

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Salah Nasif a prisoner at HMP Whitemoor on 28 August 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Salah Nasif was found hanged in his cell on 28 August 2016 at HMP Whitemoor. Mr Nasif was 57 years old. I offer my condolences to Mr Nasif's family and friends.

Although he was in low mood, I do not consider that staff could have foreseen Mr Nasif's decision to end his life. However, information-sharing between healthcare and wing staff could have been better had staff made use of a system introduced to address this following a previous death in custody. It is unfortunate that healthcare staff were unclear when to use it.

I am concerned that previous recommendations about Whitemoor's response to medical emergencies have not led to an improvement in how the prison manages such events. Finally, the investigation has also identified areas for improvement in the conduct of roll checks and family liaison.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

April 2017

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Summary

Events

1. Mr Salah Ahmed Nasif was remanded into custody on 10 September 2010 and found guilty of murder on 6 July 2012. He was given a life sentence and transferred to HMP Whitemoor on 21 September 2012.
2. Mr Nasif lived on the Over 50's spur at Whitemoor and settled in well. His health issues were angina, prostate problems and post traumatic stress disorder. Mr Nasif was seen regularly by the mental health team, including a psychiatrist.
3. From the end of March 2016, Mr Nasif's post traumatic stress disorder medication was gradually changed. He was supported by regular one to one sessions with an assistant psychologist and follow up appointments with a psychiatrist.
4. During August, Mr Nasif struggled with his mood and said the new medication made him feel sad. Mr Nasif spoke to the psychiatrist and was prescribed an antidepressant. The psychiatrist did not think Mr Nasif was at risk of suicide or self-harm.
5. On 28 August, during the early morning checks by officers, Mr Nasif appeared to be kneeling by the window. Staff assumed he was praying. The officer who unlocked his cell at 9.04am also thought Mr Nasif was praying and did not want to disturb him. When staff went to his cell half an hour later to do the daily cell checks, they found that Mr Nasif had a ligature around his neck. Staff called a code blue emergency.
6. Officers and medical staff arrived quickly. Resuscitation was not attempted because rigor mortis was present.

Findings

Assessment of risk and sharing information

7. The psychiatrist and psychologist did not think Mr Nasif was at risk of suicide or self-harm. However, their written medical notes do not always demonstrate when they actively considered this risk and no steps were taken to share general information that Mr Nasif's medication was changing and that he might feel differently as a result. Whitemoor have a system called GRASP in place to share this sort of information.

Emergency response

8. There was a delay of 12 minutes before the control room called for an ambulance and, when it arrived, there were further delays in getting the vehicle moved inside the prison to the extent that it took 25 minutes for the crew to reach Mr Nasif's side. In total, it was 60 minutes following the calling of an emergency code before paramedics reached Mr Nasif's cell. Although it did not alter the outcome for Mr Nasif, delays of this nature could be crucial in other emergency situations.

Family liaison

9. There was a long delay in notifying Mr Nasif's family of his death and a face to face visit did not take place for two days. In part, this was due to an incomplete address being recorded on Mr Nasif's electronic prison record and another address held by the safer custody unit was no longer current.

Clinical review

10. The clinical care Mr Nasif received was judged by the clinical reviewer to be equivalent to that provided to other NHS patients in the community.

Checking prisoners' well-being during roll checks and at unlock

11. Although we understand staff's desire to respect Mr Nasif's privacy, the roll checks and unlock procedures did not comply with the clear instructions put in place by the Governor.

