Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammed Sayeef Uddin, a prisoner at HMP Highpoint, on 28 December 2022

A report by the Prisons and Probation Ombudsman

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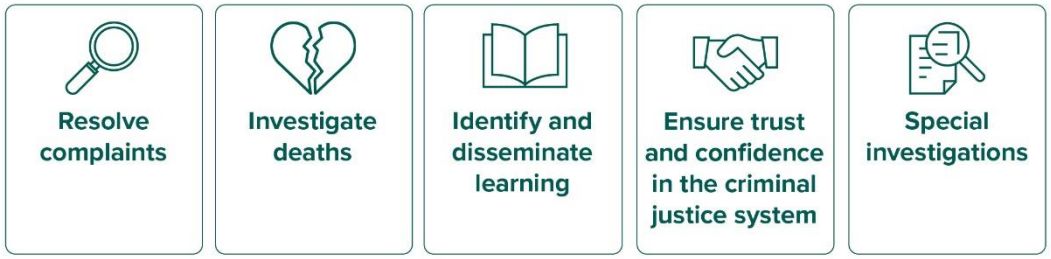
OUR VISION

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.

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 Mohammed Sayeef Uddin died after he was found hanged in his cell at HMP Highpoint on 28 December 2022. He was 39 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the physical healthcare provided to Mr Uddin at Highpoint was equivalent to that which he could have expected to receive in the community. Mr Uddin's mental healthcare was not equivalent. A full mental health assessment was never completed and Mr Uddin's level of need for talking therapies was not assessed despite clear deterioration in his mental health while he was on the waiting list.

Staff monitored Mr Uddin using suicide and self-harm prevention procedures from 9 November until he died. The investigation found several issues with the implementation of these procedures which limited the management of Mr Uddin's risks. Staff also failed to identify Mr Uddin as a self-isolating prisoner which would have meant additional support and monitoring.

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 **March 2024**

Contents

Summary

Events

1. On 3 January 2022, Mr Mohammed Sayeef Uddin, who identified as a British Asian man, was remanded to prison for drug offences. He was sentenced to three years imprisonment. On 1 November, Mr Uddin was transferred to HMP Highpoint.

2. Mr Uddin had no history of mental health issues, self-harm or suicidal ideation. He had a long history of substance misuse. Mr Uddin engaged with prison substance misuse services and stopped using methadone, an opiate substitute, while in HMP Pentonville. We found no evidence that he used illicit substances while in prison.

3. Shortly after he arrived at Highpoint, Mr Uddin's mental health started to deteriorate, and he became paranoid and anxious. He believed that other prisoners knew about him and could read and hear his thoughts. Mr Uddin stopped leaving his cell. Suicide and self-harm prevention procedures (known as ACCT) were started on 9 November and were still in place when he died.

4. On 28 December, an operational support grade officer checked on Mr Uddin during the early morning routine check and found him unresponsive. She asked colleagues for help. Other officers responded and found Mr Uddin hanged in his cell. Mr Uddin showed no signs of life and rigor mortis was present, so officers did not try to resuscitate him. Paramedics were significantly delayed arriving at the prison due to the pressures on the Ambulance Service at the time. When they were informed that there were clear signs Mr Uddin had died, they downgraded the ambulance response. They arrived at 9.36am and confirmed Mr Uddin had died.

Findings

5. Mr Uddin's ACCT was poorly managed. There was no oversight by a named case co-ordinator, a lack of meaningful actions until the third review and a lack of input from the mental health team. We found little evidence that Mr Uddin's risks were reviewed, despite the significant deterioration in his mental health and isolation from the regime.

6. The clinical reviewer concluded that the mental health care that Mr Uddin received at Highpoint was not equivalent to that which he could have expected to receive in the community. The mental health team did not complete a full assessment of Mr Uddin's mental health, even when this was agreed as a support action in his ACCT plan.

7. We found the talking therapy provision at Highpoint was under significant strain due to a long waiting list and lack of staff. Mr Uddin's level of need was not assessed as it should have been, despite the escalation in his risk. The process for assessing prisoners was confusing and healthcare and prison staff did not understand the scope of the Forward Trust's provision.

8. Mr Uddin received no key work during the 10 weeks he spent at Highpoint due to significant staffing pressures. The development of a trusting relationship might have enabled Mr Uddin to better share his anxieties. We found that since Mr Uddin's

death, managers had made efforts to increase delivery and prioritise the most vulnerable prisoners, which might have benefitted him.

9. Despite Mr Uddin not leaving his cell when he became increasingly paranoid and anxious, staff did not identify him as an isolating prisoner to ensure he received support.

Recommendations

- The Governor should review Assessment, Care in Custody and Teamwork (ACCT) processes at Highpoint, to ensure oversight of individual risks and meaningful actions taken to address them.
- The Head of Healthcare should review the current process for mental health assessments to ensure future assessments are prioritised according to need.
- The Head of Healthcare should ensure there is a system in place to identify and prioritise those on the waiting list who are most in need of talking therapies, to ensure resources are used effectively.
- The Governor should ensure staff are aware of their responsibility to identify and support prisoners who self-isolate, to reduce the associated risks.

The Investigation Process

10. We were notified of Mr Uddin's death on 3 January 2023.

11. The investigator issued notices to staff and prisoners at HMP Highpoint informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.

12. The investigator visited Highpoint on 9 January. She obtained copies of relevant extracts from Mr Uddin's prison and medical records, visited the unit where Mr Uddin died and interviewed two prisoners.

