Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammed Ahmed, a prisoner at HMP Frankland, on 13 March 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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

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

Mr Mohammed Ahmed was found hanged in his cell on 13 March 2024 at HMP Frankland. He was 46 years old. I offer my condolences to Mr Ahmed's family and friends.

Mr Ahmed was the second prisoner to take his life at Frankland since 2020. Another man took his life at the prison three days after Mr Ahmed's death.

Mr Ahmed had been in prison for 14 years and at Frankland for almost 10 years. He had never self-harmed or been subject to suicide and self-harm monitoring. Throughout his sentence, Mr Ahmed chose not to interact with other prisoners and only minimally engaged in prison life. He did not work, and did not participate in offending behaviour work or the parole process. Despite this, he was offered regular keywork and staff continued to try to engage him. He was offered support with both physical and mental health issues but generally refused to engage.

In the weeks before his death, Mr Ahmed's behaviour remained the same. We concluded that there were no signs that his risk of suicide had increased, or for staff to be concerned about him.

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 **November 2024**

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Summary

Events

1. In 2003, Mr Mohammed Ahmed was convicted of the attempted murder of his wife but was considered unfit to plead and was given a hospital order (meaning he would be sent to a secure hospital instead of prison). After four months in a medium secure psychiatric hospital, psychiatrists concluded that Mr Ahmed was being dishonest about his symptoms. He was sent back to court and resentenced to 10 years imprisonment. He was released on licence in June 2009.

2. On 2 December 2009, Mr Ahmed was recalled to prison for committing further offences and arrived at HMP Birmingham the same day.

3. On 13 July 2010, Mr Ahmed was found guilty of wounding/inflicting grievous bodily harm and given a sentence of imprisonment for public protection (IPP) with a minimum tariff of five years.

4. During his reception screen, Mr Ahmed denied any suicidal thoughts or intent to harm himself. No significant physical health issues were recorded. He had no recorded history of suicide thoughts or attempts or self-harm in the community. He had no history of substance misuse.

5. On 1 December 2014, Mr Ahmed was transferred to HMP Frankland.

6. On his arrival at Frankland, a health screen identified that in 2001, Mr Ahmed had been sectioned under the Mental Health Act so healthcare staff referred him to the mental health team. Between December 2014 and December 2021, Mr Ahmed was assessed by the mental health team at Frankland around 13 times. He was referred due to his lack of engagement and poor self-care, but no mental health issues were identified, and he was discharged from their care.

7. Little of note was recorded about Mr Ahmed's behaviour during his time at Frankland. He chose to keep to himself, engaged very little with the daily prison regimes and did not interact with other prisoners. He continuously denied any thoughts of suicide and self-harm and declined help when offered. He was never subject to Prison Service suicide and self-harm monitoring procedures (ACCT).

8. Mr Ahmed had his father listed as a contact on his telephone record, but he made no phone calls through the prison telephone system. However, he received at least one visit and maintained sporadic contact with family and friends via mail while in prison.

9. At 5.43am on 13 March 2024 during a routine check, Mr Ahmed was found lying on the floor of his cell with a ligature around his neck. Staff radioed a medical emergency code and entered the cell. It was apparent that Mr Ahmed had been dead for some time and so they did not attempt cardiopulmonary resuscitation. Paramedics attended at 6.26am and confirmed Mr Ahmed's death at 6.31am.

Findings

10. Mr Ahmed was an IPP prisoner and the IPP sentence is recognised as a trigger for self-harm and suicide. Mr Ahmed gave no particular indication that his IPP status was an issue. He had not engaged with any offending behaviour work by his own choice and refused to engage with the parole process.

11. Mr Ahmed had not given staff any reasons for concern about his risk of suicide or self-harm while in prison. He had been in prison for 14 years but chose not to engage with other prisoners or staff unless he needed something. He consistently denied thoughts or intent to harm himself.

12. The clinical reviewer concluded that the physical and mental health care Mr Ahmed received at Frankland was equivalent to what he could have expected to receive in the community.

The Investigation Process

13. HMPPS notified us of Mr Ahmed's death on 13 March 2024.

14. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

15. The investigator visited Frankland on 27 March 2024. He obtained copies of relevant extracts from Mr Ahmed's prison and medical records and viewed CCTV and body worn video camera (BWVC) footage.

