

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Imran Ahamed a prisoner at HMP Leicester on 11 December 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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 I oversee can improve their work in the future.

Mr Imran Ahamed died on 11 December 2017. He was found hanged in his cell at HMP Leicester. Mr Ahamed was 42 years old. I offer my condolences to Mr Ahamed's family and friends.

Mr Ahamed found it difficult to cope in prison due to the breakdown of his relationship with his wife and lack of contact with his daughter. Although staff identified on two occasions that Mr Ahamed was at risk of suicide and self-harm, support procedures to lessen his risk were stopped prematurely on both occasions. Little had been done to mitigate Mr Ahamed's risk to himself.

I am concerned to be repeating recommendations to Leicester about suicide and self-harm prevention procedures. In a report into a previous self-inflicted death at Leicester, which we published in April 2018, we recommended that the Prisons Group Director for East Midlands prisons should satisfy herself that effective action is taken to implement repeated recommendations to the prison about ACCT management. The Director accepted this recommendation. This report should also form part of the Director's review.

I am also concerned that, although Mr Ahamed alleged on two occasions that he had been assaulted by his cellmates, staff did not consider the impact of the alleged assaults on Mr Ahamed's well-being.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

August 2018

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Summary

Events

1. Mr Imran Ahamed was arrested and remanded into custody on 15 November 2017 for offences against his wife. He was a probation officer and this was his first time in prison. The next day, a GP prescribed him antidepressants. He did not take this medication as prescribed during his time at Leicester. On 17 November, he asked to move cells. An officer told him they would try to arrange this.
2. On 20 November, staff started suicide and self harm procedures (known as ACCT) because Mr Ahamed told staff that there was no point in living if he could not have contact with his wife and daughter. The next day, Mr Ahamed said one of his cellmates had assaulted him. Mr Ahamed moved cells that morning. Staff stopped ACCT procedures at the first case review.
3. On 22 November, a GP reviewed Mr Ahamed. He said he had no thoughts of suicide or self-harm and spoke about the future. The GP referred Mr Ahamed for emotional support. On 24 November, Mr Ahamed said he had been assaulted by his cellmate. Staff investigated the claim but found no evidence of any assault. On 28 November, a healthcare support worker offered Mr Ahamed emotional support. They discussed his current circumstances and he said he had no thoughts of suicide and self-harm. Mr Ahamed said he wanted to be prescribed sleeping tablets so the support worker said she would make an appointment with the GP and add his name to the waiting list for his sleep to be monitored. There is no evidence that this occurred.
4. On 30 November, Mr Ahamed told an officer that he was being bullied by his cellmate. The officer offered to move Mr Ahamed but he said he wanted to wait until there was a space with another Muslim prisoner. The next day Mr Ahamed told an officer that he had resolved the issues with his cellmate. On 1 December, an officer completed Mr Ahamed's ACCT post closure review with his cellmate present. Mr Ahamed said he had no thoughts of suicide and self-harm.
5. On 4 December, Mr Ahamed moved cells as he had requested. He told his new cell mate that he would "end it" if he could not talk to his wife, and he was often distressed when they were in their cell together. On 5 December, a friend of Mr Ahamed telephoned the prison to say that Mr Ahamed had told him that he wanted to end his life. Staff opened an ACCT document and started suicide and self-harm prevention procedures. That evening, during the ACCT assessment, Mr Ahamed said he had no thoughts of suicide but was struggling with not seeing his daughter. The next day staff closed this ACCT. On 9 December, Mr Ahamed's cellmate moved cells, leaving Mr Ahamed in a cell on his own.
6. On 10 December, Mr Ahamed made a series of increasingly desperate telephone calls to his friends. At 3.15pm, he made his last telephone call to a friend and left them a voicemail indicating that he would not call again. He said he was sorry and asked his friend to look after his family.
7. On 11 December, at 6.12am, an officer checked Mr Ahamed during a routine roll check. The officer said that he could not remember anything out of the ordinary,

and that Mr Ahamed must, therefore, have been in bed. At 7.15am, an officer started his roll check. He looked into Mr Ahamed's cell but the observation panel was blocked. He therefore unlocked the door and found Mr Ahamed hanged from the window bars. He raised the alarm and immediately went into the cell. With the help of another officer, he cut Mr Ahamed's ligature, lowered him to the floor and started cardiopulmonary resuscitation (CPR). Healthcare staff quickly arrived and continued administering CPR. Paramedics arrived at the prison and took over Mr Ahamed's care but pronounced him dead at 7.28am.

8. Police found several notes in Mr Ahamed's cell after his death indicating his intention to commit suicide.
9. Our investigation found that Mr Ahamed made over 450 telephone calls during the 19 days he was at Leicester. During these calls, it was clear that he was finding it difficult to cope with having no contact with his wife or daughter, he was often distressed and desperate and said that there was no point in going on without them. Prison staff were unaware of the content of these calls until after Mr Ahamed had died.

Findings

Management of ACCT

10. Staff twice assessed Mr Ahamed as being a risk to himself and started ACCT procedures each time. On both occasions, the ACCT was closed prematurely at the first case review. Not all the issues identified at the assessment had been identified, nor had staff considered all of Mr Ahamed's risk factors. Alarming, staff also did not adequately record or attach sufficient significance to information provided by one of Mr Ahamed's friends that he had said he wanted to end his life. A post-closure review took place with Mr Ahamed's cell mate present, but this did not record that staff specifically needed to engage Mr Ahamed in conversation, rather than merely observe him. Not all staff had been ACCT trained at the time.