13. NHS England commissioned a clinical reviewer to review Mr Uddin's clinical care at the prison. The investigator and clinical reviewer jointly interviewed 13 members of prison and healthcare staff. The investigator also interviewed an operational support grade officer.

14. We informed HM Coroner for Greater Suffolk of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Uddin's next of kin to explain the investigation and to ask if the family had any matters they wanted us to consider. They wanted to know what the events were leading up to Mr Uddin's death and how he killed himself, which are covered in this report.

16. Mr Uddin's family received a copy of the initial report. They did not identify any factual inaccuracies.

17. The prison also received a copy of the report. As a result of their feedback, we have corrected the spelling and grade of a member of prison staff and amended the capacity the prison holds.

Background Information

HMP Highpoint

18. HMP Highpoint is a Category C prison in Suffolk, holding up to 1,310 men across two sites (North and South). Practice Plus Group provide general and mental health services, including clinical substance misuse services. Healthcare is provided seven days a week but is not 24 hours. The psychosocial substance misuse service is contracted to Phoenix Futures. Talking therapies are contracted to The Forward Trust.

HM Inspectorate of Prisons

19. The last full inspection of HMP Highpoint was in August 2019. Inspectors reported excellent staff and prisoner relationships and decent living conditions. Inspectors noted self-harm had increased among prisoners, but it was still lower than other category C prisons. Inspectors noted that the quality of mental health care was good for prisoners in crisis.

20. Inspectors also noted that there had been three deaths since their last inspection. They said that the Prisons and Probation Ombudsman's recommendations were taken seriously, and the prison had ensured lessons were learned.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2022, the IMB reported a notable 8% decrease in self-harm and the number of prisoners supported by suicide and self-harm monitoring.

22. The IMB reported positively about the ongoing development of the key worker scheme. They noted all prisoners were allocated a key worker, but time spent with prisoners was subject to the prison's regime and staff availability.

Previous deaths at HMP Highpoint

23. Mr Uddin was the second prisoner to take his life at Highpoint in three years. There have also been three deaths from natural causes. We have previously identified issues with how night staff respond to a potential emergency, although the circumstances in the previous death were different.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

25. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key worker scheme

26. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework which says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

27. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

Background

28. On 3 January 2022, Mr Mohammed Sayeef Uddin was remanded to HMP Thameside for drug offences. Mr Uddin appeared in court again on 31 January, after which he was taken to HMP Chelmsford. Mr Uddin had been to prison before.

29. On 14 March, Mr Uddin was sentenced to three years imprisonment and taken to HMP Pentonville. The initial health screen found that Mr Uddin had a history of drug and alcohol misuse, and heroin dependency. He was prescribed methadone (an opiate substitute) to support his withdrawal. Mr Uddin disclosed no history of self-harm or suicidal thoughts.

30. On 27 June, Mr Uddin told his substance misuse worker that he had been taken off his methadone therapy in error, but his sleep had improved. He said that since he had come off methadone, he was more aware of his feelings and conscious of the stressful nature of prison. He was finding the noise on the wing and close proximity to other prisoners difficult. Mr Uddin also said that he was concerned he may have Autism Spectrum Disorder. (ASD - a developmental condition caused by differences in the brain. People with ASD often experience difficulties with social communication and interaction as well as restricted or repetitive behaviours or interests.) A referral was made to the health and wellbeing team and Mr Uddin was screened for ASD and Attention Deficit Hyperactivity Disorder (ADHD - a condition that includes symptoms such as being restless and having trouble concentrating). These screening assessments were completed and indicated that a full assessment was required to determine Mr Uddin's needs.

31. On 30 August, Mr Uddin appeared in court for further drug offences and was taken to Thameside. On 21 September, he transferred back to Pentonville.

32. On 29 September, healthcare staff recorded in Mr Uddin's medical record that a full ADHD assessment was scheduled for 6 December. They also recorded that a referral for a psychiatric assessment had been made. These appointments were cancelled because Mr Uddin transferred to HMP Highpoint as part of his sentence progression. Highpoint was made aware that they needed to reschedule the appointments.

HMP Highpoint

33. On 13 October, Mr Uddin transferred to Highpoint. He completed his prison induction and initial health screens, spoke with the chaplaincy and agreed to work with Phoenix Futures on his substance misuse issues. No concerns were recorded.

34. On 18 October Mr Uddin appeared in court and was sentenced to three years imprisonment, concurrent with his earlier sentence. He was taken to Pentonville but returned to Highpoint on 1 November. His release date was 7 February 2024.

35. On 1 November, because he arrived late, Mr Uddin did not receive a prison induction, but was told he would receive it the next day. At his initial health screen, the reception nurse recorded Mr Uddin's history of substance misuse and that he

was engaged with Phoenix Futures. The nurse noted he had no history of mental ill health and no concerns regarding suicide or self-harm.

36. The next day, Mr Uddin completed his prison induction and met with Phoenix Futures and the chaplaincy. He was told that a key worker would be allocated once he moved from the induction unit to a residential unit. (Although he was allocated a key worker some weeks later, they never met with Mr Uddin.)

37. On 3 November, Mr Uddin had his secondary health screen. During the screening, Mr Uddin said he felt anxious and worried about his 'past, present and future' so was referred to the Forward Trust, a talking therapy service (psychological therapies for depression and anxiety disorders). Mr Uddin was sent a letter on 5 November which said there was a waiting list, and he would be contacted when an appointment became available. Mr Uddin was never seen by The Forward Trust.

