Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mehdi Ghorbani, a prisoner at HMP Leeds, on 11 May 2023

A report by the Prisons and Probation Ombudsman

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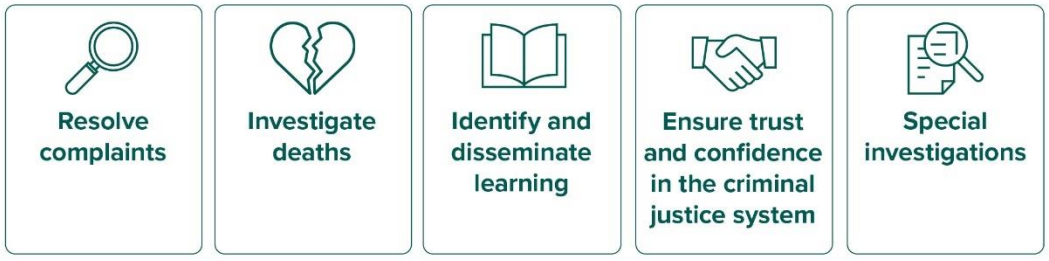
OUR VISION

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 Medhi Ghorbani was found hanged in his cell on 11 May 2023 at HMP Leeds. He was 44 years old. I offer my condolences to Mr Ghorbani's family and friends.

Mr Ghorbani was the fourteenth prisoner to die by suicide at Leeds in three years. Up to the end of 2023, there had been one self-inflicted death since Mr Ghorbani's death.

Mr Ghorbani was a vulnerable prisoner who preferred to spend time alone. While he spoke good English, his first language was Arabic, and he had very little family support during his time at Leeds.

When he arrived at Leeds in January 2023, staff recognised that Mr Ghorbani was at risk of suicide and self-harm and supported him using suicide and self-harm prevention procedures (known as ACCT). We found that staff managed the ACCT procedures well.

Mr Ghorbani's behaviour deteriorated from March. My investigation found that staff did not fully explore the change in Mr Ghorbani's behaviour. However, in the weeks before his death, Mr Ghorbani's behaviour improved and there was no indication that he was at imminent risk of suicide when he died.

The clinical reviewer concluded that the care Mr Ghorbani received at Leeds was of a good standard and equivalent to what 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 **September 2024**

Contents

Summary

Events

1. In 2017, Mr Medhi Ghorbani was convicted of rape and sentenced to ten years in prison. He was released in December 2022. In January 2023, Mr Ghorbani was recalled to HMP Leeds after he failed to comply with the conditions of his licence.

2. Mr Ghorbani was Iranian and while he preferred to speak Arabic, he spoke good English. He was a vulnerable prisoner due to the nature of his offence. His family lived in Iran, and he had no family support in the UK. He made no phone calls and received no visits while in prison. Due to his history of racist behaviour, staff decided that Mr Ghorbani could only share a cell with a prisoner of the same ethnicity.

3. Prison staff managed Mr Ghorbani under Prison Service suicide and self-harm prevention measures (known as ACCT) when he arrived at Leeds after he told staff he intended to self-harm in prison.

4. From 1 March, Mr Ghorbani's behaviour deteriorated. He accessed the safety netting that separated the wing landings, received conduct warnings for failing to attend work and was downgraded to a basic regime (meaning certain privileges were removed) after he damaged prison property. Staff referred Mr Ghorbani for a challenge, support and intervention plan (CSIP – a process used to manage difficult prisoners and victims of violence or threat) and provided regular keywork sessions to support him.

5. On 4 May, a custodial manager decided that Mr Ghorbani was suitable for the standard regime. His behaviour had improved, he appeared well presented and said he intended to apply for another job.

6. At 9.45am on 10 May, Mr Ghorbani left his cell for association (social time). At 11.52am, he told a prison officer that he was not hungry and did not want his lunch. Mr Ghorbani refused his dinner at 4.45pm.

7. An operational support grade (OSG) completed the evening routine check at 8.08pm. Mr Ghorbani was watching television in his cell. This was the last time Mr Ghorbani was seen alive.