Managing violence and bullying

11. Mr Ahamed moved cells on two occasions after alleging that he had been assaulted by cellmates. Staff completed investigations into these incidents but did not always record the information where necessary or consider the wider implications of the allegations. Nor was adequate consideration given to the impact of such incidents on Mr Ahamed's risk to himself.

Clinical care

12. The clinical reviewer concluded that Mr Ahamed's care was equivalent to that he could have expected to receive in the community. However, we are concerned that, at the time, there was no formal process to notify the prescriber if a prisoner did not take his medication. This has since been rectified. Mr Ahamed also reported sleeping problems several times. A healthcare support worker indicated that she would refer him to the GP and put him on the waiting list for officers to monitor his sleep. There is no evidence that this occurred.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
 - staff record all information relevant to risk appropriately;
 - case reviews assess risk in line with ACCT guidance;
 - ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved;
 - ACCT plans specify conversations and observations where appropriate;
 - staff review the ACCT ongoing record before undertaking a case review; and
 - all staff receive ACCT training.
- The Prison Group Director, Midlands prisons, should assure herself that effective action is taken to implement these and previous recommendations on managing the risk of suicide and self-harm at HMP Leicester.
- The Governor should review the effectiveness of HMP Leicester's violence reduction policy and its delivery, specifically ensuring:
 - all information about alleged assaults and bullying is fully coordinated and investigated;
 - the effective identification and management of victims and alleged perpetrators; and
 - the risk of suicide or self-harm to victims of violence, bullying and intimidation is considered.
- The Head of Healthcare should ensure that there is a robust referral system for prisoners with sleeping difficulties.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Leicester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. She visited HMP Leicester on 14 December 2017. She obtained copies of relevant extracts from Mr Ahamed's prison and medical records.
15. She interviewed ten members of staff and one prisoner in January and February 2018. She tried to interview the prisoners living in the cells next door to Mr Ahamed but they all refused to speak to her.
16. NHS England commissioned a clinical reviewer to review Mr Ahamed's clinical care at the prison. She attended the interview with the clinical members of staff.
17. We informed HM Coroner for Leicester City and South District of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Ahamed's wife, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked why Mr Ahamed was living in a cell on his own and whether he had been bullied.
19. Mr Ahamed's wife received a copy of the initial report. She made a number of comments which do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
20. HM Prison and Probation Service (HMPPS) also received a copy of the report.

Background Information

HMP Leicester

21. HMP Leicester is a local prison that holds 325 men. It primarily serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Leicestershire Partnership NHS Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons last inspected Leicester in January 2018. Inspectors found significant improvement since their previous inspection in 2015. They found that although Leicester was still not safe enough, the Governor and his staff were making determined efforts to improve prisoner safety. Recorded violence had risen further in 2017 but that the prison now had a clear strategy for responding to and tackling acts of violence. Further improvements were needed in this regard.
23. Inspectors also found that recommendations we had made in relation to previous deaths had been implemented and there was a drive to improve the inconsistent case management of those who were assessed as a risk to themselves. However, they concluded that the quality of ACCT documentation remained too variable, actions in caremaps were not always completed or amended, reviews were not always multidisciplinary and night observations were too brief and predictable.

Independent Monitoring Board

24. 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 January 2017, the IMB reported better management of the Assessment Care in Custody Teamwork (ACCT) process, and very good liaison between the Safer Custody and the Healthcare teams.

Previous deaths at HMP Leicester

25. Since June 2011, we have investigated the deaths of eight prisoners at Leicester, including that of Mr Ahamed. Five deaths were self-inflicted. We have previously made recommendations about risk assessment and ACCT procedures. We identified similar issues during this investigation.

Assessment, Care in Custody and Teamwork

26. 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 at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap 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 the actions of the caremap are completed. Guidance on ACCT

procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

27. Mr Imran Ahamed, who was a probation officer, was charged with offences of common assault and controlling behaviour against his wife, committed between June and November 2017. He appeared at court on 15 November 2017 and his case was adjourned until 13 December. He was remanded into custody and taken to HMP Leicester. Mr Ahamed's person escort record noted that he suffered from depression and had previously had thoughts of suicide in 2014. It was his first time in prison.
28. On reception Mr Ahamed told an officer that he had no thoughts of suicide or self-harm. A nurse assessed Mr Ahamed. She noted that he appeared a little anxious and had previously had thoughts of self-harm but had not acted on them. She noted that he received medication for mental health problems but recorded no further detail about this.
29. On 16 November, prison healthcare staff requested and received Mr Ahamed's community GP records. These noted that he had been prescribed sertraline (an antidepressant) in the community. A GP prescribed Mr Ahamed sertraline, and booked him the next available appointment with himself on 22 November, for review. Mr Ahamed moved from the first night centre to a dormitory cell to share with three other prisoners.
30. On 17 November, a nurse assessed Mr Ahamed as he said he was not eating well, drinking much water or using the toilet in his cell as he was concerned about hygiene standards. He asked for a cell move and an officer said he would see if this was possible over the next few days.
31. Mr Ahamed made over 450 telephone calls during his 19 days at Leicester. These calls started on 18 November and were mainly to two friends. They were not monitored before Mr Ahamed died and staff were unaware of their content.
32. The investigator listened to a sample of these calls Mr Ahamed was preoccupied with resolving issues with his wife and repeatedly asked his friends to contact her as he wanted to find out if she wanted a reconciliation and to renew their relationship. During these calls Mr Ahamed was often distressed, said he felt helpless, desperate and repeatedly asked his friends for help. On 18 November, he asked his friend to go and see his wife and said he would kill himself if he did not, as he could not live without her and his daughter. He said he was finding it difficult to cope in prison and his mental health was declining. He said he was also worried about being assaulted in prison.
33. On 20 November, at 3.00pm, staff started suicide and self-harm monitoring procedures, known as ACCT. An officer noted that Mr Ahamed said he had a history of suicidal thoughts, had recently had a nervous breakdown and could not cope with life. He said that there was no point in living if he could not have contact with his wife and daughter. Staff also noted that Mr Ahamed suffered from depression and would be moved to a double cell. Mr Ahamed was observed hourly until his first ACCT review.
34. A custodial manager (CM), completed an ACCT assessment at 5.00pm. Mr Ahamed repeated that he was struggling to cope without his wife and daughter.