38. On 6 November, a nurse completed an ADHD screening with Mr Uddin. The screening indicated that a full assessment was required but Mr Uddin was told the healthcare provider at Highpoint would not fund a full assessment.

39. On 9 November Mr Uddin told wing staff he feared for his safety, was scared, would like a cell with a shower and wanted to isolate. Wing staff asked the Safer Prisons Team to visit Mr Uddin. An officer visited Mr Uddin, who said he was engaging with Phoenix Futures and had begun working on his drug misuse. He said he was worried that he was being spoken about by other prisoners but did not provide any specific details or names. The officer referred Mr Uddin to the mental health team.

40. Later, Mr Uddin met with a substance misuse worker. He made comments which referenced self-harm and thoughts of suicide. She contacted the Safer Custody Team to alert them. At 4.20pm, staff started suicide and self-harm prevention measures, (known as ACCT) and implemented an immediate care plan. They observed Mr Uddin on an hourly basis until he could be fully assessed.

41. The next day, an officer completed Mr Uddin's initial ACCT assessment. Mr Uddin reported feeling anxious, depressed and paranoid that other prisoners would think he was a sex offender. Mr Uddin said he would like to move to a quieter wing, have a shower in his cell and complete an education course to help lift his mood.

42. After the ACCT assessment, a Custodial Manager (CM) chaired the first ACCT review. A nurse from the mental health team, an officer and Mr Uddin attended. Mr Uddin said he felt paranoid and repeated that he wanted to move to a quieter unit and to a cell with a shower. The CM noted that a move to the North Side of the prison, which was quieter, would be considered but that it could not happen immediately due to the lack of available spaces. They encouraged Mr Uddin to speak to staff if he needed support and apply for work or a course to occupy his time, to which he agreed. Observations were reduced to every two hours. Support actions from the review were not recorded. The next ACCT review was scheduled for 16 November.

43. Over the next week, staff recorded in the ongoing record of the ACCT that Mr Uddin remained anxious and depressed, that he felt ashamed, and was paranoid other prisoners were talking about him.

44. Mr Uddin's ACCT was reviewed again on 16, 22 and 28 November. Healthcare staff only attended the review on 22 November. On 22 November, support actions were recorded which noted Mr Uddin should have a full mental health assessment, continue to work with Phoenix Futures and move to a different location at Highpoint.

45. On 23 November, a worker from Phoenix Futures visited Mr Uddin in his cell (the substance misuse worker was on leave). At Mr Uddin's request, she provided him with an in-cell pack to complete regarding his use of drugs. On 29 November, the day after his ACCT review, the substance misuse worker visited Mr Uddin. He told her that continued to be 'up and down'. She noted that he was difficult to engage and very quiet.

46. During an ACCT review on 1 December, Mr Uddin spoke about having thoughts of self-harm, but that he did not intend to act on them. He wanted to speak to someone from the Safer Prisons Team and said his priority was a move to the North Side of the prison. The support actions were updated accordingly. The next day, the Safer Prisons Team visited Mr Uddin who said he was very anxious and worried. Mr Uddin said he was not under threat or being bullied but was nervous in case this did happen. Mr Uddin was provided with a distraction pack (a variety of quizzes, reading material and other activities to help distract during long periods of time spent alone).

47. On 3 December at around 2.40am, Mr Uddin made a small cut to his wrist. Officers cleaned and dressed the wound and ACCT observations were increased to twice an hour. Mr Uddin's ACCT was reviewed later in the day. Nobody from the mental health team attended. Mr Uddin said he did not want to be 'here' but did not elaborate on what he meant. Observations remained at twice an hour. The next review was scheduled for 5 December.

48. On 5 December, a Supervising Officer (SO) chaired Mr Uddin's ACCT review. Initially, Mr Uddin declined to attend, but she went to his cell to encourage him to engage. Mr Uddin explained that he was tired and had spoken to lots of people about the same thing. She told Mr Uddin that she had been allocated as his case coordinator and that she would be a consistent point of contact, which would mean that he would not have to keep repeating himself. (This was the only review that she chaired). Mr Uddin told those present that he had been experiencing thoughts of suicide and self-harm for several months, but that he had no current plans to act on them. Mr Uddin said he would eventually like to move to a prison in the southeast of England, but in the short term wanted to move to the North Side of the prison and have his own shower. The support actions were updated to note Mr Uddin should engage with the ACCT process. Observations remained twice an hour.

49. On 7 December, Mr Uddin's ACCT was reviewed. Mr Uddin appeared dishevelled, and staff encouraged him to have a shower, which was added as an action on his support plan. Mr Uddin said he had no thoughts of self-harm but had thought about suicide, although he had no specific plans. Mr Uddin was encouraged to leave his cell and find something purposeful to do. A nurse noted Mr Uddin was on The Forward Trust waiting list and caseload (he was only on the waiting list at this point) and that no further action was required by the mental health team. She recorded in Mr Uddin's medical record that he spent most of the day in bed, under the covers in the dark and when asked, he said his head was 'gone'. Observations were reduced to hourly. The next ACCT review was scheduled for 13 December.

