

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Mohammed Saeed-Alim a prisoner at HMP Manchester on 19 October 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 Mohammed Saeed-Alim was found hanged in his cell at HMP Manchester on 19 October 2016. He was 30 years old. I offer my condolences to Mr Saeed-Alim's family and friends.

Mr Saeed-Alim was a vulnerable man with complex needs. The investigation found that he was appropriately managed and supported in a small specialist unit within the prison, with a high level of interaction and engagement with staff. It is therefore surprising that we also found a significant missed opportunity to reassess his risk when he stopped taking his medication in the days before his death.

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**

**June 2017**

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# Summary

## Events

1. Mr Saeed-Alim was serving a life sentence with a minimum tariff of 18 years for terrorist-related offences and attempted murder. He arrived at HMP Manchester on 12 November 2015, having been transferred from HMP Belmarsh. Prior to that, he had been a patient at Broadmoor Hospital.
2. Mr Saeed-Alim had a diagnosis of Aspergers Syndrome and Emotionally Unstable Personality Disorder (EUPD), along with depression and anxiety. He was prescribed anti-psychotic and antidepressant medication and was held in the Specialist Interventions Unit (SIU), a centrally managed unit for high risk prisoners with complex needs.
3. Mr Saeed-Alim was subject to suicide and self-harm monitoring (ACCT procedures) upon his arrival at Manchester, and continued to be monitored until 14 December. He was monitored under ACCT procedures again from 27 May to 3 June 2016, after he had self-harmed.
4. On 16 October, a mental health staff nurse noted in Mr Saeed-Alim's medical record that he had refused his medication for the past 48 hours. The nurse said this would need to be followed up but did not say how or by whom.
5. On 19 October, during a security cell search at around 2.05pm, Mr Saeed-Alim was found hanging in his cell by a ligature suspended from the light fitting. Officers immediately raised the alarm and Mr Saeed-Alim was cut down. Healthcare staff attended the cell and began emergency life saving treatment until the ambulance arrived at around 2.20pm. It was not possible to revive Mr Saeed-Alim and he was pronounced dead by the prison doctor at 2.41pm.

## Findings

6. We consider that Mr Saeed-Alim was well supported in the SIU and displayed a good level of engagement with both prison staff and healthcare professionals. Despite this we found that there was a missed opportunity to assess any deterioration in his mental health, and his risk of suicide and self-harm when he suddenly stopped taking his medication. Although this was noted in his medical record, it was not made known to prison staff nor was it followed up by mental health professionals.
7. When staff discovered Mr Saeed-Alim, they responded quickly but failed to use the medical emergency code in line with national instructions. While the failure to use the medical emergency code did not result in a delay in calling for an ambulance, it is important that the code is used when appropriate as any delay in the emergency response could be critical. Manchester's staff instruction about handling medical emergencies did not reflect the requirement of the national instruction to call an ambulance immediately, but this has since been rectified.

## Recommendations

- The Governor and Head of Healthcare should ensure that the mental health in-reach team are immediately informed when a prisoner is not complying with anti-psychotic and other mood altering medication. They should ensure that, where appropriate, discipline staff are made aware of non-compliance with medication so that a full risk assessment can take place.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. NHS England commissioned a clinical reviewer to review Mr Saeed-Alim's clinical care at the prison.
10. The investigator visited Manchester on 27 October 2016. She obtained copies of relevant extracts from Mr Saeed-Alim's prison and medical records. She and the clinical reviewer later interviewed six members of staff at the prison. The clinical reviewer also interviewed one member of healthcare staff by telephone.
11. We informed HM Coroner for Manchester of the investigation and have sent him a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Saeed-Alim's mother to explain the investigation. Mr Saeed-Alim's mother wanted to know if prison staff had been aware of any changes in her son's mood and, if so, whether they responded to this appropriately.
13. Mr Saeed-Alim's family received a copy of the initial report. They did not raise any concerns in relation to factual accuracy of the report.