He was confused about the charges he was facing and their implications. He said he had no current or past thoughts of suicide or self-harm. He also said he was struggling because of his current cellmates. The CM noted that he was due to move to a double cell the following day, which Mr Ahamed was pleased about. Mr Ahamed acknowledged that he had anger issues but said he did not want to take medication again.

35. At 7.50pm, Mr Ahamed spoke to an officer. He was very tearful and said he was not coping. He wanted to move to another cell as said he was not getting on with his cellmates and asked to see healthcare staff. The officer radioed for a nurse to attend. There is no further note in the ACCT ongoing record or medical record as to whether a nurse saw Mr Ahamed.
36. On 21 November, at 9.10am, a chaplain visited Mr Ahamed. The ACCT ongoing record noted that Mr Ahamed was low in mood but said he had no thoughts of self-harm. The chaplain recorded that Mr Ahamed was struggling with his first time in prison and said he had been punched twice by one of his cellmates, although he did not identify which one. Mr Ahamed said he was hoping to move to a double cell that day. The chaplain submitted an intelligence report, violence reduction document and noted the alleged assault on Mr Ahamed's record. The incident was also reported to a manager who arranged for Mr Ahamed to move cells at 9.30am.
37. Staff later completed a fact-finding report about the assault. Mr Ahamed said he did not think he had been taken seriously when he had previously asked to move cells. He said he did not want any further action to be taken now he had moved cells.
38. At 11.15am on 21 November, staff held Mr Ahamed's first ACCT case review. A Supervising Officer (SO), chaired the review with Mr Ahamed and a nurse from the mental health team. The SO told the investigator that Mr Ahamed seemed settled. He said that he was not aware that Mr Ahamed had moved cells that morning or that he had alleged that he had been assaulted. Mr Ahamed explained that he was in prison charged with assaulting his wife, suffered from depression but had no thoughts of suicide or self-harm.
39. The nurse recorded that Mr Ahamed appeared unkempt and Mr Ahamed said he had not been taking his medication. (Mr Ahamed did not take his medication at all between his arrival and 2 December. After this, he took it on five of the remaining eight days he was in prison.) They discussed that addressing his depression by complying with his medication regime might help him reconcile with his wife. The nurse recorded that Mr Ahamed appeared to be making plans for the future and that staff considered that seeing his daughter again was a protective factor against the risk of him harming himself. The nurse agreed to make Mr Ahamed an appointment to see the prison GP to discuss his mood. The SO told the investigator that they closed Mr Ahamed's ACCT on the basis he would be assessed by a doctor.
40. During this time, Mr Ahamed continued to make several calls a day to his friends, asking for their help in resolving issues with his wife and asking her to drop the charges against him. Mr Ahamed told his friends he was hoping to get bail as he

could not cope in prison. He continued to sound distressed and desperate during telephone calls listened to by the investigator.

41. On 22 November, a GP assessed Mr Ahamed, who said he was missing his wife and daughter and was not sleeping well. Mr Ahamed said he had no thoughts of suicide or self-harm and spoke about his hopes for the future. He said that Mr Ahamed had good insight into his problems. The GP offered to increase his dose of sertraline but Mr Ahamed said he did not want to take any medication. The GP referred Mr Ahamed for emotional support and said he could come back to see him if his mood worsened.
42. On 23 November, a healthcare support worker, went to see Mr Ahamed to offer him emotional support but he was not in his cell. Mr Ahamed made an application to see the GP because of his difficulties in sleeping.
43. On 24 November, at 5.30pm, Mr Ahamed told staff that he had been assaulted by his cellmate. A CM spoke to Mr Ahamed and his cellmate about the alleged assault. He found no evidence that an assault had taken place and told Mr Ahamed that he needed to provide further details if he wished to pursue this allegation.
44. On 27 November, a healthcare support worker, declined Mr Ahamed's application to see a doctor, saying that, as the GP had already assessed him, he should speak with his emotional support worker.
45. On 28 November, his emotional support worker assessed Mr Ahamed. She noted that he was low in mood. He asked to use the telephone to find out if he had got bail as there had been a hearing that morning. Mr Ahamed telephoned his friend who told him that he had not been granted bail. He told his friend that he could not cope in prison and he wanted to apply for bail again at his next hearing on 13 December.
46. The emotional support worker said that when Mr Ahamed returned from his telephone call, he was visibly upset. Mr Ahamed told her that he had been on sick leave from work for two years due to workplace bullying, which had led to his depression and arguments with his wife. He said he was sorry for what he had done and wanted to make it up to his family. Mr Ahamed said he had no thoughts of suicide and self-harm. He said his aunt was arriving from abroad that day to support him as he had no other family in the UK. Mr Ahamed said he had not been taking his sertraline as he did not want to take medication. She offered him a doctor's appointment to review this but he declined.
47. Mr Ahamed told her that he had not slept for four months and would like to be prescribed sleeping tablets. They discussed the process for such a prescription, which involved Mr Ahamed being referred to officers to assess how much he slept over three nights. The GP would then review this information and prescribe sleeping tablets if appropriate. Mr Ahamed agreed to this and she told the investigator that she had made a GP appointment for Mr Ahamed although there was no evidence of this on his medical record. She also put him on a waiting list for the sleep assessment which should have been picked up by healthcare night staff and passed to the officers.