50. On 13 December, Mr Uddin was moved to the North Side of Highpoint, into a cell with a shower. A SO chaired an ACCT review. There was no representation from the mental health team. Mr Uddin said he had seen the mental health team but was unsure if they were working with him so the SO made a referral. Mr Uddin said he wanted to transfer to a different prison but did not say where. He said he did not know how he was feeling but asked to speak to someone from the Safer Prisons Team, which was added as a support action. Observations remained hourly, while Mr Uddin settled onto the unit. The next day, Mr Uddin was added to the maths education class.

51. On 15 December, a SO chaired an ACCT review, attended by a nurse from the mental health team and Mr Uddin. The review was completed in Mr Uddin's cell as he would not come out. He spoke to staff from underneath a sheet and said that he had been feeling low for weeks and wanted to move to a different prison for a fresh start. The review noted Mr Uddin's eyes appeared bloodshot and he was encouraged to speak to the GP, but Mr Uddin said he wanted to speak to a psychiatrist. The nurse said she would make a referral. Mr Uddin said that when he recently self-harmed he had wanted to 'bleed out' and thought he may have self-harmed in the past but could not remember. The review discussed Mr Uddin's history of drug misuse and the impact on his mental health. Staff agreed that Phoenix Futures would be invited to the next review. Mr Uddin disclosed that when he was first sentenced, he was fine, but now believed he could hear things being said about him over the radio and tannoy system. He accepted that he could be imagining this. Mr Uddin said he was not under threat but would only eat his food if staff collected his meal for him as he did not like to leave his cell. Observations remained hourly. The next ACCT review was scheduled for 20 December.

52. On 16 December, Mr Uddin was given a negative warning for not attending his maths class. This was later rescinded by a SO, as he was deemed not well enough to attend due to his mental health.

53. On 20 December, the prison Imam went to visit Mr Uddin. The Imam described him as looking sad and worried. Mr Uddin said he had lots of challenges in his life, that he was not able to speak but probably would the next time. He offered to speak to Mr Uddin in the chapel the following week, which he accepted. (The Imam was on leave for a week but had arranged to meet Mr Uddin on 29 December).

54. Later, a SO chaired an ACCT review. This review was attended by a CM from the safer prisons team, the mental health clinical lead and Mr Uddin. A member of Phoenix Futures submitted a written contribution but did not attend. The review was held in Mr Uddin's cell because he would not leave; he said that he had not left his cell since the previous ACCT review. He said that since he cut his wrist, he had odd sensations in his hands and feet which felt like pins and needles. The clinical lead checked Mr Uddin's wrist and noted the cut may have a little infection, but it did not require medical attention.

55. Mr Uddin said he had not left his cell as he felt like a 'freak show'. He said that he believed people could read his thoughts and heard his personal information being shouted over the tannoy. Mr Uddin said he could hear the person in the cell next door but nobody else at the review could. The clinical lead told Mr Uddin that an appointment had been made for him to see the psychiatrist on 23 December. (On 22 December at around 4.00pm, the psychiatrist was cancelled due to a

miscommunication between the agency contracting the psychiatrist and the healthcare team). The member of Phoenix Future's written contribution stated that Mr Uddin had not returned a work pack relating to cocaine use and when his Phoenix Futures file arrived on the North Side, he would be allocated a new substance misuse worker. Observations were reduced to every two hours. The next ACCT review was scheduled for 23 December.

56. On 23 December, a SO chaired an ACCT review attended by a nurse and Mr Uddin. The review was held in Mr Uddin's cell and initially, he only spoke to staff from under his bedsheet. Mr Uddin said he could not leave his cell as other prisoners knew everything about him. The review noted Mr Uddin's cell was messy and that he needed a shower. Despite being encouraged, Mr Uddin said he could not leave his cell. Staff also suggested that Mr Uddin collect his meals from the servery rather than staff deliver them to his cell, but he was not willing to do so as he did not want to leave his cell. Mr Uddin told the nurse that he thought his wrist was infected, so she made an appointment for healthcare to examine him the next day. (Mr Uddin did not attend and declined any further healthcare examination of his wrist.) Observations were reduced to every three hours, as Mr Uddin said he had no thoughts of suicide or self-harm. The next ACCT review was scheduled for 29 December.

57. On 25 December, an officer completed an ACCT observation for Mr Uddin. He recorded that Mr Uddin's cell door was unlocked, but not open. Mr Uddin said he was very anxious about other prisoners and did not want to come out of his cell. He said that officers and prisoners knew what he was thinking, by way of something that had been 'implanted in his head without his permission'. Mr Uddin said he did not participate in exercise as he would feel like a 'freak show' because people could read his thoughts. Mr Uddin said he had a good appetite and ate meals brought to his cell by officers. The officer noted later that Mr Uddin had not eaten his lunchtime meal.

58. The officer recorded that Mr Uddin appeared 'beleaguered' by his problems and although polite, he was anxious. Mr Uddin told him he was getting worse. The officer asked if there was anything he could do, but Mr Uddin said there was not. He encouraged him to press his emergency cell bell if there was anything he wanted to talk about.

59. While the officer was talking to Mr Uddin, another prisoner came into the cell to check on Mr Uddin and said that he regularly visited him as they knew each other from Pentonville. When he left, Mr Uddin said he was a 'good sort'. The officer spoke to a SO, as he was concerned about Mr Uddin but did not know his background as he worked on another unit. The SO said that Mr Uddin had already been referred to the mental health team.