Recommendations

- The Head of Healthcare should ensure important elements of medical assessments, such as those concerning the risk of suicide and self-harm are recorded in the patient's contemporaneous clinical record in keeping with the GMC's Good Medical Practice.
- The Governor and Head of Healthcare should deliver a training programme for all clinical staff members to ensure they are aware of GRASP and when it should be used.
- The Governor should ensure that:
 - East of England Ambulance Service and HMP Whitemoor have a protocol in place agreeing what initial clinical information is required before despatching an ambulance (and the need for urgency in emergency situations);
 - all prison staff understand their responsibilities during medical emergencies and that cell numbers and location are given at the time of the emergency code;
 - the control room calls an ambulance immediately an emergency code is called;
 - there are no unnecessary delays in ambulances reaching prisoners.
- The Governor should ensure that:
 - annual updates of next of kin details including name, telephone numbers and addresses are requested from prisoners and noted in their NOMIS prison record;
 - in line with Prison Rule 22, when a prisoner dies, his next of kin are informed as soon as possible.
- The Governor should ensure that when conducting roll counts or unlocking or locking a cell door, staff check that prisoners are safe and that there are no immediate issues that need attention.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Whitemoor informing them of the investigation and asking anyone with relevant information to contact her. Several prisoners asked to be interviewed and she spoke to them during subsequent visits to the prison.
13. The investigator visited Whitemoor on 2 September 2016. She obtained copies of relevant extracts from Mr Nasif's prison and medical records.
14. The investigator interviewed 13 members of staff and 10 prisoners at Whitemoor in September and October. She provided feedback to the deputy governor.
15. NHS England commissioned a clinical reviewer to review Mr Nasif's clinical care at the prison and he did some joint interviews with the investigator.
16. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation. He gave us the results of the post-mortem examination, and we have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Nasif's sister and brother, to explain the investigation and to ask whether the family had any matters members wanted the investigation to consider. They did not have any specific questions.
18. Mr Nasif's family received a copy of the initial report. They had no further comments or questions about the report.

Background Information

HMP Whitemoor

19. HMP Whitemoor is a high security prison, which holds around 450 men serving long sentences. Since April 2015, Northamptonshire Healthcare NHS Foundation Trust has been the healthcare provider.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Whitemoor was in January 2014. Inspectors reported that the prison held a high number of Muslim prisoners who accounted for around 40 percent of the total prisoner population. Most prisoners felt safe and the prison was generally impressively calm and ordered with relatively few violent incidents. However, black and minority ethnic, Muslim and foreign national prisoners were much less positive about a range of issues relating to safety and respect. Inspectors felt this area needed a consistently high level of attention.

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 May 2016, the IMB reported that Whitemoor was well led but not enough managerial time was devoted to delivering better prisoner outcomes. They commented that staffing profiles left no room for manoeuvre. Prisoners were not always able to benefit from a consistent or foreseeable regime.

Previous deaths at HMP Whitemoor

22. Mr Nasif was the fifth prisoner to die at Whitemoor since August 2014. Three of these deaths were from natural causes and one was self-inflicted. Our investigation into the self-inflicted death in September 2014 raised concerns about a nine minute delay in the control room ringing 999 after staff first raised the alarm, and concerns about the length of time it took the ambulance crew to make their way to the man's cell.

Key Events

23. In September 2010, Mr Salah Ahmed Nasif was remanded into custody facing murder charges. Suicide and self-harm prevention measures were started, but closed a few days later. In November, he told a nurse he had cut his wrists about two months earlier, shortly after committing the offence, in an attempt to end his life. Mr Nasif said he felt anxious and paranoid at times and this prevented him socialising with others. He was prescribed lorazepam (an anti-anxiety drug).
24. On 6 July 2012, Mr Nasif was found guilty of murder and sentenced to life imprisonment, with a minimum period of 19 years to serve.
25. On 21 September 2012, Mr Nasif was transferred to HMP Whitemoor. His ongoing health issues were identified as angina, post-traumatic stress disorder and prostate problems. Mr Nasif was prescribed appropriate medications to treat his physical health conditions. He was prescribed lorazepam and pericyazine (both anti-anxiety drugs) for post-traumatic stress disorder

Mr Nasif's Residential Management

26. Mr Nasif lived on C wing which has a spur specifically for prisoners who are over 50 years old. The foreign national co-ordinator met Mr Nasif and recorded that his spoken English was reasonably good.
27. Mr Nasif settled at Whitemoor and was described as polite and respectful to staff and other prisoners. He attended education and work, preferring to mix with a small group of friends. Mr Nasif saw members of the healthcare team regularly for the management of his ongoing health issues. He was seen frequently by the mental health team, including a psychologist and psychiatrist.
28. In December 2015, a prisoner held a screwdriver to Mr Nasif's neck. He claimed it was just "horseplay" but Mr Nasif, who experienced high levels of anxiety and had a fear of awkward social situations, told staff he felt threatened. The other prisoner was moved out of the workshop and onto a different spur and there were no further problems.
29. In February 2016, an officer became Mr Nasif's personal officer. He was aware that the mental health team met with Mr Nasif regularly, but did not know any more. He thought Mr Nasif's English was good enough to communicate with staff. He made personal officer entries in Mr Nasif's case notes, but not fortnightly, as the policy stated he should. He told the investigator he usually speaks to all of his nominated prisoners every time he is on duty, but does not always make a record of doing so.
30. A prisoner met Mr Nasif when he arrived at Whitemoor and they became close friends. He described Mr Nasif as a very quiet person, even shy. They often spoke to each other in Arabic and had both grown up as teenagers in Baghdad. For a long time, the two men lived next door to each other on the Over 50's spur. When the prison made their landing a no smoking landing, Mr Nasif was obliged to transfer to a different landing. He felt this was unfair for Mr Nasif and did not take into account his health problems or his difficulties in climbing stairs, which