48. The emotional support worker said she would see Mr Ahamed again the following week but did not manage to do so due to work pressures. However, she did check his medical record during that period and told the investigator that she thought this was reasonably positive. She booked their next appointment for 12 December.
49. On 29 November, at 3.00pm, an officer received a call from Mr Ahamed's aunt on the safer custody line. His aunt said she had concerns about Mr Ahamed's safety and mental health. The officer told a manager and said she would make the safer custody team aware. Mr Ahamed's aunt said she wanted to visit him, but there were no visiting spaces available until 5 December. At 4.15pm, an officer spoke to Mr Ahamed about his current mood. He said he was worried about his mental health and issues in the community. She noted that she had no major concerns about him, advised him he could speak to staff at any time and offered suggestions to keep his mind occupied and get him more time out of his cell.
50. On 30 November, Mr Ahamed told an officer that he was being bullied by his cellmate. He showed the officer some defence marks from the night before when he said they had been arguing for over an hour. The officer suggested that Mr Ahamed move cells but he said he would only share with another Muslim prisoner and wanted to stay where he was until such a cell became available. The officer reported the alleged incident to the safer custody department.
51. An officer told the investigator that Mr Ahamed had also spoken to him about his cellmate bullying him and not letting him watch the television channels he wanted. The officer said he spoke to Mr Ahamed's cellmate indicating that bullying would not be tolerated and if they could not agree what to watch on television, then he would take the television away. At 6.30pm, the officer took the television away for the evening. The next day, the officer said that Mr Ahamed and his cellmate told him that they had resolved their differences.
52. The officer told the investigator that Mr Ahamed seemed different to many other prisoners: he seemed quite vulnerable and was softly spoken. He said that Mr Ahamed would often ring his cell bell in the evening as he wanted to use the telephone. An officer said that Mr Ahamed was a quiet prisoner, who did not self-isolate but tended to associate with a small number of other prisoners.
53. A prisoner, met Mr Ahamed soon after he arrived at the prison. Mr Ahamed told him that he was being bullied by his cellmate who would not let him wash before Muslim prayers, would not let him put his drink on a table and had slapped him.
54. On 1 December, a SO spoke to Mr Ahamed in his cell to complete his ACCT post closure interview. Mr Ahamed's cellmate was also present but Mr Ahamed said he was happy to continue. Mr Ahamed said he was still depressed and anxious and he was seeing the prison GP. He said he had no thoughts of suicide or self-harm. Mr Ahamed said that he had friends and family that visited him. The review noted that Mr Ahamed attended education sessions at the prison. When asked how the prison could assist Mr Ahamed, he said that they could help him to receive some counselling and to become more active so he could come out of his cell. He also requested mediation so that he could speak to his wife and daughter, and arrange a visit with his daughter.

55. Mr Ahamed had continued to telephone his friends who contacted his wife on his behalf, at his insistence. On 3 December, Mr Ahamed's aunt told him that his wife wanted nothing more to do with him. Mr Ahamed asked his aunt to bury him next to his mother if something happened to him. He said he could not cope in prison and he could not "take it anymore". He asked his wife to look after their daughter.
56. On 4 December, Mr Ahamed moved cells, to share with another Muslim prisoner, as requested. He told staff that he was happier and got on better with his new cellmate. His cellmate said that Mr Ahamed talked a lot about his wife and his daughter and about reconciling with them. He said he could not live without his wife and daughter and he would "end it" if he could not talk to his wife. He often became upset and cried a lot when they were in their cell together. The cellmate said he repeatedly told him to get another partner but Mr Ahamed would get angry about this and said he only wanted his wife. He said he tried to persuade Mr Ahamed not to kill himself by highlighting the things he had to live for. He also told Mr Ahamed not to kill himself while he was in the cell. He did not speak to staff about Mr Ahamed's risk of suicide.
57. His cellmate said he also told Mr Ahamed that if he told staff he was suicidal they would take him to the segregation block and remove all his belongings so that he could not kill himself. After this, Mr Ahamed stopped telling him that he wanted to end his life so frequently. He thought this was about two days after they had started sharing a cell.
58. On 4 December, Mr Ahamed telephoned his aunt. He said he was "dying" in prison and could not "hold on anymore" and she should not get angry if something happened to him. He also rang his friend and told him it would be his last conversation with anyone. He asked his friend to ring his wife while they were themselves speaking on the telephone, so he could talk to her for the last time. However, he also said that he was intending to plead not guilty on 13 December. Over the next few days Mr Ahamed made a series of distressed telephone calls to his friends, indicating that he could not cope and that there was no point in living without his wife and daughter.
59. On 5 December, an officer received a call at the gate from Mr Ahamed's friend. She noted in Mr Ahamed's computerised record that his friend said Mr Ahamed was very depressed, and had told him that he wanted to end his life and did not want to live anymore. The officer noted that she had informed an officer in safer custody. The officer opened an ACCT document at 10.04am. She noted that the gate had received a call from Mr Ahamed's friend that morning and Mr Ahamed had told his friend what to do with his body if anything happened to him. The friend had told staff that Mr Ahamed had previously attempted suicide. The officer told the investigator that she was unaware of the other information an officer had noted in Mr Ahamed's computerised record. However, the investigator later noted that the officer in safer custody had submitted an intelligence report which contained this information.
60. The officer spoke to Mr Ahamed who said he was struggling to cope without contact with his daughter. He said he felt hopeless and was going to have a

“breakdown”. The officer noted that staff should observe Mr Ahamed hourly. Mr Ahamed received a visit from his aunt that afternoon.

