

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Ismaiel Hussain, following his release from HMP Parc, on 12 September 2021**

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

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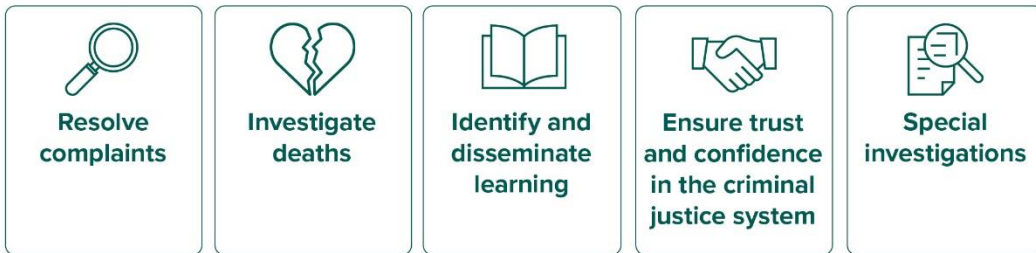
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## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ismaiel Hussain died in hospital on 12 September 2021 after being found hanging in his cell at HMP Parc. He was 25 years old. I offer my condolences to his family and friends.

Mr Hussain had been at Parc before and was well known to staff. In the relatively brief period that he had been at the prison, he gave staff no reason to think that he was at risk of harm to himself. The evening before he was found hanging, Mr Hussain had made numerous calls to his partner. He told her that he intended to take his own life. However, this was not reported to prison staff.

I found that staff relied too much on Mr Hussain's presentation and what he told them, rather than all available evidence when assessing his risk of suicide and self-harm.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**November 2023**

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# Summary

## Events

1. On 18 July 2021, Mr Ismaiel Hussain was arrested for domestic violence. He spent the night in police custody and was released on bail the next day.
2. Following his release from police custody, Mr Hussain spoke to his community Offender Manager (COM) and told him that he had secreted a 'rusty nail' on his person when he had been arrested. He said that if he had not been released, he planned to use it to harm himself.
3. On 20 July, Mr Hussain was recalled to prison for breaching his licence conditions. He was taken to HMP Cardiff. Staff completed his reception screen. There were no risk markers recorded on his reception documents. However, the digital Person Escort Record (PER) indicated that in 2019, Mr Hussain had self-harmed in prison. There was no information in the PER about Mr Hussain's plan to harm himself if he had not been released from police custody.
4. Staff asked Mr Hussain about his previous acts of self-harm and if he had any current thoughts of self-harm or suicide. He said no. Staff at Cardiff did not consider starting suicide and self-harm procedures (known as ACCT).
5. On 3 August, Mr Hussain transferred to HMP/YOI Parc.
6. Staff completed his reception health screening and asked him about his previous self-harm. Mr Hussain told the nurse that his self-harm had been a 'coping mechanism' but denied current thoughts of self-harm. He also said that he had previously been prescribed medication for depression and anxiety and that he had been feeling low in mood. Healthcare staff prescribed his medication later that day.
7. Around 8.25am on 27 August, an officer was unlocking prisoners for work. He heard Mr Hussain's cellmate kicking his door and shouting for the officer to open it. When the officer unlocked the door, he saw Mr Hussain hanging at the back of the cell.
8. The officer immediately radioed a medical emergency code and entered the cell. He cut Mr Hussain down and put him in the recovery position. Other staff joined him, and they started cardiopulmonary resuscitation (CPR).
9. At 8.48am, the paramedics arrived. Mr Hussain was taken to hospital and taken to the hospital's Intensive Treatment Unit (ITU).
10. On 1 September, Mr Hussain was granted early release on compassionate grounds which meant that he was released from prison.
11. At 1.00am on 12 September, it was confirmed that Mr Hussain had died in hospital.

## Findings

### Management of Mr Hussain's risk of suicide and self-harm

12. When Mr Hussain entered prison custody, he had risk markers for self-harm from 2019 and had been recalled to prison. These are potential risk factor for early days in custody. In addition, Mr Hussain had a documented history of mental health issues, including depression and anxiety.
13. Other information relating to more recent thoughts and acts of self-harm were not recorded on documents that arrived with him into prison. The Probation Service did not share this information with prison staff.
14. We are concerned that reception staff at Parc relied too heavily on what Mr Hussain said and how he presented. There is no evidence that staff gave sufficient consideration to his other risk factors. We are also concerned that at interview, some staff were not fully aware of what factors, such as licence recall, would potentially increase a prisoner's risk.

