week, often on the telephone. He said that if contact

raised any concerns, he would follow up, but otherwise he asked a few standard questions.

49. On 28 June, the PPU received the Kurdish notice back from Mr Kabiri with a note indicating that he did not read Kurdish (this had been recorded as his preferred language in error). They hand delivered a replacement notice later the same day, which explained in English that Mr Kabiri was not allowed to contact his sons via telephone or letter.
50. The same day, the Imam went to the wing and spoke to Mr Kabiri in a private room. Mr Kabiri told him about the circumstances which had led to his arrest and said that he had felt “witchcrafted” by his wife. Mr Kabiri said that he could not recall much of what had happened before he was arrested but that he was shaking, had a knife in his hand and his wife was wounded. Mr Kabiri asked the Imam whether he would be considered guilty in the court of God, and they discussed this further. The Imam shared prayers with Mr Kabiri and offered to support him. The Imam said that although Mr Kabiri was distressed, he did not consider that he was a risk to himself.
51. At 4.20pm, Mr Kabiri rang the PAL and left a voicemail asking for advice on his financial management because no one had contacted him. An officer explained to Mr Kabiri that PAL could signpost but was unable to follow up referrals. PAL sent another referral to Nacro.
52. Prisoner A was friends with Mr Kabiri and they spoke most days, although Prisoner A’s understanding of English was limited. He told us that he never had any concerns that Mr Kabiri was a risk to himself, and he was always smiling, joking and talking to people. He said that after Mr Kabiri had spoken to the Imam, he looked sad and the following day he saw him crying. However, when he asked about it, he said that he was okay.
53. Staff we spoke to said that Mr Kabiri was always polite, seemed happy and got on well with other prisoners. They did not observe any signs that he might have been in crisis.
54. Between 21-28 June, Mr Kabiri was living in a cell on his own, after his cellmate was moved to the segregation unit. On 28 June, he moved into a shared cell with Prisoner B. Prisoner B told us that Mr Kabiri seemed “a bit stressed out”. Mr Kabiri told him that he did not know how he had ended up killing his wife and he thought that she must have used black magic on him. Mr Kabiri said he was worried about his children because they had been left with no parents and that he would not see them again until he was an “old man”. Mr Kabiri said that he wanted to tell his children to sell his belongings and use the money for whatever they needed. However, he said that he could not speak to his children and did not know who could help him try to establish contact. He also said that he could not get help from the PAL with his bank account.
55. Prisoner B helped Mr Kabiri to use the prisoner kiosk, and Mr Kabiri saw that he had a visit booked with someone that he did not know. Prisoner B said that Mr Kabiri was pleased about the visit and wanted to find out who they were. (We found that Mr Kabiri’s children’s social worker had arranged to visit on 4 July.)

56. Prisoner B said that Mr Kabiri was worried that he would receive a life sentence. Mr Kabiri did not think he would cope with a long sentence and would kill himself if he got one. Prisoner B said that he tried to encourage him to wait and see if he was convicted. He said that he did not think Mr Kabiri had any thoughts of suicide when they shared a cell but only considered he might be at risk after being sentenced. Mr Kabiri told him that he preferred sharing a cell with him than being in a cell on his own.
57. On 29 June, the Probation Service Officer received an application from Mr Kabiri asking for help to contact his bank to cancel his direct debits. She called him and confirmed that his rent would be paid while he was on remand. Mr Kabiri said that he wanted to keep his property but sell his belongings. She asked if he had any friends that could help, but Mr Kabiri said that he did not, so she advised him to wait for the outcome at court. She also gave Mr Kabiri his bank's customer service number. Mr Kabiri told her that he was missing his children who he had no contact with, and he did not know where they were. She was aware that Mr Kabiri was not allowed contact with his children. She told Mr Kabiri that she would refer him to Families First (based in the prison) for professional support and advice in relation to his children. Mr Kabiri said that he had no money and was on his last vape capsule. He said no one would be supporting him from the community. She referred him to Novus, who are the education and employment department in the prison.
58. The Probation Service Officer told the investigator that she had no concerns that Mr Kabiri was a risk to himself. She said that he seemed to be planning for the future and wanted to engage with the services she spoke about. She said that he was clearly concerned about his children and other immediate needs but did not seem distressed.
59. On 30 June at around 3.00pm, Mr Kabiri called the PAL and asked to see someone from family support. The PAL operator took his details and said that they would get back to him as soon as possible. Mr Kabiri thanked them and said that he really needed help. The PAL operator sent an application to Families First and the Safer Custody Department. We have not been able to find out why the PAL operator contacted the Safer Custody Department, who had no record of the referral.

