Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Abdullah Popalzai, a prisoner at HMP Pentonville, on 29 November 2019

A report by the Prisons and Probation Ombudsman

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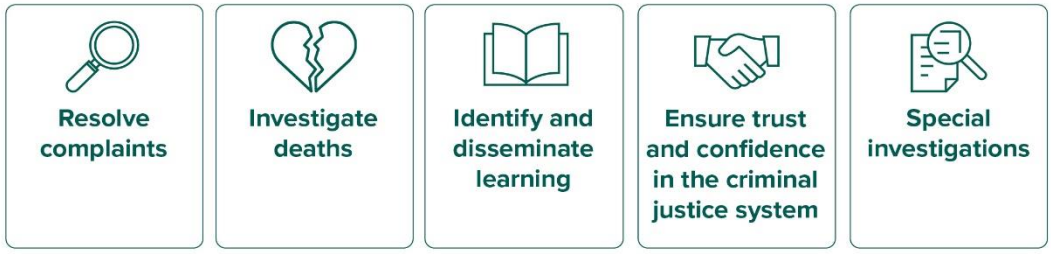
OUR VISION

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

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 Abdullah Popalzai was found hanged in his cell at HMP Pentonville on 29 November 2019. He was 20 years old. I offer my condolences to those who knew him.

This is a worrying case.

In September 2019, Mr Popalzai appeared at court and was assessed as requiring detention under the Mental Health Act in a psychiatric hospital but, because there was no transport available, he was remanded to Pentonville instead. He had significant mental health needs and was vulnerable and challenging. I do not consider that prison was a safe location for him, and I am concerned that the delay in referring him to a secure hospital meant that he stayed in prison for longer than he should have done. I am also concerned that, despite his poor English, an interpreter was not regularly used to assess his ongoing needs.

Mr Popalzai had several risk factors for suicide and self-harm. I am concerned that both healthcare and prison staff under-estimated Mr Popalzai's risk to himself and missed a number of opportunities to monitor him under suicide and self-harm prevention procedures (known as ACCT).

This is not the first time we have made recommendations about the failure to identify and manage risk at Pentonville. The Governor and the Prison Group Director for London must ensure that improvements are made urgently.

The report identifies a number of other weaknesses which must also be addressed.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2022**

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Summary

Events

1. On 24 September 2019, Mr Abdullah Popalzai appeared in court charged with grievous bodily harm and a court psychiatrist recommended that he should be detained in hospital under the Mental Health Act. However, there was no transport available to take him to hospital and he was instead remanded to HMP Pentonville. During the transfer, escort staff noted that he had harmed himself and said that he would kill himself. His English was poor.

2. When Mr Popalzai arrived at Pentonville, prison and healthcare staff did not consider that he was at risk of suicide or self-harm. A nurse noted his previous contact with court health professionals and that he had previously threatened to kill himself if he was treated against his will in hospital. Mr Popalzai was admitted to the prison's inpatient unit, where his behaviour was described as volatile and threatening.

3. On 9 October, a prison psychiatrist assessed Mr Popalzai, using an interpreter. Two days later, he was referred to a secure hospital for assessment due to his acute paranoid psychosis. A hospital psychiatrist assessed him on 18 October and a week later, it was confirmed that he should be sectioned under the Mental Health Act and that he was on the waiting list for a bed in a secure hospital.

4. On 22 November, two prison psychiatrists signed Mr Popalzai's medical reports to transfer him to hospital as they had been told that a bed was available. The following day, a nurse told Mr Popalzai that he was going to be transferred to hospital. On 25 November, it was confirmed that he would transfer on the afternoon of 29 November, although staff say that Mr Popalzai was not aware of the date.

5. At around 12.30pm on 29 November, an officer found Mr Popalzai unresponsive in his cell with a ligature tied around his neck. Nurses and officers tried to resuscitate him, and ambulance paramedics arrived and assisted. Their attempts were unsuccessful and at 1.18pm they confirmed that Mr Popalzai had died.

Findings

6. We are concerned that staff at Pentonville under-estimated Mr Popalzai's risk of suicide and self-harm, that they did not identify his risk factors and that he was not monitored under ACCT procedures.

7. Although Mr Popalzai had told healthcare staff that he would take his life if he was transferred to hospital, they gave him advance notice that he was going to be transferred and did not review his risk or put additional observations in place on the day the transfer was due to take place.

8. Mr Popalzai spoke little English and had been identified as requiring assessment and treatment at a secure mental health unit. However, it took 15 days after his arrival at Pentonville before a prison psychiatrist used an interpreter to complete his initial assessment.

9. Despite Mr Popalzai's significant mental health needs, this was the only time in his eight weeks at Pentonville that the prison's mental health team used an interpreter. We are concerned about the delay in securing an interpreter for his assessment and that one was not used during his regular assessments and in supporting him during his time at the prison.

10. Mr Popalzai rarely left his cell, frequently not leaving it in a 24-hour period. We consider that his very restricted regime is likely to have contributed to his already serious mental health issues, but there is no evidence that prison or healthcare staff took this into account. We were told that many of the regime issues arose because of insufficient prison officer staffing levels in the inpatient unit.

11. Although healthcare staff responded quickly when Mr Popalzai was found hanged in his cell, a medical emergency code was not called, and this led to a short delay in calling an ambulance.

12. Transfers from prison to hospital under the mental Health Act should take place within 14 days, but Mr Popalzai had been waiting for over a month when he died.

13. Healthcare staff did not properly follow the process for transferring Mr Popalzai to hospital. Although efforts were made to secure a hospital place for him, they did not inform the Ministry of Justice about the need for a transfer until 25 November.

14. Although Mr Popalzai's care plans were reviewed regularly, there is little evidence that healthcare staff adhered to them and staff did not consider managing his care under a multi-professional, complex case clinic approach.

Recommendations

- **The Governor and Head of Healthcare should ensure that all staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that staff:**
    - **do not rely solely on what a prisoner says or how he presents when assessing a prisoner's risk of suicide or self-harm;**
    - **consider whether a prisoner has any risk factors or triggers for suicide and self-harm as set out in PSI 64/2011;**
    - **read and use all available information (such as person escort records and medical records);**
    - **start ACCT procedures where appropriate;**
    - **record the information considered and the reasons for the decision; and**
    - **consider use of the enhanced case management approach for prisoners with complex needs.**

- **The Prison Group Director for London should arrange to meet the Ombudsman, within one month of the date of this report, to discuss what action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.**

