Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Akash Akeel, a prisoner at HMP Leeds, on 31 December 2022

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 HM 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 Akash Akeel was found hanging in his cell at HMP Leeds on 31 December 2022. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 28 years old. I offer my condolences to Mr Akeel's family and friends.

This was the fourth self-inflicted death at Leeds in 2022 and the eleventh in three years. There have been a further four self-inflicted deaths since.

My investigation found that there was a missed opportunity to assess Mr Akeel's risk of suicide when he asked for antidepressant medication six weeks before his death. Healthcare staff prescribed antidepressants but failed to monitor that Mr Akeel was taking them. He had not collected any of his antidepressant medication by the time he died.

The clinical reviewer concluded that Mr Akeel's mental health care at Leeds was not equivalent to that which he could have expected to receive in the community.

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 **December 2023**

Contents

Summary

Events

1. Mr Akash Akeel was remanded into custody at HMP Leeds on 27 October 2022, charged with attempted burglary, stalking and harassment. He had been in prison many times before.

2. Reception staff noted that Mr Akeel had a history of suicide attempts and self-harm but these incidents were over three years before and they had no current concerns. Mr Akeel had previously been on medication for anxiety and depression (mirtazapine) but not since 2021.

3. On 18 November, Mr Akeel asked to restart mirtazapine. A nurse assessed him by telephone on 2 December and agreed to prescribe mirtazapine at a low dose for one week and then a higher dose. She did not refer Mr Akeel to the mental health team.

4. On 16 December, a pharmacy technician noticed that Mr Akeel had not collected his medication. She asked a GP if she could issue the higher dose and he agreed. No action was taken to establish the reasons why Mr Akeel had not collected his medication.

5. On the morning of 29 December, Mr Akeel told a nurse that he was not being unlocked to get his medication. The nurse highlighted this to the pharmacy but no one took any action.

6. That evening, Mr Akeel got into a fight with another prisoner. Staff moved him to the segregation unit.

7. On 30 December, staff moved Mr Akeel from the segregation unit back to a standard wing. He was in a cell on his own and, due to his involvement in the fight, staff had removed his television.

8. On the morning of 31 December, Mr Akeel had an adjudication with a prison manager at which he pleaded guilty to the charge of fighting. The manager told him that he could keep his television (she was unaware it had already been removed). It was not returned to him.

9. At around 8.00pm on 31 December, during a routine check, staff found Mr Akeel hanging from his bed rail. He had used a sheet as a ligature. Staff immediately called a medical emergency code, cut the ligature and started cardiopulmonary resuscitation (CPR). Healthcare staff arrived shortly afterwards. Ambulance staff arrived at 8.14pm and took over attempts to resuscitate Mr Akeel. However, they were unable to do so and at 8.56pm, confirmed that he had died.

Findings

10. There was no indication that Mr Akeel was at imminent risk of suicide when he died. However, opportunities were missed to assess his mental health when he asked for antidepressant medication six weeks before.

11. The nurse who prescribed Mr Akeel's antidepressant medication did not do a mental health referral as she should have done. The clinical reviewer considered that an assessment tool should have been used to risk assess Mr Akeel given his history of mental health issues.

12. Mr Akeel had not collected any of his antidepressant medication by the time he died. Staff failed to follow this up when a pharmacy technician noticed it on 16 December. They again failed to follow it up properly when it became apparent during a medication review.

13. The clinical reviewer concluded that Mr Akeel's mental healthcare was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should review the procedures in place for assessing the mental health needs of prisoners who have requested mental health support.

- The Head of Healthcare should review processes to ensure prescribed treatments are effectively administered and issues are promptly resolved.

The Investigation Process

14. HMPPS notified us of Mr Akeel's death on 31 December 2022.

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

16. The investigator obtained copies of relevant extracts from Mr Akeel's prison and medical records.

17. NHS England commissioned an independent clinical reviewer to review Mr Akeel's clinical care at the prison.

18. The investigator and clinical reviewer interviewed eight members of staff at Leeds. The interviews were conducted remotely by telephone and video in March 2023.

19. We informed HM Coroner for West Yorkshire Eastern District of the investigation. The Coroner provided us with a copy of the post-mortem report. We have sent the Coroner a copy of this report.