# Background Information

## HMP Manchester

14. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester Mental Health and Social Care Trust provide 24 hour nursing care and the healthcare centre includes an inpatient unit. Mr Saeed-Alim was located in the prison's Special Intervention Unit (SIU) which is a centrally managed unit for high risk prisoners who do not meet the criteria for the close supervision unit, but who have complex needs that would make it difficult for them to be managed and supported within the normal prison environment.

## HM Inspectorate of Prisons

15. The most recent inspection of HMP Manchester was conducted in November 2014. Inspectors reported good relationships between staff and prisoners. Inspectors found that Manchester focused on preventing self-inflicted deaths and learned lessons from each incident. Levels of self-harm were comparatively low and care for those at risk was good. Vulnerable prisoners generally felt safe, however support for victims of violent incidents needed to be improved. Health provision was generally good but too few prison staff had mental health awareness training. Inspectors noted that there was a high incidence of mental health and substance misuse problems.

## Independent Monitoring Board

16. 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 29 February 2016, the IMB reported that the health and welfare of prisoners was given a high priority. The IMB commented that the main challenges for the prison have been mobile phones, drugs and weapons.

## Previous deaths at HMP Manchester

17. Mr Saeed-Alim was the fourth prisoner to take his life at Manchester since January 2014. Since Mr Saeed-Alim's death, there has been one further apparently self inflicted death in February 2017. Previous investigations have identified deficiencies in the emergency response.

## Assessment, Care in Custody and Teamwork

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
19. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

20. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **Emergency response**

21. PSI 03/2013, *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.

## Key Events

22. Mr Mohammed Saeed-Alim was a high profile prisoner serving a life sentence with a minimum tariff of 18 years for terrorist-related offences and attempted murder. He was sentenced for the offences in January 2009. He had no previous convictions prior to this offence so had never been in prison.
23. Mr Saeed-Alim had a diagnosis of Aspergers Syndrome and Emotionally Unstable Personality Disorder (EUPD), along with depression and anxiety. He also had a history of self-harm. Mr Saeed-Alim was remanded to HMP Belmarsh from June 2008 where he was admitted to the healthcare wing for mental health assessment and monitoring. When he moved from healthcare to the prison's main location in September 2008, his mental health deteriorated and he began to self-harm. Due to his high risk and complex needs, he was transferred to Broadmoor Secure Hospital in April 2009 for mental health assessment and treatment.
24. Mr Saeed-Alim remained at Broadmoor for more than six years. During this time, he engaged in therapeutic treatments but struggled to manage his emotions and continued to self-harm.
25. In July 2015, Mr Saeed-Alim assaulted a nurse by cutting her face with a broken CD. He was transferred back to Belmarsh in August 2015 and referred to the Central Case Management Group to consider appropriate ways of managing him within the high security prison estate. He was admitted to the healthcare unit at Belmarsh until a suitable location could be found for him.
26. Mr Saeed-Alim was moved to HMP Manchester on 12 November 2015, after he was assessed as suitable for a place on the Specialist Interventions Unit (SIU) – a centrally managed unit for high risk prisoners with complex needs. He was subject to suicide and self-harm prevention measures (ACCT monitoring) on his arrival at Manchester, as he had threatened to harm himself by drinking cleaning fluids when he was at Belmarsh. He was prescribed anti-psychotic and antidepressant medication and observed five times per hour.
27. Mr Saeed-Alim made good progress on the SIU, engaging well with staff and complying with his medication. Staff had no concerns about his risk of suicide and self-harm and, after a gradual reduction in observations and four ACCT reviews at Manchester, ACCT monitoring stopped on 14 December.
28. On 27 May 2016, Mr Saeed-Alim caused injuries to his left arm and neck with a plastic fork. He said he had self-harmed because another prisoner on the SIU was being restrained and he did not like seeing people getting hurt. ACCT monitoring started and Mr Saeed-Alim said he did not want to die and had no further thoughts of self-harm. His risk of harm was assessed as low and, as there were no further concerns, ACCT monitoring stopped on 3 June. The ACCT process was followed appropriately and Mr Saeed-Alim was adequately monitored and supported throughout.
29. On 11 July, Mr Saeed-Alim was sentenced to a further 16 months imprisonment for actual bodily harm committed against the nurse at Broadmoor Hospital.

