Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bahman Razvani, a prisoner at HMP Wakefield, on 31 July 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

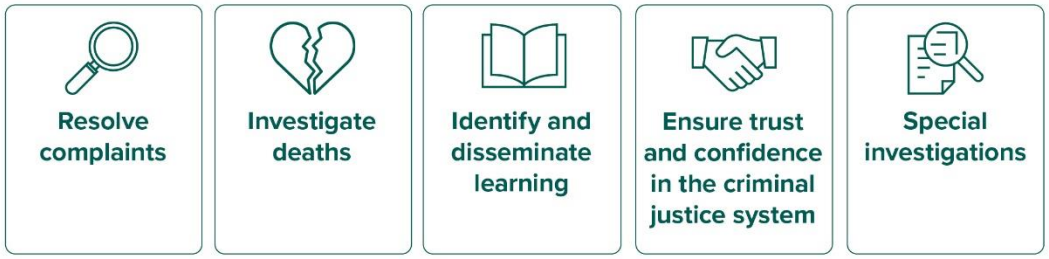
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Bahman Razvani, an Iranian national, was found hanged in his cell at HMP Wakefield on 31 July 2024. He was 33 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Razvani received appropriate care at Wakefield and that there was no evidence that he was at imminent risk of suicide or self-harm in the days before his death. I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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Summary

Events

1. On 28 July 2021, Mr Bahman Razvani, an asylum seeker from Iran, was remanded to HMP Leicester charged with rape and sexual assault. He was later sentenced to 12 years in prison with an extended licence of eight years.

2. In March 2022, Mr Razvani transferred to HMP Whatton and in October was briefly supported through prison suicide and self-harm procedures (known as ACCT) when he said he had taken an overdose as he was feeling depressed. This was the only time staff assessed Mr Razvani as being at risk of suicide or self-harm.

3. On 14 November 2023, Mr Razvani transferred to HMP Wakefield.

4. Mr Razvani had some history of assaulting other prisoners, but in June 2024, he was the victim of an assault, and he was sent to hospital where he had surgery. On return to Wakefield, he moved to a different wing.

5. Mr Razvani largely kept to himself and his main contact with other prisoners was when he asked them for vapes. However, Mr Razvani did not isolate himself from other prisoners and there are no indications that he was fearful of them.

6. During a routine welfare check at 5.01am on 31 July, staff found Mr Razvani hanged in his cell. An officer radioed a medical emergency code and staff responded quickly. Staff found that Mr Razvani had signs of rigor mortis, indicating that he had been dead for several hours. Staff correctly decided that it was not appropriate to try to resuscitate him.

Findings

7. We are satisfied that staff at Wakefield appropriately assessed Mr Razvani's risk of suicide and self-harm and that they could not reasonably have prevented his death.

8. The clinical reviewer concluded that Mr Razvani's care at Wakefield was equivalent to that which he could have expected to receive in the community.

The Investigation Process

9. HMPPS notified us of Mr Razvani's death on 31 July 2024.

10. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

11. The investigator visited Wakefield on 8 August. He obtained copies of relevant extracts from Mr Razvani's prison and medical records, and he interviewed two prisoners.

12. The investigator interviewed nine members of staff and two prisoners at Wakefield on 4 and 5 September. He interviewed two further staff via MS Teams on 10 September and 17 October.

13. NHS England commissioned a clinical reviewer to review Mr Razvani's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with clinical staff.

14. We informed HM Coroner for West Yorkshire Eastern District of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. Despite great efforts by Wakefield, Mr Razvani's family have not been located and therefore we were unable to contact them.

16. We shared our initial report with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies.

Background Information

HMP Wakefield

17. HMP Wakefield is a high security prison in West Yorkshire. There are four main residential wings, a segregation unit, a close supervision centre for the most challenging prisoners and a unit with prisoners on the autism spectrum. Practice Plus Group provides the majority of healthcare services, while clinical psychology is provided by Midlands Partnership Foundation Trust.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Wakefield was in October and November 2022. The Chief Inspector reported that at the previous inspection in 2018, Wakefield was found to be a successful prison delivering some very good outcomes and the findings at the latest inspection were similar. However, inspectors found that prisoner on prisoner assaults were increasing with limited effective action being taken to address this. Inspectors found that levels of self-harm were higher than at the time of the previous inspection but had been reducing over the course of the year and were lower than seen at comparable prisons. Inspectors noted that most prisoners said they were treated respectfully, they had a member of staff they could turn to, and they had a named key worker (with whom they had regular and consistent contact).