- **The Governor and Head of Healthcare should ensure that:**
    - **if a prisoner is not fluent in English, interpretation services are used for first night healthcare screening, initial and regular assessments and ward rounds to provide effective nursing care planning and support; and**
    - **all operational and healthcare staff understand how to book interpretation services.**
- **The Governor and Head of Healthcare should:**
    - **provide guidance to staff on how to safeguard prisoners deemed too volatile to be unlocked from their cells;**
    - **ensure that prisoners in the inpatient unit who are unable to leave their cells are offered materials to occupy themselves and that the offer is noted in their medical records; and**
    - **remind all senior clinicians to raise their concerns directly with the Mental Health Lead and Governor if prisoners are not able to access the wing regime or in cell activities due to staffing levels.**
- **The Governor should ensure that staffing levels in the inpatient unit are sufficient to offer all prisoners on the unit a full regime.**
- **The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including that staff radio an appropriate emergency code.**
- **The Governor and Head of Healthcare should ensure that healthcare staff:**
    - **understand and follow the national guidance on transferring prisoners to hospital under the Mental Health Act; and**
    - **inform NHS England and the Ministry of Justice's Mental Health Casework Section promptly when a prisoner is assessed as needing to be transferred**.
- **The Head of Healthcare and the manager of the inpatient unit should review care plans and clinical records together to ensure that the aims and actions of the care plans are being carried out satisfactorily.**
- **The Head of Healthcare and Mental Health Lead should ensure that:**
    - **there is more integrated working within the wider healthcare team; and**
    - **multi-professional complex case clinic referrals are considered for patients awaiting a mental health transfer to hospital.**
- **The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report, including GPs and psychiatrists, and that a senior manager discusses the Ombudsman's findings with them.**

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator visited Pentonville on 15 November 2019. He obtained copies of relevant extracts from Mr Popalzai's prison and medical records.

17. NHS England commissioned a clinical reviewer to review Mr Popalzai's clinical care at the prison.

18. NHS England (London Region) also commissioned another clinical reviewer to conduct an independent review under the NHS England *Serious Incident Framework* of Mr Popalzai's care and treatment from his arrest on 19 September 2019 to his death on 29 November 2019. This review considered the care Mr Popalzai received from the liaison and diversion services at Barkingside Magistrates Court, as well as the care he received in prison.

19. We have not considered the actions of the court liaison and diversion services in this report as they are outside the PPO's remit.

20. The investigator interviewed 14 members of staff at Pentonville, some jointly with the clinical reviewer. All the interviews were conducted remotely because of the COVID-19 restrictions.

21. We suspended our investigation in May 2020 while we waited for the reviews from both clinical reviewers.

22. We informed HM Coroner for London (Inner North) of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

23. Mr Popalzai had no recorded next of kin, and the Ombudsman's family liaison officer was therefore unable to contact anyone about this investigation. However, Mr Popalzai's next of kin was later identified by the Coroner and a copy of this report has been sent to them.

24. Mr Popalzai's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Pentonville

25. HMP Pentonville is a local prison in London that holds around 1,200 prisoners. The prison primarily serves the courts of north and east London. Practice Plus Group (formerly known as Care UK) provides healthcare services at the prison in partnership with Barnet, Enfield and Haringey Mental Health Trust.

HM Inspectorate of Prisons

26. HM Inspectorate of Prisons carried out an unannounced inspection of Pentonville in April 2019. Inspectors reported that ACCT support processes remained weak, and were generally poorly managed, and that staff did not always know how to start ACCT procedures or fully understand the range of possible triggers for suicide and self-harm. Inspectors reported that interpreting services were not always used when needed. They also said that Pentonville had suffered the consequences of inadequate staffing for far too long.

27. Although inspectors reported that health services were very good overall, and that mental health provision was particularly impressive, they found that patients waited too long for transfer to secure hospitals. They found it unacceptable that three-fifths of patients requiring transfer under the Mental Health Act had to wait more than two weeks for transfer during 2018/2019. They recommended that patients requiring care in external mental health services should be transferred promptly.

28. Inspectors reported that while Pentonville had not systematically implemented PPO recommendations following investigations into previous deaths in custody, nearly all the PPO's healthcare recommendations had been met.

29. HMIP carried out an Independent Review of Progress in January 2020 to review the progress made in achieving the key recommendations from the 2019 inspection. They found that no meaningful progress had been made to improve ACCT management or in implementing PPO recommendations.

30. In November 2020, HMIP also carried out a scrutiny visit (a shortened inspection during the COVID-19 pandemic) Inspectors reported that the prison was trying to address a large number of outstanding PPO recommendations, but some critical concerns had still not been effectively resolved, including the inconsistent management of ACCT procedures. They also found that the use of interpreting services was poor. Inspectors noted that some modifications had been made to the regime in the inpatient unit but said that there continued to be delays in facilitating transfers to hospital under the Mental Health Act.

Independent Monitoring Board

31. 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 ending March 2020, the IMB reported that incidents of self-harm at Pentonville had risen by 14% over the

reporting year. The IMB also reported that the prison had a large proportion of prisoners with severe mental illness and that there were sometimes delays in the process of sectioning patients under the Mental Health Act.

Previous deaths at HMP Pentonville

32. Mr Popalzai was the fourth prisoner to take his life at Pentonville since May 2017. Since his death, there have been a further four self-inflicted deaths at the prison.

33. There are a number of similarities between our findings in this investigation and in other investigations. In three of the previous investigations into previous deaths we expressed concerns about failures to identify and assess prisoners' risk to themselves. We have raised similar concerns following our investigations into three subsequent self-inflicted deaths at Pentonville (in February and July 2020 and March 2021). The most recent self-inflicted death (June 2021) is still being investigated.

34. In our report into the death of a prisoner in August 2019, we asked the Prison Group Director for London to write to the Ombudsman, setting out what she was doing to satisfy herself that effective action was being taken to improve the quality of ACCT assessments and reviews at Pentonville. She responded in October 2020 setting out actions that had been and would be taken to ensure improvements.

35. In our report into the death of a prisoner in November 2018, and in the death of another who died from a drug-related death at Pentonville, we also made recommendations about calling a medical emergency code promptly.

Assessment, Care in Custody and Teamwork (ACCT)

36. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. As part of the process, a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the caremap actions have been completed. After closure, a follow-up interview should take place within seven days.

37. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies prisoners as they move around the prison. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

Transfers of prisoners to hospital under the Mental Health Act

38. PSI 50/2007 and NHS England's *Good practice guidance* outline the process for transferring a prisoner to a psychiatric hospital under the Mental Health Act. In October 2007, a revised version of procedures for the transfer of prisoners to hospital was issued. This acknowledged that there had been unacceptable delays in transferring prisoners in the past and provided a best practice flowchart for all key stakeholders.

39. In order for a prisoner to be transferred to hospital, two independent medical practitioners must assess the prisoner and agree on the diagnosed mental disorder and the need for inpatient treatment. These assessments are valid for two months.

40. The PSI and best-practice flow-chart state that the Ministry of Justice's Mental Health Casework Section (MHCS) the NHS England health and justice commissioning team must be informed when a prisoner is first assessed as needing to transfer to a mental health unit. The commissioning team then appoints a case manager to lead on finding a hospital bed promptly. If the local service does not immediately have a bed space, the case manager should identify the most clinically appropriate alternative service. The MHCS then issues a transfer warrant, which is valid for 14 days and allows the prisoner to be transferred to hospital under the direction of the Secretary of State.

Key Events

Background

41. Mr Abdullah Popalzai came to the United Kingdom from Afghanistan as an asylum seeker in early 2017. He spoke Pashto and Urdu, and his English was limited. (Mr Popalzai's name is recorded in several different ways by different services and organisations.)