30. On 14 July, Mr Saeed-Alim had a review with a psychiatrist. The psychiatrist told the clinical reviewer that Mr Saeed-Alim wanted to stop taking his medication. He stopped his antidepressant and reduced his anti-psychotic medication, replacing it with mood stabilising medication. Mr Saeed-Alim was content with the change of medication and the psychiatrist told him that he would continue to be monitored by the mental health team with a review in six weeks.
31. On 6 September, Mr Saeed-Alim had a review with a mental health nurse. He reported feeling more settled on his medication and that his moods were more stable. She noticed that there had been no review of his medication since it was changed in July, so she booked a medication review with the psychiatrist for 22 September. She told Mr Saeed-Alim that she would no longer be working with him and he would have a new mental health nurse at his next appointment. Mr Saeed-Alim appeared accepting of this and she recorded in his notes that she felt their therapeutic relationship ended in a positive manner.
32. On 18 September, Mr Saeed-Alim had a visit from his mother and two brothers. His prison record said he had not seen them for two years and he had been anxious about the visit, but it went well and he appeared happy and settled.
33. On 22 September, Mr Saeed-Alim had a medication review with the psychiatrist. The psychiatrist noted that his mood had improved so he stopped his anti-psychotic medication completely and increased the dosage of his mood stabiliser. He said he would review him again in six weeks.
34. Mr Saeed-Alim met with his new mental health nurse for the first time on 27 September. She recorded that his mood was stable and he engaged well with her during the session. He told her that he was experiencing "dark dreams", he was worried about his fluctuating moods and he said that he was feeling physically unwell. He said he had no thoughts of suicide or self-harm. Mr Saeed-Alim asked her if he could meet her on a weekly basis and she agreed to this. She later discussed Mr Saeed-Alim's symptoms with the psychiatrist, who told her that the symptoms could be due to the change in medication and he should be monitored for one week.
35. On 28 September, Mr Saeed-Alim was due to attend his Managing Challenging Behaviour Strategy (MCBS) review meeting, but he did not attend as he said he was physically unwell. The meeting went ahead in his absence, chaired by a Governor. He and those present discussed Mr Saeed-Alim's progression plan, which included a referral to the Westgate Unit, a specialised personality disorder unit at HMP Frankland. He told the investigator that Mr Saeed-Alim was aware of this progression plan and that he had not expressed any concerns about moving to the Westgate Unit.
36. On 7 October, Mr Saeed-Alim had his second appointment with his named mental health nurse. He reported that he was feeling better in mood and in good physical health. He recognised that his mood fluctuations had been due to the change in medication. He said he had no thoughts of suicide or self-harm and she encouraged him to speak to staff if he felt distressed. She arranged his next appointment for 24 October.

37. On 16 October, a mental health staff nurse noted in Mr Saeed-Alim's medical record that he had refused his medication for the past 48 hours. He told the investigator that Mr Saeed-Alim had always taken his medication previously. He said he made a note in Mr Saeed-Alim's medical notes to record the fact. He said he expected that either the psychiatrist or the named mental health nurse would assess the situation. He said he could have contacted the named mental health nurse or the psychiatrist directly, but he did not think it required urgent attention, as he could not see any obvious decline in Mr Saeed-Alim's mental health.
38. On 19 October, a planned security cell search was due to take place in the SIU. Mr Saeed-Alim was described as being in good spirits during the morning and staff had no concerns about him. Prisoners were locked in their cells in the afternoon and Mr Saeed-Alim was seen by an officer at around 12.30pm.
39. The Dedicated Search Team (DST) began the search of the SIU at around 2.00pm on 19 October. On entering Mr Saeed-Alim's cell at approximately 2.05pm, they found him hanging from the light fitting by a ligature made from a sheet. A DST manager and an officer helped to take the weight of Mr Saeed-Alim's body while another officer cut the sheet from the light fitting. Another officer also arrived at the cell after his colleagues shouted for assistance, and the officers moved Mr Saeed-Alim onto his bed to begin cardiopulmonary resuscitation (CPR). The manager of the SIU cut the ligature from around Mr Saeed-Alim's neck and an officer radioed for healthcare assistance. The control room called for an ambulance at 2.07pm.
40. Mr Saeed-Alim was moved onto the floor of his cell where officers continued CPR. Two nurses arrived within a few minutes of the radio call and took over emergency treatment until paramedics arrived at around 2.20pm. The paramedics and nurses continued with attempts to revive Mr Saeed-Alim but he was pronounced dead by two prison GPs at approximately 2.41pm.

