Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Milad Fathy, a prisoner at HMP Leeds, on 29 January 2023

A report by the Prisons and Probation Ombudsman

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

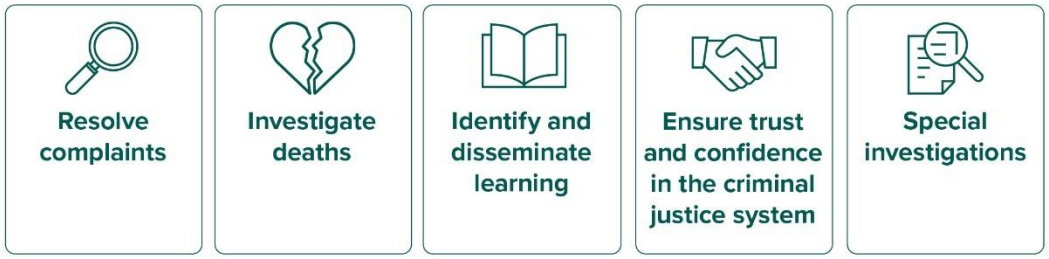
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 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 Milad Fathy was found hanged in his cell on 29 January 2023 at HMP Leeds. He was 33 years old. I offer my condolences to Mr Fathy's family and friends.

Mr Fathy was the 12th prisoner to take his own life at Leeds since January 2020, and the fourth in a seven-week period in December 2022 to January 2023. Since Mr Fathy's death, four more prisoners have taken their lives at Leeds.

These facts are clearly concerning. Since I started as Ombudsman in April 2023, I have twice visited Leeds and met the Governor and Prison Group Director, to talk over the strategies they are implementing to identify and support prisoners at risk of suicide and self-harm, and to equip their staff with the tools to help them.

Mr Fathy was a man who was recently sentenced, which can be a trigger for suicide. He had other risk factors and had previously been monitored under suicide and self-harm prevention procedures (known as ACCT). While I am satisfied that staff checked his welfare in line with expectations following his sentencing – and that it is not unreasonable that they chose not to start new ACCT procedures at the time – this case is a reminder that in a busy local prison there are prisoners who might be at risk and that staff must remain vigilant to potential risk factors and triggers.

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 **March 2024**

Contents

Summary

Events

1. On 1 June 2022, Mr Milad Fathy, an Iranian national, was remanded to HMP Leeds after being charged with sexual assault, robbery, attempted robbery and possession of a bladed article. He had a history of substance misuse and depression and was referred to the mental health and substance misuse teams upon his arrival.

2. Between June and August, staff monitored Mr Fathy under suicide and self-harm prevention procedures (ACCT) on several occasions, due to incidents of suicidal ideation, paracetamol overdose and apparent food refusal. On 29 August, a multidisciplinary team decided to close the ACCT procedures as they were satisfied that Mr Fathy was no longer a risk to himself.

3. On 21 December, a Primary Care Advanced Nurse Practitioner (ANP) assessed Mr Fathy and prescribed him mirtazapine (an antidepressant) to treat his low mood. The ANP tasked a GP to assess Mr Fathy's prescription within two weeks, in accordance with national guidelines. This did not happen.

4. On 24 January 2023, Mr Fathy attended court via video-link and received a sentence of seven years in prison. Afterwards, officers completed two welfare checks and did not report any concerns.

5. At 8.27pm on 29 January, an officer saw Mr Fathy hanging from the top bunk bed in his cell. The officer immediately radioed a medical emergency 'code blue', indicating a life-threatening situation, and entered the cell.

6. Officers and healthcare staff responded quickly to the code blue and began performing cardiopulmonary resuscitation (CPR). At 9.16pm, paramedics confirmed that Mr Fathy had died.

Findings

7. Mr Fathy had some risk factors for suicide and self-harm and, less than a week before he died, he was sentenced to seven years in prison. Staff checked his welfare afterwards and, while it is likely that his risk was higher than suggested, we are satisfied that it was reasonable at the time not to start ACCT procedures.

8. The clinical reviewer found that healthcare provision for Mr Fathy did not meet expectations. His antidepressant prescription was not reviewed in line with national guidelines, and he did not have a care plan to support his low mood.

9. A defibrillator was not brought to the emergency response.

Recommendation

- The Head of Healthcare should ensure that staff create care plans to support prisoners under their care, setting out a treatment plan including timescales for review.

The Investigation Process

10. HMPPS notified us of Mr Fathy's death on 30 January 2023.

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

12. The investigator visited Leeds on 9 February 2023. He obtained copies of relevant extracts from Mr Fathy's prison and medical records.