61. At 5.15pm, the officer completed a fact-finding report following the incident which had allegedly occurred between Mr Ahamed and his then cellmate on 30 November. Mr Ahamed told the officer that his cellmate had scalded him with hot water and hit him while he was sharing a cell, but that he did not have any injuries. He said that his cellmate had not let him change television programmes. However, he confirmed that he got on well with his new cellmate and his situation had been resolved in this way. His previous cellmate denied the allegations when the officer spoke to him but the officer assessed him as unsuitable to share a cell in the future.
62. The officer also completed Mr Ahamed’s ACCT assessment with him. Mr Ahamed said that he had told his friend that if he died in prison, he wanted his body taken back to Sri Lanka to be buried near his mother as he had nothing left in this country. He said he was not allowed contact with his wife due to the offences he had been charged with. Mr Ahamed said he had never self-harmed or attempted suicide in the past although he said he had had thoughts of suicide in 2014 and had been prescribed antidepressants. He told the officer that he had no current thoughts of suicide but was struggling with not seeing his daughter. He said he had decided to ask a solicitor to apply for contact with his daughter. The officer said that Mr Ahamed came across as quite positive during the assessment. Mr Ahamed said he was in court on 13 December. The officer noted that Mr Ahamed was prescribed antidepressants and therefore needed a referral to the mental health team to consider his medication and coping methods.
63. On 6 December, at 11.20am, a SO chaired the first ACCT case review. Although an officer’s name is recorded on the review, she was not present. The SO could not remember whether he had spoken to her before the review but he spoke to a nurse. They discussed Mr Ahamed’s background and family circumstances. The SO and the nurse then conducted the review with Mr Ahamed. Mr Ahamed said his cellmate was very supportive and they got on well. They discussed why the ACCT had been opened and Mr Ahamed said he had no thoughts of suicide or self-harm. He was frustrated about being in prison but said he was looking to the future and wanted to reconcile with his wife and daughter. The nurse told the investigator he was very passionate about this.
64. The nurse encouraged Mr Ahamed to take his antidepressants, which he had not been complying with. He agreed to try harder. She noted that he was low in mood but she considered that this was a normal reaction to his situation. The SO said that he was aware that the ACCT had been opened due to concerns raised by a friend about Mr Ahamed’s risk to himself but that he assessed that some*⁸ of this risk had been mitigated simply by Mr Ahamed talking to his friend. He said he had no concerns that Mr Ahamed was a risk to himself. All present agreed that they would close the ACCT.
65. Around 7 or 8 December, his cellmate said that they had been locked in their cell for the evening, when a Listener came to speak to Mr Ahamed at around 6.00pm. He said that Mr Ahamed told the Listener that he felt suicidal. He said the Listener asked an officer to open Mr Ahamed’s cell. He did this and Mr Ahamed

made a telephone call. His cellmate said that he told the officer that Mr Ahamed was “talking stupid” and that he was going to “do something stupid”. After Mr Ahamed came back to the cell, he said he seemed a bit better, sat down and talked about his court case.

66. The officer said that the cellmate did not say this to him and that he would have opened an ACCT if he had. The officer said that Mr Ahamed often asked to be let out of his cell to use the telephone after he was locked up. The officer facilitated this whenever he could. He never noticed Mr Ahamed looking stressed or upset when using the telephone.
67. The cellmate said that on 9 December, he asked to move cells as sharing with Mr Ahamed was making him feel depressed. He constantly talked about his family. At the time, the cellmate was also aware that his cousin’s cellmate had just been released and so he asked to move to share with his cousin. He did not speak to staff about Mr Ahamed’s low mood. He moved cells that day.
68. On 10 December, another prisoner said he heard Mr Ahamed shouting and sounding stressed when using the telephone. The prisoner said that Mr Ahamed had been attempting to contact his wife via his friend as he wanted her to drop the charges against him. He also said that he told Mr Ahamed that his telephone calls were recorded and could be listened to, which shocked Mr Ahamed.
69. The investigator listened to all the telephone calls made by Mr Ahamed on 10 December. By 10am, Mr Ahamed had left four voicemails for his friend, asking what was happening with his wife. He rang him again at 10.10am and spoke to his friend. He said he could not “take it anymore” and wanted to talk to his wife but his friend explained that she would not answer the telephone. Mr Ahamed was very distressed. He called his friend again an hour later asking if he had contacted her as he needed to hear something from her. His friend said he would try but he could make no promises. Mr Ahamed said he would call back at 2.00pm when he was next unlocked.
70. The cellmate saw Mr Ahamed during the morning. He said he saw him speaking on the telephone but did not notice how he was acting or whether he was upset. An officer recalled that during the afternoon of 10 December, Mr Ahamed asked him when he was due in court, which he thought was the following Tuesday. The officer could not confirm at the time and said he would check for him again in the morning. Nothing else stood out to the officer. He did not notice Mr Ahamed using the telephones more than normal on that day or any other. He said that as it was a Sunday, Mr Ahamed could have used the telephones during association on any of the four landings.
71. Mr Ahamed rang his friend again at 2.15pm. His friend told him that he had not managed to speak to Mr Ahamed’s wife yet. Mr Ahamed begged him to try again and said he would call him back. Mr Ahamed called his friend back 20 minutes later and was told that Mr Ahamed’s wife had texted his friend to say she could not speak while she was at work but did not want to talk about Mr Ahamed in any event. Mr Ahamed called his friend and left a voicemail at 2.43pm to say he was sorry, and that he appreciated everything he had done for him. He also asked his friend to look after his wife. Thirty minutes later, at 3.15pm, he left the same friend a voicemail to say that this was “the hardest thing ever”; it was sad the way

things had happened; to tell his wife that he loved her; and that he was not being selfish because he did not want to “lose nothing at all” and it was best for the family. Mr Ahamed again asked his friend to look after his family, said this was the last call he would make, that he would never call again and he was sorry. Mr Ahamed made no more telephone calls.