the move would require. Other prisoners told us that Mr Nasif was very unhappy at having to move landings.

31. On 24 June 2016, a categorisation review board decided that Mr Nasif should remain a category B prisoner within the high security estate. The Head of Offender Management explained this was because Mr Nasif needed to do other programmes in order to address his risk of violence before moving to another establishment. He also said that although Mr Nasif had done an education course, he needed to improve his English so he could take a meaningful part in other programmes across the prison estate.

Mr Nasif's clinical care

32. In January 2016, a trainee psychologist began regular (weekly or fortnightly) appointments with Mr Nasif, looking at strategies that might help him manage his post traumatic stress disorder and ongoing difficulties with anxiety. Mr Nasif said his current dose of lorazepam was no longer effective and he was waiting for an appointment with the psychiatrist. He wanted an increase in his medication as well as psychological intervention.
33. Mr Nasif continued to suffer from anxiety at certain times of the day. A psychiatrist decided to change Mr Nasif's medication to a different benzodiazepine and gradually reduce the prescription of lorazepam. This was discussed and agreed with Mr Nasif on 30 March 2016. Throughout the following weeks and months Mr Nasif continued to be seen by the trainee psychologist and psychiatrist.
34. Mr Nasif's transition from lorazepam to clonazepam was undertaken gradually over several months. By 28 July, lorazepam had been fully replaced by clonazepam. When the trainee psychologist met Mr Nasif that day, she felt he was relatively upbeat in mood despite some anxiety about the lorazepam stopping completely. Mr Nasif said he had had a good few weeks and that his anxiety symptoms were generally well controlled.
35. The trainee psychologist told us they talked about whether Mr Nasif thought about suicide or self-harm a number of times, but he always replied not, in quite a categorical manner and said he did not think about such things. Mr Nasif would sometimes begin their sessions saying he felt low, but much of this concerned the process of changing his medication. Mr Nasif was often keen to see the psychiatrist because he wanted to talk about his medication. She felt he saw the solution to his feelings as being through medication rather than talking therapies.
36. On 5 August, the trainee psychologist told Mr Nasif their regular sessions would be ending in a month as she was leaving her post. Although no formal treatment sessions could be set up until a new psychology assistant was appointed, the plan was for Mr Nasif to have further sessions with the mental health team leader.
37. Over the next few weeks the entries in his medical record indicate Mr Nasif was ambivalent about not having lorazepam and attributed a number of negative symptoms to this. He was worried about returning to work when the workshop reopened. On 18 August, he told the trainee psychologist he felt "very bad", low

in mood and depressed. Mr Nasif said his anxiety was being controlled but he was left feeling lethargic, unmotivated and bored. By the end of the session, however, she felt Mr Nasif's mood had lifted.

38. On 25 August, at their final appointment, the trainee psychologist recorded in SystmOne that Mr Nasif was struggling with anxiety and dizziness and wanted to see the psychiatrist. He told her the medication made him feel "sad" and that he had withdrawn from social activities. She said this was not the first time he had retreated from social activities and that many of their sessions had concerned encouraging him to get involved with things that were going on. It did not, therefore, cause her undue concern. She tried to explain to Mr Nasif that sadness and anxiety are part of life and that no medication would be able to eliminate these feelings entirely. She could not remember whether she specifically asked him about suicide or self-harm thoughts at this appointment.
39. The trainee psychologist arranged for Mr Nasif to see the psychiatrist that day. Mr Nasif told the psychiatrist of depressive symptoms such as low mood, feeling sad, a lack of motivation and self-isolation. The psychiatrist decided to begin a course of sertraline (an anti-depressant). Although not noted in SystmOne, he told the clinical reviewer that it is his customary practice to explore suicidal and self-harm thoughts during his consultations with patients as a matter of routine. He concluded that Mr Nasif was not at risk of suicide or self-harm.