### Early Day in Custody Tool

15. We are concerned that the Early days in Custody (EDiC) tool used at Parc, is open to misinterpretation and confusing for the staff using it.

## Recommendations

- The Director should remind staff of the importance of considering all of a prisoner's current risk factors when assessing risk and that they should not rely solely on what a prisoner says, how they present or their past behaviour in prison.
- The Director should ensure that where Early Days in Custody or other induction processes identify risk factors, not already known, staff should clearly document the details of these and any defensible decision not to open an ACCT.
- The Director should ensure that staff are reminded of the risk factors that they should be looking out for when prisoners arrive at prison custody from court or another establishment.
- The Probation Service should remind community Offender Managers of the importance of sharing appropriate risk information in a timely manner with HMPPS staff, and the process for doing so, particularly in cases where an individual has been recalled to custody.
- The Director should review the current EDiC Tool and ensure that it is in a format that is clear, concise, and easy to understand.
- The Head of Healthcare should ensure that when additional information relating to a prisoner's background, suggested interventions and decisions is shared between healthcare staff and operational staff, the information is recorded in the prisoner's medical record so that it is accessible to the wider healthcare team.

## The Investigation Process

16. HMPPS notified us of Mr Hussain's death on 13 September 2021.
17. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
18. The investigator obtained copies of relevant extracts from Mr Hussain's prison and medical records.
19. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Hussain's clinical care at the prison. The investigator and clinical reviewer interviewed ten members of staff at Parc on 2 and 3 November 2021.
20. We informed HM Coroner for Cardiff, Bridgend and Glamorgan Valleys of the investigation. We sent the Coroner a copy of our report. No post-mortem examination was carried out at the request of Mr Hussain's family.
21. The Ombudsman's family liaison officer contacted Mr Hussain's family to explain the investigation and to ask if they had any matters that they wanted the investigation to consider. Mr Hussain's family wanted to know:
  - Why had Mr Hussain not received his recall pack, despite making requests for this?
  - Did the Probation Service share information with the prison about Mr Hussain's mental health?
22. At an inquest held on 8 November 2023, the coroner said 'on 27 August 2021, Ismaiel Hussain was found suspended by a ligature from his cell window at HMP Parc prison. He later died on 12 September 2021 at the Princess of Wales Hospital, Bridgend. His intention could not be ascertained. The coroner's conclusion on Mr Hussain's death was 'misadventure.'

## Background Information

### HMP/YOI Parc

23. HMP/YOI Parc is a medium security prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under the age of 18.
24. G4S Medical Services provide primary physical and mental health care services. There are 24-hour general healthcare and palliative care facilities. A local GP practice provides GP services, including a daily clinic and out-of-hours cover.
25. The Mental Health In-reach Team (MHIT) and secondary mental health services are provided by Swansea Bay University Health Board (SBUHB).

### HM Inspectorate of Prisons

26. The most recent inspection of Parc was in November 2019. Inspectors found that the level of self-harm remained high despite some improvement over the previous 12 months and combined with the relatively large number of self-inflicted deaths continued to cause concern.
27. HMIP found that the recommendations made by the Prisons and Probation Ombudsman were taken seriously. They were reviewed by safer custody staff regularly and monitored at the monthly safer custody strategy meeting. Although quality assurance measures were in place for prisoners assessed at risk of suicide or self-harm, weaknesses in the quality of recording, observational checks and caremaps were identified.

### Independent Monitoring Board

28. 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 28 February 2019, the IMB reported that although incidents of violence and self-harm remained high, the safer custody team had expanded with several caseworkers developing and delivering a range of interventions to prisoners at risk.

### Previous deaths at HMP/YOI Parc

29. Mr Hussain was the eighteenth prisoner to die at Parc since January 2019. Of the previous deaths, 12 were from natural causes, three were drug related and two were self-inflicted.

### Early Days in Custody (EDiC)

30. The EDiC process consists of several stages, the first being an initial assessment, which uses information taken from a prisoner's transfer report, before they arrive at the prison. Prisoners are then seen in the reception for a brief discussion around

safety and routines of the prison. The following day they will be seen again for a more in-depth assessment. The new system means that prisoners are spoken to by a single team and information is recorded on a database so that all departments can access and review the information.