## Events of 1 July

60. Prisoner C, who knew Mr Kabiri, told us that in general he seemed happy and chatty, and he had no concerns about him. On 1 July at around 11.30am, he came back from the gym and saw Mr Kabiri standing at his cell door looking out through his observation panel. They had a brief conversation during which he said that Mr Kabiri was laughing and seemed his usual self.
61. Mr Kabiri rang the PAL at 11.32am and 11.33am. It went through to voicemail both times, and on the second occasion he left a voicemail asking to see someone from family support as soon as possible as no one had come to see him when they said they would. He also asked for help putting his solicitor's number on his prison phone account. The PAL office was shut for lunch, and no one picked up Mr Kabiri's voicemail until after he had died. Since Mr Kabiri's death, the PAL remains open over lunchtime.

62. PCO C was the only member of staff working on the wing that morning. She said that while she was unlocking prisoners to collect their lunch, Mr Kabiri asked if he could use the kiosk to add his solicitor's number. She said that it was not possible at that time, but she would try to let him out that afternoon to do it. She told us that on that day the wing was on a restricted regime due to staff shortages, which meant that prisoners were unlocked for about 45 minutes a day, to exercise. At around 11.55am, staff locked Mr Kabiri back in his cell. At 12.05pm, PCO C completed a roll count on the wing. CCTV does not cover Mr Kabiri's cell but shows her checking the surrounding cells. She said that she opened Mr Kabiri's door and asked where his cellmate was. Mr Kabiri was watching television, turned to her, smiled and told her that his cellmate was at court.
63. PCO C unlocked prisoners after lunch for exercise at around 1.30pm. When she got to Mr Kabiri's cell, she could not open his door. She looked through his observation panel, saw Mr Kabiri hanging from the top bunk of his bed and screamed out in shock. At 1.38pm, she ran to PCO D, who was on the floor below, while shouting her name. PCO D heard PCO C scream and saw her running across the wing shouting her name. She ran to join her, and they came together about 30 seconds after PCO C had left Mr Kabiri's cell. PCO D looked through the observation panel and could see Mr Kabiri sat on the floor behind the door and facing the observation panel with a ligature tied around his neck. She struggled to open the door due to the weight of Mr Kabiri against it but managed to do so when she applied more force. As she entered the cell, PCO D radioed a code blue (an emergency code indicating that a prisoner is not breathing or is having difficulty breathing). Staff in the control room immediately requested an ambulance.
64. PCO D used her anti-ligature knife to cut through the ligature which was made of bedding. She moved Mr Kabiri out of the cell to give the officers more space to perform CPR but was obstructed by prisoners who had gathered around her. She asked them to move away. Some of them nudged and kicked Mr Kabiri, which she believed was due to frustration over their exercise time being interrupted. Less than one minute after she arrived, a Custodial Operations Manager (COM) reached the cell with other staff. The COM dispersed the other prisoners, helped her move Mr Kabiri further out of the cell, and started CPR.
65. Two minutes after the code blue, a healthcare assistant arrived at the cell. She checked Mr Kabiri for signs of life and then took over CPR. More healthcare staff arrived with an emergency bag and defibrillator. They inserted an airway, administered oxygen and took it in turns to administer CPR. Paramedics arrived at the prison at 1.48pm and took over Mr Kabiri's care. At 2.33pm, paramedics pronounced that Mr Kabiri had died.
66. PCO C assisted locking prisoners in their cells. Several prisoners had to be restrained because they would not comply and were frustrated about missing exercise and the amount of time they had been locked in their cells. Police found a note in Mr Kabiri's cell in which he referred to the alleged offence and indicated that he did not want to live if his sons were not with him. He asked for forgiveness.
67. A prisoner said that prisoners told him that others were aware of Mr Kabiri's alleged offence and had threatened that he needed to be careful when he came out of his cell. He did not witness this himself nor was he able to identify the names of the prisoners who told him. We have not found any other evidence to corroborate this.