42. In June 2017, Mr Popalzai registered with a GP. He was referred to social and mental health services, diagnosed with moderately severe depression and prescribed a short course of antidepressants. He did not subsequently engage with mental health services.

2018

43. On 11 April, Mr Popalzai was remanded to HMP Pentonville after he failed to attend court on a charge of possessing cannabis. The reception nurse noted that he was anxious, felt low and had thoughts of suicide and self-harm. Suicide and self-harm monitoring procedures (known as ACCT) were started. Mr Popalzai told the prison GP, who used an Urdu interpreter, that he saw ghosts and felt that people were trying to harm him. The GP referred him to the prison's mental health team, but he was released from court the following day before he was assessed.

2019

44. On 19 July 2019, Mr Popalzai was remanded to HMP Thameside charged with arson. The prison's substance misuse team saw him and noted that he was confused and appeared to be hallucinating, probably due to alcohol withdrawal. Mr Popalzai was due to be assessed by the prison GP but was released on bail on 23 July after a court appearance.

45. On 19 September, Mr Popalzai was arrested and charged with assaulting a traffic warden, causing actual bodily harm. He was detained in police custody. A mental health liaison and diversion practitioner tried to assess him with a Pashto interpreter but was unable to do so due to Mr Popalzai's challenging and uncooperative behaviour. The practitioner concluded that that there was not enough evidence to refer Mr Popalzai for an assessment under the Mental Health Act. He said that a further assessment should be considered if Mr Popalzai presented with symptoms of mental disorder the following day.

46. On 20 September, Mr Popalzai appeared at court. A forensic mental health practitioner with the court's liaison and diversion team tried to arrange an urgent psychiatric assessment for Mr Popalzai but one was not available. She noted that Mr Popalzai's behaviour had become more extreme and that he was responding to visual hallucinations, hearing voices, harming himself and displaying behaviours indicative of psychosis. She concluded that Mr Popalzai posed a high risk to himself and others. She planned for him to have a full psychiatric assessment under the Mental Health Act when he next appeared at court on 24 September.

She noted that he would need an interpreter and transport arrangements if he was to be transferred to hospital. (Her assessment was later shared with Thameside.)

47. Mr Popalzai was remanded to Thameside as the court was concerned about his risk to the public.

HMP Thameside

48. A reception nurse noted that Mr Popalzai spoke little English but could be understood, appeared cheerful and talkative, denied any substance misuse, had no history of mental illness, denied thoughts of suicide and self-harm and was not known to community mental health teams. A secondary health screen the following day came to a similar conclusion but noted that Mr Popalzai appeared not to understand questions put to him due to his poor English.

49. On 23 September, the forensic mental health practitioner spoke with a mental health nurse at Thameside and shared her 20 September assessment of Mr Popalzai, including that she had arranged for him to have a psychiatric assessment when he next attended court on 24 September. The nurse noted that Mr Popalzai would be discussed at the prison mental health team's next referral meeting.

50. On 24 September, Mr Popalzai appeared at court. A forensic psychiatrist assessed him and noted that Mr Popalzai was hearing voices, that ghosts were influencing his thoughts and that his mood changed from smiling and engaging to verbally aggressive. He noted that Mr Popalzai was not taking any medication and that he said that he would kill or hang himself if he was treated against his will in hospital or was handed over to the Home Office. He concluded that Mr Popalzai presented with psychosis and was a risk to himself and others and he recommended that he should be detained in a psychiatric hospital under the Mental Health Act for assessment and treatment.

51. Although a hospital bed was found just before Mr Popalzai appeared at court, there was no ambulance or police escort available to take him there. The court remanded Mr Popalzai to Pentonville until his next court appearance on 21 October 2019 due to his risk to the public and said that the prison could transfer him to a secure hospital under the Mental Health Act if he displayed mental health issues.

52. The psychiatrist noted in his psychiatric report, which was shared with Pentonville and added to his medical records, that if Mr Popalzai was remanded into custody, the prison's mental health team should liaise with the hospital to assess and transfer him and that the prison should manage him under ACCT procedures because of a risk of suicide.

HMP Pentonville

53. The escort officer taking Mr Popalzai to Pentonville noted on the person escort record (PER) that Mr Popalzai banged and kicked the cell door in the escort van on his way to Pentonville and had shouted that he would kill himself.

54. At 5.30pm on 24 September, Mr Popalzai arrived at Pentonville. An officer, whom the prison thought was an officer who has since resigned, noted on the PER that Mr

Popalzai wanted to kill himself and had sustained facial injuries, likely caused by banging his face on a wall or door.

55. A Supervising Officer (SO) completed a first night priority process sheet. She, who had seen the PER form, recorded that Mr Popalzai had mental health issues and had not indicated whether he was at risk of suicide or self-harm.

56. An officer noted that Mr Popalzai had no known history of self-harm and had not previously been monitored under ACCT procedures but presented with evidence of mental illness. He later noted that Mr Popalzai could understand English and had no thoughts of self-harm.

57. A mental health nurse completed an initial health screen. Because Language Line, a telephone interpreting service, was not available, he asked a colleague who spoke Pashto to interpret. He noted that Mr Popalzai had a history of substance misuse, had never received treatment from a psychiatrist, engaged well, had no thought disorder, emotional distress or perceptual disturbances and was able to recall old information and process new information. He noted that Mr Popalzai had headbutted the wall of the escort van and sustained injuries to his face but had no thoughts of self-harm.

58. Mr Popalzai then saw a prison GP, who reviewed his medical records and noted his facial injuries from banging his head a few days earlier and that he had reported seeing "dark, shadowy" figures most nights. He noted that Mr Popalzai was alert and denied thoughts of self-harm but was smiling inappropriately. The GP referred him to the mental health team.

59. On 25 September, a mental health nurse assessed Mr Popalzai. He did not use an interpreter. He noted that it was difficult to communicate with Mr Popalzai due to his poor English and that he was distracted, covered his face with his hands, talked about ghosts in his cell and said he heard voices. The nurse concluded that Mr Popalzai exhibited evidence of a psychotic illness and referred him for admission to the prison's mental health inpatient unit.

60. Mr Popalzai was discussed at the prison's daily multi-disciplinary health and wellbeing meeting. It was noted that Mr Popalzai had been referred for a mental health assessment at Thameside.

61. On 26 September, a mental health nurse from Thameside contacted her colleagues at Pentonville to ensure they were aware of Mr Popalzai's mental health needs and that his psychiatric assessment was on his medical record. Nurses reviewed him over the following days and noted that he spoke little English and was distracted but denied thoughts of suicide or self-harm.

62. On 28 September, a mental health nurse reviewed Mr Popalzai. She noted that he denied thoughts of self-harm, had a shirt tied around his head, spoke little English and jumped from one topic of conversation to another, which she found difficult to follow.