72. CCTV shows an officer unlocking Mr Ahamed at 4.00pm to collect his dinner. He came out of his cell two minutes later, collected his meal and returned to his cell three minutes later, briefly stopping to talk to a prisoner in the cell next door. An officer locked him into his cell. At 4.27pm, the cellmate spoke briefly to Mr Ahamed through his observation panel. He said that that Mr Ahamed was sitting on his bed, looked sad and depressed and did not reply when he spoke to him.
73. At 4.54pm, an officer looked into Mr Ahamed’s cell through the observation panel to complete the evening roll check. The officer finished his shift at 6.00pm that day. He was responsible for helping to complete the roll check but said he could not remember who had checked Mr Ahamed. Nothing out of the ordinary stood out to him during the roll check. Officers completed further checks at 7.08pm and 8.20pm. No concerns were noted.

Events of 11 December

74. An officer was working over the night of 10-11 December. He said that he was not aware of Mr Ahamed ringing his cell bell. Leicester does not have an electronic record of when cell bells are called. Around 6.00am, the officer started his morning roll check. He looked through the observation panel at each prisoner, turning on the night light in the cell. CCTV shows him looking into Mr Ahamed’s cell for a few seconds with his finger on the light switch at 6.12am. Although he could not specifically remember checking Mr Ahamed, he said that if there was anything out of the ordinary, he would have noticed it and therefore he believed Mr Ahamed must have been in bed at that time.
75. An officer started work around 7.15am and began his roll check. When he opened Mr Ahamed’s observation panel, he could not see into his cell. At the time, he believed the night light was not working but this was later proved not to be the case. Mr Ahamed had obstructed the panel with a piece of black material. The officer immediately unlocked Mr Ahamed’s cell and found him hanged from the window bars by a bed sheet. It was 7.19am according to the CCTV. He tried to radio a code blue emergency but realised he had not yet turned on his radio. He shouted “code blue” three times and also shouted Mr Ahamed’s cell location. (A code blue emergency indicates circumstances where a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically.) Once he could hear an officer running towards him, he went into Mr Ahamed’s cell and supported his weight. Both Mr Ahamed’s cell windows were open and it had been snowing.
76. When an officer heard the officer shout a code blue, she immediately ran up the stairs, radioing a code blue emergency at the same time. She assisted the officer in supporting Mr Ahamed’s weight and cut him down using her anti-ligature knife. They lowered Mr Ahamed to the floor and an officer checked for signs of life. The officer noted that Mr Ahamed was cold and the upper half of his

body, including his arms, were stiff. The officer began chest compressions. Several other staff reached the cell within a minute having also heard the officer shouting for assistance. Other staff said Mr Ahamed was cold and his skin was purple.

77. Having heard the radio transmissions, a CM also radioed a code blue, requested the control room to call an ambulance and asked that healthcare staff attend. The control room immediately requested an ambulance. Paramedics arrived at the prison gate during the call. A nurse reached Mr Ahamed's cell at 7.21am, followed by another nurse. Another nurse brought the emergency bag. A nurse assessed Mr Ahamed for signs of life and noted that Mr Ahamed had a stiff neck and jaw. Staff continued with CPR. The nurses attached a defibrillator and administered oxygen. They were unable to insert an airway into Mr Ahamed due to his stiff jaw. At 7.28am, paramedics got to Mr Ahamed's cell. At 7.31am, the paramedics pronounced Mr Ahamed dead. They noted that Mr Ahamed had rigor mortis in his hands, feet and jaw.
78. Police found several notes in Mr Ahamed's cell after he died. These recorded his intention to kill himself and requested that he was buried in Sri Lanka with his mother. In one of these letters he indicated that it was 3.24pm on 10 December. He wrote that he could not live without his wife and daughter.

Contact with Mr Ahamed's family

79. When Mr Ahamed first arrived at Leicester, he listed two friends as his next of kin. In other documents, he later also listed his wife and aunt as next of kin. A CM and a SO were appointed as the family liaison officers at 8.10am on 11 December. The prison was advised by HMPPS that they should inform Mr Ahamed's wife of his death first, even though she was the victim of his alleged offence. At 1.00pm, they informed Mr Ahamed's wife of his death at her home address and offered their condolences. The prison offered to contribute £3,000 to the funeral expenses, in line with prison policy.
80. On 19 December, the CM informed a family friend, who was arranging Mr Ahamed's funeral, that the prison would not pay for Mr Ahamed to be repatriated to Sri Lanka, as he had wanted, as he was not a foreign national. This was in line with prison policy. Mr Ahamed was buried in Liverpool.

Support for prisoners and staff

81. After Mr Ahamed'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. Most staff felt well supported apart from a SO, who said that no one had spoken to him about Mr Ahamed's death.
82. The prison posted notices informing other prisoners of Mr Ahamed'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 Ahamed's death.