19. Inspectors found that there were insufficient activity places. Prisoners in full-time employment spent up to nine hours a day unlocked but the many unemployed prisoners had as little as three hours out of their cells. Although inspectors also noted that prisoners were unlocked for around seven hours a day at weekends, which was more than at most prisons.

20. Inspectors found that an appropriate range of primary health care services was available, although waiting times were often too long. They also found the mental health team skill mix did not provide an adequate range of interventions and treatment so only core tasks and risks were being managed on a day-to-day basis.

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 April 2023, the IMB noted that it considered Wakefield to be generally safe and calm despite the challenging and changing prisoner profile. However, they also noted that there had been 106 prisoner on prisoner assaults in the year, a sharp increase from the 51 assaults recorded in the previous year. The IMB reported that there were no specific trends to account for the assaults, although retaliation was one of the main reasons. The IMB were concerned about the number of inexperienced officers.

Previous deaths at HMP Wakefield

22. Mr Razvani was the 18th prisoner to die at Wakefield since June 2021. Of the previous deaths, two were self-inflicted and the remainder were from natural causes. There were no similarities between Mr Razvani's death and the previous deaths.

23. Up to the end of December 2024, there has been one further death due to natural causes since that of Mr Razvani.

Assessment, Care in Custody and Teamwork

24. 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. 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.

25. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. 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 the Prison Safety Framework (and pre-January 2025, Prison Service Instruction (PSI) 64/2011).

Key worker scheme

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

    - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.

    - Key workers must have completed the required training.

    - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

27. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

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

Key Events

29. On 28 July 2021, Mr Bahman Razvani was remanded to HMP Leicester charged with rape and sexual assault. At the time of his arrest, Mr Razvani was seeking asylum. He was originally from Iran. Mr Razvani was later convicted and sentenced to 12 years in prison with an extended licence of eight years.

30. By the time of his death, Mr Razvani had been in the UK for over three years. Staff who dealt with him said that he spoke in broken English, but they considered that his understanding of English was reasonable.

31. In March 2022, Mr Razvani transferred to HMP Whatton. While at Whatton, Mr Razvani was supported through prison service suicide and self-harm procedures (known as ACCT) from 4 to 10 October 2022 after he said that he had swallowed five or six mirtazapine (antidepressant) tablets. A GP had last prescribed Mr Razvani the mirtazapine on 28 July as not in-possession (he was required to attend the medication hatch each day and swallow the tablet in front of a nurse) and within a few weeks he had stopped collecting it.

32. Mr Razvani said that he had taken the tablets because he was feeling depressed, but when he was interviewed further, he said that he had no thoughts of suicide. This was the only time that Mr Razvani was supported through the ACCT process.

33. In November, a GP again prescribed Mr Razvani mirtazapine not in-possession. At a physical care review in December, Mr Razvani told a nurse that he took mirtazapine to help him sleep.

HMP Wakefield

34. On 14 November 2023, Mr Razvani moved to HMP Wakefield.

35. A nurse saw Mr Razvani for a reception health screen. Mr Razvani said that he had no thoughts of self-harm or suicide although he was in receipt of mirtazapine for stress and anxiety. She noted that Mr Razvani engaged well during the assessment.

36. A GP prescribed Mr Razvani mirtazapine not in-possession. Mr Razvani moved to A wing, a standard residential wing. On 14 December, staff stopped Mr Razvani's mirtazapine prescription as he had not been collecting it. An advanced nurse practitioner saw Mr Razvani for a review and noted that he denied low mood or anxiety but wanted mirtazapine to help him sleep. The nurse noted that he advised Mr Razvani that mirtazapine was not appropriate for use just to aid sleep.

37. On 21 December, Mr Razvani told staff that he had been assaulted by another prisoner. A nurse noted that he had several superficial injuries to his head, none of which required treatment. The other prisoner also claimed to have been assaulted and Wakefield were unable to determine who was the perpetrator.

38. On 24 March 2024, Mr Razvani had a fight with a different prisoner. Staff intervened quickly to stop the fight and Mr Razvani did not sustain any injury. Neither prisoner gave any explanation for the fight.

39. On 5 June, Mr Razvani was assaulted by another prisoner inside a cell (this was again a different prisoner). Nurses checked Mr Razvani and noted that he was bleeding from his nose and mouth, had swelling and bruising to his face and neck and appeared to be under the influence of an illicit substance (staff believed that he might have been given a substance to make it easier to carry out the assault). Mr Razvani was sent to hospital for treatment. At hospital he was treated for multiple fractures to his face, and a tear in an artery in his neck.