8. At 5.25am on 11 May, the OSG went to Mr Ghorbani's cell to complete the morning routine check. He saw Mr Ghorbani had ligatured from his cell window. The OSG immediately called a medical emergency code, went into the cell and cut the ligature. Staff decided not to start cardiopulmonary resuscitation (CPR) because it was clear that Mr Ghorbani had died. Healthcare staff arrived shortly after and agreed that CPR was not appropriate. Ambulance staff arrived at 5.32am and confirmed that Mr Ghorbani had died.

Findings

9. ACCT procedures provided good support to Mr Ghorbani. Case reviews were multi-disciplinary and care map actions reflected his mental health needs, his concerns about medication and the need to gain suitable employment.

10. After his behaviour deteriorated, Mr Ghorbani received conduct warnings. While staff made CSIP referrals and held regular keyworker sessions, they did not fully explore the change in Mr Ghorbani's behaviour, consider if he should be referred to the safety intervention meeting and the mental health team or offered additional support on the wing.

11. There was no indication that Mr Ghorbani was at imminent risk of suicide in the days leading to his death. His behaviour had improved, and he had returned to the standard regime. While Mr Ghorbani refused his meals on 10 May, staff did not consider that this was unusual behaviour.

12. The clinical reviewer concluded that Mr Ghorbani's mental health care was equivalent to what he could have expected to receive in the community. Mental health nurses attended ACCT reviews and completed a mental health assessment when Mr Ghorbani asked for support.

The Investigation Process

13. HMPPS notified us of Mr Ghorbani's death on 11 May 2023.

14. 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.

15. The investigator visited Leeds on 8 June. She obtained copies of relevant extracts from Mr Ghorbani's prison and medical records and spoke to three prisoners.

16. The investigator interviewed two members of staff at Leeds between August and September 2023

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

18. We informed HM Coroner for West Yorkshire 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. We wrote to Mr Ghorbani's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Ghorbani's family did not ask any questions but asked for a copy of our report.

20. Mr Ghorbani's family received a copy of the initial report. The solicitor representing the family did not raise any further issues, or comment on the factual accuracy of the report.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Leeds

22. 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

23. 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 had done to address this major issue. Inspectors reported reduced levels of violence since the last inspection with significantly fewer prisoners saying that they felt unsafe.

24. Inspectors reported that mental health services were good, although there were gaps in non-urgent care. They reported that a 40% staff 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 prisoners who had daily in-possession medication. Inspectors found that prisoners who were not collecting their medication were usually followed up robustly.

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

Independent Monitoring Board

26. 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 2022, the IMB reported that they considered the prison to be a safe place for prisoners. However, the number of self-inflicted deaths was a concern.

Previous deaths at HMP Leeds

27. Mr Ghorbani was the thirty third prisoner to die at Leeds since May 2020. Of the previous deaths, 18 were due to natural causes, 13 were self-inflicted and one is awaiting classification. Up to the end of 2023, there had been one self-inflicted death since Mr Ghorbani's death.

28. As a result of the number of self-inflicted deaths, Leeds is receiving support and monitoring from HMPPS headquarters.

Assessment, Care in Custody and Teamwork

29. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Incentives and Earned Privileges (IEP) Scheme

30. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

Challenge, Support and Intervention Plan

31. A challenge, support and intervention plan (CSIP) is the national case management model for managing those who are violent or pose raised risk of harming others through violent behaviour.

32. It works alongside the zero-tolerance approach by challenging violent behaviours and setting clear expectations on what behaviours are not acceptable and making sure that punitive measures are not applied in isolation, placing equal focus on ensuring individuals with challenging behaviours, so they can progress towards a more positive outlook where they choose not to reoffend.

33. CSIP should be targeted at those individuals who display more challenging violent behaviours or those who show signs they are highly likely to display this behaviour. These challenging behaviours could be identified by the nature or frequency of their violence, or the extent to which their behaviour strongly indicates that they are likely to display more challenging violent behaviours. It is important that CSIP is never used in place of an ACCT plan.

Key Events

34. On 11 August 2017, Mr Medhi Ghorbani was convicted of rape and sentenced to eight years in prison. He was sent to HMP Leeds. He spent time in several prisons before he was released on licence from Leeds on 13 December 2022. Mr Ghorbani was recalled to prison on 28 January 2023 after he failed to comply with the conditions of his licence.