63. On 29 September, Mr Popalzai was admitted to the inpatient unit, where a mental health nurse assessed him. He noted Mr Popalzai's previous contact with court health professionals and that he had previously threatened to hang himself if he

was treated against his will in hospital or was handed to the Home Office. He noted that Mr Popalzai responded to external stimuli, was uncooperative, displayed signs of psychosis, posed a risk of violence and spoke very little English (although no interpreter was requested). He referred Mr Popalzai to the prison psychiatrist for an assessment.

64. On 30 September, a forensic psychiatrist tried to assess Mr Popalzai, but officers advised him not to due to Mr Popalzai's unpredictable behaviour (as he had reportedly spat at staff). He noted that Mr Popalzai was aroused and shouted in his own language. He noted that no therapeutic engagement had been possible and planned for him to be checked once it was safe. He sought information to establish Mr Popalzai's address so that he could refer him to a hospital in the right catchment area.

65. That day, an officer noted that Mr Popalzai had shouted out and banged his cell door for most of the day, and that he refused to speak to staff. He was given his meals in his cell.

66. On 1 October, a nurse noted that she had been allocated as Mr Popalzai's primary mental health nurse, which meant she was responsible for reviewing his care plan. She noted that Mr Popalzai, who was being checked every 30 minutes, was overly aroused, angry and racially abusive. She noted that he was too unwell to mix with other prisoners.

67. On 2 October, a nurse noted that staff could not offer Mr Popalzai a full regime because of his "mental state" and poor behaviour. The psychiatrist tried to assess him at his cell door but noted that it was not possible due to due to the language barrier. The doctor planned to request a Pashto interpreter.

68. On 3 October, Mr Popalzai was discussed at the ward round as his behaviour was too unpredictable for him to attend. The psychiatrist later reviewed him at his cell door and noted that he remained distressed. He requested a Pashto interpreter.

69. On 4 October, a mental health nurse noted that Mr Popalzai had been seen crying on his bed, was verbally abusive and threatening and that staff should remain cautious. He also noted that although Mr Popalzai was hard to understand, his English was good enough to make requests that met his needs.

70. A nurse wrote Mr Popalzai's first full nursing plan which noted the need for an interpreter. She also noted that Mr Popalzai had previously threatened to hang himself if he was transferred to hospital.

71. Over the following days, Mr Popalzai appeared to settle.

72. On 7 October, the psychiatrist tried to assess Mr Popalzai again, but was unable to without a Pashto interpreter.

73. On 9 October, the psychiatrist assessed Mr Popalzai through his cell door with a Pashto interpreter. He noted that Mr Popalzai was angry and emotional and that he reported hearing voices in his head, which were more pronounced at night. He planned for Mr Popalzai to be reviewed during a ward round the following day.

74. On 10 October, the psychiatrist and a consultant psychiatrist reviewed Mr Popalzai at his cell as he was too volatile to attend the ward round. They noted signs of psychosis but were again unable to assess him fully due to the language barrier. They planned for Mr Popalzai to remain in the inpatient unit for ongoing monitoring of his mental health.

75. On 11 October, the psychiatrist referred Mr Popalzai to a consultant psychiatrist at the Newham Centre (a secure psychiatric unit) for further assessment and referral under the Mental Health Act. The psychiatrist told his colleague that Mr Popalzai continued to respond to unseen stimuli and would benefit from a period of assessment in hospital. He asked him to assess Mr Popalzai's suitability for admission to the Newham Centre.

76. On 12 October, a nurse reviewed Mr Popalzai and noted that he was irritable and hostile and that it was difficult to understand him. She noted that his cell was clean and tidy but that he continued to wear a t-shirt on his head. She again noted that he needed an interpreter. She considered that Mr Popalzai posed a low risk to himself but a high risk to others because of his continuing racial abuse and spitting at staff.

77. On 14 October, it was noted that Mr Popalzai had slept well overnight. A nurse noted that Mr Popalzai had not been disruptive and had eaten. She assessed his risk to himself as low.

78. On 15 October, Mr Popalzai flooded his cell. It was noted he had been agitated and aggressive. A nurse later noted that he had settled but had had minimal interaction with others and could be heard "screaming at times". The following day, he continued to be abusive and threatening to staff.

79. On 17 October, the psychiatrist and consultant psychiatrist discussed Mr Popalzai at the ward round. He refused to engage and was abusive and threatening. They noted that it was difficult to assess his mental health due to his poor English.

80. On 18 October, the psychiatrist assessed Mr Popalzai, with a Pashto interpreter. He noted that Mr Popalzai banged his head violently against the cell door and was threatening and agitated. He concluded that Mr Popalzai presented with acute paranoia and recommended that he should be admitted to hospital under the Mental Health Act for urgent assessment and treatment with antipsychotic medication. (The Newham Centre's consultant psychiatrist's visit and assessment were not noted on Mr Popalzai's medical record and the prison psychiatrists had to wait for the outcome of his assessment.)

81. On 23 October, A nurse reviewed Mr Popalzai's care plan. The nurse noted that he remained unsettled, refused to have his observations taken, should remain on 30-minute observations and that an interpreter should be used.

82. On 24 October, a nurse noted that Mr Popalzai had an unsettled night. He continued to respond to unseen stimuli and had punched and kicked the cell's walls and door when he was told he could not leave his cell because it was night-time. The psychiatrist and consultant psychiatrist could not assess Mr Popalzai due to his unpredictability and because he refused to engage.

83. The psychiatrist wrote to the consultant psychiatrist at the Newham Centre to ask if Mr Popalzai would be admitted to hospital. The consultant psychiatrist confirmed that Mr Popalzai had been accepted for transfer to the Newham Centre for his paranoid psychosis but said that bed availability was limited. On 25 October, formal confirmation was received that Mr Popalzai was on the waiting list for a bed.

84. On 27 October, an officer introduced himself to Mr Popalzai as his keyworker, but a nurse advised him against interacting with him as it would likely cause him further distress. On 28 October, a nurse again noted the need for an interpreter so that Mr Popalzai could take part in one-to-one sessions as part of his care plan.

85. On 31 October, the psychiatrist and consultant psychiatrist discussed Mr Popalzai during the ward round. He did not attend as his behaviour remained unpredictable. They tried to assess him later that day, but Mr Popalzai refused to engage. Pentonville asked the hospital for an update on bed availability but was told one was still not available.

86. On 2 November, an officer noted that Mr Popalzai was deteriorating and becoming more guarded and non-responsive to staff. On 4 November, Mr Popalzai appeared at court and was found guilty of assault. On 7 November, the psychiatrist and consultant psychiatrist noted that he appeared less “disturbed” than the previous week. On 10 November, a nurse reviewed Mr Popalzai. She noted that he slept all day on the floor and did not engage much with staff.

87. On 11 November, Pentonville asked the hospital for an update on bed availability. On 14 November, further plans were made to chase the hospital about bed availability.

88. On 17 November, a mental health nurse noted that Mr Popalzai had not engaged with night staff and had been shouting and kicking his cell door. The nurse noted that Mr Popalzai was walking on his bed, talking to himself and spent much of the day asleep.