16. The investigator interviewed three members of staff at Frankland on 8 May.

17. NHS England commissioned a clinical reviewer to review Mr Ahmed's clinical care at the prison.

18. We informed HM Coroner for County Durham and Darlington of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Ahmed's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Ahmed's family did not have any questions. Mr Ahmed's family received a copy our initial report and highlighted no factual inaccuracies.

20. An inquest into Mr Ahmed's death concluded on 1 August 2025. A jury concluded that Mr Ahmed dies as the result of pressure on the neck by hanging.

Background Information

HMP Frankland

21. HMP Frankland is a high security prison for male prisoners. There is 24-hour inpatient care. Spectrum CIC Healthcare provides primary care, GP, substance misuse and pharmacy services. Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

22. The most recent inspection of Frankland was in January 2020. Inspectors reported that prisoners were positive about the service they received from all mental health providers. Tees, Esk and Wear Valleys NHS Foundation Trust provided a mental health stepped care model, supported by a psychiatrist, nurses and a part-time psychological and well-being practitioner. The service was available Monday to Friday, 8.00am until 6.00pm, and access was through a daily application process. Cases were discussed and allocated for assessment within four working days, or sooner if urgent. All applications were returned to the prisoner to let them know of their appointment, which was positive.

23. The quality of suicide and self-harm prevention procedures (known as ACCT) varied widely; case reviews were not always multidisciplinary, care maps lacked detail and there was inconsistency of case managers. However, most prisoners on ACCT the inspection team had spoken to were positive about the support they received.

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 30 November 2022 and published in May 2023, the IMB reported that it was satisfied that staff and senior managers worked hard to maintain a safe environment whilst dealing with prisoners with challenging behaviours.

Previous deaths at HMP Frankland

25. Mr Ahmed was the second self-inflicted death at Frankland since January 2020. There was a further self-inflicted death at the prison three days after Mr Ahmed's death. There were no similarities with issues found in earlier investigations.

Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and

supervise the prisoner. Staff should complete observations at irregular intervals to prevent the prisoner anticipating when they will occur.

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

Key worker scheme

28. The key worker scheme provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

29. 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.

Imprisonment for Public Protection

30. Imprisonment for Public Protection (IPP) sentences were introduced in 2005 and abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk. The abolition was not applied retrospectively. There are about 3,000 IPP prisoners, of which half have never been released.

31. Since June 2022, the Secretary of State for Justice must approve all Parole Board recommendations for the release or return to open conditions of prisoners serving IPP sentences.

32. In September 2022, the Justice Select Committee (JSC) published a report of its review of IPP sentences. The JSC found that the indefinite nature of the sentence contributed to feelings of hopelessness and despair that had resulted in high levels of self-harm and some suicides within the IPP population. They recommended that all IPP prisoners be re-sentenced.

33. In February 2023, the Government announced that it would not re-sentence IPP prisoners. In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP action plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to "maximise their prospects of achieving a safe and sustainable release."

34. In September 2023, we issued a Learning Lessons Bulletin on the self-inflicted deaths of IPP prisoners after 2022 saw the highest number of these deaths since the sentence was introduced. We concluded that an IPP sentence should be considered as a potential risk factor for suicide and self-harm. We also identified a number of risk triggers associated with IPP prisoners including parole hearings, prison transfers and change in security categorisation.

Key Events

35. In 2003, Mr Mohammed Ahmed was convicted of the attempted murder of his wife but a psychiatric report considered he was unfit to plead and he was given a hospital order. He spent four months in a medium secure psychiatric hospital but following further assessments, psychiatrists concluded that Mr Ahmed was 'malingering and feigning his symptoms'. Mr Ahmed admitted to this when challenged. Mr Ahmed was resentenced to 10 years imprisonment. It was noted by psychiatrists that Mr Ahmed was never mentally ill and had manufactured symptoms to avoid conviction. He was released on conditional licence in June 2009.

36. Mr Ahmed was remanded to HMP Birmingham on 2 December 2009, charged with wounding/inflicting grievous bodily harm to his probation officer. On 13 July 2010, Mr Ahmed was found guilty, and he received a sentence of Imprisonment for Public Protection (IPP) with a minimum tariff of five years. He would be eligible for parole in July 2015.