35. Mr Ghorbani arrived in England in 2006 from Iran. He was confirmed as a British citizen in 2017. While Mr Ghorbani's preferred spoken language was Arabic, he spoke good English. Mr Ghorbani did not make any telephone calls or receive any visits during his time in prison.

HMP Leeds

36. When Mr Ghorbani arrived at Leeds on 28 January, prison staff completed a cell sharing risk assessment (CRSA). This recorded that Mr Ghorbani was a high risk for sharing a cell because he had demonstrated racist behaviour towards other prisoners. The CRSA said that Mr Ghorbani could share a cell with a prisoner who shared the same ethnicity. A prison officer completed Mr Ghorbani's first night induction interview. He noted that Mr Ghorbani was known to prison staff at Leeds, he engaged well and was aware of the support available to him. He did not express any thoughts of suicide and self-harm. Mr Ghorbani was allocated a keyworker who completed regular welfare checks.

37. A nurse completed Mr Ghorbani's initial health assessment and noted his history of depression and anxiety. Mr Ghorbani said he also suffered from epilepsy. He was prescribed antidepressant medication and medication to treat his epilepsy which he was not allowed to keep in his cell. The nurse made a referral to the mental health team. Mr Ghorbani said that he had attempted suicide by ligature two months previously and intended to self-harm in prison.

ACCT: 28 January- 20 February

38. At 6.00pm on 28 January, an officer started ACCT monitoring and decided that staff should monitor Mr Ghorbani twice an hour, have three quality conversations during the day and monitor him five times during the night.

39. Mr Ghorbani told the officer at his ACCT assessment that he had attempted to hang himself two weeks before he came into prison and had not yet received his antidepressant medication from healthcare.

40. On 29 January, a Senior Officer (SO) held an ACCT case review with a mental health nurse and Mr Ghorbani. The SO noted that Mr Ghorbani's parents lived in Iran, and he had no family in this country. He preferred to be in a cell on his own and asked to move to F wing, the vulnerable prisoners' wing. Mr Ghorbani said he was Muslim and wanted to see the Imam. The SO noted that Mr Ghorbani was unable to do some jobs due to his epilepsy and he should ask staff about suitable roles. She added four actions to Mr Ghorbani's caremap (designed to identify the main areas of concern and the actions required to reduce risk): staff should contact

healthcare about Mr Ghorbani's prescribed medication, Mr Ghorbani should engage with the mental health team, see the Imam and gain suitable employment. She assessed Mr Ghorbani's risk as medium and decided that his observations would remain unchanged.

41. On 30 January, a Custodial Manager (CM) held an interim case review after a self-inflicted death in the prison. Mr Ghorbani asked when he would move to F wing but did not have any other concerns. The CM explained that he would move when a place became available.

42. On 2 February, a nurse completed a mental health assessment. She noted that Mr Ghorbani did not have any mental health concerns or issues related to his diet, sleep, self-care, substance misuse or bullying. Mr Ghorbani was aware of the support available to him and declined further input from the mental health team. That day, Mr Ghorbani moved to a shared cell on F wing, with a prisoner of the same ethnicity. An officer was appointed as his keyworker. The officer retired from HMPPS shortly after Mr Ghorbani's death and did not respond to our request for an interview.

43. During a case review with a SO and a nurse on 7 February, Mr Ghorbani said that he felt settled on F wing and was receiving his prescribed medication. He was taking part in wing activities and had no current thoughts of suicide and self-harm. Mr Ghorbani said he did not have anything in common with his cellmate, and the SO said she would make wing staff aware, which she did. She assessed Mr Ghorbani's risk as low and reduced his observations to one irregular observation every two hours. The frequency of conversations remained unchanged.

44. On 8 February, Mr Ghorbani started work in the sewing workshop.

45. On 13 February, the SO held a case review with a nurse and Mr Ghorbani. She noted that Mr Ghorbani engaged well and was in good spirits. Mr Ghorbani said that he would now be serving two years until the end of his sentence. He was receiving good support from prison staff, got on well with his cellmate and had no current thoughts of suicide and self-harm. Prison staff agreed to stop ACCT monitoring. Staff assessed Mr Ghorbani's risk as low and the actions on his caremap were complete. The post-closure phase would end on 20 February.