89. On 21 November, a mental health nurse noted that Mr Popalzai had slept during the night. The psychiatrist and consultant psychiatrist discussed him during the ward round, which he again did not attend due to his behaviour. The psychiatrist reviewed him later at this cell door. He noted that Mr Popalzai was “quite aroused”, shouting out in Farsi, demanding to be released and complaining that he was “being killed in prison”. He noted that he could not assess Mr Popalzai due to the language barrier and planned to chase the hospital about bed availability.

90. On 22 November, the psychiatrist and consultant psychiatrist were told that a bed was available for Mr Popalzai, and they signed his medical reports to transfer him to hospital under the Mental Health Act.

91. On 23 November, a mental health nurse noted that Mr Popalzai had had a disturbed night and had been verbally abusive to staff. A nurse noted that Mr Popalzai had woken at lunchtime and asked when he would be going home. The nurse told him that he would not be going home but to hospital at some point. (The nurse told the investigator that he provided no further detail about when Mr Popalzai might be transferred.) He noted that Mr Popalzai was calm and accepted what he

had been told but pointed to the walls of the cell and said that there had been people in his cell at night. He reassured Mr Popalzai that this was not the case.

92. On 25 November, it was confirmed that Mr Popalzai would be transferred to hospital on 29 November. The psychiatrist notified the Ministry of Justice's Mental Health Casework Section that Mr Popalzai needed to be transferred. On 26 November, the Mental Health Casework Section approved the warrant for Mr Popalzai's transfer to hospital and arrangements were made to transfer him to hospital by ambulance. (Prisoners are not told transfer dates for security reasons.)

93. That day, it was noted that Mr Popalzai continued to be abusive to staff and responded to unseen stimuli. A nurse noted that although Mr Popalzai took a shower, his behaviour prevented him from taking part in wing activities.

94. That night, a nurse noted that despite starting the night shouting, Mr Popalzai had settled in the early hours and had slept well.

95. On 27 November, a nurse noted that Mr Popalzai continued to be racially abusive to staff, remained unsettled and continued to respond to unseen stimuli. He remained in his cell all day.

Events of 28 November

96. On 28 November, a nurse noted that Mr Popalzai had been quiet overnight, had not engaged with staff but appeared to have slept well.

97. The psychiatrist and consultant psychiatrist reviewed Mr Popalzai during the ward round, which he did not attend. They noted that he remained unpredictable and continued to lack insight into his condition and refused to take medication. The psychiatrist later reviewed Mr Popalzai through his cell door and reported that he was lying on his bed, covered in a sheet, and that he did not respond when they called his name several times. The doctor noted that a secure ambulance had been requested for Mr Popalzai's transfer to hospital.

98. An officer who was on duty during the ward round, told us that Mr Popalzai was not discussed in detail because of his transfer to hospital the following day. She said that she did not think that Mr Popalzai knew he was going to hospital.

99. Another officer noted that Mr Popalzai had had a quiet day and had not banged on his cell door or been rude to staff as much as previously. A nurse also noted that Mr Popalzai had been quieter and seemed low but had not been unlocked due to his behaviour.

100. A nurse arrived for work that evening and at the handover, he was told that Mr Popalzai remained unsettled. He said he had previously read about Mr Popalzai transferring to hospital and he had learned that evening that there was now a specific plan to transfer him. He said that during the handover no one discussed monitoring Mr Popalzai under ACCT procedures.

Events of 29 November

101. On 29 November, Nurse A noted that Mr Popalzai had woken up at 12.30am, shouting, swearing and banging his cell door, and that this continued until the morning with only intermittent pauses. He said this contrasted with the previous few nights but reflected previous patterns of behaviour. He said that he had no meaningful conversation with Mr Popalzai that night. At 6.55am, he noted in Mr Popalzai's medical records that he would be transferring to hospital later that day.

102. Nurse A handed over to Nurse B at around 7.30am but said he did not mention Mr Popalzai's transfer during the handover. Nurse B could not recall if Nurse A said anything about Mr Popalzai.

103. Nurse A said that Nurse B told her at around 8.30am that she would be escorting Mr Popalzai to hospital at around 2.00pm. She said that as far as she knew, Mr Popalzai did not know that he would be going to hospital that afternoon and she did not tell him about it.

104. Mr Popalzai remained on 30-minute observations and a nurse checked on him at midday. At around 12.20pm, a nurse gave Officer A a verbal handover before her lunch break and confirmed that all the prisoners, including Mr Popalzai, had been checked.

105. When Officer A checked on Mr Popalzai at 12.29pm, she found him hanging from a ligature. She shouted to a Custodial Manager (CM) and other members of staff for assistance. Officer B responded and joined Officer A at the cell. The CM arrived seconds later and called an emergency code blue after the officers had entered the cell. Officer B confirmed by radio that an ambulance was required, and one was called at 12.31pm.

106. Officer A supported Mr Popalzai, while Officer B cut the ligature, which was made from a bed sheet and tied to the aerial socket. The CM checked for signs of life and immediately started cardiopulmonary resuscitation (CPR) with the assistance of her colleagues. A nurse arrived at around 12.31pm and took the lead in managing the resuscitation efforts. Other nursing colleagues brought emergency medical equipment, including oxygen, and helped with the CPR. A defibrillator was used but it advised no shock. Staff continued trying to resuscitate Mr Popalzai until paramedics arrived and took over at 12.43pm. At 1.18pm, paramedics confirmed that Mr Popalzai had died.

Contact with Mr Popalzai's family

107. Mr Popalzai left no next of kin details and the prison's family liaison officer tried unsuccessfully to identify his next of kin by contact with his solicitor, the police and the Afghan Embassy.

Support for prisoners and staff

108. The duty governor, the Head of Reducing Re-offending, 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. The

prison posted notices informing other prisoners of Mr Popalzai's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Popalzai's death.

Post-mortem report

109. A post-mortem examination found that Mr Popalzai died from suspension following a critical compression of his neck. Post-mortem toxicology results found no illicit substances in his system.

Findings

110. Mr Popalzai had significant and complex mental health issues and, on the day he arrived at Pentonville, he had been assessed as needing treatment in a psychiatric hospital, and as posing a risk to himself and others. The clinical reviewer noted that he did not engage with staff and was repeatedly hostile and abusive. She said that it proved impossible for staff to form a therapeutic relationship with Mr Popalzai, which could have led to treatment and, as he had not been sectioned under the Mental Health Act, he could not be compelled to accept medication while in custody.

111. Prisons are not a safe or appropriate location for people with severe and untreated mental illness. Pentonville lacked the resources and facilities to provide the level of support and care that Mr Popalzai required, and we do not consider that he should have been in prison.

112. Nevertheless, things could, and should, have been done better while he was at Pentonville, as we discuss below.

Identifying and managing Mr Popalzai's risk of suicide and self-harm.

113. Prison Service Instruction (PSI) 64/2011 on safer custody requires 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. The PSI states that prisoners who self-harm or express thoughts of doing so must be managed under ACCT procedures.

Reception

114. Mr Popalzai arrived at Pentonville on 24 September with a significant number of risk factors, including his youth; recent contact with psychiatric services; his planned transfer to a secure hospital; his lack of family and social support; his asylum status; his history of substance misuse; his irrational and disruptive behaviour; his difficulty understanding English and possible cultural difficulties. He also arrived with a PER recording that he had said that he would kill himself, and staff noted on his arrival that he had a facial injury, likely caused by banging his face on a wall or door (that is, by self-harm).