60. At around 2.00pm, a SO chaired an ACCT review with an officer and Mr Uddin. The SO noted the review was being conducted because it was Christmas Day, a potentially emotional day for prisoners. Mr Uddin spoke to staff from under his bed covers. He said that his family did not celebrate Christmas, but that he would speak to them later. Mr Uddin was asked why he had not attended healthcare regarding the cut on his wrist and he said he might attend the next day. The SO noted that this was a brief interaction, as Mr Uddin said he wanted to sleep. The next ACCT review was scheduled for 29 December.

61. An officer from the safer prisons team also visited Mr Uddin. He told her that he did not celebrate Christmas and did not require any support. This was the last entry in Mr Uddin's prison record before he died.

62. Between 1 and 26 December, Mr Uddin made 10 calls to his family. The investigator listened to these calls, but most of the time Mr Uddin did not speak in English. (All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample.) The investigator made a request for translated transcripts of the calls, but Highpoint was unable to provide these as the period for storing the calls had lapsed and they were unable to recover the recordings. Although the investigator was unable to establish the content of the conversations, she observed that Mr Uddin was quiet and sounded withdrawn. During the last call, on 26 December, Mr Uddin spoke to his sister and some of the conversation was in English. They spoke about family and shopping.

63. On 27 December, an Operational Support Grade (OSG) started her night shift on Mr Uddin's unit. She noted in Mr Uddin's ACCT ongoing record that she checked him at 8.35pm, 11.30pm and at 2.22am with no concerns.

Events of 28 December

64. CCTV footage shows that the OSG checked Mr Uddin again at 5.06am. She used her torch and briefly looked through the observation panel, where she saw Mr Uddin at the back of the cell leaning against the window. She asked if he was OK and believed she heard him say yes. She said she did not think there was anything unusual about Mr Uddin being stood by the window as he had done this before.

65. At 6.12am, the OSG started the early morning routine check and arrived at Mr Uddin's cell about 30 seconds later. CCTV shows she used her torch to look through the observation panel, then switched the light on from outside the cell. She looked into the cell for around a minute before walking away. At 6.15am, she returned to Mr Uddin's cell and looked in through the observation panel for around 44 seconds before walking away. She said Mr Uddin appeared slumped forward by the window and his tongue was swollen and protruding. She believed he was dead but said she was trying to understand what she was seeing, as she could not see the ligature. She walked to the wing office and telephoned the night response team to request assistance.

66. At around 6.15am, an officer spoke to the OSG, who told him that she "could not get a response from Mr Uddin". He, accompanied by his colleagues, walked to Mr Uddin's unit. CCTV shows that they arrived on the unit five minutes later. An officer looked through the observation panel, saw Mr Uddin ligatured and staff entered the cell. Another officer immediately radioed a code blue medical emergency (used when a prisoner is unconscious or has breathing difficulties) and the control room requested an ambulance. A Custodial Manager (CM), who was the night operational manager, responded to the code blue and arrived a short time later.

67. Mr Uddin had used a ligature made from bed sheets to hang himself, which he had attached to the window. Officers cut the ligature and laid him on the floor. They described Mr Uddin as extremely cold; his skin blue and rigor mortis was present. A defibrillator was attached to Mr Uddin which showed he had no shockable rhythm. This information was conveyed to paramedics who were responding to the

emergency. They advised that staff should not start cardiopulmonary resuscitation (CPR) because there were clear signs that Mr Uddin had been dead for some time.

68. Paramedics were significantly delayed arriving at the prison due to the pressures on the Ambulance Service at the time. When they were informed that there were clear signs Mr Uddin had died, they downgraded the ambulance response. They arrived at 9.36am and confirmed Mr Uddin's death.

Contact with Mr Uddin's family

69. The prison appointed a family liaison officer (FLO). The prison did not have address details for Mr Uddin's next of kin, so made initial contact by telephone to break the news of his death. The FLO and a CM later travelled to Mr Uddin's family address, and they offered ongoing support.

70. Highpoint contributed towards the costs of Mr Uddin's funeral, which was held on 6 January 2023, in line with national instructions.

Support for prisoners and staff

71. After Mr Uddin's death, the trauma risk management (TRiM) manager and the Deputy Head of Residence debriefed all staff involved in the emergency response. They provided staff with the opportunity to discuss any issues arising and offered support.

72. The prison care team also contacted staff. While some staff said they felt well supported, others did not. The OSG said she did not feel supported at all, and two SOs said they would have benefitted from more proactive support.

73. The prison posted notices informing other prisoners of Mr Uddin's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Uddin's death. Prisoners who lived on the same unit said they felt very well supported.

Post-mortem report

74. The pathologist concluded that the cause of Mr Uddin's death was asphyxia due to hanging. Toxicology results did not find anything of significance.

Findings

Assessment of risk of suicide and self-harm

75. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* contains requirements for staff using Assessment, Care in Custody and Teamwork (ACCT) procedures. Staff are required to use ACCT when they identify that a prisoner is at risk of suicide and self-harm, based on identified risk factors and triggers. The PSI says that ACCT case reviews should be multidisciplinary where possible, that a support plan should be completed at the first review, and that it must reflect the prisoner's needs, level of risk and the triggers of their distress. Support actions must be tailored to meet the individual needs of the prisoner, be aimed at reducing the prisoner's risk to themselves and be time-bound.

76. Mr Uddin was monitored using ACCT procedures between 9 November and his death on 28 December 2022. During this time, Mr Uddin made cuts to his arm and reported escalating feelings about self-harm and suicide. He also withdrew completely from the regime and stopped looking after himself. There were some examples of positive practice, including that staff arranged for him to move at his request to a single cell on a quieter wing. However, we found several issues with ACCT management.