Post-mortem report

83. The post-mortem report indicated that Mr Ahamed's cause of death was hanging.

Findings

Assessment of risk and management of ACCT

84. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Ahamed had a number of these risks when he arrived at Leicester. It was his first time in custody, he was charged with a violent offence against his wife, his relationship had broken down, he had a history of suicidal thoughts and he was diagnosed with depression. While at Leicester, further risk factors became apparent, such as reports of assault and bullying by cellmates, and informing his friend by telephone that he expected to die, which was reported to staff. The clinical reviewer also notes that he not eating well and was underweight, was having sleeping difficulties and was not complying with prescribed medication, which were all additional risk factors.
85. Mr Ahamed was managed under ACCT procedures very briefly on two occasions on 20 November and 5 December. Both ACCTs were closed at the first review. We are concerned that this was premature and did little to support Mr Ahamed. While this might not have affected the eventual outcome, it is also possible that more effective ongoing support might have helped address Mr Ahamed's underlying risk of suicide.
86. Guidance in the ACCT document says that staff can end ACCT procedures at the first case review, if the case review team believe it is safe to do so and if all the issues identified in the assessment interview are resolved. On 20 November, during the assessment, Mr Ahamed had said that he was struggling to cope without his wife and daughter, he was confused about the charges against him and the implications of these, and was not getting on with his cellmates. That night, Mr Ahamed was tearful and told an officer he was not coping. The next morning, he told a chaplain that he had been punched by one of his cellmates. He moved cells. Although he told the ACCT assessor that he had no current or past thoughts of suicide, two hours earlier he had told the officer opening the ACCT that he had a history of suicidal thoughts and that there was no point in living if he did not have contact with his wife or daughter. Given this conflicting information, we believe staff should have acted cautiously regarding the information Mr Ahamed gave them the next day.
87. On 21 November, staff closed Mr Ahamed's ACCT. They had not read the ACCT ongoing record and therefore were not aware of the fact that Mr Ahamed had been tearful the night before or had moved cells that morning due to allegedly being assaulted. In addition, all the issues from the assessment had not been resolved.
88. During Mr Ahamed's post closure review on 1 December, his cellmate was present. This was a prisoner with whom Mr Ahamed had reported difficulties and we consider that the review should not have taken place with him present.
89. On 5 December, Mr Ahamed's friend telephoned the prison and told an officer that Mr Ahamed had said he was depressed, wanted to end his life and had specified where he wanted to be buried. Staff informed safer custody, who opened an ACCT but they did not record the information about wanting to end his

life in the ACCT, only that Mr Ahamed had told his friend where he would like to be buried. This was a serious omission. Mr Ahamed said he was struggling not having contact with his wife and daughter and had been prescribed antidepressants. The next day a SO and a nurse closed Mr Ahamed's ACCT at the first review. At the time, the nurse had received no formal ACCT training, although we understand that this has since been rectified. We consider that, given Mr Ahamed had said he wanted to end his life the day before, and all the issues identified at his ACCT assessment had not been addressed, staff should not have closed this ACCT, certainly not without a better and more in-depth understanding of the issues with which Mr Ahamed was struggling.

90. Mr Ahamed was due back in court on 13 December, two days after he died. He had spoken about his court case to several members of staff but no one seems to have considered that the anxiety associated with this might increase his risk to himself.
91. Leicester's safer custody meeting minutes of 19 October 2017, noted that ACCT reviews were often of unsatisfactory quality and staff needed to be reminded that they needed to complete ACCT observations and conversations to a good standard. Only observations were ever specified in Mr Ahamed's ACCT. Staff may have got a more accurate representation of his risk by having regular conversations with Mr Ahamed.
92. When inspectors from HMIP were at Leicester completing their most recent inspection, they noted that of 362 ACCTs opened in 2017, five were closed at the first review. Alarming, two of these relate to Mr Ahamed and two to a previous self-inflicted death at the prison in October 2017. This is an investigation in which we were also critical of ACCT procedures being closed prematurely.
93. Once again, we do not consider that staff appropriately considered Mr Ahamed's level of risk and, instead, relied too heavily on what Mr Ahamed told them. The clinical reviewer also supports this view. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **staff record all information relevant to risk appropriately;**
 - **case reviews assess risk in line with ACCT guidance;**
 - **ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved;**
 - **ACCT plans specify conversations and observations where appropriate;**
 - **staff review the ACCT ongoing record before undertaking a case review; and**
 - **all staff receive ACCT training.**
94. In a report published in April 2018, following a self-inflicted death at Leicester, we recommended that the Prisons Group Director should satisfy herself that effective action is taken to implement repeated recommendations to the prison about ACCT management. The Director accepted this recommendation and said

that she would monitor action taken in response to our recommendations when she visited Leicester and identify any areas of improvement required with the Governor. This report should also form part of the Director's discussions with the Governor.

The Prison Group Director, Midlands prisons, should assure herself that effective action is taken to implement these and previous recommendations on managing the risk of suicide and self-harm at HMP Leicester.

Staff relationships with Mr Ahamed

95. The distress and desperation which Mr Ahamed felt is starkly apparent when listening to the telephone calls he made to his friends and family. He also told his friend on at least one occasion that he wanted to kill himself. In addition, the sheer number of these calls is very telling about Mr Ahamed's state of mind.
96. Telephone calls at Leicester are not routinely monitored and staff did not listen to Mr Ahamed's telephone calls. They were not, therefore, aware of their content. Mr Ahamed also confided in his cellmate about his thoughts of suicide. Unfortunately, his cellmate did not pass this information on to staff.
97. It is clear that Mr Ahamed intentionally withheld information from staff about how he was feeling and his thoughts of suicide. While we understand that it would have been difficult to elicit this information from Mr Ahamed if he was resistant, we are concerned that there is no evidence of any meaningful interactions between staff and Mr Ahamed, outside of ACCT reviews. He had no personal officer. Closing an ACCT document the day after he had told his friend that he wanted to kill himself did little to foster such relationships and enhance staff's understanding of Mr Ahamed's difficulties. We are also concerned that staff did not notice the amount of time Mr Ahamed was spending on the telephone or how distressed he was when making many of these calls. This is particularly concerning as Mr Ahamed had twice been on an ACCT.
98. We are pleased that Leicester is soon to start implementing a new offender management model as part of a national roll-out. This includes every prisoner having a keyworker who will be their first point of contact and assist them with any difficulties they are having in prison. We hope that it will assist in lessening the distress and isolation felt by prisoners like Mr Ahamed in the future. We therefore make no recommendation but record our concern at a troubling lack of meaningful engagement between staff and Mr Ahamed.