20. The Ombudsman's family liaison officer contacted Mr Akeel's father to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Akeel's father asked why his son was in a cell on his own and he expressed concerns about the number of deaths of Asian men at Leeds. We have addressed these issues in this report. Mr Akeel's father also raised additional concerns, via his local MP, most of which were not directly related to Mr Akeel's death. We have responded to these additional concerns in separate correspondence.

21. We shared our initial report with Mr Akeel's father. He did not raise any factual inaccuracies.

22. We shared our initial report with the Prison Service. The Prison service requested revised wording to one paragraph which has been amended within our report. The action plan has been annexed to this report.

Background Information

HMP Leeds

23. HMP Leeds is a local prison holding up to 1,100 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

24. The most recent full inspection of HMP Leeds was in June 2022. Inspectors found that Leeds was a well-led prison where leaders and managers were visible about the wings and supportive staff-prisoner relationships were observed. Although levels of self-harm were falling, there had been eight self-inflicted deaths since the last inspection in 2019 but inspectors acknowledged the work that the prison was doing to address this major issue. Inspectors reported reduced levels of violence since the last inspection with significantly fewer prisoners saying that they felt unsafe.

25. Inspectors reported that mental health services were reasonably good, although there were some gaps in non-urgent care. They reported that a 40% vacancy rate had affected the ability to deliver services in 2022 but all vacancies had since been filled. Pharmacy services were safe and effective but risk assessments were not always followed adequately, including those for some prisons who had daily in-possession medication. Inspectors found that prisoners not attending for medication were usually followed up robustly.

26. Inspectors reported that the availability of key work sessions was better than at other local prisons, with 69% of prisoners saying they had a key worker and 61% saying the sessions were helpful. Inspectors found that most key work sessions were delivered by the same person.

27. The prison had a clear commitment to equality and diversity with an appointed equality manager and an equality action plan. The Governor chaired an Equality Assurance meeting every two months but inspectors found little evidence that analysis of data provided led to any action. There had been 61 discrimination incidents in a six-month period to which the prison provided an adequate response, although inspectors noted investigation into the incidents was limited.

Independent Monitoring Board

28. 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 31 December 2020, the IMB reported concerns about the standard of accommodation and pressures on mental health services due to severely mentally ill prisoners arriving from the courts. They were also concerned about the impact of staffing levels on the delivery of key work sessions.

Previous deaths at HMP Leeds

29. Mr Akeel was the 31st prisoner to die at Leeds since December 2019. Of the previous deaths, 18 were due to natural causes, ten were self-inflicted, one was drug related, and one is awaiting classification. There have been seven deaths since of which four were self-inflicted and three were due to natural causes. We found no evidence that there was a disproportionate number of Asian men taking their own lives at Leeds.

30. In a previous investigation at Leeds, we found that the prisoner's mental health care was not equivalent to that which he could have expected to receive in the community. We were told that changes had been made to the mental health referral process.

31. We have previously made recommendations about the operation of the key work scheme at Leeds. The prison told us that they had changed the allocation process so that it was based on location rather than using an auto allocation tool, with the aim that key workers would be more accessible and could have ad hoc conversations outside the allocated key worker time.

Key work scheme

32. The key work 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 system 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.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key work 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.

Key Events

33. Mr Akash Akeel was remanded into custody at HMP Leeds on 27 October 2022, charged with theft, stalking and harassment. The alleged offences were against his ex-partner who had a restraining order in place against him. Mr Akeel had been in prison many times before.

34. Reception staff noted a history of suicide attempts and self-harm and discussed this with Mr Akeel. He said that he had not tried to harm himself for a long time and had no current thoughts of suicide or self-harm. (Mr Akeel's records noted that he had attempted to hang himself in prison in 2019.) Mr Akeel had a history of depression and anxiety for which he had previously taken medication (mirtazapine) but was not currently taking it. He had no other mental health or substance misuse issues and staff had no concerns about him.

35. Mr Akeel told staff that he was racist and homophobic so could only share a cell with a heterosexual person of the same ethnicity. His cell sharing risk assessment (CSRA) was therefore assessed as high risk. After his induction, he was moved to a suitable shared cell on D Wing.

36. On 28 October, Mr Akeel had his first key work session with Officer A. Officer A noted that Mr Akeel was keen to speak to his family and did not want to engage with her.