46. On 17 February, the results of a routine mandatory drugs test showed that Mr Ghorbani tested positive for cannabis. A nurse made a referral to the substance misuse service.

47. During an ACCT post-closure case review on 20 February, prison staff noted that Mr Ghorbani remained settled on F wing, was attending English classes and continued to work. He said he had no current thoughts of suicide and self-harm and was aware of the support systems place.

20 February-10 May

48. During a substance misuse assessment on 22 February, Mr Ghorbani agreed to attend the drug and alcohol recovery group to offer him support on relapse prevention strategies.

49. On 1 March, staff noted that Mr Ghorbani was showing no interest in his job and spent most of his time reading a book. Staff described Mr Ghorbani as a loner who rarely spoke to staff or other prisoners.

50. On 9 March, Mr Ghorbani climbed onto the landing safety netting for approximately 20 minutes. Because this is dangerous (and against prison rules), staff gave him an Incentives and Earned Privileges (IEP) scheme warning (meaning he was at risk of having reduced access to some in cell items and other privileges) and submitted a CSIP referral form. An officer from the safer custody team decided that the incident would not be investigated under the CSIP process. They noted that Mr Ghorbani was frustrated because he was unable to access the money in his community bank account. Prison staff said they would send a referral to The Growth Company (a support service for prisoners who need help with financial issues). Mr Ghorbani also wanted to be in a single cell because he was not getting on with his cellmate. Prison staff moved Mr Ghorbani's cellmate to another cell on 14 March. As Mr Ghorbani's CSRA said he could only share a cell with a prisoner of the same ethnicity, he lived in a cell on his own until his death.

51. On 21 March, Mr Ghorbani asked to see the mental health team to discuss his anxiety and depression.

52. Mr Ghorbani attended a meeting with an advisor from The Growth Company. Mr Ghorbani said he was not in debt and was able to budget his money. He asked for support with managing his community bank account. The advisor wrote to Mr Ghorbani's bank on 6 April to enable the prison's finance department to access his account.

53. On 31 March and 4 April, prison staff gave Mr Ghorbani an IEP warning for refusing to attend work. Mr Ghorbani told prison staff that he did not have any issues and felt tired.

54. On 5 April, a mental health nurse saw Mr Ghorbani. She noted that he engaged well and did not display any signs of psychosis. Mr Ghorbani was not distressed or agitated, and his personal hygiene was good. The nurse discharged Mr Ghorbani from the mental health service.

55. On 13 April, Mr Ghorbani smashed the television in his cell. Prison staff placed Mr Ghorbani on the basic regime and set him four targets: to comply with all instructions given by staff, not to receive any negative IEP warnings or adjudications, to be respectful towards staff and not to damage prison property. Prison staff gave Mr Ghorbani a radio. An IEP review was arranged for 20 April. There is no record that the review took place.

56. On 14 April, Mr Ghorbani flooded his cell and damaged his sink. Mr Ghorbani told staff he wanted to move to another cell on a different landing. Prison staff submitted another CSIP referral. An officer from Safer Custody saw Mr Ghorbani and noted that staff had not raised concerns that he was isolated or vulnerable. Mr Ghorbani was calm and said he did not have any issues. The officer decided that the incident would not be investigated further under CSIP. Mr Ghorbani moved to another single cell.

57. Mr Ghorbani was subsequently found guilty of damaging prison property at a disciplinary hearing on 17 April and his punishment was loss of access to the prison shop for 14 days. Mr Ghorbani told prison staff that he had damaged his cell because he wanted to move upstairs where it was less noisy.

58. On 17 April, a GP at the prison saw Mr Ghorbani after he asked to see the mental health team because he felt anxious. Mr Ghorbani said he did not have any current thoughts of suicide and self-harm but was having difficulty sleeping. He said that he was taking his medication regularly and his last epileptic seizure was a few months previously. The GP made a referral to the mental health team.