## Key Events

31. On 5 July 2019, Mr Hussain was sentenced to three years and six months in prison for supply and possession of a class A drug. In 2020, he was released on Home Detention Curfew (HDC). In February 2021, his HDC had ended, and he received conditional licence conditions. His licence period was due to end in November.
32. On 18 July, Mr Hussain was arrested for assaulting his partner. He stayed in police custody overnight and was released on bail the next day, with the condition that he should not contact his partner.
33. After his release from police custody on 19 July, Mr Hussain spoke to his COM. He told him that when he was arrested, he had hidden a 'rusty nail' on his body and if he had not been released, he would have used it to harm himself. The COM recorded this information on the Probation Service database (DELIUS). There is no evidence that this information was shared with other agencies or was later shared with the prison.
34. After reviewing Mr Hussain's alleged offences and the increase in his risk, the Probation Service revoked Mr Hussain's licence and recalled him to prison.

### HMP Cardiff

35. On 20 July, Mr Hussain arrived at HMP Cardiff as a licence recall. The Person Escort Record (PER) form recorded that there were no concerns and no risk markers for previous self-harm. The digital PER (a digitally generated form completed prior to transfers between court and/or prison) noted that in June 2019, Mr Hussain had self-harmed in prison. The information Mr Hussain shared with his COM, about his plan to self-harm the day before, was not recorded in the PER or on any other documents he came into prison with.
36. During the induction process, prison and healthcare staff asked Mr Hussain about any previous self-harm and whether he had any current thoughts of self-harm or suicide. Mr Hussain said no. He told staff that he was happy to share a cell, had no immediate concerns and that he had been in prison before and knew how to ask for help.
37. On 21 July, a mental health nurse completed a routine mental health screening for Mr Hussain. Mr Hussain told her that he had been diagnosed with anxiety and depression and was previously prescribed sertraline, but this had not helped him. He said that his mood was currently 'up and down' but he felt that this was due to his nephew's funeral which was taking place the next day. Mr Hussain denied any thoughts of self-harm and said that his fiancé was a protective factor. The nurse recorded that Mr Hussain did not require input from the Primary Care Mental Health Team (PCMHT) at that time.
38. Mr Hussain told staff that it was his two-month-old nephew's funeral the next day and that he wanted to speak to the chaplaincy team. He spoke to them the following day.

## HMP/YOI Parc

39. On 3 August, Mr Hussain transferred to Parc.
40. The PER form which accompanied Mr Hussain to Parc recorded no risk markers. The digital PER recorded that he had previously self-harmed in 2019.
41. A nurse completed Mr Hussain's reception health screening. He told her that he had previously been prescribed medication for depression and anxiety, but he had not collected these in the community due to the COVID-19 pandemic.
42. She noted that Mr Hussain had a history of self-harm. Mr Hussain told her that his previous self-harm had been a 'coping mechanism.' He said that he had been feeling low in mood due to the anniversary of his son's death which had been on 1 August. He said that he had no current thoughts of harming himself and that he felt he had more support in prison. The nurse advised him to seek support from the chaplaincy team and to consider bereavement support. She had no immediate concerns about Mr Hussain and did not feel that opening an ACCT or an Assisted Living Plan (ALP) was needed.
43. The nurse e-mailed a Senior Operational Manager (SOM), (who was responsible for A wing where Mr Hussain was located) and summarised her discussion with Mr Hussain. She confirmed that she felt that an ACCT or ALP was not needed at that time and what she planned to do next. This included asking the SOM if Mr Hussain could be moved to B3 block with an Operational Manager (OM), as he found her very supportive, she would add Mr Hussain to the Support and Risk meeting for discussion next week, and that she asked Mr Hussain to submit an application the Mental Health Team so that they could offer support and that he said that he was happy to do so.
44. On 4 August, a member of the chaplaincy team, saw Mr Hussain. Mr Hussain told him about his recent bereavement and the anniversary of his son's death. He offered him chaplaincy support and said that a member of the chaplaincy team would complete one to one work with him if needed. There is no evidence that Mr Hussain accepted this offer of support.
45. The same day an Early Days in Custody (EDiC) caseworker, saw Mr Hussain. She recorded that Mr Hussain had told her about his previous self-harm and about his bereavement. He also said that he had received mental health support and prescribed medication from his community GP. She gave Mr Hussain a mental health referral application form to complete (mental health referrals are prisoner led). She had no immediate concerns about Mr Hussain's well-being or risk to himself.
46. On 7 August, the nurse sent a follow up email to the SOM and said that Mr Hussain had been prescribed his medication and that she had spoken with the OM, who was happy for Mr Hussain to move to B3 block once he had completed his induction.
47. Mr Hussain moved to B3 block. B3 is primarily used for young adults aged between 18-25. Mr Hussain moved there with his cellmate as they had both arrived at Parc together and had been supporting each other on the induction wing.