13. The investigator interviewed eight members of staff at Leeds in February and March 2023.

14. NHS England commissioned a clinical reviewer to review Mr Fathy's clinical care at the prison. She completed all staff interviews jointly with the investigator.

15. 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.

16. The Ombudsman's family liaison officer contacted Mr Fathy's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Fathy's family asked to know why he was taken off ACCT monitoring, and what assessments were completed to inform this decision. They said Mr Fathy had a history of bipolar disorder and asked about mental health support. Mr Fathy's family also queried why prison staff did not have up to date contact details for them. We have addressed these issues in our report.

17. We shared our initial report with HM Prison and Probation. They identified one factual inaccuracy.

18. We also shared the initial report with Mr Fathy's family. They did not provide any feedback.

Background Information

HMP Leeds

19. HMP Leeds is a local prison holding up to 1,218 men who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services. Midlands Partnership Trust provides psychosocial substance misuse services.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Leeds was in June 2022. Inspectors reported that the number of deaths was high, including eight self-inflicted deaths since their last inspection (in November 2019).

21. In July 2023, HMIP published an independent review of progress at Leeds. Inspectors found that leaders had failed to make progress in reducing the rate of suicide at the prison. They noted that seven prisoners had taken their own lives since their last inspection just 13 months earlier, and that Leeds now had the second highest rate of self-inflicted deaths of any prison in England and Wales.

22. Inspectors found that unemployment and long periods spent locked up during the weekend were common factors in many of these deaths. They also noted that leaders seemed unable to focus on these key issues while they were managing an unwieldy plan with more than 100 recommendations from the various recent reviews, audits and investigations that followed the incidents.

Independent Monitoring Board

23. 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 December 2022, the IMB stated that they generally considered Leeds to be a safe place for prisoners, however they were concerned about the number of self-inflicted deaths in custody. They noted that recommendations from PPO reports into deaths in custody had been accepted by the prison and any recommendations implemented.

Previous deaths at HMP Leeds

24. Mr Fathy was the 32nd prisoner to die at Leeds since January 2020. Of the previous deaths, 11 took their own lives. Since Mr Fathy's death, four more prisoners have taken their lives at Leeds. Our report into the death of a man who died four weeks before Mr Fathy found that he received inconsistent key work.

Assessment, Care in Custody and Teamwork

25. 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 made at irregular intervals to prevent the prisoner anticipating when they will occur.

26. Part of the ACCT process involves assessing immediate needs and drawing up a support plan 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 support plan are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key worker scheme

27. The key worker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversations which each of their allocated prisoners.

28. The key worker scheme was suspended across the estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, the Prison Service used an Exceptional Delivery Model until May 2022. This involved weekly conversations with prisoners identified as vulnerable due to their risks or circumstances.

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.

Key Events

30. On 1 June 2022, Mr Milad Fathy, an Iranian national, was remanded to HMP Leeds after being charged with sexual assault, robbery, attempted robbery and possession of a bladed article. It was his first time in prison. Mr Fathy's Person Escort Record (PER, which contains information about a prisoner's risk) noted that he was at risk of suicide and self-harm. Mr Fathy also had a history of substance misuse and depression. Evidence indicates that Mr Fathy could communicate well in English and did not require an interpreter.

31. Upon his arrival, Mr Fathy told the reception nurse that he had a history of bipolar disorder (a major mental illness characterised by extreme changes in mood) and said that he had considered hanging himself two weeks earlier but changed his mind. He said he had no current thoughts of suicide and self-harm. Mr Fathy also told the nurse that he used cannabis. The nurse referred Mr Fathy to the mental health and substance misuse teams.

32. On 2 June, an officer completed a key work induction session with Mr Fathy to explain the purpose of the key worker scheme.

33. On 3 June, a mental health nurse completed a mental health assessment for Mr Fathy. Mr Fathy told the nurse that he had been prescribed antidepressant medication in the past but could not remember the dose. He also requested some counselling. Mr Fathy said that he had been diagnosed with bipolar disorder, but staff could find no evidence to support this in his medical records. The nurse completed referrals for counselling and to primary care to consider prescribing antidepressants.

34. On 6 June, the substance misuse team met Mr Fathy, but he declined any interventions from them, stating he did not have any substance misuse issues.

35. On 7 June, an officer completed a key work session with Mr Fathy. Mr Fathy expressed concerns about what would happen to his council house while he was in prison but said he hoped to be bailed at the end of the month. The officer raised no concerns about his wellbeing.