37. On 30 October, Mr Akeel had his second key work session with Officer B. Mr Akeel asked to speak to a Listener (prisoners trained by Samaritans to provide emotional support to fellow prisoners) so Officer B discussed this with a male colleague who subsequently went to speak to Mr Akeel. He told Officer B that Mr Akeel was feeling better after they had spoken and that he had been embarrassed to talk to her because his offence was related to domestic violence. Officer B noted that she thought Mr Akeel would benefit from having a male key worker.

38. On 31 October, Mr Akeel had his third key work session with Officer C, another female officer. He asked if he could move to another wing with his current cellmate and she agreed to request this on his behalf. Mr Akeel moved to C Wing on 3 November.

39. On 18 November, Mr Akeel requested to restart mirtazapine medication for depression (which he had not been prescribed since 2021). Healthcare staff noted that his request would be reviewed by a doctor.

40. On 22 November, Mr Akeel had his fourth key work session with Officer D, another female officer. He told Officer D that he had no phone credit and needed to phone his family as his grandfather was unwell. She was unable to help him but said she would ask one of the wing supervising officers (SO). An SO later spoke to Mr Akeel and said she was unable to help him with emergency phone credit. She described him as ungrateful and displaying a poor attitude. A prison manager later approved emergency phone credit for Mr Akeel to contact his family.

41. On 29 November, Mr Akeel had his fifth key work session with Officer D. She noted that he did not want to engage with her and described him as ungrateful.

42. On 2 December, an Advanced Nurse Practitioner (ANP) carried out a telephone triage with Mr Akeel. He told her that he was having trouble sleeping, had no appetite and no concentration. He said that he was not having any visits but he had been in touch with his family by telephone. He was worried about his grandfather who had cancer. Mr Akeel said he had no thoughts of suicide or self-harm but the ANP did not use any assessment tools to establish his level of depression. She agreed to restart mirtazapine and prescribed a dose of 15mg for one week and then 30mg. She said that she expected Mr Akeel to have his medication in possession for seven days at a time. She planned that he would be reviewed again in four to six weeks.

43. On 16 December, a pharmacy technician noticed that Mr Akeel had not been collecting his mirtazapine medication. She was due to issue a 30mg dose and consulted a doctor to ask if she should do so, as he had not yet taken the lower 15mg dose. The doctor agreed Mr Akeel could start taking the 30mg dose. No further action was taken to find out why Mr Akeel had not been collecting his medication.

44. On 26 December, Mr Akeel had his sixth key work session with Officer E, another female officer. She noted that he had just woken up and did not want to engage with her. He said he was keen for the wing to return to normal regime the next day (after Christmas).

45. On the morning of 29 December, Mr Akeel had a telephone medication review with a nurse. He told her that staff were not unlocking him so that he could get his medication. The nurse noted in his medical record that he said he was still low in mood but did not have any thoughts of suicide or self-harm. The nurse told the investigator and clinical reviewer that she was unable to assess how the medication was working for him so she simply highlighted to the pharmacy department that staff needed to ensure that Mr Akeel was unlocked to collect his medication. She said she did not check what, if any, medication he had received since it was prescribed on 2 December (in fact he had not collected any medication). She expected that he would have a further review in two weeks.

46. On the evening of 29 December, Mr Akeel got into a fight with another prisoner. Staff moved him to the segregation unit under restraint and noted that he was compliant throughout. A nurse assessed him in the segregation unit. She noted he had received a bang to his head during the fight so she gave him head injury advice. He declined an ice pack for his injury. The nurse noted that he had no mental health or substance misuse concerns and she considered he was fit for segregation. She said she had reviewed Mr Akeel's medical notes before she assessed him but she had not noticed the entry which stated he had not been receiving his mirtazapine. She noted that he would be assessed the following morning by a general nurse or a mental health nurse (but this did not happen).

Events of 30 and 31 December

47. On 30 December, Mr Akeel was due to be checked by healthcare staff in the segregation unit. A healthcare assistant made a note in his medical record that she tried to see him but he refused. It is not clear why she was trying to see him but, as

a healthcare assistant, she would not have been the qualified nurse responsible for assessing him in the segregation unit.

48. Later that day, staff moved Mr Akeel from the segregation unit to a different cell on E Wing. Due to Mr Akeel's involvement in the fight, a custodial manager (CM) reviewed his incentives and earned privileges (IEP) status and reduced it to basic level. The CM also removed Mr Akeel's television for seven days and scheduled a review of his IEP status for 5 January. Due to his high risk CSRA, Mr Akeel was placed in a cell on his own. Prior to going into the segregation unit he had been in a shared cell.