48. On 12 August, Mr Hussain contacted a Prison OM, via the 'duty line.' She told the investigator that due to ongoing cases of COVID-19 in the prison, face to face contact with prisoners had been restricted. The 'duty line' was initiated so that prisoners could maintain contact with their OMs over the telephone and discuss any issues they might have had.
49. The OM talked to Mr Hussain about his recall to prison. He told her that the alleged offences he had been charged with had all been withdrawn. The OM told Mr Hussain that he would not be automatically released from prison but that he had to wait for a report from the Probation Service and that once this had been received, she would discuss the next steps with him. She told him that the Parole Board could decide to re-release him or review his case in six, nine or 12-months' time. A date for the Parole Board review had not been scheduled at this time.
50. Mr Hussain told the OM that he was still waiting for his 'recall pack' (recall documents that provide the reasons for the recall and the process that would follow. Prisoners are required to sign the paperwork to confirm that they understand why they have been returned to prison custody). Mr Hussain said that while at Cardiff he had only been given paperwork to sign and had not been provided with a copy. The OM called the case management team in the Offender Management Unit at Parc and asked for a copy of the recall dossier to be sent to Mr Hussain. During their conversation, Mr Hussain said that he had settled on B3 and he raised no other concerns.
51. On 20 August, a Prison Custody Officer (PCO), the duty key worker, spoke to Mr Hussain. She recorded that Mr Hussain said that he felt safe and very supported by staff on B3. She asked him how he was coping with his mental and physical health. He said that he was doing well and that when he felt anxious, he would speak with staff. Mr Hussain told PCO Harris that he had not had any thoughts of self-harm and felt confident that the staff would provide support if he needed it. PCO Harris said that although her contact with Mr Hussain was brief, B3 was her normal workplace so she was aware of him and had no concerns about his well-being.

### **Events of 26 August**

52. Prison cells at Parc have telephones which can be accessed by prisoners using a Personal identification Number (PIN) between the hours of 6.00am – 11.00pm.
53. On the 26 August, Mr Hussain made 15 calls to his partner from 3.33pm into the evening. During his first call, he was calm and talked about waiting to receive letters and photos from her. He asked her to contact his solicitor about his parole and they talked about her plans to go out that evening. He told her not to speak to any boys.
54. As the evening progressed, Mr Hussain's calls to his partner became more heated. He became hostile, threatened her and said that she had to return home by a certain time. Mr Hussain then told his partner that he had a knife, that he intended to harm himself and that he would kill himself.
55. Mr Hussain made his last call to his partner at 10.47pm. He passed the telephone to his cellmate, who told Mr Hussain's partner that Mr Hussain had 'had enough.'

Mr Hussain took the telephone back and was crying. He told his partner that he had 'put a rope up the window' and would kill himself.

56. The cellmate told the investigator that Mr Hussain had been his usual self during the day and that between 6.00pm and 7.00pm, they were on the unit for association. He said that when they returned to their cell and were locked up at 7.00pm, Mr Hussain did not seem himself. He said that Mr Hussain began telephoning his partner.
57. The cellmate said that he did not believe Mr Hussain was going to do anything to himself. He just thought he was saying things to scare his partner so that she would stay home. He said that Mr Hussain continued to use the telephone until 11.00pm when they automatically switch off. The cellmate said that after the telephones were switched off, Mr Hussain sat writing and told Mr Morris that he had written letters to his mum and his partner and asked him to post them the next day.
58. The cellmate said that he fell asleep and woke up at around 11.30pm. He saw that Mr Hussain was crying. He fell asleep again and woke at around 1.30am to use the toilet. He said that Mr Hussain was asleep in bed.
59. Mr Hussain and the cellmate did not raise any concerns with staff about Mr Hussain's well-being during the evening and overnight.