Events of 27 and 28 August

40. Mr Nasif telephoned his sister every Saturday and his last call to her was on 27 August. We had a recording of this call translated and there was nothing to suggest Mr Nasif was feeling particularly low and he did not say anything about ending his life.
41. On Saturday 27 August, a prisoner said he and Mr Nasif took their exercise together. They spoke about Iraq and family matters. Mr Nasif talked of his father and grandfather and reflected that it had been "a better time" then. Around 2pm in the afternoon, the two men spoke again, and he thought everything seemed fine.
42. At around 3.30pm, Mr Nasif spoke to a prisoner for half an hour. The prison was going to be in 'lockdown' on the following (Sunday) afternoon. Mr Nasif spoke about his anti-depressant medication and said he was due to take his first dose that day. The prisoner told him it would take a while to feel the effects and that he must give it time to work and build up within his body. Mr Nasif replied that he was, "very tired" and said, "I don't know if I can make it or not". He did not like the thought of spending lots of time in his cell the next day and said he was scared of this time. The prisoner told him to come downstairs in the morning and that they could play pool, cook something and "have a laugh together". The prisoner did not share any of this conversation with officers.
43. Around 4pm, a prisoner who lived in the cell next door said Mr Nasif "had words" with someone because of the mess they had left in the showers. He said the dispute did not become physical, but he thought Mr Nasif had been upset. Soon afterwards, it was tea time and, at around 4.50pm, prisoners were then locked into their cells overnight.

44. Around 8.15pm, the night staff arrived and at around 9pm a routine roll check took place. Between 10pm and 11pm a prisoner who lived in the cell next door but one said he heard an unusual noise, like a heavy bang or thud coming from the direction of Mr Nasif's cell. He did not hear anything else.
45. One of the staff working on C wing overnight did an early morning roll count, starting at around 5.00am. He said the check normally takes about 15 to 20 minutes. When he reached Mr Nasif's cell, he said it looked as though Mr Nasif was standing looking out of the window.
46. The early relief officer arrived on C wing about 7.25am with a colleague. He counted the prisoners on landing three. He said Mr Nasif was by the window, apparently looking out. He could not remember whether he was kneeling or standing, but said he assumed that Mr Nasif was all right and continued to the next cell.
47. Unlock started at around 9.05am. When Officer A got to Mr Nasif's cell she saw he was on his knees at the window. The cell was quite dim as the curtains were partially drawn. She thought he was praying and did not want to be disrespectful by disturbing him, so continued unlocking the other cells on the spur.
48. Mr Nasif did not come out of his cell to collect his medication as he normally would. Several prisoners said they remembered an officer shouting up for him to come and collect his medication.
49. At about 9.30am, Officer A and Officer B began daily cell fabric checks and reached Mr Nasif's cell at 9.38am. Officer A asked if they could do his "bars" (a security check). When Mr Nasif did not respond, she entered the cell, switched on the light and saw him kneeling by the window. A ligature of green bed sheet that was attached to the window bars was around his neck. His hand was also holding one of the window bars. She cut the ligature, shouted, "code blue" and issued a code blue radio message. Neither she nor her colleague made any attempts at resuscitation because Mr Nasif was cold and stiff when touched.
50. A Supervising Officer (SO) ran to the cell and two other officers arrived as he got there. The nurse who was on C wing issuing medication reached Mr Nasif's cell within two minutes and assessed Mr Nasif. The emergency healthcare response arrived at 9.41am. Rigor mortis had set in, so no resuscitation attempts were made.
51. The manager in the control room said he is aware of the instruction that 999 should be called immediately when a code blue is made. He told us the East of England Ambulance Trust insist on knowing the name and date of birth before they will despatch an emergency ambulance and this is why he did not call 999 immediately. They also ask for details such as the name and date of birth of the prisoner and circumstances, such as whether a nurse or GP is present or if a defibrillator has been used.
52. When he heard Officer A's emergency message he rang C wing and spoke to an officer, asking her to find out what was happening. After a few minutes he said she rang back and told him a prisoner had been found with a ligature, a nurse was there and rigor mortis had set in. He said he required the prisoner's name in

order to ring the ambulance service. He said it is not usual practice to say prisoners' names over the radio system because other prisoners would be able to hear.