115. Given all of this, we are very concerned that reception staff did not open ACCT procedures when Mr Popalzai arrived at Pentonville.

116. The reception officer told the investigator that she would only look at the first two pages of the PER and therefore did not see the entries about self-harm so did not start ACCT procedures. We do not consider this is acceptable. The PER is there to provide information needed to keep the prisoner and other people safe. We appreciate that reception in a local prison like Pentonville is a very busy place, but staff who are responsible for making key safeguarding decisions when prisoners first arrive, have a clear responsibility to read the PER and take account of the information it contains.

117. The nurse who assessed Mr Popalzai in reception and noted that he had headbutted the wall of the escort van and sustained injuries to his face, told the investigator that he did not start ACCT procedures as Mr Popalzai was not suicidal and that actions such as his were sometimes out of frustration or anger. There is nothing to indicate that the nurse reviewed Mr Popalzai's previous medical records which stated Mr Popalzai's risk. The nurse said he did not have access to court records but generally had access to PERs. He could not recall whether he had seen Mr Popalzai's PER.

118. A prison GP saw Mr Popalzai that evening and noted his facial injuries from banging his head a few days earlier, psychotic features and that Mr Popalzai had reported seeing "dark" figures at night but had denied thoughts of self-harm.

119. Healthcare staff failed to review the psychiatrist's psychiatric report, which identified a risk of suicide and recommended that Mr Popalzai should be monitored under ACCT procedures if he was remanded into custody, although Pentonville received the report on 24 September. Neither the nurse nor the GP started ACCT procedures.

Self-harm

120. We are also concerned that although both prison and healthcare staff repeatedly recorded that Mr Popalzai was banging his head violently against the cell door or punching the wall, they did not consider starting ACCT procedures. Staff interpreted such behaviour as frustration or anger, rather than considering whether it might be self-harm.

Transfer to hospital

121. On 29 September, five days after Mr Popalzai's arrival at Pentonville, a nurse noted in his medical records that he said he would hang himself if he was transferred to hospital for treatment - information which was first recorded in the psychiatric report which the prison had received on 24 September. We are, therefore, very concerned that, after the nurse told Mr Popalzai on 23 November that he was going to be transferred to hospital, healthcare staff did not consider whether this might increase Mr Popalzai's risk and did not consider opening ACCT procedures.

122. Although there is no evidence to suggest that staff told Mr Popalzai the exact transfer date, we cannot be sure that he did not know that he was going to be transferred on 29 November, and, from 23 November onwards, he certainly knew that a transfer was imminent.

123. A psychiatrist said that there was no discussion at the ward round on 28 November about Mr Popalzai's heightened risk, and there was no clinical reason to increase his observations at the time as he "didn't really show any or verbalise anything to us that he has any intent to harm himself".

124. However, as we have said over many years, our investigations repeatedly show that staff often place too much weight on how a prisoner presents or what he says, rather than identifying his risk factors. Serious mental health issues are a well-recognised risk factor for suicide and self-harm.

125. Prisoners' intent on suicide rarely say so and often withhold the extent of their distress from staff, and although Mr Popalzai had stated his intention to self-harm before he arrived at Pentonville, he subsequently denied it. In addition, Mr Popalzai's mental illness meant his behaviour was volatile and irrational and little reliance could therefore be placed on the fact that he denied suicidal intentions. While a prisoner's presentation and comments are important and reveal something of the level of their risk, they are only a reflection of their state of mind at the time and should be considered as a single piece of evidence when judging risk. Staff should make a considered evaluation of all risk factors when assessing the risk of suicide and self-harm. We do not consider this was done in Mr Popalzai's case.

Challenging behaviour

126. As we have said, it proved impossible for prison or healthcare staff to form a relationship with Mr Popalzai.

127. His significant mental health issues seem to have meant that healthcare staff focused on his clinical care without considering ACCT monitoring. In addition, both healthcare and prison staff appear not to have considered Mr Popalzai's risk to himself because they were focussed on his risk to others. It is striking that none of the staff who had contact with Mr Popalzai considered that he might be at risk of suicide or self-harm.

128. The clinical reviewer said it was not clear if nursing staff made consistent and sustained attempts to engage with him because of his behaviour. A number of the entries in Mr Popalzai's prison record suggest that prison staff saw him simply as difficult, rather than as someone who was very mentally unwell. For example:

- "Continuously misusing his cell bell for non-emergency reasons and addressing male officers as `my brother'." (28 September)
- "Abdullah has been banging and shouting all day. He was banging the door so hard it appeared that more than one person was banging. When asked what he wants, he just rants." (20 October.)
- "Popalzai has spent the day in his cell. When staff went to him, he ranted something incomprehensible." (23 October)
- Spent the day in his cell. He appears to be always sulking. One cannot have a conversation with him without him shouting. A lot of pent up anger." (25 October)

129. We have identified in many previous investigations that challenging behaviour can often mask vulnerability. For this reason, we consider that managing risk of suicide and self-harm, treating mental ill health and managing challenging behaviour need to be better integrated.

130. The consultant psychiatrist said that she was not sure it would have made any difference if Mr Popalzai had been monitored under ACCT procedures, other than to consider putting him on a constant watch, which would have been intrusive.

131. We accept that we cannot know whether ACCT monitoring might have changed the outcome for Mr Popalzai. But it would have encouraged closer multi-disciplinary working which would have helped to give prison staff a better understanding of his behaviour and needs. And, most importantly, it would have explicitly recognised that Mr Popalzai posed a risk to himself and should therefore have identified that being told about the transfer to a secure hospital might be a trigger for suicide or self-harm. As a result, staff might have considered more carefully how, what and when Mr Popalzai should be told about the transfer and might have considered increasing his observations in the days before his transfer.

132. Given Mr Popalzai's extremely volatile and disruptive behaviour, he might also have benefitted from being managed under the enhanced ACCT case management process which would have brought together staff members with broader experience of dealing with complex cases and a higher level of coordination between multidisciplinary teams.

133. Our recent investigations have repeatedly found that ACCT procedures are poorly managed at Pentonville. Following a self-inflicted death in August 2019, we recommended that the then Prison Group Director for London should write to the Ombudsman, setting out what she was doing to satisfy herself that effective action was being taken to improve the quality of ACCT assessments and reviews at Pentonville. In response she told us that an in-depth review of the ACCT process had taken place and that assurance checks had been introduced.

134. However, since the self-inflicted death in August 2019, there have been five further self-inflicted deaths at Pentonville (including Mr Popalzai's) and in the four that we have investigated at the time of writing, we have continued to identify concerns about risk assessment and the use of ACCT. It is clear that more needs to be done. We, therefore, make the following recommendations:

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

- **do not rely solely on what a prisoner says or how he presents;**
- **consider whether a prisoner has any risk factors or triggers for suicide and self-harm as set out in PSI 64/2011;**
- **read and use all available information (such as person escort records and medical records);**
- **start ACCT procedures where appropriate;**
- **record the information considered and the reasons for the decision; and**
- **consider use of the enhanced case management approach for prisoners with complex needs.**

The Prison Group Director for London should arrange to meet the Ombudsman, within one month of the date of this report, to discuss what

action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.