#### **Events of 27 August – 12 September**

60. On 27 August, a PCO was on duty. At around 7.30am, he started to deliver milk cartons and a breakfast pack to each cell. The PCO told the investigator that this was also an opportunity to complete a welfare check and involved opening the cell door.
61. When he entered Mr Hussain's cell, Mr Hussain was sat up in bed and his cellmate was sleeping. As he stepped into the cell he said 'good morning' to Mr Hussain and asked how he was. Mr Hussain asked to speak to the OM. The PCO told him that she was in a meeting until around 9.00am but asked if there was anything he could help with. Mr Hussain said 'no' and that he just wanted to speak with the OM. The PCO said that it was a 'normal' conversation. Mr Hussain was not upset, and he gave the PCO no cause for concern. When he left the cell, Mr Hussain was watching television.
62. The cellmate said that he woke up at around 7.30am and heard Mr Hussain having a conversation with someone who he believed was the PCO. He recalled Mr Hussain asking to speak with the OM then he went back to sleep.
63. At around 8.30am, the cellmate woke up again. He said that he could sense Mr Hussain standing by his bed. He thought that Mr Hussain was looking out of the window. He tapped his leg and then touched his hand, which felt cold. He said as he came around from his sleep, he realised that Mr Hussain had a bedsheet around his neck and was hanging from the window bars. He immediately began shouting to his cousin, who was in the cell next door and told him to call for help.
64. At 8.25am, the PCO had begun unlocking prisoners to attend work. As he continued around B3, he heard the cellmate kicking his door and shouting for him to open it. The PCO said that he unlocked the door and the cellmate was crying and

said 'Ishy' (this is how Mr Hussain was referred to by friends and those who knew him). The PCO said 'what do you mean Ishy?' The cellmate stepped to the side and the PCO said that he saw Mr Hussain hanging at the back of the cell.

65. The PCO immediately radioed a code blue (indicating that a prisoner is unconscious or is having breathing difficulties) and entered the cell. He lifted Mr Hussain up and cut the ligature between his neck and the window. He laid Mr Hussain onto the floor and put him in the recovery position. Control room staff called an ambulance at 8.33am. The PCO removed the ligature from around Mr Hussain's neck and checked for a pulse and signs of breathing. Two OMs and a nurse attended.
66. The nurse assessed Mr Hussain and started CPR. She told staff that the ambulance needed to be high priority and this information was relayed to the control room. Staff brought a defibrillator and attached it to Mr Hussain and continued with CPR. At 8.37am, more nursing staff arrived and brought a response bag containing oxygen which was applied to Mr Hussain. The defibrillator indicated no shockable rhythm and advised for CPR to continue. Nursing staff observed that Mr Hussain was making efforts to breath independently and a pulse was detected.
67. At 8.48am, paramedics arrived at the cell. They took over Mr Hussain's care and treatment. Mr Hussain was taken to hospital. He was breathing but unconscious.
68. Mr Hussain was taken straight to the hospital's ITU. He remained sedated and unconscious. On 29 August, the hospital told the prison that Mr Hussain had been taken off sedation and although he had opened his eyes and was breathing independently, he did not respond to pain stimulus or voice commands. He was placed back under sedation and the hospital scheduled a further brain scan.
69. The next day, the hospital told the prison that Mr Hussain's condition was unlikely to improve and that a discussion would take place with his family about withdrawing life support.
70. On 31 August, the prison applied for Mr Hussain's early release on compassionate grounds. On 1 September, the application was successful, and Mr Hussain was released from prison. No prison escort staff were with him at hospital from this date.
71. Mr Hussain's life support was later withdrawn, and he continued to receive palliative treatment.
72. At 1.00am on 12 September, Mr Hussain died in hospital.

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

73. On 27 August, the prison appointed two members of staff, from the prison chaplaincy team, as the Family Liaison Officers (FLO). They contacted Mr Hussain's family, and a FLO informed them that Mr Hussain had been taken to hospital.
74. A FLO spoke with the family again on 28 August. The family gave the FLO an update on Mr Hussain's condition. Mr Hussain was released from prison on

compassionate grounds on 1 September. Both FLO's had no contact with the family until 13 September, when they were informed of Mr Hussain's death.

75. Mr Hussain's funeral took place on 15 September. The prison offered to contribute toward the funeral costs in line with national policy.