## **Contact with Mr Kabiri's family**

68. The prison appointed a family liaison officer (FLO). Mr Kabiri's mother was listed as his next of kin. The FLO spoke to the police to see if they could help her notify Mr Kabiri's mother. The police informed Mr Kabiri's sons of his death and his nephew in Dubai. His nephew told the police that Mr Kabiri had no other family and both of his parents had died.
69. The FLO telephoned Mr Kabiri's nephew and offered her condolences. The prison offered a contribution to Mr Kabiri's funeral expenses in line with HMPPS policy. The FLO remained in contact with Mr Kabiri's nephew.

## **Support for prisoners and staff**

70. After Mr Kabiri's death, the Deputy Director 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.
71. The prison posted notices informing other prisoners of Mr Kabiri'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 Kabiri's death.

## **Post-mortem report**

72. The coroner recorded Mr Kabiri's preliminary cause of death as hanging. The post-mortem examination confirmed this.

# Findings

## Assessment and management of risk

73. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.
74. We have considered whether staff should have recognised that Mr Kabiri was at risk and used ACCT procedures to support him. Mr Kabiri had several significant risk factors for suicide and self-harm, as identified by PSI 64/2011. These included a history of mental health issues, previous suicide attempts, it being his first time in custody and in the early days of that experience, his lack of social support and, perhaps most significantly, the offence he had been charged with. We have considered whether there were any missed opportunities for staff to identify Mr Kabiri's risk factors and consider whether they indicated he was at an increased risk of suicide.

### *Key work*

75. Mr Kabiri had three key work sessions during his time at Doncaster, which is positive for a prisoner in the early days in custody. However, these sessions were with three different officers, none of whom seemed to know the offence he had been charged with or that he was not allowed contact with his children. In fact, he told two of the officers that he had regular contact with his family.
76. PCO A, who had been allocated as Mr Kabiri's key worker shortly before he died, said that the key worker scheme was not working well at Doncaster. He said each PCO was a key worker to around ten prisoners and it had become a "fast paced tick boxing exercise".
77. The Director of Doncaster told the investigator that staff had time to meaningfully engage with prisoners and evidence this on their records. He said that key worker sessions are quality assured and any issues are addressed with the PCO and wing manager. We are concerned that despite these assurances, engagement was not meaningful, and staff lacked professional curiosity as to why Mr Kabiri was in prison and whether there were any risks that needed to be managed. They failed to properly enquire about any other issues he was facing, which is concerning given it was his first time in custody.
78. Following a death in 2021, we recommended that staff had meaningful contact with every prisoner, particularly those new to custody for whom risks might increase. The prison accepted this recommendation and noted it would be completed by May 2022. Following their inspection in March 2022, HMIP noted that although prisoners had regular key worker sessions, these were often with different officers and not constructive. We make the following recommendation:

**The Director should ensure that key work is delivered by a consistent member of staff and that officers have sufficient time to meaningfully engage with prisoners, in line with the HMPPS key worker scheme.**

*Mr Kabiri's contact with his children*

79. Shortly after Mr Kabiri was remanded to Doncaster, the police advised that he should not have contact with his sons, who had witnessed the alleged offence. The Public Protection Unit delivered this news to Mr Kabiri by letter. Mr Kabiri had made clear to staff the importance of ongoing contact with his children and his fears about the future. We found no evidence that the PPU told wing staff, the safer custody team or Mr Kabiri's key worker of the change in his circumstances, which was likely to cause him significant distress. We are also concerned that news of this nature was delivered in writing with no direct staff contact. We make the following recommendation:

**The Director should ensure that where the Public Protection Unit is responsible for delivering potentially distressing information to prisoners:**

- **they ensure that relevant staff responsible for supporting the prisoner are made aware, and**
- **consider whether the information would be better delivered in person as well as, or instead of, by letter.**

80. Mr Kabiri's outward presentation did not indicate any significant risks. He consistently told staff that he had no thoughts of suicide and self-harm. He seemed to settle well, developing relationships with other prisoners and staff, and apparently planning for the future by seeking advice about his children. Without the benefit of any single member of staff considering his risks holistically, we accept that staff did not identify him as being at imminent risk of suicide and so did not consider beginning ACCT procedures.