The use of interpreters

135. Mr Popalzai's spoke Pushto and Urdu and healthcare and prison staff at Pentonville agreed that his English was limited. Although he spoke enough English to make his basic needs known, he was not able to communicate at the more sophisticated level required to discuss his mental health issues.

136. A nurse identified Mr Popalzai's limited knowledge of English when he arrived at Pentonville on 24 September. Because Language Line (the telephone interpretation service) was not available, he asked a senior officer, who spoke some Pushto, to interpret for him. Although this was inappropriate due to confidentiality issues, we understand why he did so. However, he incorrectly recorded that an interpretation service had been used.

137. On 2 October, the psychiatrist planned for a Pashto interpreter to enable him to assess Mr Popalzai. We are concerned that it took 15 days before the psychiatrist used an interpreter to complete Mr Popalzai's initial assessment. The psychiatrist said that it had been difficult to get a Pashto speaker. However, a review of Mr Popalzai's medical records would have revealed that he also understood Urdu, a more widely spoken language. The delay in being able to assess Mr Popalzai contributed to the delay in transferring him to hospital.

138. The language barrier remained a problem for both healthcare and prison staff in their dealings with Mr Popalzai. Although a nurse repeatedly noted the need for an interpreter in Mr Popalzai's care plans, she never sought or arranged one. She told the investigator that the process of getting a translator at Pentonville was different to the process she knew elsewhere.

139. In her report for NHS England, the clinical reviewer noted that it was particularly striking that in the eight weeks Mr Popalzai spent at Pentonville, staff only interviewed him once with an interpreter. We agree that it is hard to understand how the healthcare team could have supported Mr Popalzai effectively with his mental health needs without regular interpretation. She also noted that the lack of interpretation would have contributed to clinicians considering Mr Popalzai in a 'snapshot in time' and not considering his traumatic past and history of mental health concerns holistically.

140. Our investigation found that many staff were not aware of the process for obtaining interpretation services at Pentonville. The prison's mental health lead told us that arranging interpreters was not an issue, that Language Line was available, and that an interpreter could attend the prison three times a week and attend ward rounds if necessary, provided arrangements were put in place.

141. We are very concerned that without the assistance of interpreters, staff would have been unable properly to identify or understand Mr Popalzai's issues and needs, to have adequately assessed his risk of self-harm and to have provided him with the support he required. This was a significant failing. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **if a prisoner is not fluent in English, interpretation services are used for first night healthcare screening, initial and regular assessments and ward rounds to provide effective nursing care planning and support; and**

- **all prison and healthcare staff understand how to arrange interpretation services.**

Access to regime and in-cell activities

142. Mr Popalzai seldom left his cell during the two months he spent at Pentonville. He rarely took showers, did not exercise in the open air, mix with other prisoners or engage in in-cell activities.

143. We accept that Mr Popalzai's erratic behaviour made it difficult for healthcare and prison staff to provide him with a full regime. We also recognise that challenging prisoners can be a considerable drain on staff resources. However, we found no evidence of a clear operational policy to inform staff about their responsibility to provide a suitable regime for prisoners considered too dangerous and volatile to be unlocked.

144. Withdrawing from the prison regime can also be a sign that an individual is at heightened risk of suicide or self-harm. However, no one considered the effect on Mr Popalzai of self-segregating and we are very concerned that there is no evidence that nurses or officers made an effort to encourage him to leave his cell to exercise and shower or to engage him in other activities or to offer him other distractions such as a television or reading materials.

145. A nurse agreed that the regime that Mr Popalzai received was not dissimilar to that in the segregation unit. We consider that his regime was not only more restricted than that in the segregation unit, but also lacked the additional measures in place to protect segregated prisoners.

146. Although we cannot be sure how the restricted regime and lack of activities affected Mr Popalzai, we consider it is likely that they had an additional impact on his mental health.

147. We were told that many of these issues were a consequence of insufficient staffing levels in the inpatient unit, often caused by officers being deployed from the unit to other areas of the prison. A CM said she had often complained about staffing levels to senior managers, and she said it was a daily battle to facilitate a full regime. The mental healthcare lead had also raised concerns about the level of staffing in the unit.

148. The inpatient unit holds prisoners with complex mental health needs, like Mr Popalzai. It appears to have become the norm for prisoners in the unit not to access regimes and activities. We, therefore, consider it essential that staff numbers are maintained at the required levels, and that nurses and officers work together to facilitate and encourage time out of cell and in-cell activities.

149. We make the following recommendations:

The Governor and Head of Healthcare should:

- **provide guidance for staff on how to safeguard prisoners deemed too volatile to be unlocked from their cells;**
- **ensure that prisoners in the inpatient unit who are unable to leave their cells are offered materials to occupy themselves and that the offer is noted in their medical records; and**
- **remind all senior clinicians to raise their concerns directly with the Mental Health Lead and Governor if prisoners are unable to access the wing regime or in-cell activities due to staffing levels.**

The Governor should ensure that staffing levels in the inpatient unit are sufficient to offer all prisoners a full regime.

Emergency response

150. PSI 03/2013 on medical emergency response codes requires staff to radio a code blue when a prisoner has difficulty breathing or is unconscious. This should automatically trigger the control room to call an ambulance and healthcare staff to attend with the appropriate equipment.

151. When Officer A found Mr Popalzai hanging, she shouted for assistance and used her radio but did not call an emergency code blue as she should have done because, she said, she panicked. She did not immediately enter the cell but waited until colleagues arrived as she was worried about Mr Popalzai's previous violent and unpredictable behaviour.

152. We consider that it was reasonable in the circumstances for Officer A to be concerned for her personal safety and to wait for assistance to arrive before going into Mr Popalzai's cell by herself. We do not criticise her for this. However, we consider that she should have immediately radioed an emergency code blue when she saw Mr Popalzai hanging.

153. The delay in calling an emergency code blue led to a delay of about two minutes in the control room calling an ambulance. While the failure to radio an emergency code blue immediately is unlikely to have affected the outcome in this case, in another emergency, it could do. We make the following recommendation:

The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including that staff radio an appropriate medical emergency code.

Transfer to hospital under the Mental Health Act

154. As we have said, we do not consider that prison was a safe or appropriate place for Mr Popalzai given his significant mental health needs. The reasons why Mr Popalzai was remanded to Pentonville instead of being admitted to a psychiatric

hospital have been considered in the clinical reviewer's specialist report and are outside the PPO's remit. We have, however, looked at why it took so long to arrange a hospital transfer for him.

155. At the time, the guidance was that prisoners with severe mental health problems should be transferred to a mental health unit within 14 days of their first medical recommendation for transfer. A second medical opinion and all administrative tasks, including finding a bed, should also be completed in the same timeframe.