59. An officer held a keyworker session with Mr Ghorbani on 21 April. He noted that the cell was untidy with a strong odour. Mr Ghorbani said he understood that his behaviour was unacceptable and told the officer that he was listening to music on his radio and felt well. He agreed to clean his cell and open the windows.

60. On 24 April, a mental health nurse completed a mental health assessment. Mr Ghorbani said he had no current thoughts of suicide and self-harm. He was well presented, calm and appeared to concentrate well. She noted that there was no evidence of a low mood or anxiety. Mr Ghorbani was discharged from the mental health service.

61. On 1 May, an officer held a keyworker session. Mr Ghorbani said that he was getting on well and did not have any issues. The officer noted that Mr Ghorbani was still on the basic regime and encouraged him to continue to behave well.

62. On 4 May, a CM held an IEP review. She noted that Mr Ghorbani's behaviour had improved. He had not received any IEP warnings and he engaged well with staff. Mr Ghorbani said he wanted to work, and he intended to apply for a new job. She decided that Mr Ghorbani should be returned to a standard regime.

63. Over the next few days, prison staff completed routine welfare checks on Mr Ghorbani and did not note any concerns.

Events of 10 and 11 March

64. At 9.45am on 10 May, CCTV showed Mr Ghorbani returning to his cell from the exercise yard. At 11.52am, Officer A unlocked Mr Ghorbani's cell for lunch. Mr Ghorbani told him that he was not hungry and pushed his cell door shut from the inside. Mr Ghorbani left his cell shortly after and asked to borrow a vape from another prisoner. The investigator spoke to that prisoner, who said that Mr Ghorbani did not have friends on the wing and spent most of his days reading in his cell. The prisoner said that Mr Ghorbani's request for a vape was their only interaction.

65. Mr Ghorbani returned to his cell where he remained until 4.36pm, when Officer A unlocked his cell for dinner. Mr Ghorbani refused his meal and again shut his cell door from the inside. The officer returned to Mr Ghorbani's cell at 4.45pm, but Mr Ghorbani said that he was not hungry. An Operational Support Grade (OSG) made an entry in the wing observation book that Mr Ghorbani had refused his meals. Mr Ghorbani remained in his cell and staff did not note any concerns.

66. Officer A told the investigator that it was not unusual for Mr Ghorbani to refuse his meals. He described Mr Ghorbani as a quiet man who preferred to remain in his cell alone. He did not consider that Mr Ghorbani should be managed under the food refusal policy.

67. At 8.08pm, the OSG completed the evening routine check. In a written police statement, he said that Mr Ghorbani was in his cell watching television and did not raise any concerns. This was the last time Mr Ghorbani was seen alive. Mr Ghorbani did not ring his cell bell during the night.

68. At 5.25am on 11 May, the OSG went to Mr Ghorbani's cell to complete the morning routine check. He looked through the observation panel and saw Mr Ghorbani ligatured from his cell window. He radioed an emergency code blue (indicating a prisoner is unconscious or has breathing difficulties). Control room staff called an ambulance immediately.

69. Staff immediately responded and arrived at 5.27am. A CM opened the cell door and entered the cell. An officer cut the ligature from Mr Ghorbani's neck. In a statement, the CM said that Mr Ghorbani was rigid, his skin was grey, he felt cold, and he could not find a pulse. He believed that rigor mortis was present. A nurse arrived and agreed that staff should not start CPR. Paramedics arrived at 5.32am and confirmed that Mr Ghorbani had died.

Contact with Mr Ghorbani's family

70. On 11 May, the prison appointed a family liaison officer (FLO). He identified Mr Ghorbani's father as his next of kin. As Mr Ghorbani's father did not speak English, Mr Ghorbani's family asked a family friend to act as the family contact.

71. The FLO arranged for Mr Ghorbani to be repatriated to Iran. The prison contributed towards the cost of Mr Ghorbani's funeral in line with national policy.

Support for prisoners and staff

72. 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 and on a case by case basis after all other types of 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.

73. After Mr Ghorbani'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 also offered support.

74. The prison posted notices informing other prisoners of Mr Ghorbani'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 Ghorbani's death.

75. Safer custody staff gave prison listeners and the wing manager postvention leaflets to share with prisoners and staff.