77. ACCT procedures were not managed by a single manager to ensure consistency. In total, Mr Uddin's ACCT was reviewed 13 times, by nine separate case managers. The assigned case coordinator chaired only one review on 5 December, despite being put in place following feedback from Mr Uddin that he kept having to repeat his feelings to different members of staff. This led to a lack of oversight in the management of the ACCT. Five of the reviews were not attended by someone from the mental health team, so were not multi-disciplinary. This limited staff's ability to consider Mr Uddin's risk in a holistic way.

78. Support actions were not agreed until the third ACCT review. We found little evidence that staff considered Mr Uddin's risk factors and signs that the risk was escalating, such as withdrawal from the regime, increasing thoughts of self-harm and reduced engagement. On 23 December, observations were lowered, despite evidence that Mr Uddin was becoming more withdrawn and isolated. The SO, who lowered observations to every three hours, said she had not received adequate ACCT training as a case coordinator. Despite a full mental health assessment being noted as one of the support actions, an assessment was never completed.

79. Mr Uddin did not want his family involved in the ACCT process, but there is no evidence this was explored further, or that other prisoners that regularly checked on Mr Uddin were identified as another source of support.

80. The ongoing ACCT record did not make clear whether staff had meaningful engagement with Mr Uddin during ACCT checks and conversations, so we were unable to verify this.

81. Overall, ACCT management was not sufficiently robust. There was a lack of oversight and proper review of Mr Uddin's risks as they escalated. The focus

seemed to be on the process as opposed to Mr Uddin as an individual and his associated needs. We make the following recommendations:

The Governor should review ACCT processes at Highpoint, to ensure oversight of individual risks and meaningful actions taken to address them.

Clinical care

82. The clinical reviewer found that some aspects of Mr Uddin's physical healthcare were equivalent, and others were not. The clinical reviewer has identified how Mr Uddin's physical healthcare could have been improved. We do not repeat these recommendations, but they should be addressed by the Head of Healthcare.

83. The clinical reviewer concluded that Mr Uddin's mental health care was not equivalent to that which he could have expected to receive in the community. He makes recommendations for the Head of Healthcare to review initial assessment of need processes and risk escalation assessment processes.

Mental health

Assessment

84. Despite clear signs that Mr Uddin's mental health had deteriorated during his time at Highpoint, a full mental health assessment was never completed. This meant there was never an assessment of Mr Uddin's mental capacity to make decisions about his care or whether he required intervention to address his needs.

85. When he first arrived at Highpoint, the psychiatrist referral made at Pentonville, Mr Uddin's previous prison, was not transferred and prioritised. Mr Uddin became increasingly withdrawn, disengaged from all activities, expressed thoughts of suicide and self-harm, and showed signs of paranoia. Completing a full mental health assessment would have helped staff identify his particular risk factors and decisions on how they could be managed and might have led to a medication prescription as well as a timelier referral to a psychiatrist.

86. A full mental health assessment was recorded as a support action in Mr Uddin's ACCT on 22 November. When he self-harmed on 3 December, there should have been an escalation of this assessment.

87. On 15 December, Mr Uddin was referred to a psychiatrist and an appointment was scheduled for 23 December. This appointment was cancelled at short notice the afternoon before, due to a miscommunication between Highpoint and the healthcare agency who contracted psychiatry services (at the time, Highpoint did not have a psychiatrist). We were unable to establish the root of this confusion. We understand a psychiatrist has now been employed at Highpoint.

88. The lack of a full mental health assessment was a significant oversight by staff supporting Mr Uddin. Earlier support might have helped to prevent or reduce the deterioration in his mental health. We make the following recommendation:

The Head of Healthcare should review the current process for mental health assessments to ensure assessments are prioritised according to need.

Talking therapies

89. On 3 November Mr Uddin said he felt anxious and worried about his 'past, present and future' so was referred to the Forward Trust, a talking therapy service (psychological therapies for depression and anxiety disorders). He was told there was a waiting list, and he would be contacted when therapy became available but there was no availability before he died.

90. The Forward Trust told us that initial assessments of need are usually completed while prisoners are on the waiting list. Mr Uddin was on the waiting list for two months, during which he self-harmed and staff observed significant deterioration in his mental health, but his level of need was not assessed. The team leader for the Forward Trust said that there were long waiting lists and significant delays in assessing those referred at the time that Mr Uddin was at Highpoint. This was due to staff shortages and challenges in recruiting qualified staff.

91. The team leader confirmed that there was no specific process in place to identify prisoners most in need and who should be prioritised for talking therapies. The Forward Trust staff did have access to medical records, but it was not routine practice for these to be used to inform an assessment of cases on their waiting list. Prison and healthcare staff said that the Forward Trust would not work with any prisoner subject to an ACCT, but she said that the Forward Trust have and will continue to work with prisoners on ACCT. She said each prisoner's needs would be assessed to determine suitability, taking into account referral time, release date and if they were a veteran. We were told that the waiting list is not necessarily subject to continual review so it is difficult to understand how the Forward Trust would identify suitability.

92. We asked for an update on provision in the summer of 2023 and the team leader confirmed waiting lists remain significant. Staffing levels have slowly improved and are better than at the time Mr Uddin was at Highpoint, but the vacancy for a Psychology Wellbeing Practitioner remains.