36. On 9 June, primary care staff completed a medicines reconciliation and found no evidence that Mr Fathy was prescribed any regular or repeat medication.

37. On 26 June, Mr Fathy was moved from regular accommodation on C Wing to a single cell in A Wing, which is a 'drug free wing' or 'IFSL', as staff felt this would be a more suitable environment for him. ('Incentivised Substance Free Living' or 'IFSL' is an initiative where prisoners have incentives to live and remain substance free.)

38. On 29 June, following a court hearing which he attended via video-link, Mr Fathy told a prison officer that he felt suicidal because he thought he had been unfairly imprisoned and was innocent. The officer started ACCT procedures.

39. The next morning, a nurse from the mental health team attempted to assess Mr Fathy as part of the ACCT process, but he refused to engage, saying he was "sick of professionals coming to his cell" to talk to him.

40. Later that morning, an ACCT review meeting took place which was attended by a multi-disciplinary team, including the mental health nurse. Mr Fathy told staff that he had made a "flippant comment" the day before about self-harm due to feeling frustrated, but never had any thoughts of harming himself. Officers recorded that Mr Fathy had several protective factors, including his strong family support network. Due to Mr Fathy's previous substance misuse issues, staff referred him to DART (Drug Alcohol Rehabilitation Team). As Mr Fathy was located on the drug free wing, staff noted that he would have more opportunities to work with DART. All present at the meeting agreed that the ACCT should be closed.

41. On 2 July, staff re-started Mr Fathy's ACCT procedures after he began acting strangely and said he planned to stop eating so that he could end his life.

42. On 3 July, a mental health nurse assessed Mr Fathy. He denied any thoughts of suicide and self-harm but said he would continue his food refusal. She fed this back to the ACCT review team who continued to monitor him.

43. On 6 July, an officer spoke to Mr Fathy in his cell as part of the ACCT review process. He recorded that Mr Fathy had clearly been eating food in his cell, as there were empty food packets and Mr Fathy told him he was eating. Following an ACCT review meeting, the multi-disciplinary team chose to close Mr Fathy's ACCT due to his improved presentation and behaviour, and the fact he was eating again. Staff booked a GP review for 8 July, to assess any potential risks relating to his period of food refusal.

44. On 8 July, following assessment, the GP re-started Mr Fathy's ACCT after he told him he had thoughts of hanging himself and was refusing food again. Mr Fathy told the GP that he felt that his human rights had been "abused" from the time he was arrested. At a case review the following day, staff added one support action: for Mr Fathy to continue with food intake.

45. On 13 July, staff transferred Mr Fathy from A Wing to B Wing following an altercation with another prisoner.

46. On 15 July, staff closed Mr Fathy's ACCT procedures as they were satisfied that he was eating normally and was no longer a risk to himself. They also noted that he was engaging with DART and talking regularly to his family.

47. On 21 August, Mr Fathy was charged with a prison disciplinary offence after an officer saw a prisoner on B Wing pass a brown substance to him which smelt like cannabis.

48. In the evening, while completing a routine roll check on Mr Fathy's cell, an officer noted that he was unresponsive and surrounded by empty packets of paracetamol tablets. The officer radioed a medical emergency 'code blue', indicating a life-threatening situation. Upon arrival, healthcare staff stood down the ambulance and completed an assessment of Mr Fathy, recording that his observations were all within normal limits. Mr Fathy told staff that he wanted to die. Staff re-started the ACCT procedures.

49. The next day, a nurse assessed Mr Fathy. He told her that he took the overdose to be with his father who had died from suicide in 2009. However, Mr Fathy also said

that he took the tablets because he had a migraine and could not cope with it. He said he had no further thoughts of harming himself or ending his life.

50. On 29 August, staff closed Mr Fathy's ACCT procedures after noting that he had engaged in his unit's regime, was eating and sleeping well, and did not have any thoughts of self-harm. (This was the last occasion on which Mr Fathy was monitored under ACCT procedures.)

51. On 21 September, the deputy governor approved Mr Fathy's application to reside on F Wing, which is the vulnerable prisoner unit (VPU). Over the following months, Mr Fathy began attending more frequent court hearings, via video-link, and received regular welfare checks.

52. On 23 September, an officer completed a key work session with Mr Fathy. Mr Fathy said he was "finding it okay" on his new unit but felt uneasy about being a VP. He said he had contact with his family, but that they lived in London which made visits difficult. Mr Fathy asked about seeing a GP. The officer told him he would need to put in an application to healthcare to arrange this, and Mr Fathy said he would do. He recorded that Mr Fathy presented well and described him as "polite and respectful throughout". He raised no concerns.