40. Mr Razvani returned to Wakefield on 7 June and was placed in the healthcare unit for three days for observation. A GP also prescribed him clopidogrel, a medicine used to prevent blood clots.

41. Investigation into the reasons behind the assault indicated that Mr Razvani had possibly insulted a prisoner who then arranged for another prisoner to assault him. There was a suggestion that Mr Razvani had been given an illicit substance to subdue him. As the assault occurred inside a cell there was no CCTV recording of the incident. Wakefield reported the assault to the police, but Mr Razvani refused to press charges.

42. On 10 June, Mr Razvani moved from the healthcare unit to B wing, a standard residential wing.

43. Wakefield's managing chaplain at the time told the investigator that he was on B wing on 15 June carrying some puzzle books when Mr Razvani approached him and asked if he had anything for him. The chaplain said that he would bring him some books and let him choose what he wanted. He asked Mr Razvani about his faith. Mr Razvani said that he was Muslim, but he did not attend worship as he preferred his own company. The chaplain said that he thought Mr Razvani might benefit from seeing an Official Prison Visitor (OPV - a volunteer who visits prisoners who might not receive many visits from family or friends). He asked Mr Razvani about an OPV visit and he said that he would like that. He said that OPV's were a limited resource and arrangements for a visit were still in process when Mr Razvani died.

44. The chaplain took Mr Razvani some puzzle books two days later and they had one other contact in passing which was around a week before Mr Razvani's death. He said that there was nothing about Mr Razvani's demeanour to suggest he was at risk of suicide or self-harm.

45. On 10 July, an advanced nurse practitioner (ANP) spoke to Mr Razvani after she was told that he had stopped collecting his clopidogrel. She explained to him that the medicine would minimise his risk of suffering a stroke following his injuries during the assault. She noted that Mr Razvani spoke broken English, but he confirmed that he understood the importance of taking the medication and said that he would resume taking it.

46. Mr Razvani took his clopidogrel on 11 July, but he again failed to collect it on 12 July and the ANP spoke to him again about the importance of taking it. He again said that he would take it. Mr Razvani was compliant with the medication after this.

47. An officer told the investigator that she worked on B wing and became Mr Razvani's key worker on 15 July. She said Mr Razvani was never rude to her, but he never

really wanted to speak to her. She said that he would often be in bed and say 'not now' when she tried to speak to him. She said that she tried to interest him in education, but he was resistant to attending an assessment to see what courses were suitable for him. She said that her main contacts with him were when she was managing the servery, and he would frequently ask for extra portions. She said that nothing occurred to make her fear that he intended to harm himself in any way. (As Wakefield has an insufficient number of work and education places for its population, Mr Razvani was not sanctioned for neither working nor going to education.)

48. Another officer gave similar evidence to the key worker. She also said that she would sometimes see Mr Razvani engaging with other prisoners, but he only tended to speak if he needed something.

49. Prisoner A lived in the cell next to Mr Razvani. He told the investigator that Mr Razvani was very quiet when he first arrived on B wing, so he made a point of speaking with him. He said that Mr Razvani seemed generally low in mood although he did not believe he was considering harming himself.

50. Prisoner B lived on the opposite side of the landing to Mr Razvani, He told the investigator that Mr Razvani tended to approach him to ask for vapes. He said that he would give Mr Razvani vapes, provided that he would pay him back, which he did. He said that he saw no signs to suggest that Mr Razvani was intending to take his life.

51. Prisoner C also said that Mr Razvani constantly asked him for vapes. Mr Razvani told him that he was from Tehran (in Iran), and that he had family living in the UK.

52. Prisoner D lived in a cell on the opposite side of the landing. He told the investigator that he was also from Iran. He said that other prisoners on B wing tried to goad Mr Razvani and that staff ignored him. He said that Mr Razvani was concerned at not knowing when he would be released and in the last three days he was alive spoke about killing himself. He said that he told Officer A about what Mr Razvani had said. He said that he also spoke separately to Officer B to say that Mr Razvani should be given some telephone credit so he could contact his family. (Mr Razvani had not made any phone calls since May and had stopped adding funds to his phone account. He apparently had no contact with his family.)

53. Officer A told the investigator that he often supervised the servery so would see Mr Razvani when he collected his meals. He said that Mr Razvani was always polite and well behaved, but he did not have a great deal of interaction with him apart from him asking for extra food. He said that Prisoner D did not raise any concerns to him about Mr Razvani and he had no concerns himself to suggest Mr Razvani was at risk of taking his life.