93. The lack of a process to determine priority is a concern, particularly where there is a long waiting time for prisoners to benefit from the service. The information we received on the current assessment processes was confusing and prison and healthcare staff did not understand how the Forward Trust worked with individuals on ACCTs. A more robust system should be established for identifying escalating risks and prioritising prisoners accordingly, that is clearly understood by staff across the prison. We therefore recommend:

The Head of Healthcare should ensure there is a system in place to identify and prioritise those on the waiting list who are most in need of talking therapies, to ensure resources are used effectively.

Staff engagement with Mr Uddin

Key work

94. Under the Offender Management in Custody (OMiC) model rolled out by His Majesty's Prison and Probation Service (HMPPS) in 2018, every prisoner should have a dedicated key worker as their first point of contact. The purpose of the model is to improve safety by building better relationships between staff and prisoners.

95. Highpoint's Self-isolating Strategy, dated June 2021, states that 'Key Worker contact is key!! Engaging with Prisoners on a regular basis will allow any changes in behaviour to be noticed at an earlier stage. Gaining the appropriate support promptly can ensure that the Prisoner feels safe whilst in the establishment. A minimum of two Key Worker contact entries is required on prison records per month'.

96. During his eight weeks at Highpoint, Mr Uddin did not have a key work session. An officer was appointed as his key worker a few days before she started a week of nights and annual leave so never had the opportunity to meet with Mr Uddin. The officer said that staff are not detailed specific time to complete their key work and had to find time in between their usual shifts and duties. This meant that key work sessions were often rushed or deprioritised.

97. Mr Uddin was being monitored by ACCT procedures and had several vulnerabilities which should have meant he was prioritised for key work. This might have enabled meaningful engagement and the sharing of concerns. We found that the key worker scheme at Highpoint did not comply with the OMiC model. We are unable to measure the impact on Mr Uddin, but we know that regular key work sessions with a consistent officer help to improve wellbeing and therefore safety for prisoners.

98. The Deputy Governor confirmed that at the time Mr Uddin was at Highpoint very little time was afforded to key working due to significant resourcing pressures. Since Mr Uddin's death, a dedicated a custodial manager has been assigned to the role of supporting key working in the prison. All prisoners now have an identified key worker within 24 hours, are seen within 48 hours (previously averaged 54 days before a prisoner was seen) and the regime for the day has changed to allow for ongoing key working. The prison is striving to provide key work to all prisoners at least every two weeks. Key work completion is monitored at daily operational briefings where those prisoners who may not have had a key working session or are subject to special monitoring, such as ACCT, are identified and prioritised. Delivery of key work has increased from 17% at the time Mr Uddin spent at Highpoint to 35% at the time of writing.

99. We accept that key work delivery has been impacted by staffing pressures at Highpoint. Managers have made efforts to improve delivery since Mr Uddin's death which has increased over time but remains low, while maintaining other essential parts of the regime. We note that while all prisoners may now be assigned a key worker, only a third of prisoners actually benefit from this contact. Cohorts identified as particularly vulnerable are rightly being prioritised.

Self-isolation

100. Highpoint's Self-isolating Strategy sets out the requirements for staff who identify prisoners who are self-isolating. The strategy addresses all staff and says, 'if you notice a prisoner is not engaging, mixing with peers, collecting meals, attending to self-hygiene you must make your Wing Manager and the Safer Prisons Team aware and ensure a case note is completed'. It then describes the steps that should be taken to support prisoners to reintegrate into the regime and prison community, including an initial assessment and the creation of a reintegration plan. The plan should be discussed each day at the daily operational briefing and all interactions with the prisoner should be recorded on their prison record. This support plan should take into account other support measures, such as ACCT.

101. Mr Uddin did not leave his cell for the eight weeks he spent at Highpoint. He was visited by other prisoners on the unit but otherwise withdrew from the regime in the weeks before he died. He stopped collecting his meals, stopped showering, spoke to staff from under a blanket and became increasingly anxious and paranoid. Staff should have put self-isolation measures in place to monitor the risks and support Mr Uddin to engage again. Mr Uddin's self-isolation was noted in his ACCT record, but self-isolation procedures were not used.

102. We spoke to Safer Custody managers and a nurse in the mental health team, who had differing views on whether Mr Uddin met the criteria for a self-isolating prisoner and the policy to follow if he had been. Some staff believed that the self-isolating policy only applied to prisoners who wanted their door locked. Because Mr Uddin did not request this, monitoring was not considered. It is important that staff understand their responsibility to identify prisoners who are self-isolating, particularly those working in the Safer Custody and mental health teams. For Mr Uddin, identification of his isolation might have resulted in enhanced case management and additional support that could have reduced his risk. We therefore make the following recommendation:

    The Governor should ensure all staff know how to identify and support prisoners who self-isolate, in line with Highpoint's Self-isolating Strategy.

Emergency response

103. PSI 03/2013, *Medical Emergency Response Codes*, sets out the actions staff should take in a medical emergency. It requires all prisons to have a medical emergency response code protocol in place to ensure a timely, appropriate and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff are alerted, the correct equipment is brought, and an ambulance is called immediately.

104. The OSG completed an ACCT check at around 5.06am on 28 December by using her torch to look into Mr Uddin's cell. She said she saw what she thought was Mr Uddin leaning up against the window at the back of his cell, and when asked if he was okay believed she heard him answer yes. It is likely that Mr Uddin was already dead.