53. On 4 November, an officer completed a key work session with Mr Fathy. Mr Fathy said he had settled in well on the VP wing. The officer raised no concerns.

54. On 21 December, a Primary Care Advanced Nurse Practitioner (ANP) assessed Mr Fathy and prescribed him mirtazapine (an antidepressant) to treat his low mood. National Institute for Health and Care Excellence (NICE) guidelines state that a person should be checked two weeks after commencing treatment to see if symptoms are improving and to see if there are any side effects. She tasked a GP to assess Mr Fathy within two weeks in accordance with the guidelines. However, there is no documentation to suggest such an appointment occurred. In interview, the GP told us that he was aware that a person prescribed mirtazapine should be reviewed after two weeks and said he was sure he would have done it. However, he acknowledged that he did not document it and therefore could not confirm he had reviewed Mr Fathy's prescription.

55. On 26 December, an officer completed a key work session. He recorded that Mr Fathy was "less than willing" to talk to him as it appeared he had just woken up and did not want to get out of bed. Mr Fathy said he did not require anything and said he was happy on F Wing. The officer raised no concerns.

2023

56. On 12 January, an officer completed a key work session for Mr Fathy. She recorded that Mr Fathy wanted to sleep and said he was not interested in applying for work. She said she would come and see him again when he was more awake, to discuss his progress and rehabilitation. The officer raised no concerns about his presentation or behaviour.

57. On 23 January, Mr Fathy attended a court hearing via video-link and was told he would be sentenced the next day. An officer completed a keywork session with Mr Fathy later that day and raised no concerns.

58. On 24 January, Mr Fathy received a sentence of seven years in prison. An officer recorded that he checked Mr Fathy's welfare afterwards. He did not record any concerns.

59. In the evening, an officer completed a further welfare check on Mr Fathy. He did not report any concerns and told us that Mr Fathy appeared to be his usual self.

60. At 12.21pm on 29 January, Mr Fathy telephoned his mother and spoke about appealing his sentence. This is the last telephone call recorded for him.

61. At 4.37pm, Mr Fathy went into his cell and was seen talking to other prisoners. An officer locked his cell door behind him. At 4.43pm, an officer checked Mr Fathy through his cell observation panel and raised no concerns.

Emergency response

62. At 8.27pm, an officer completed the evening count of prisoners on F Wing. He observed Mr Fathy through his cell observation panel and saw him hanging from the top bunk bed. He immediately called a medical emergency 'code blue', indicating a life-threatening situation, and entered the cell.

63. Officers responded quickly to the code blue and began performing cardiopulmonary resuscitation (CPR). Healthcare staff arrived shortly afterwards and took over the CPR. There is no evidence that a defibrillator (a machine that monitors heart rhythm and delivers an electric shock if required) was brought to the scene.

64. At 9.16pm, paramedics confirmed that Mr Fathy had died.

Contact with Mr Fathy's family

65. At around 10.20pm on 29 January, an operational manager telephoned a Supervising Officer (SO), the prison family liaison officer, to inform her of Mr Fathy's death. He told the SO that he had a named next of kin for Mr Fathy but no telephone number. After searching Mr Fathy's prison records, contacting several stakeholders, and listening to Mr Fathy's recent telephone calls, the SO identified up to date contact details. She told us that there was uncertainty about whether Mr Fathy's family spoke English and that they had to listen to several telephone calls (the majority of which were not in English) to confirm that this was the case. Due to the time already passed, she decided to telephone the next of kin to inform them of Mr Fathy's death, rather than attend their home address.

66. At 10.28am on 30 January, the SO telephoned Mr Fathy's next of kin and broke the news of his death.

67. Leeds contributed to the costs of Mr Fathy's funeral in line with Prison Service instructions.

Support for prisoners and staff

68. After Mr Fathy's death, an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

69. The prison posted notices informing other prisoners of Mr Fathy'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 Fathy's death.

Post-mortem report

70. The post-mortem report concluded that the cause of Mr Fathy's death was hanging.

Findings

Identifying the risk of suicide and self-harm

69. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Leeds should have recognised Mr Fathy as at risk and begun ACCT procedures to support him in the time before his death.

70. Mr Fathy had some risk factors for suicide and self-harm. He had been monitored under ACCT procedures on several occasions in the past and had taken an overdose of medication in prison. He spoke of a family history of suicide and did not receive visits from his family (although he spoke to them on the telephone). Mr Fathy was prescribed antidepressants. In the week before his death, Mr Fathy received a seven-year prison sentence, which he told his mother he planned to appeal.