HMP Frankland

37. On 1 December 2014, Mr Ahmed was transferred to HMP Frankland.

38. A nurse completed a transfer health screen with Mr Ahmed on his arrival at Frankland. Mr Ahmed denied any thoughts of suicide and self-harm. During his time at Frankland, Mr Ahmed was never subject to Prison Service suicide and self-harm monitoring procedures (known as ACCT) and had never attempted suicide or self-harmed either in prison or the community.

39. The nurse recorded that Mr Ahmed was asthmatic and prescribed inhalers and noted that he had poor vision. She also noted that he had been sectioned under the Mental Health Act in 2001, and referred him to the mental health team.

40. Between December 2014 and December 2021, mental health nurses assessed Mr Ahmed at least 13 times. Staff referred him to the mental health team over concerns about his lack of engagement and poor self-care, but following assessments, the mental health team did not identify any mental health issues and he was discharged from their care.

41. Mr Ahmed had his father listed as an approved contact number on his telephone account, but he did not make any calls using the prison telephone system. Mr Ahmed did receive at least one visit, and maintained sporadic contact with family and friends via letters.

42. Mr Ahmed later suffered with mobility issues and continued to have poor vision. Staff assigned a 'buddy' (a prisoner who has volunteered to help support prisoners who are older and/or suffering with mobility issues) to help him with daily tasks. (Mr Ahmed did not engage with the buddy process and at the time of his death did not have an allocated buddy.) Healthcare staff saw Mr Ahmed regularly to check on his well-being, but he often refused any support offered. He also declined support from social care who asked to complete an assessment of his care needs in 2019. Mr Ahmed said that he was coping on his own.

43. On 29 December 2021, a psychiatrist assessed Mr Ahmed. He recorded that there was no clear evidence of a severe and enduring mental illness, but he would review Mr Ahmed again in four to six weeks. He also recorded that he had spoken with staff on the wing who told him that Mr Ahmed's presentation had always remained the same which included spending prolonged periods in his cell and poor personal care. Records indicate that Mr Ahmed was considered not to be clinically mentally unwell, but he displayed signs of an anti-social personality disorder.

44. On 22 February 2022, the psychiatrist saw Mr Ahmed in his cell. Mr Ahmed told him that he was 'doing the best he could' and said that he did not wish to have any support from mental health staff. Staff raised no concerns about Mr Ahmed, and Mr Ahmed denied any thoughts of suicide and self-harm. The psychiatrist discharged Mr Ahmed from the mental health team caseload and recorded the reasons as the absence of a mental disorder and Mr Ahmed's unwillingness to engage.

45. On 9 January 2023, a mental health nurse completed a mental health assessment after Mr Ahmed self-referred. She recorded that when she arrived to speak to Mr Ahmed, he initially said that he did not wish to engage with her, but she persisted, and Mr Ahmed reported having command hallucinations at least twice a week and that he had a history of mental illness. She recorded that Mr Ahmed would be added to the mental health team caseload while she waited for the psychiatrist to review him.

46. On 1 February, the mental health nurse saw Mr Ahmed again. He reported fleeting thoughts of self-harm but said that he had no plans to act on those thoughts. She also recorded concerns about Mr Ahmed's presentation and questioned whether he was caring for himself adequately. She noted that he had been referred to the psychiatrist and that she would speak with primary care colleagues about Mr Ahmed's physical appearance. Mr Ahmed declined to engage any further and told her that he had no thoughts of suicide or harming himself, and if he needed the support of mental health staff he would contact them.

47. On 20 February, the mental health nurse visited Mr Ahmed again in his cell. She recorded that Mr Ahmed appeared low in mood but when asked, he said that he felt fine. Mr Ahmed also denied any thoughts of suicide and self-harm.