53. After ascertaining that the incident was in Mr Nasif's cell the officer rang and told the manager. She thought this was about four minutes after the code blue was first called. After leaving the office again to try and find out more, the officer rang the manager back for a second time and said, "I think he's dead. A nurse is there". She said she did not know Mr Nasif had used a ligature until later, when one of the nurses came and spoke to her.
54. At 9.50am, the officer support grade called 999. Twelve minutes had elapsed since the code blue radio message had been called. The ambulance arrived at Whitemoor's gate at 10.13am and reached the entrance to C wing at 10.27am. A dog handler and officer support grade escorted the ambulance through the three internal prison vehicle gates. CCTV inside the wing shows the paramedics reaching Mr Nasif's cell at 10.38am. At 10.52am, a paramedic pronounced Mr Nasif dead.

Contact with Mr Nasif's family

55. Two managers were in charge of the prison when Mr Nasif died. One checked the information held on Mr Nasif's electronic case notes. Mr Nasif's sister was named as the next of kin, but there was only a partial address. The safer custody office holds next of kin names, addresses and phone numbers. When the manager of the safer custody office arrived at lunchtime, a home address for Mr Nasif's sister was identified.
56. Managers decided to ask a prison closer to the family address in London to break the news of Mr Nasif's death because it would take around two and a half hours to drive there. An officer spoke to the duty governor at HMP Wormwood Scrubs, but they were not able to assist until 4pm. The Governor decided this was too late and, at 1.45pm, asked the local police if they could arrange for the Metropolitan Police to visit the family to break the news. The address the duty governor had for Mr Nasif's sister was over a year old and, when the police arrived, they found the family had moved away. The Governor then tried to telephone Mr Nasif's sister but received no answer.
57. An officer was appointed as the family liaison officer. She called Mr Nasif's sister, aware that, despite several attempts, no one had managed to make contact over the course of the day. At 10.00pm, Mr Nasif's sister answered the phone and she broke the news of her brother's death. Later that evening, a nephew called the prison, requested more information and asked to be the main point of contact.
58. On 30 August, the operational manager, with responsibility for safer custody, and an officer (who took over responsibility for family liaison) met Mr Nasif's family in their home. The officer subsequently kept in contact with Mr Nasif's family, and Whitemoor offered help with the funeral arrangements and contributed to the costs, in line with national instructions.

Support for prisoners and staff

59. After Mr Nasif's death, the Governor 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.
60. The prison posted notices informing other prisoners of Mr Nasif's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Nasif's death.

Information from prisoners after Mr Nasif's death

61. All the prisoners we spoke to, apart from one, were shocked and upset by Mr Nasif's death.
62. A prisoner knew Mr Nasif was seeing the trainee psychologist for anxiety and commented that he did not think he was practising the required techniques he was being taught on a regular basis. He said Mr Nasif was very depressed in the months before his death and seemed mentally and physically tired. He stopped going to the gym, often seemed dizzy and unable to continue with day to day activities. He thought Mr Nasif's medication might have stopped working.
63. Several other prisoners we spoke to thought Mr Nasif's biggest concern was his medication. He was upset by it being changed and worried about it. A prisoner thought Mr Nasif's balance of mind was affected by the different medication. Another prisoner thought Mr Nasif was worried about the trainee psychologist's departure and that their sessions were ending. The prisoner who lived in the cell next door to Mr Nasif said that when talking on 25 August, Mr Nasif had told him, "Its shit in here. Boring. Depressing". He jokingly replied along the lines of: "Let's hang ourselves, then. You go first." Mr Nasif replied "This is a shit life. When I leave this life, I'll know it is".

Post-mortem report

64. A post-mortem examination found Mr Nasif died from asphyxiation due to hanging. Toxicology tests showed the presence of paracetamol in the range expected for a therapeutic dose. A very low dose of clonazepam was detected.