### **Support for prisoners and staff**

76. On 27 August, a hot debrief with all staff involved in the emergency response was carried out to ensure that they had the opportunity to discuss any issues arising, and to offer support. After Mr Hussain died, the prison offered additional support to staff. In early November, a 'cold' debrief was conducted with those staff involved in the initial emergency response.
77. The prison posted notices informing other prisoners of Mr Hussain's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case Mr Hussain's death had adversely affected them. Staff and prisoner peer supporters supported Mr Hussain's cellmate. He was also placed on an ACCT for additional support.

### **Post-mortem report**

78. At Mr Hussain's family's request and in keeping with their religious faith, no post-mortem or other tests were carried out following his death.

# Findings

## Management of Mr Hussain's risk of suicide and self-harm

79. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Parc should have recognised Mr Hussain as at risk and started ACCT procedures.
80. When Mr Hussain entered custody, he had risk markers for self-harm from 2019. He had committed a domestic violent offence and was a licence recall, which are seen as potential risk factors for early days in prison custody. In addition, he had a documented history of poor mental health and told staff that he was low in mood because of the recent death of his nephew and the anniversary of his son's death. Other information relating to more recent thoughts and acts of self-harm were not recorded on the PER documents that arrived with him into prison. There is no evidence that the community Probation Services shared this information with prison staff.
81. We consider that reception staff at Parc, even with the information available to them, relied too heavily on what Mr Hussain said and how he presented and did not give sufficient consideration to his other risk factors. When interviewing staff at Parc, the investigator was also concerned that some staff were not fully aware of what factors, such as licence recall, would potentially increase an individual's risk.
82. Mr Hussain's actions came sometime after his arrival into prison, and at a time when staff felt that he was coping well. We cannot say for certain whether closer monitoring would have prevented his actions. We make the following recommendations:
  - **The Director should remind staff of the importance of considering all of a prisoner's current risk factors when assessing risk and that they should not rely solely on what a prisoner says, how they present or their past behaviour in prison.**
  - **The Director should ensure that where Early Days in Custody or other induction processes identify risk factors, not already known, staff should clearly document the details of these and any defensible decision to not open an ACCT.**
  - **The Director should ensure that staff are reminded of the risk factors that they should be looking out for when prisoners arrive into prison custody from court or another establishment.**
  - **The Probation Service should remind community offender managers of the importance of sharing appropriate risk information in a timely manner with HMP staff, and the process for doing so, particularly in cases where an individual has been recalled to custody.**

## Early Days in Custody Tool

83. The Early Days in Custody (EDiC) tool has many sections that staff need to complete. One section of the tool asks the prisoner questions with answers being based on a scale of 1 – 10, with 1 indicating not at all and 10 indicating 'very'. For example, one of the questions asked was, 'how safe do you feel at Parc?' Mr Hussain answered nine, indicating that he felt safe. The next question asked, 'how anxious do you currently feel?' Mr Hussain answered 10, which, based on the format used, would indicate that he was very anxious. However, at interview, a caseworker who completed the forms with Mr Hussain said that for this question, 10 indicates 'not at all.' She told the investigator that Mr Hussain had said that he was not at all anxious.
84. The current EDiC form and scoring system is open to misinterpretation and very confusing for anyone reading and completing it, particularly for those who are not familiar with the scoring system. Given that this is a tool used by multiple users across the prison, it is important that the information recorded, and the scoring is clear. We make the following recommendation:

**The Director should review the current EDiC Tool and ensure that it is in a format that is clear, concise, and easy to understand.**

## Clinical care

85. The clinical reviewer concluded that the care Mr Hussain received at Parc was equivalent to that which he could have expected to receive in the community.
86. He considered that Mr Hussain's physical health needs were responded to in a timely and appropriate way. His mental health needs were appropriately assessed, and he was prescribed appropriate medication. Healthcare staff gave Mr Hussain advice about ongoing support for his mental health.
87. The clinical reviewer was concerned, however, that although Mr Hussain's mental health needs were assessed and responded to in a timely and appropriate way, not all relevant information relating to his mental health was recorded in his medical record. We recommend:

**The Head of Healthcare should ensure that when additional information relating to a prisoner's background, suggested interventions and decisions are shared between healthcare staff and operational staff, the information is recorded in the prisoner's medical record so that it is accessible to the wider healthcare team.**

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