## **Clinical Care**

81. The clinical reviewer concluded that aspects of Mr Kabiri's care were of a good standard but that overall, it was only partially equivalent to that he could have expected to receive in the community. She noted that Mr Kabiri's physical healthcare and the emergency response were informed by good clinical practice. However, the clinical reviewer had concerns about the lack of information sharing during the reception health screen and the lack of mental health referral.

82. National Institute for Health and Care (NICE) Guidance says that healthcare staff completing reception health screens should have access to PERs. The nurse who completed Mr Kabiri's initial healthcare screen told us that, since May 2022, she had not seen PERs when screening new arrivals in the reception area. This meant that she missed key risk information on Mr Kabiri's previous suicide attempts. We shared our concerns about this with the Head of Healthcare, who said that the PER should have been accessed by the nurse and that she would look to address the issues we found. To support this work, we make the following recommendation:

**The Director and Head of Healthcare should ensure that Person Escort Records (PERs) are available to and referenced by healthcare staff completing reception screenings, to ensure that care planning is informed by individual risks.**

83. The Practice Plus Group Local Operating Procedure (LOP) for Registration of New Patients in Reception, Transfers and First Night in Custody notes that “all patients remanded or sentenced for a murder charge are to be referred to a GP within 24 hours of their arrival and referred to the Mental Health Team”. The nurse was not aware of this expectation. She referred Mr Kabiri to the GP for a physical health review but did not make a referral to the mental health team. The clinical reviewer commented that the lack of referral for a mental health assessment was a missed opportunity to have considered Mr Kabiri’s situation holistically, including his medical history, separation from his children and alleged offence of murdering his wife.
84. Since Mr Kabiri’s death, the nurse has become aware of this expectation. The Head of Healthcare told us that because of the learning, she would be completing an audit of the last ten prisoners in Doncaster who had been charged with murder to check that they had been referred to the mental health team. She had also reminded healthcare staff about when they needed to refer prisoners to the mental health team.
85. Following a death in 2020, we recommended that prisoners were appropriately referred to the mental health team from their reception screening. This was accepted and noted as complete in December 2021. It is therefore disappointing to be repeating this recommendation.

**The Head of Healthcare should ensure that all healthcare staff refer prisoners who have been charged with murder to a GP and the Mental Health Team within 24 hours of their arrival at Doncaster, in line with the local operating procedure.**

## **Emergency response**

86. PCO C unlocked Mr Kabiri’s cell without looking through the observation panel. She told the investigator that she does not usually look into prisoners’ cells when unlocking them for exercise. This is unsafe both for her (to check that there is no obvious threat to her before she opens the door) but also for prisoners, as this is an opportunity to check on their welfare. While this did not impact on the outcome for Mr Kabiri, we would like to bring this to the Director’s attention as an area of learning.
87. When PCO C found Mr Kabiri hanging, she screamed and ran to get help. She said that she did not go into the cell on her own because she was unable to push the door open (Mr Kabiri was blocking it). She said that she was in shock and had tried to radio a code blue but was unsuccessful, which was why she ran to PCO D. We recognise the difficult circumstances that PCO C was responding to and do not criticise her actions. Help was requested as quickly as possible, and she was back at Mr Kabiri’s cell within 30 seconds.

88. Staff told us that when they moved Mr Kabiri out of the cell, other prisoners kicked and nudged him. We and the clinical reviewer considered that the lack of regard for Mr Kabiri from other prisoners was shocking and put additional pressure on staff responding to the emergency. We commend the staff response to this additional challenge, which would have been distressing and unsettling to witness.

## **Inquest**

89. The inquest into Mr Kabiri's death concluded on 27 June 2023. The cause of his death was confirmed as suicide.

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**May 2023**

**Prisons &  
Probation**

**Ombudsman**  
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