156. The NHS guidance states that once a prisoner is identified as possibly needing a transfer under the Mental Health Act, the Mental Health Casework Section in the Ministry of Justice must be informed of the prisoner's details immediately. This is partly so they can satisfy themselves at the outset that the proposed hospital will have the appropriate level of security.

157. In January 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths of prisoners with mental health issues. We said that where a secure hospital had been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect the prison and the hospital to take all possible steps to ensure that this takes place within the 14-day target. We also said that prisons need to be extra vigilant about the care of prisoners awaiting transfer to a secure hospital as they are at particular risk of suicide.

158. A psychiatrist first identified that Mr Popalzai needed treatment in a secure hospital on 24 September. He noted that if Mr Popalzai was remanded to prison custody, the prison should initiate the process for transfer to hospital. Another psychiatrist tried to assess Mr Popalzai on 30 September, but officers told him that this would not be possible due to Mr Popalzai's unpredictable behaviour. It was not until 9 October that he assessed Mr Popalzai and then referred him to the Newham Centre on 11 October. Mr Popalzai was then assessed by a consultant psychiatrist from the Newham Centre and his transfer to hospital was confirmed on 24 October. However, it was not until 22 November, after an available bed in hospital had been confirmed that the prison psychiatrist and consultant psychiatrist completed the required assessments and reports for the transfer warrant to be issued. The psychiatrist sent the relevant form to the Mental Health Casework Section on 25 November.

159. We are concerned that despite Mr Popalzai's significant mental health issues and the psychiatrist's recommendation that he should be transferred to hospital, there was a delay of 15 days before he was assessed and a further delay of a month before the prison's Mental Health Team informed NHS England and the Mental Health Casework Section that a transfer was required. Mr Popalzai had been waiting for admission to a secure hospital for eight weeks, when this should have taken place within 14 days.

160. In her report, the clinical reviewer noted that HMIP's annual report 2017/18 said that only 33.7% transfers from prison to hospital were completed within 14 days. Data on prison transfer to hospital waiting times in their area are routinely audited by Barnet Enfield & Harringay NHS Trust. In November 2019, this showed that of the six prisoners awaiting transfer in their area, only one had waited less than two weeks, while one prisoner had waited 13-20 weeks.

161. The clinical reviewer reported that an eight week wait for a bed in hospital for a prisoner at Pentonville was by no means exceptional, and that a recent ten-year review of the 2009 Bradley Report (People with mental health problems or learning disabilities in the criminal justice system) found that:

> "There remains a pressing need for a clear blueprint for the full range of mental health and wellbeing assessment and support in prisons, for changes to prison regimes to become more psychologically informed, and for a better system to transfer people to hospital when they need urgent help. Ten years on from the Bradley Report, serious self-harm and tragic loss of life continues in our prisons and the need for concerted action to bring about significant system change remains."

162. After Mr Popalzai's death, the mental health in-reach team at Pentonville sent a letter of concern to NHS Commissioners about delays in transfers to hospital, saying that the situation was unacceptable and was getting worse. They said that, despite their best efforts, Pentonville's inpatient unit is not a place of safety for those requiring sectioning under the Mental Health Act

163. The clinical reviewer concluded that an earlier transfer to hospital would have provided Mr Popalzai with the care and treatment he needed. She noted that Mr Popalzai required prompt access to a hospital bed on two occasions, but that on both occasions, a bed was not available for him within the agreed timescales.

164. The investigator was told it was common practice at Pentonville not to submit the information requesting a transfer until a bed had been secured and that staff believed (incorrectly) that there was no need to contact the Mental Health Casework Section until that time.

165. The consultant psychiatrist told us that she and her colleagues at Pentonville had extensive experience of transferring prisoners to hospital under the Mental Health Act and were aware of HMPPS guidelines and NHS England's good practice guide. She agreed that the guidance recommended contacting the Mental Health Casework Section as soon as a patient was identified as suitable for transfer but said that this was not standard practice at Pentonville as the Mental Health Casework Section could not issue a warrant until a bed was confirmed and the issue of a warrant had never led to a delay in transferring a prisoner to hospital. She said that the delays in transfers were caused by waiting for assessments to take place and the availability of a bed.

166. We appreciate that the lack of clarity about Mr Popalzai's home address contributed to the delay in finding him a suitable hospital bed, and that the consultant psychiatrist said that the prison had no experience of the Mental Health Casework Section helping to find beds for patients. However, HMIP had expressed concern about waiting times for transfers in 2019. We would, therefore, have expected every avenue to have been explored in an attempt to make improvements and that the guidance on the transfer of prisoners to a mental health unit would have been strictly followed.

167. We make the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare staff:

- **understand and follow the national guidance on transferring prisoners to hospital under the Mental Health Act; and**

- **inform NHS England and the Ministry of Justice's Mental Health Casework Section promptly when a prisoner is assessed as needing to be transferred**.

Care plans

168. A nurse created care plans for Mr Popalzai which were reviewed frequently. However, Mr Popalzai did not engage with them. Although the care plans are clear, there is little evidence that the nurse or other healthcare staff adhered to them or that the plans informed Mr Popalzai's daily care due to his non-compliance and communication difficulties.

169. We consider that Mr Popalzai should have been referred to the prison's multi-professional complex case clinic (MPCCC) meetings, where his history could have been explored further and the wider team could have had an input into his care. It appears that a MPCCC referral was not considered because healthcare staff considered that, as Mr Popalzai was under the care of the mental health team and was waiting for assessment for transfer to hospital, he only needed input from the mental health team. Practice Plus Group's own investigation found that the mental health team was working independently of the wider healthcare team and that many general healthcare staff did not feel it was their place to complete MPCCC referrals.

170. We recommend:

The Head of Healthcare and the manager of the inpatient unit should review care plans and clinical records together to ensure that the aims and actions of the care plans are being carried out satisfactorily.

The Head of Healthcare and Mental Health Lead should ensure that:

- **there is more integrated working within the wider healthcare team; and**

- **multi-professional complex case clinic referrals are considered for patients awaiting a mental health transfer to hospital.**

Learning lessons

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

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

Inquest verdict

172. The inquest hearing into the death of Mr Popalzai was held on 20 November 2023. It confirmed that the medical cause of Mr Popalzai's death was suspension by

ligature. It concluded that Mr Popalzai took his own life by ligaturing himself using a torn bedsheet, attached to an uncovered television aerial socket on the wall of his cell, the aerial socket cover was absent and as such had exposed a potential ligature point. The inquest reported that if the cover had been properly present and secured with security screws, Mr Popalzai would not have been able to attach the ligature to this point.

173. The inquest also concluded that had an ACCT been opened, staff on the healthcare wing would have had greater visibility of the risk Mr Popalzai posed to himself, and as identified by the psychiatrist at court. It was also recorded that he had been recommended for admittance to hospital and could have received urgent medical treatment for his acute psychosis if a suitable bed and transport had been available earlier.

174. The inquest concluded that it is likely that Mr Popalzai became aware during the night of 28 November 2019 of his transfer to hospital the following day, as Mr Popalzai had stated on multiple occasions that he would hang or kill himself if he were to be transferred to a hospital.

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