49. Around 10.00am on 31 December, a prison manager chaired a disciplinary hearing for the charge of fighting. Mr Akeel told her that the fight occurred after he went to the other prisoner's cell to return some music CDs and they argued. He pleaded guilty to the charge. The manager noted a negative conduct report on C Wing, stating that he had difficulty following instruction and was often rude and disrespectful to staff. She said Mr Akeel agreed that a move to a different wing would be beneficial to him and she noted he had already moved to E Wing where he could have a fresh start.

50. The manager told Mr Akeel that she would impose a minimum punishment and he could keep his television. However, Ms Littlewood said she did not know that the CM had already removed Mr Akeel's television under the IEP process. As the adjudication and IEP processes are different, she could not have reversed the CM's decision in any case. Mr Akeel would not have been aware of this difference. The manager said that she had no concerns about Mr Akeel and, when he left the room, he was smiling and wished her a happy new year.

51. At around 4.50pm, Mr Akeel pressed his cell bell and an officer responded. Mr Akeel wanted to know when he could have his television as the manager had told him during his adjudication that he could keep it. The officer said he told Mr Akeel he would need to check with managers and get confirmation of this before his television could be returned. He said Mr Akeel seemed satisfied with the response.

52. In-cell telephone records show that Mr Akeel used his phone at 7.27pm. The investigator listened to Mr Akeel's calls. (All calls made by prisoners using the prison telephone system are recorded and staff listen to a selection either based on intelligence or suspicion, or at random. There is no evidence that staff had listened to any of Mr Akeel's calls before his death.) The call at 7.27pm lasted only a few seconds. Mr Akeel said 'I've only gone and done it' and sounded distressed, but would not explain what he meant. His partner asked what he had done and said she would call the prison. Mr Akeel then hung up. There is no record that Mr Akeel's partner did call the prison that evening.

53. Around 8.00pm on 31 December, an officer was carrying out the evening routine check when she came to Mr Akeel's cell and found that the observation panel was covered with tissue. She knocked on the door and tried to get a response from him but he did not respond. She alerted an operational support grade (OSG), and he came to the cell to try to get a response from Mr Akeel. At around 8.05pm, after failing to get a response, the officer called a code blue (a medical emergency code which tells the control room that a prisoner is unresponsive or not breathing and an ambulance is required immediately). The officer and the OSG tried to get into the

cell but it was blocked by a privacy board which delayed their entry. Once in the cell, they found Mr Akeel suspended from the top bunk. He had used a sheet as a ligature. Staff cut the ligature and started cardiopulmonary resuscitation (CPR) while waiting for healthcare staff to arrive.

54. Healthcare staff arrived around 8.08pm and took over CPR. Ambulance staff arrived at 8.14pm and continued attempts to resuscitate Mr Akeel. However, they were unable to do so and at 8.56pm, confirmed that he had died.

Information received after Mr Akeel's death

55. Mr Akeel had been making telephone contact with his partner, despite there being a no contact order in place. He managed to do this by providing the prison with a different name and number for his partner. In the days leading up to his death, he told his partner that he was going to take his life but she dismissed this. He told her he was unhappy about the outcome of his disciplinary hearing and being moved to a different wing with no television.

Contact with Mr Akeel's family

56. Shortly after midnight on 1 January 2023, the prison's family liaison officer and the prison's imam visited the home address of Mr Akeel's mother and brother to break the news of his death. The prison contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

57. 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 also offered support.

58. The prison posted notices informing other prisoners of Mr Akeel's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Akeel's death.

Post-mortem report

59. The post-mortem report concluded that Mr Akeel died from hanging. Toxicology results are not yet available.

Findings

Assessment and management of Mr Akeel's risk

60. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others or from others (Safer Custody)*, requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures.

61. Mr Akeel had been in prison many times before and had last been released from prison in November 2021. He had not been subject to ACCT monitoring since May 2019 and there was no evidence that he had self-harmed or attempted suicide since that time. Staff identified that he had no substance misuse issues but he had a history of depression and anxiety for which he had previously taken medication. Although staff did not make a mental health referral at that time, they ensured that Mr Akeel was aware of how to raise any mental health concerns, which he subsequently did on 18 November. We consider that staff assessed Mr Akeel's risk appropriately on reception and reasonably concluded that he did not require the support of ACCT monitoring at that time. We found no evidence that Mr Akeel required the support of ACCT monitoring at any other time. Although Mr Akeel expressed suicidal thoughts to his partner on the telephone in the days before his death, staff would not have been aware of this as there was no reason for them to monitor his calls and his partner did not inform the prison.