54. Officer B also told the investigator that Mr Razvani was very quiet and tended to keep to himself. She said that Prisoner D did not say that Mr Razvani should be given some telephone credit, he only said that Mr Razvani was unable to contact his family (although he also said that Mr Razvani did not know where his family was). She said that she did not pursue the issue with Mr Razvani as she had had no concerns about his welfare.

Events of 30 July

55. The investigator watched CCTV footage for 30 July. As Mr Razvani neither worked nor went to education, he remained in his cell during the morning until he was unlocked for lunch at 11.26am. All prisoners were then locked back into their cells by around 12.20pm so officers could take their lunch breaks.

56. Mr Razvani remained locked in his cell during the early afternoon but just after 5.00pm he was unlocked to collect his evening meal and for a period of association. CCTV shows that over the following 90 minutes Mr Razvani spent time wandering in and out of his cell. He generally kept to himself, but he spoke to three other prisoners. The investigator's assessment of Mr Razvani was that he appeared comfortable in his surroundings and content to remain largely alone.

57. Shortly after 6.30pm, staff began locking prisoners into their cells for the evening. Officer C locked Mr Razvani into his cell at 6.35pm. He told the investigator that Mr Razvani was very quiet, and he tended to keep to himself. However, there was nothing to suggest that he had any issues with other prisoners or that he was at risk of harming himself. He said that he shared a joke with Mr Razvani when he locked him in his cell on 30 July as Mr Razvani thought that he (the officer) could not see that he was already in his cell and he said 'boss, I'm here', and he laughed.

58. At 7.49pm, Officer D made a routine check on Mr Razvani. She said that when making checks she always asked prisoners if they were all right. She said that when she spoke to Mr Razvani that evening, he responded by giving her a thumbs-up signal. This was the last check on him before the discovery of his death.

59. Prisoner A told the investigator that he heard Mr Razvani talking to himself in his cell that evening and, at around 11.30pm, heard a noise from the cell which he thought was Mr Razvani opening or closing a cupboard door.

Events of 31 July

60. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to staff radio communications. He also obtained information from Yorkshire Ambulance Service. The following account is based on these sources and prison documentation relating to the emergency response.

61. Shortly before 5.00am on 31 July, Officer D began a routine check of all prisoners on B wing. She checked Mr Razvani at 5.00am, and when she looked into his cell she saw him hanging from a ligature made from a bed sheet tied to the window bars. He was in a standing position with his feet on the floor. She radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). Further staff, including a Custodial Manager (CM), arrived within around 40 seconds. The CM looked into the cell and unlocked the door. Two officers supported Mr Razvani's body, and the CM untied the ligature. Staff placed Mr Razvani on his bed and the CM checked for a pulse. Mr Razvani had no pulse and the CM noted that his body was cold, and that rigor mortis had set in (rigor mortis is the stiffening of the muscles and occurs several hours after death). Since there were clear signs of death, staff did not attempt cardiopulmonary resuscitation. Staff also found that Mr Razvani had looped a strip of the bed sheet around his wrists with his arms behind his back.

62. A nurse was in the healthcare centre when he heard the code blue and arrived on B wing at 5.05am. He checked Mr Razvani and noted that there were clear signs that Mr Razvani had been dead for a considerable amount of time.

63. Control room staff had immediately requested an ambulance following the code blue. Paramedics arrived at 5.20am and took charge of Mr Razvani's care. Paramedics noted signs of rigor mortis as well as other indications that Mr Razvani had died some hours earlier. The paramedics pronounced life extinct at 5.24am.

Contact with Mr Razvani's family

64. Wakefield appointed a family liaison officer (FLO). The FLO made extensive efforts to try to identify Mr Razvani's next of kin, including telephoning several numbers in Iran that Mr Razvani had telephoned in the past. He was assisted by a Farsi speaker from The Big Word interpretation service. None of these calls established that the numbers belonged to anyone who knew or was related to Mr Razvani. The FLO also contacted Wakefield's police liaison officer and Mr Razvani's solicitors, but he was again unable to identify Mr Razvani's next of kin. After pursuing enquiries for several days Wakefield concluded that they had exhausted all possibilities and that they should proceed with Mr Razvani's funeral arrangements.

65. Wakefield subsequently discovered that Mr Razvani's religion required that he should be buried with specific requirements relating to the burial plot and the service arrangements. Wakefield identified a funeral director in Bradford that could provide the necessary services and they proceeded with arrangements at a cost that was considerably higher than for a more typical service and burial.

Support for prisoners and staff

66. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer support) to identify prisoners most affected by the death.

67. As the staff involved in the emergency response had worked a night shift, no hot debrief was held on the morning of Mr Razvani's death. However, the Governor and Duty Governor remained on duty the following evening to speak to staff as they arrived for their next night shift. The staff care team also offered support.