48. On 22 February, the psychiatrist visited Mr Ahmed in his cell in order to complete an assessment. He recorded that Mr Ahmed said that he was all right and had nothing to discuss. He said that he challenged Mr Ahmed and reminded him that he had told the mental health nurse that he was low in mood and was hearing voices. Mr Ahmed told him that his mood fluctuated due to stress which was caused mostly by his thoughts of life after his release. He said that he was on an IPP sentence and had declined to engage with the parole process or offending behaviour work so was unlikely to be released. Mr Ahmed spoke about voices that told him to clean his cell or move furniture, but he was able to ignore these with relative ease. Mr Ahmed said that he did not want any help from the mental health team. He was aware that medication could help but said that he would let staff know if he was willing to accept it. Mr Ahmed denied any thoughts of suicide and self-harm. The psychiatrist concluded that Mr Ahmed was not mentally unwell, had the ability to make decisions and did not require mental health support.

49. On 27 February, the mental health nurse visited Mr Ahmed on the wing and spoke with him about his assessment with the psychiatrist. Mr Ahmed told her that he was feeling all right and neither low in mood nor happy. Mr Ahmed said that he still heard the voice but denied that it told him to harm himself and said that he had no such thoughts. Mr Ahmed said that he was 'usually ok' and would ask for help if he needed it. She told Mr Ahmed that following the psychiatrist's assessment, he would be discharged from the mental health team caseload. She asked Mr Ahmed if there was anything else he felt the mental health team could support him with: Mr Ahmed said no.

50. The mental health team had no more contact with Mr Ahmed. However, on 17 July, a prison offender manager (POM) referred Mr Ahmed to the mental health team to see if they could motivate Mr Ahmed to engage with risk assessments. The mental health team triaged the referral and noted that there was no clinical reason for the referral and no change in Mr Ahmed's presentation, therefore the referral was not progressed. Primary care nursing staff continued to see Mr Ahmed to administer medication for a skin condition, but he raised no other concerns.

51. Mr Ahmed was eight years past his tariff (minimum time to serve before parole), which had expired in July 2015. In that time, Mr Ahmed had five parole reviews, with the last review on 29 June 2023. The Parole Board decided on each occasion that Mr Ahmed should remain in prison, as he had consistently refused to address his offending behaviour or engage with the parole process.

52. Between 28 February 2023 and March 2024, Mr Ahmed's keyworker attempted to hold around 26 keywork sessions with Mr Ahmed. On each occasion the keyworker asked Mr Ahmed how he was feeling, and Mr Ahmed responded with 'same old' and declined to expand further. On occasions, Mr Ahmed refused to engage and said that he had no issues and if he did, he would speak with staff. Mr Ahmed continued to keep to himself and had little engagement with other prisoners. He denied any thoughts of suicide or self-harm and raised no concerns. Mr Ahmed's presentation and behaviour stayed the same.

Events of 12/13 March 2024

53. An officer said in a written statement that on the evening of 12 March, she arrived for her night duty at 6.30pm. Day staff gave her a handover and they reported no concerns.

54. At 8.45pm, during a routine check, the officer said that she saw Mr Ahmed sitting on his bed. He did not acknowledge her when she looked through the observation panel in the cell door, but he gave her no cause for concern. This was the last time Mr Ahmed was seen alive. During the night, she continued patrolling the wing, checking on those that were subject to ACCT monitoring, but she had no reason to check on Mr Ahmed as he was not subject to ACCT monitoring and records show that he did not press his emergency cell bell.

55. At 5.40am on 13 March, the officer was completing a final routine check before ending her shift. She reached Mr Ahmed's cell and looked through the observation panel. She said that when she shone her torch into the cell she could not see Mr Ahmed on his bed, and as she scanned around the cell she saw him on the floor and turned the cell night light on. She said that Mr Ahmed was lying parallel to his

bed, with his head against the wall. She began calling him but got no response. At 5.43am, she radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties).

56. The officer said that she remained at the door and on further inspection realised that Mr Ahmed had a ligature around his neck, which was tied to the bedframe. She said that she made a dynamic risk assessment not to enter the cell on her own as Mr Ahmed was listed as a risk to females.

57. A Supervising Officer (SO), a Custodial Manager (CM) and a nurse arrived on B wing at approximately 5.45am, activated body worn video cameras and entered the cell. The CM said that Mr Ahmed was lying on the floor with his feet tied to the bottom of the bed and a ligature attached to the top of the bed and tied around his neck. He said that he cut the ligature, and it was clear to him that Mr Ahmed was dead with clear signs of rigor mortis (stiffening of the body that occurs after death). He said that the nurse agreed that they should not attempt CPR.