Clinical care

62. When the ANP carried out a telephone triage assessment with Mr Akeel on 2 December, she agreed to restart mirtazapine but she did not make a referral to the mental health team. She told the investigator and clinical reviewer that she was not a mental health nurse but she considered there was no need for a mental health referral. However, the Head of Healthcare said that she would have expected a mental health referral to be made in circumstances where medication for anxiety and depression was considered necessary. The clinical reviewer also considered that a mental health referral should have been made given that Mr Akeel had a history of mental health issues.

63. The clinical reviewer also noted that no consideration was given to undertaking any standardised assessment tools or assessments of risk, such as the Correctional Mental Health Screen for men (a tool designed to assist in the early detection of psychiatric illness during the prison intake process).

64. Mr Akeel never collected his antidepressant medication before he died. It is unclear whether the ANP, the prescriber, explained to him what he needed to do to collect his medication. This was not followed up when a pharmacy technician noted two weeks later that Mr Akeel had not collected his medication. It was again not properly followed up on 29 December, when it was identified during a medication review that Mr Akeel had not collected his medication. Although the nurse told the pharmacy, no further action was taken.

65. The clinical reviewer concluded that Mr Akeel's mental health care was not equivalent to that which he could have expected to receive in the community. We make the following recommendations:

The Head of Healthcare should review the procedures in place for assessing the mental health needs of prisoners who have requested mental health support.

The Head of Healthcare should review processes to ensure prescribed treatments are effectively administered and issues are promptly resolved.

Key work

66. Within his first four days at Leeds, because he moved between different units, Mr Akeel had three key work sessions with three different female officers, all introducing themselves to him as his key worker. We consider the timing of these sessions at almost daily intervals was unnecessary and would have been confusing for Mr Akeel. After he moved to C Wing, Mr Akeel had a further three sessions with two different female officers.

67. Although Officer B noted at the second key work session that she thought Mr Akeel would benefit from having a male key worker, he continued to have female key workers, who reported that Mr Akeel was not willing to engage with them and that he had a poor attitude.

68. Since Mr Akeel's death, the prison has undertaken work to address shortcomings in the provision of key work. The Acting Head of Recovery set out the current activities:

- The formulation of guidance to staff on responding to prisoner non-engagement with key work.
- Work on the induction unit to improve the provision of key work.
- Rolling out a priority group scheme to ensure that prisoners with specific risk factors, such as high risk cell sharing, are prioritised for key work.
- Trialling a new quality assurance process to provide robust feedback to key workers.
- Monitoring key work compliance (53% of key work sessions were delivered in June 2023, compared with 20% in December 2022.)

69. We are pleased to note the focus on improving key work at Leeds and, as a result, make no recommendation.

Governor to note

Segregation

70. While we consider that it would not have changed the decision that Mr Akeel was fit for segregation, we note that the nurse who carried out the segregation health screen did not notice that Mr Akeel had not been taking his antidepressant medication. She should have known this from a review of the medical records.

Removal of television

71. When Mr Akeel was involved in a fight on 29 December, staff automatically downgraded him to basic regime in accordance with the prison's violence reduction policy and removed his television.

72. The manager did not know that this had happened when she told him that she would not remove his television under the adjudication process. Clearly this was confusing for Mr Akeel. Access to a television, particularly when the prisoner is in a single cell, on New Year's Eve and at times when the regime is limited (such as over public holidays) can be a distraction and therefore a protective factor against suicide. However, given Mr Akeel had not been identified as vulnerable or at risk, and given that removal of his television was appropriate under the IEP process, we consider staff actions were reasonable.

Autism and learning disability

73. We found some historic evidence in Mr Akeel's medical notes that he may have had autism spectrum disorder and possibly other learning disabilities, although he had no formal diagnosis. This could have impacted on Mr Akeel's ability to engage with staff in the typical way they might expect. Staff described him as ungrateful, unwilling to engage, and with a poor attitude. It is possible that had they been aware of his history of possible autism and learning disabilities they might have had a better understanding of his behaviour and communication needs.

Inquest

74. The inquest, held from 27 to 29 January 2025, concluded that Mr Akeel died by suicide.

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

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T l 020 7633 4100