### **Contact with Mr Saeed-Alim's family**

41. On 19 October at 7.00pm, a Governor from nearby HMP Channings Wood visited the home of Mr Saeed-Alim's grandparents to inform them of his death. The prison contributed to the cost of Mr Saeed-Alim's funeral, in line with Prison Service Instructions.

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

42. After Mr Saeed-Alim's death, a senior prison manager 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.
43. The prison posted notices informing other prisoners of Mr Saeed-Alim's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Saeed-Alim's death.

## Post-mortem report

44. The Coroner found Mr Saeed-Alim's cause of death was hanging, although the post-mortem and toxicology reports were not available at the time of issue of this initial report.

# Findings

## Missed medication

45. The clinical reviewer concluded that overall the level of clinical care Mr Saeed-Alim received at Manchester was equivalent to that which he could have expected to receive in the community. He considered that Mr Saeed-Alim's mental health was well managed by the mental health in-reach team but he had some concerns about medication management in the days leading up to his death. We consider that Mr Saeed-Alim was well supported in the SIU and displayed a good level of engagement with both prison staff and healthcare professionals. It is therefore surprising that relevant staff were not made aware when Mr Saeed-Alim, a vulnerable, high risk prisoner with complex needs, began to refuse his mood stabilising medication.
46. A nurse said that, after two days of Mr Saeed-Alim refusing his medication, he recorded this on SystemOne (the electronic medical record), expecting that the mental health nurse or psychiatrist would make an assessment of the situation. SystemOne allows for a "task" to be sent to alert staff that action needs to be taken but he did not do this. Therefore, neither the psychiatrist nor the named mental health nurse were aware that Mr Saeed-Alim was refusing his medication.
47. In addition, SystemOne is not available to discipline staff in the SIU – they are staff who have day to day management of the most challenging, vulnerable and high risk prisoners. We consider that discipline staff should be made aware of missed medication so that they can assess and manage any risk appropriately. We therefore make the following recommendation:

**The Governor and Head of Healthcare should ensure that the mental health in-reach team are immediately informed when a prisoner is not complying with anti-psychotic and other mood altering medication. They should ensure that, where appropriate, discipline staff are made aware of non-compliance with medication so that a full risk assessment can take place.**

## Emergency response protocol

48. When staff found Mr Saeed-Alim hanged in his cell, they responded promptly, cut him down and started CPR. An officer said that he called for healthcare assistance but he did not use the correct medical emergency code which indicates that a prisoner is unresponsive and an ambulance is required. Fortunately, the control room called an ambulance as soon as the call came over the radio and this did not result in a delay on this occasion but, in other cases, any delay could be critical.
49. PSI 03/2013, *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be

written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.

50. The medical emergency response protocol in place at Manchester at the time of Mr Saeed-Alim's death did not reflect the instructions in PSI 3/2013. It stated: "ECR [the control room] automatically calls an ambulance only where it is certain one is needed. In all other cases Hotel One [emergency response nurse] will make that decision". This instruction could have resulted in delays in calling an ambulance immediately and automatically, without the need for further information. In our reports into three other self-inflicted deaths at Manchester in 2016, we found the same issue regarding the emergency response and made a recommendation for change. Since Mr Saeed-Alim's death, Manchester has updated the medical emergency response protocol in line with national guidance and we therefore make no recommendation.

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