Post-mortem report

76. The pathologist gave Mr Ghorbani's cause of death as hanging. A toxicological analysis did not detect any illicit substances in Mr Ghorbani's blood.

Findings

Assessment of Mr Ghorbani's risk

77. Mr Ghorbani had a number of risk factors that increased his risk of suicide and self-harm. He had been recalled to prison within the last four months. He was a vulnerable prisoner both due his offence and because English was not his first language, and he had no contact with friends or family. He made no phone calls and received no visits. Despite being able to share a cell with a prisoner of the same ethnicity, he preferred to be in a cell alone. Mr Ghorbani was often disconnected from other prisoners with little social support.

78. Mr Ghorbani was supported by ACCT procedures when he arrived at Leeds, after he told staff he had attempted suicide in the community and intended to self-harm in prison. We consider that the ACCT procedures provided good support to Mr Ghorbani. Staff held regular multidisciplinary case reviews which appropriately assessed his risk. They added actions to Mr Ghorbani's caremap which reflected his mental health needs, medication and the need to gain suitable employment. The ACCT was closed when staff assessed that Mr Ghorbani's risk had reduced and the caremap actions had been completed.

79. From 1 March, Mr Ghorbani's behaviour deteriorated. He refused to attend work, accessed the safety netting and there were two incidents of damaging prison property, which resulted in a downgrade to the basic regime. As Mr Ghorbani's behaviour was not violent, staff decided that he did not meet the criteria for CSIP However, they did not consider alternative supportive interventions, such as referral to the safety intervention meeting and the mental health team, additional keyworker sessions, purposeful activity or a wing buddy. This was a missed opportunity to fully explore the change in Mr Ghorbani's behaviour.

80. However, in the weeks leading up to his death, Mr Ghorbani's behaviour improved. He engaged well with staff, appeared well presented and he had been upgraded to standard regime. Staff did not consider that the decision to refuse his meals on 10 May was unusual behaviour for Mr Ghorbani and there was no indication that he was at imminent risk of suicide.

81. Since Mr Ghorbani's death, Leeds has introduced various measures to improve the quality of CSIP management, including a written summary to justify why a CSIP investigation is not appropriate. Staff also need to demonstrate that they have fully considered other supportive actions and how these could have a positive impact on a prisoner's behaviour. We make no recommendation.

Mental and clinical healthcare

82. The clinical reviewer concluded that Mr Ghorbani's mental and clinical healthcare was equivalent to what he could have expected to receive in the community.

83. Mr Ghorbani had a diagnosis of epilepsy. He was fully compliant with taking his medication and he did not have any seizures during his time at Leeds.

84. Mental health nurses attended Mr Ghorbani's ACCT case reviews. When Mr Ghorbani asked to see the mental health team, nurses saw him promptly and completed a mental health assessment.

85. The clinical reviewer considered that, overall, Mr Ghorbani received a good standard of care.

Governor to note

IEP reviews

86. Mr Ghorbani's IEP level was reduced to basic on 13 April after he smashed the television in his cell. Leeds' local IEP policy states that prisoners who are downgraded to basic after a serious single incident will have an IEP review after seven days to monitor their progress. This did not happen, and Mr Ghorbani remained on basic regime until 4 May. This was a missed opportunity to assess how Mr Ghorbani was coping on the basic regime and whether he was suitable to return to the standard IEP level. We bring this to the Governor's attention.

Good practice

87. The decision of prison and healthcare staff not to attempt cardiopulmonary resuscitation was appropriate and demonstrated that they were aware of the Resuscitation Council's guidelines on when resuscitation was likely to be futile and ensured that Mr Ghorbani's dignity was preserved.

Inquest

88. At the inquest held on 25 June 2024, the Coroner concluded that Mr Ghorbani died from hanging. The conclusion reached by the jury was that Mr Ghorbani committed suicide.

89. The Coroner concluded that the support Mr Ghorbani received from the prison service was appropriate and the healthcare provided was equivalent, however it was not clear if inadequate keyworker programme management, the discharge process from the mental health in-reach service, or insufficient communication between healthcare staff and prison staff contributed to Mr Ghorbani's death.

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