Managing violence and bullying

99. A PPO publication of June 2011 found there was evidence of bullying and intimidation in 20 per cent of self-inflicted deaths we investigated. In our PPO thematic report into self-inflicted deaths in 2013-14, we found that reports or suspicions that a prisoner is being threatened or bullied, or is vulnerable due to debt, need to be recorded, investigated and robustly responded to.
100. Leicester's *Violence Reduction Strategy*, published in February 2017, states that any alleged assaults must be reported to the safer custody department. Staff

should also review a prisoner's suitability to share a cell, consider any sanctions that are needed and record the incident on a prisoner's computerised record. Safer custody should investigate the incident and consider placing a prisoner on a perpetrator action plan or victim support plan. Intelligence reports should also be submitted.

101. Mr Ahamed moved cells on two occasions after telling staff that he had been assaulted by different cellmates. On one occasion, staff closed Mr Ahamed's ACCT the same day without considering the impact of this alleged assault on his risk of suicide and self-harm. Staff did complete fact-finding reports into both assaults. These recommended no further action since by the time they had taken place Mr Ahamed had moved cells. Only one member of staff, a chaplain, completed an intelligence report.
102. Staff told the investigator that Mr Ahamed was a quiet prisoner who they considered might be vulnerable due to his job in the community as a probation officer. Despite these alleged assaults within two weeks of Mr Ahamed arriving at Leicester, there is no evidence that staff considered placing Mr Ahamed on a victim support plan, or the alleged perpetrators on a perpetrator action plan. We recognise the difficulty in substantiating claims where alleged assaults or intimidating behaviour have taken place between prisoners in their cell. However, we are concerned that more was not done to consider the implications of the alleged assaults on Mr Ahamed's mental well-being. We make the following recommendation:

The Governor should review the effectiveness of HMP Leicester's violence reduction policy and its delivery, specifically ensuring:

- **all information about alleged assaults and bullying is fully coordinated and investigated;**
- **the effective identification and management of victims and alleged perpetrators; and**
- **the risk of suicide or self-harm to victims of violence, bullying and intimidation is considered.**

Clinical care

103. The clinical reviewer confirmed in an email to the investigator, that, overall, she considered that Mr Ahamed's clinical care was equivalent to that he could have expected to receive in the community.

Compliance with medication

104. A prison GP prescribed Mr Ahamed sertraline on 16 November, as he had been prescribed this in the community. The doctor reviewed him on 22 November and Mr Ahamed said he did not want to take any medication. The doctor had not been informed that Mr Ahamed had not collected any of his medication up to this point. In fact, Mr Ahamed only took his medication on five occasions while he was at Leicester: on 3, 5, 6, 9 and 10 December. No note was made of this non-compliance in Mr Ahamed's medical record, nor was the GP made aware. Mr Ahamed told a healthcare support worker that he had not been taking his

medication on 28 November. She offered to book a GP appointment to review this but he declined.

105. The Head of Healthcare, told us that there is now a process in place at Leicester for pharmacists to inform a nurse manager or GP if a prisoner misses three days of their antidepressant medication or one day of their antipsychotic medication. Given this, and the fact that healthcare staff were aware that Mr Ahamed had not been taking his medication, we do not make a recommendation in this regard.

Sleep issues

106. Mr Ahamed told a prison GP he was having difficulties sleeping on 22 November. He said Leicester has a strict policy on the prescription of sleeping tablets. A prisoner is first referred to officers to have their sleep monitored over three nights. He said that this did not seem to be Mr Ahamed's main issue in their consultation on 22 November so it did not seem necessary to refer him at that stage. The doctor said that Mr Ahamed could always make an application to see him if his mood deteriorated.
107. The next day, Mr Ahamed made an application to see a GP due to having difficulties sleeping. Four days later a healthcare support worker declined this application as he had seen the GP the day before. She told the investigator that she thought this was appropriate as he had seen the GP the day before.
108. On 28 November, Mr Ahamed told a healthcare support worker that he had not slept for four months and would like to be prescribed sleeping tablets. The healthcare support worker said that she would make an appointment for Mr Ahamed with the GP about his sleep issues. There is no evidence that one was made or that this information was passed onto officers to monitor Mr Ahamed's sleep. We make the following recommendation:

The Head of Healthcare should ensure that there is a robust referral system for prisoners with sleeping difficulties.

Emergency response

109. When officers found Mr Ahamed hanging they reacted quickly and competently and started CPR. Healthcare staff continued CPR when they arrived, despite signs of rigor mortis. A nurse told the investigator that she continued with CPR as, although Mr Ahamed was cold and had a stiff neck, his window was open and it had been snowing outside. She thought that this might explain Mr Ahamed's condition. In the circumstances, she thought it was best to continue, as she was doubtful. Once she realised she was unable to insert an airway, she was more confident that signs of rigor mortis were present. The paramedics arrived soon after this. In the circumstances, we are not critical of the nurse's decision to continue CPR.

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