Findings

Assessment of risk and sharing information

65. During their contact with him, neither the psychiatrist nor the psychology assistant found indications that Mr Nasif was at risk of suicide or self-harm. Both saw him regularly. Although the psychiatrist told the clinical reviewer that he had made a point, in accordance with his standard practice, of assessing whether Mr Nasif was at risk of self-harm when he saw him, no annotation of this assessment or its outcome is recorded in the medical record. The trainee psychologist did not always make a written note of her assessment of Mr Nasif's suicide or self-harm risk either, although she said they had discussed it several times. Good medical practice is that the assessment and outcome are recorded in the patient's record.

The Head of Healthcare should ensure important elements of medical assessments, such as those concerning the risk of suicide and self-harm are recorded in the patient's contemporaneous clinical record in keeping with the GMC's Good Medical Practice.

66. Staff outside of the medical team did not know any details about Mr Nasif's post traumatic stress disorder, or the medication he was receiving. We do not think wing staff were in a position to be able to make an assessment as to whether Mr Nasif's risk of suicide or self-harm had changed.

67. A custodial manager explained that Whitemoor has a system - General Risk Advice and Support Plan (GRASP) – for sharing risk related information from partner agency staff to operational staff. The system was introduced to address a previous recommendation from us. It is intended to be used in situations where information is held by others, including healthcare staff, which may help in the management of prisoners presenting a potential risk to themselves, but where an ACCT is not thought necessary because there is not thought to be an immediate risk of suicide or self-harm.

68. The system aims to share information about, for example, ongoing mental health issues and factors which may affect future risk of suicide or self-harm. The form specifically lists medication changes as a potential risk factor. Once completed, the GRASP form is kept in the residential unit where the prisoner lives, with copies in the safer prisons office and orderly office. Use of this system in Mr Nasif's case would have meant the C wing supervising officer and officers on blue spur were aware of the medication changes and associated issues.

69. The custodial manager believed GRASP was for people who are very difficult to manage. For example, because they assault staff verbally or physically but have mental health needs at the same time. He did not think it was for prisoners like Mr Nasif. The trainee psychologist told us she did not know what GRASP was used for.

70. The custodial manager told us that although medical information is held in confidence, healthcare might share medication changes if they thought the change would have a detrimental affect on the person's wellbeing.

71. Mr Nasif's mood was such that starting antidepressants was warranted when the psychiatrist saw him on 25 August. He had told the trainee psychologist he felt sad and had withdrawn from wing activities. Medical staff may not have considered Mr Nasif to be at risk of suicide or self-harm, but it is clear he told them he was struggling to cope and we feel the GRASP system was set up to share information of this kind. We do not think Mr Nasif's death was foreseeable, but wing staff should have been aware that long term mental health medication was changing and that he might feel differently as a result.

The Governor and Head of Healthcare should deliver a training programme for all clinical staff members to ensure they are aware of GRASP and when it should be used.

Emergency response

72. There was a delay of 12 minutes between the code blue at 9.38am and the ambulance being called at 9.50am. PSI 03/2013, *Medical Emergency Response Codes*, states that when a medical emergency is called over the radio network, an ambulance must be called immediately.
73. In addition to the delay in calling an ambulance, it took nearly 15 minutes for the ambulance crew to make their way from Whitemoor's gate to C wing and a further ten minutes for the crew to reach Mr Nasif's cell. While we acknowledge that Whitemoor is a high security establishment, we think this is too long and the prison needs to explore ways to speed up internal movement in emergency situations. In another high security prison, officers and dog handlers are used to line the route, with several gates opened at once.
74. Although, in Mr Nasif's case, the delay did not affect his chance of survival as he had been dead for some time when found, it is crucial that all staff follow the agreed emergency procedures in order to give prisoners the best chance of survival in a medical emergency and that there are no delays in getting ambulances to prisoners.
75. We have made previous recommendations about delays in calling 999 and were told Whitemoor had reviewed and updated the policy on medical emergencies and circulated it to all staff. As recently as 24 August 2016, just four days before Mr Nasif died, a custodial manager sent an email to the control room staff, including the manager in the control room, reminding them that the emergency services must be called without delay. And yet, this policy was not followed.
76. The manager told us that the Ambulance Service is reluctant, or refuses, to despatch emergency resources unless certain clinical information is available. While we appreciate he had reservations about calling 999 without the information he felt was necessary, it is unacceptable that 12 minutes passed following the code blue radio message before this happened. He and the officer differ about their recollection of events and when Mr Nasif's name was relayed to the control room. The person making a code blue or red radio message should include information about the cell number as this enables the prisoners' name to be established quickly. The officer did not do this. We make the following recommendation:

The Governor should ensure that:

- **East of England Ambulance Service and HMP Whitemoor have a protocol in place agreeing what initial clinical information is required before despatching an ambulance (and the need for urgency in emergency situations),**
- **all prison staff understand their responsibilities during medical emergencies and that cell numbers and location are given at the time of the emergency code,**
- **the control room calls an ambulance immediately an emergency code is called,**
- **there are no unnecessary delays in ambulances reaching prisoners.**

Family liaison

77. There was an unacceptably long delay in notifying Mr Nasif's sister of his death. In part, this was because the prison had an incomplete address, and when a full address was found, it was not current. Thereafter, there was a further delay in arranging for staff to attend the family home and a face to face meeting did not take place until 30 August.
78. Prison Rule 22(1) states, "If a prisoner dies the governor shall, if he knows his or her address, at once inform the prisoner's next of kin..." PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* mandates that, wherever possible, this must be done in person by a family liaison officer and another member of staff and that "time will be of the essence".
79. The safer custody department at Whitemoor files next of kin details of all prisoners when they arrive in the prison. Whitemoor relied on prisoners to tell them of any changes. Since Mr Nasif's death, safer custody has decided to send the next of kin information page to prisoners requesting updates, on an annual basis.

The Governor should ensure that:

- **annual updates of next of kin details including name, telephone numbers and addresses are requested from prisoners and noted in their NOMIS prison record;**
- **in line with Prison Rule 22, when a prisoner dies, his next of kin are informed as soon as possible.**

Clinical review

80. The clinical reviewer judged that Mr Nasif's health issues were correctly identified at Whitemoor, dealt with appropriately and managed in accordance with his needs.
81. The clinical reviewer concluded that the health care provided to Mr Nasif was equivalent to that provided to other NHS patients in the community.

Checking prisoners' well-being during roll checks and at unlock

82. Whitemoor's night instructions state that the night officer will check the roll at 5:45am by seeing the faces, or getting a response from every prisoner, and report the roll to the control room by 6:00am. The instruction goes on to say that a clear acknowledgement (hand movement, full eye contact, dialogue) or evidence of physical movement is required.
83. The night officer said he did not try to get a verbal response from Mr Nasif, because he assumed that because he was looking out of the window he was fine.
84. A supervising officer said that when night staff are relieved, the first member of staff on duty should carry out a check on every prisoner. They should satisfy themselves that they receive enough of a response to confirm each prisoner is alive and well. He added that if he himself could not see a prisoner moving, he would stay until he saw breathing or clear signs of life. If he had any further concerns, he would seek a clear response, such as by knocking on the door and asking whether the prisoner was okay.
85. The early relief officer who carried out the early check around 7.30am, said officers do not wake up every prisoner at that time (although some are already awake). He felt the main purpose of the check was to be certain the prisoner was in the cell and that nothing was obviously amiss. He said Mr Nasif was by the window looking out and as he thought he was all right, he moved on to the next cell.
86. Whitemoor issued an instruction on 20 March 2014 stating that all operational staff have an obligation to ensure prisoners are responsive, and must check on their wellbeing when unlocking them.
87. Officer A said she assumed Mr Nasif was praying when she unlocked his cell at 9.04am, and said it is usual practice not to disturb someone if they are praying because this would be seen as disrespectful.
88. Prison Service Instruction 05/2016, *Faith and pastoral care for prisoners*, issued in June 2016, states that as a norm, a Muslim in prayer cannot communicate with anyone else until the prayer is completed. Notwithstanding the advice about not disturbing prisoners during prayer, the officer should have remained watching Mr Nasif at his cell door until she was certain she saw motion of some kind such as breathing or movement within prayer.
89. Of the ten prisoners we spoke to during this investigation, nearly all said that during morning unlock, some officers say 'good morning', check they are alright and seek a response, while other staff simply unlock the door and move on to the

next cell. While we understand how, at a quick glance, staff thought Mr Nasif was all right, we are not satisfied that the checks comply with the clear instructions issued by the Governor about the standard required of roll checks and unlock procedure and recommend:

The Governor should ensure that when conducting roll counts or unlocking or locking a cell door, staff check that prisoners are safe and that there are no immediate issues that need attention.

**Prisons &
Probation**

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Independent Investigations