71. PSI 64/2011 identifies that court appearances, especially sentencing, can be a trigger for suicide and self-harm. It states that after speaking to a prisoner (about a potential trigger), staff should use their judgement in combination with all available evidence to inform their decisions about prisoners who might pose a risk to themselves.

72. Prison staff completed welfare checks on Mr Fathy after his sentencing and again later that day. Neither officer identified any concerns for his wellbeing.

73. While Mr Fathy had some risk factors for suicide and self-harm, and hindsight suggests that his risk was greater than thought, we are satisfied that it was not unreasonable for staff to conclude that he did not need to be monitored under ACCT procedures at the time or to identify that he was in crisis.

Self-inflicted deaths at HMP Leeds

74. Mr Fathy was the fourth prisoner to take his own life at Leeds in a seven-week period in December 2022 to January 2023. Four prisoners took their lives at the prison in the remainder of 2023.

75. The Governor has recognised that more work needs to be done to improve safety and, with regional support, produced an action plan to identify and progress many different actions points to help staff identify and support prisoners who might be at risk of suicide and self-harm. Actions include providing additional peer support, further risks and triggers training for staff, and considering procedures and support following court appearances. In September 2023, the Ombudsman met the Prison Group Director for Yorkshire and the Governor when they discussed progress against the action plan.

76. We are satisfied that senior managers at Leeds have identified the significance of the increasing number of self-inflicted deaths and have taken steps to address this.

Clinical care

Mental health

77. The clinical reviewer concluded that the health care Mr Fathy received at Leeds was not of the standard reasonably expected, and therefore not equivalent to that which he could have expected to receive in the wider community.

78. NICE (National Institute for Health and Care Excellence) Guidelines NG222, published in June 2022, state that a person should be checked two weeks after commencing treatment with antidepressants to check to see if symptoms are improving and consider any side effects.

79. Prior to his death, Mr Fathy reported feeling low in mood and was prescribed an antidepressant medication (mirtazapine) to help him. Although a GP completed an appointment with Mr Fathy on 11 January (three weeks after he started taking the medication), there is no documented evidence that he reviewed Mr Fathy's mental health, just his poor sleep.

80. At interview, the GP told us he was aware that mirtazapine should be reviewed after two weeks and was sure he would have done it. However, he acknowledged that he did not document it and therefore could not confirm that he had reviewed the prescription.

81. The clinical reviewer also noted that healthcare staff did not create a care plan to support Mr Fathy with his low mood or consider other forms of treatment, including talking therapy.

The Head of Healthcare should ensure that staff create care plans to support prisoners under their care, setting out a treatment plan including timescales for review.

Governor to Note

Key work

82. Leeds' key worker policy states that prisoners should be allocated a consistent and dedicated key worker. Mr Fathy received seven keywork sessions while at Leeds, however five of the seven sessions were delivered by a different member of staff. His final keywork session took place on 23 January 2023, which was five days before his death.

83. Consistency in key work is important as it allows a dedicated member of staff to build a relationship with a prisoner and for coherent discussion and progression of any issues that arise. This is particularly important for groups who might not be as familiar with the prison environment, such as first-time prisoners or foreign nationals.

84. Our investigation into the death of a man four weeks before Mr Fathy highlighted similar issues with inconsistent key working. In that investigation, the Acting Head of Recovery set out work she had taken to improve the provision of key work at Leeds.

While we are pleased to note this focus, it is important that Leeds continues to strive to meet its obligations in this matter.

Emergency response

85. The clinical reviewer found that a defibrillator was not brought to the scene of the emergency response. Although Mr Fathy showed no signs of life when he was discovered, and using a defibrillator may not have impacted on the outcome, this is still a cause for concern.

Next of kin contact details

86. After Mr Fathy's death, it became apparent that the prison did not have up to date contact details for his next of kin. Although contact details were eventually found, this caused a delay in informing Mr Fathy's family of his death and led to the decision being taken to inform the family via telephone rather than in person due to the length of time already passed. The delivery of an unexpected death message is always likely to be a traumatic experience for family members. This is especially the case in a self-inflicted death. The threshold at which the decision is taken to do so over the phone rather than in person should be extremely high. We accept that the decision was well-intentioned, and we make no recommendation, but the Governor will wish to consider whether in these circumstances that threshold had been met. Mr Fathy's family told us that they were unhappy that they were not informed in person.

Inquest

87. The inquest into Mr Fathy's death concluded on 9 December 2024, and returned a verdict of suicide.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T l 020 7633 4100