68. The prison posted notices informing other prisoners of Mr Razvani'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 the death and made Listeners available.

Security reports following Mr Razvani's death

69. Following Mr Razvani's death, officers submitted security reports about comments made by other prisoners. One report said that a prisoner had been speaking on the

telephone on the evening of Mr Razvani's death and had been crying. The other security report was about another prisoner reporting that Mr Razvani had spoken to him in the days before his death and had said his family were going to die, or were already dead, and that he had been crying when he said this. The investigator spoke to both prisoners about these reports. Both prisoners denied making such reports to staff.

Post-mortem report

70. The pathologist gave Mr Razvani's cause of death as hanging. The pathologist noted that people who hang themselves occasionally bind their wrists to hamper their chances of self-rescue. His toxicology report had no significant findings.

Findings

Assessment of risk of suicide and self-harm

71. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, in place at the time of Mr Razvani's death, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

72. While in prison, the only time that Mr Razvani was supported through ACCT was for a week in October 2022 when he was at HMP Whatton. On that occasion, Mr Razvani reported to staff that he had taken five or six antidepressant tablets as he was feeling depressed. When staff interviewed him further, he said that he had no thoughts of suicide.

73. Mr Razvani had a number of potential risk factors: he appeared to have no external support, such as family members or friends in the community, he formed no proper friendships at Wakefield, he was serving a long sentence and possibly faced extradition back to Iran at the end of his sentence. Despite these risk factors, there is nothing in Mr Razvani's records from Wakefield to indicate that he was at imminent risk of suicide or self-harm. The only suggestion that he might have been at risk was a report to the investigator from Prisoner D. He said that Mr Razvani had spoken about his concerns at not knowing when he would be released, and he spoke about killing himself. The prisoner said that he reported the conversation to Officer A. The officer said that the prisoner did not report any concerns to him, and he had had no concerns himself that Mr Razvani might be at risk.

74. We have no independent means to definitively distinguish between prisoner D's evidence and that of Officer A. However, none of the other three prisoners we spoke to reported any concerns that Mr Razvani was at risk of harming himself and nor did any of the staff who were interviewed during the investigation. The investigator's own assessment of Mr Razvani from watching CCTV was that he appeared comfortable on the wing, albeit he largely kept to himself.

75. In addition, the investigator spoke to the Head of Safer Prisons and Equalities. The investigator asked about several potential issues with Mr Razvani: that he had been the victim of a serious assault, that he largely kept to himself, that he neither worked nor went to education, that English was not his first language. The Head said that any member of staff can access the LanguageLine translation service if needed, but he believed that Mr Razvani had been able to navigate prison systems without staff needing to use LanguageLine. He also told the investigator about the weekly multi-disciplinary Safety Intervention Meeting (SIM) where potentially vulnerable prisoners are discussed, and a support plan put in place for them if appropriate. He said that any member of staff can refer a prisoner to the SIM by emailing the safer custody team and the referral did not need to be detailed. He said that there was

nothing about Mr Razvani to suggest that he was struggling and no obvious reason why anyone would have needed to refer him to the SIM.

76. On balance, we do not consider that there were any indications that Mr Razvani was at risk or needed any additional support.

Clinical care

77. The clinical reviewer concluded that Mr Razvani's physical and mental health care at Wakefield was of a good standard and was equivalent to that he could have expected to receive in the community. She noted that the prison took appropriate action to remind Mr Razvani of the importance of taking clopidogrel and also noted that the prison appropriately stopped the prescription of mirtazapine when he stopped collecting that medication. The clinical reviewer made no recommendations.

Governor to note

78. When Officer D discovered Mr Razvani hanging, she radioed a code blue and waited for other staff to arrive before going into his cell. She said she had been trained that there needed to be three members of staff present before she went into a cell during night state. More staff arrived 40 seconds later and went into the cell. This delay did not affect the outcome for Mr Razvani. However, we are concerned that the officer did not make a dynamic risk assessment in line with national policy about going into the cell on her own when there is a risk to life. Wakefield's Local Security Strategy does not detail this expectation that staff go into a cell to preserve life if it is safe to do so. We bring this to the Governor's attention.

Good practice

79. Once staff discovered Mr Razvani's religion, they ensured he was buried in line with this, despite the extra cost to the prison. This demonstrated both sensitivity and attention to detail and was an example of good practice.

Inquest

80. An inquest into Mr Razvani's death that concluded on 22 July 2025 found that his cause of death was suicide by hanging.

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