58. At approximately 6.26am, paramedics arrived at the prison and at 6.31am, they confirmed that Mr Ahmed had died.

Contact with Mr Ahmed's family

59. The prison appointed a family liaison officer (FLO). She tried to check next of kin details against Mr Ahmed's last visit, which had been in 2023. Due to the distance from Frankland to the last known address of Mr Ahmed's nominated next of kin, she asked HMP Buckley Hall and HMP Birmingham whether they could deploy family liaison officers to visit the next of kin and break the news of Mr Ahmed's death.

60. Buckley Hall could not help but offered to ask the local police to visit Mr Ahmed's next of kin. At 4.00pm, the FLO noted that police were on their way to the next of kin's address. However, Rochdale police reported that it was not the correct address for Mr Ahmed's next of kin (and was in fact the address of the next of kin of a different prisoner at another prison).

61. At 1.00pm on 14 March, Birmingham police confirmed that Mr Ahmed's next of kin had been notified of his death. The family provided a contact number and the FLO telephoned them at 1.30pm to offer her condolences, explain the circumstances of Mr Ahmed's death and the process that would follow.

62. The prison contributed towards the funeral cost in line with national policy.

Support for prisoners and staff

63. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners 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.

64. After Mr Ahmed's death, a 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 offered support and the local branch of the Samaritans was contacted as part of the postvention process.

65. The prison posted notices informing other prisoners of Mr Ahmed'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.

Post-mortem report

66. The post-mortem gave Mr Ahmed's cause of death as pressure on the neck caused by a ligature. Toxicology tests found no illicit drugs in his body.

Findings

Assessment of risk

67. Mr Ahmed had some risk factors for suicide. He was serving an IPP sentence (and was over tariff), had limited contact with friends and family, isolated himself from other prisoners and minimally engaged in prison life.

68. Mr Ahmed gave no indication that his IPP status was a particular concern. He had been at Frankland since December 2014, and in that time, it is clear that he chose not to engage with any offending behaviour work or the parole process, despite encouragement from staff.

69. Staff had noted no concerns about Mr Ahmed's risk of suicide or self-harm at any time during his imprisonment. He had no recorded history of suicide attempts or self-harm, either in the community or custody. Mr Ahmed, for his own reasons, seldom engaged with other prisoners and staff and would speak only when spoken to, or when he needed something. Staff told us that Mr Ahmed's behaviour was the same throughout his time in prison, and they considered that this was normal for him. Staff said that they had not witnessed any changes in Mr Ahmed's behaviour in the days before his death that would have raised concerns.

70. Mr Ahmed was never subject to suicide and self-harm monitoring (ACCT) in prison. The investigation did not find any missed opportunities or occasions when evidence suggested his risk of suicide had increased. We do not think that staff could have predicted his actions.

Clinical care

71. The clinical reviewer found consistent evidence in Mr Ahmed's medical records of his refusal to participate in healthcare services and interventions offered to him. When required, his physical healthcare needs were attended to, however, he often refused to participate in the provision of care.

72. The clinical reviewer found that in the 12 months prior to his death, Mr Ahmed had been referred to mental health services but refused to engage. He had also been reviewed by a consultant psychiatrist in 2022 and 2023, who found no severe or enduring mental illness and there were no overall changes in his mental health presentation.

73. The clinical reviewer concluded that the care provided to Mr Ahmed was equivalent to what he could have expected to receive in the community.

Governor to note

Family liaison

74. The initial details obtained for Mr Ahmed's next of kin were taken from a visits list and were, in fact, incorrect and for another prisoner of the same name. This should not have happened.

75. It is good practice, particularly in the long-term estate, for next of kin details to be regularly reviewed so that they are readily available if needed.

Good practice

76. During his time at Frankland, despite his unwillingness to engage, Mr Ahmed received regular keywork sessions from a consistent assigned keyworker, who kept clear records of those contacts. It was evident that in addition to the delivery of keywork, staff tried hard to engage with Mr Ahmed, despite his resistance.

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