105. When the OSG completed her next early morning routine check, she said that she could not see a ligature but saw Mr Uddin slumped by the window of his cell. She remained outside the cell for nearly a minute looking through the observation panel. In interview, she told us that she believed that Mr Uddin was already dead because she could see that his tongue was swollen and protruding from his mouth. She did not radio a medical emergency code but walked to the wing office and used the telephone to ask for assistance. Other officers said they were not aware of the seriousness of the situation until they reached the unit.

106. The OSG said she was aware of the emergency medical code procedure but decided not to use her radio as she believed Mr Uddin was beyond help and the radio signal was not always good. She also said she did not want to alarm other prisoners on the unit.

107. The OSG did not follow local procedures when she first identified that Mr Uddin was not responding. The delay did not impact on the outcome for Mr Uddin, who had been dead for some time, but we know that any delay may be critical in an emergency, and staff should radio for help at the earliest opportunity. We would have recommended the Governor investigate her actions, but she resigned on 5 January 2023. On 23 January, the Governor issued an order to staff reiterating the need to use medical emergency codes when appropriate, in line with Prison Service instructions. As the prison has already addressed the learning from the OSG's actions, we do not make a recommendation.

Governor to note

Safety Intervention Meetings

108. Staff at Highpoint hold a weekly Safety Intervention Meeting (SIM) to discuss managing risks to prisoners and the prison. It is attended by managers responsible for residential units and safety, and the mental health team. On 17 and 24 November, the SIM recorded that Mr Uddin was unemployed but in a good place with no thoughts of self-harm. On 17 December, the minutes show that Mr Uddin had been assigned a key worker and prison offender manager. There is no mention of the fact that he was not coming out of his cell and no concerns were recorded. On 8 December, information from his ACCT review was noted and that Mr Uddin was difficult to engage, said he was under threat but would not give names. On 15 December, after Mr Uddin had moved to the North Side of the prison, no other concerns were recorded. The last time Mr Uddin was discussed was on 22 December. No concerns were recorded despite his declining mental health and isolation.

109. We also found inaccurate information on Mr Uddin's circumstances was recorded by the SIM. He was incorrectly recorded as attending education, the wrong key worker was named and neither Mr Uddin's key worker or prison offender manager were involved as part of the ACCT process or support planning.

110. All contributions to the SIM should be meaningful and accurately reflect a prisoners' risk and vulnerabilities, to ensure effective decisions can be made on risk management. We were unable to establish why information was missing or inaccurate. This was most likely due to the way that information is collated, which we bring to the attention of the Governor.

Body Worn Video Cameras

111. PSI 04/2017, *Body Worn Video Cameras (BWVC),* requires prison staff to use BWVCs during any reportable incident, including medical emergencies. It requires staff to start recording at the earliest opportunity, to maximise the material captured by the camera. BWVC's are an important source of evidence for PPO investigations, and wider learning for prisons following an incident.

112. Body worn video cameras were not activated by staff who found Mr Uddin. Based on the other evidence available to us, we are satisfied that the emergency response was appropriate. We also recognise that during an emergency, event staff might forget to switch on their cameras. Body worn video footage might be vital in future incidents, so we highlight this learning for the Governor's consideration.

Key work

113. We have discussed the deficiencies in the delivery of key work, above, and the progress that Highpoint are making. We are sure that the Governor will continue to monitor this issue until delivery reaches acceptable levels.

Head of Healthcare to Note

ADHD assessment

114. At Pentonville, Mr Uddin told staff he was concerned he might have Attention Deficit Hyperactivity Disorder (ADHD). An initial assessment suggested a full assessment was required. This was arranged but cancelled when Mr Uddin transferred to Highpoint. On 6 December, Mr Uddin was assessed again at Highpoint and identified as requiring a full assessment, but a nurse told him that this would not be funded by Highpoint. We do not know why a further assessment was completed and we question the timing of the assessment, given Mr Uddin was subject to an ACCT.

115. We heard conflicting information from the mental health team regarding the process for identifying ADHD and the support available to prisoners at Highpoint. We cannot measure the impact of the decision not to fund an assessment on Mr Uddin, but it is possible that he had additional needs that impacted on his engagement with staff. The mixed messaging and lack of progress on exploring his concerns might have affected his wellbeing. We do not make a recommendation but bring the learning to the attention of the Head of Healthcare.

Substance misuse

116. Mr Uddin had a history of substance misuse, but he remained drug free at Highpoint. Mr Uddin disclosed his thoughts about suicide and self-harm for the first time to his substance misuse worker on 9 November. When Mr Uddin later moved to a different unit, a new substance misuse worker was identified to replace her, but there was a delay in his paper file being sent over which meant he had no further contact with Phoenix Futures in the month before he died.

117. Although Phoenix Futures staff can access prisoners' electronic medical records, they were not used to record their contacts because staff did not have sufficient

training. This is likely to create issues with information sharing between substance misuse workers and healthcare in future. We bring the learning to the attention of the Head of Healthcare.

Inquest

118. The inquest into Mr Uddin's death concluded in May 2024. Mr Uddin's death was asphyxia by ligature. The inquest found that Mr Uddin's suicide was on the balance of probabilities contributed more than minimally to the following:

- Not having a full mental health assessment
- Long waiting lists for services
- The cancellation of a psychiatry appointment
- No mental health training for prison staff, that have an immediate duty of care
- No key worker available
- No health care cell visits, despite Mr Uddin's anxieties over leaving his cell
- Lack of opportunities to explore medication
- Lack of continuity of care, including inadequate systems and procedures in place to ensure the effective flow of information and communication between sites

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