Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Zacaria Gauji, a prisoner at HMP Leeds, on 26 October 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 Zacaria Gauji, a Libyan national, was found hanged in his cell on 26 October 2023 at HMP Leeds. He was 37 years old. I offer my condolences to Mr Gauji's family and friends.

Mr Gauji's was the thirteenth self-inflicted death at Leeds in three years.

It is difficult to say how high Mr Gauji's risk of suicide and self-harm was and whether Leeds should have offered him more support because interpreting services were used so inconsistently. Leeds has recognised this failure in their management of Mr Gauji and begun to rectify the problem. However, staff reluctance or ignorance about how and when to use interpreting services, which are widely available, remains too regular an issue in the deaths of foreign national prisoners. HMPPS must do more to promote their use.

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 **April 2025**

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Summary

Events

1. On 19 December 2022, Mr Zacaria Gauji was remanded to prison charged with affray and possession of an offensive weapon. Mr Gauji was from Libya and spoke Arabic. His comprehension of and ability to speak English was inconsistently represented across his record.

2. On the 10 August 2023, Mr Gauji transferred to HMP Leeds from HMP Hull to attend court. Mr Gauji did not make any telephone calls or receive any visits during his time in prison.

3. Mr Gauji had been subject to suicide and self-harm prevention procedures (known as ACCT) at HMP Hull because he had made cuts to his chest. The ACCT had been closed 17 days before he transferred to Leeds.

4. Reception and healthcare staff at Leeds did not think that Mr Gauji needed an interpreter. They noted his history of self-harm but did not think that he needed ACCT support.

5. On 21 August, a mental health nurse assessed Mr Gauji and used interpreting services. The nurse did not consider that Mr Gauji needed any mental health intervention.

6. During the rest of August, Mr Gauji expressed some anxieties and smashed his cell up. On 1 September, a further mental health assessment was carried out, but the nurse did not use an interpreter. She did not consider Mr Gauji needed further assessment and closed the referral.

7. On 30 September, Mr Gauji was relocated to the Segregation Unit (used to keep prisoners apart from other prisoners) after smashing up his cell again. There is no record that nurses assessing his suitability for the unit used interpreting services.

8. On 19 October, Mr Gauji was moved to a standard residential wing. On 25 October, an Arabic-speaking officer was allocated as Mr Gauji's keyworker, but the officer was on night duties at the time, so another officer who did not speak Arabic took over the duty temporarily.

9. On 26 October, the temporary keyworker went to see Mr Gauji and found he had hanged himself. Another nearby officer called a medical emergency code. Prison and healthcare staff began CPR. The paramedics arrived at 3.25pm. They carried out life-saving techniques, but Mr Gauji was declared dead at 3.59pm.

Findings

10. Staff did not always use interpreting services as they should have done. It was therefore difficult to ascertain what risk Mr Gauji actually presented and whether a different decision about starting ACCT monitoring and his mental healthcare should have been made. Leeds is taking steps to improve staff use of the interpreting phone line service, Language Line.

11. The clinical reviewer concluded that the care Mr Gauji received at Leeds was equivalent to what he could have expected to receive in the community.

The Investigation Process

12. HMPPS notified us of Mr Gauji's death on 26 October 2023.

13. 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.

14. The investigator visited Leeds on 9 November. She obtained copies of relevant extracts from Mr Gauji's prison and medical records.

15. The investigator interviewed nine members of staff at Leeds on 15 and 17 January 2024.

16. NHS England commissioned a clinical reviewer to review Mr Gauji's clinical care at the prison. She carried out joint clinical interviews with the investigator.

17. 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.

18. The Coroner told us that Mr Gauji's passport was in the name Zakaria Gaouz and the post-mortem report was produced in that name. As the deceased was remanded in the name of Zacaria Gauji, we have used that name in our report.

19. The Ombudsman's office contacted Mr Gauji's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

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

Background Information

HMP Leeds

21. HMP Leeds is a local prison for 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

22. 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 on 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.

23. 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.

24. Inspectors reported that the availability of keywork 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 keywork sessions.

25. In August 2023, HMIP published a review of progress at Leeds. They found the establishment had the second highest rate of self-inflicted deaths of any prison in England and Wales. Leaders were struggling to focus on key issues when they had over 100 recommendations from the various inspections, audits and reviews conducted because of those deaths. Action to deal with self-harm had started too late and prisoners had limited time out of their cells.

26. However, for those prisoners able to access activity, the breadth of the education, and skills and work curriculums had improved. There was still a need to improve the provision of English, mathematics, and English for speakers of other languages to make sure that the high levels of need in the population were met.

Independent Monitoring Board

27. 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

28. Mr Gauji was the 33rd prisoner to die at Leeds since October 2020. Of the previous deaths 19 were from natural causes, 12 were self-inflicted and the cause of one death had not yet been established. Up to the end of September 2024, there had been three self-inflicted deaths since Mr Gauji's death.

29. 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

30. Assessment, Care in Custody and Teamwork (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.

31. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

Keywork

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

33. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the keywork 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

34. On 19 December 2022, Mr Zacaria Gauji was remanded to HMP Durham charged with affray and possession of an offensive weapon. Mr Gauji was originally from Libya, and the extent of his grasp of English was inconsistently recorded across the records. He had PNC (police national computer) warning markers for self-harm – in 2022, he had strangled himself to the point of unconsciousness while in a police custody cell.

35. On the 10 January 2023, Mr Gauji was transferred to HMP Hull where he was subject to suicide and self-harm prevention procedures (known as ACCT) on more than one occasion. He had made threats to kill himself, refused food and on one occasion staff found a noose in his cell. He spent time in the segregation unit (used to keep prisoners apart from other prisoners for reasons including because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison). He was often aggressive to staff. His last ACCT was open very briefly after he made cuts to his chest. The ACCT was closed on 23 July, with staff remarking he had never been more settled.

HMP Leeds

36. On the 10 August, Mr Gauji transferred to HMP Leeds because his court case was transferring to Bradford Crown Court.

37. A nurse carried out Mr Gauji's first night screen. She noted that an interpreter was not needed as he answered questions appropriately. She considered the Person Escort Record (PER - accompanies the individual as they move from or between police custody, court and prison and records details about risk) which noted Mr Gauji's history of aggressive behaviour and that he had been on an ACCT previously which was now closed. Mr Gauji said he had no thoughts of suicide but had some scars from some deliberate self-harm – he told her these were from over a year ago. She recorded that his mood was normal although he said he struggled with anxiety and depression and asked to be referred to the mental health team. She referred Mr Gauji to the mental health team but did not consider ACCT monitoring was necessary.

38. Prison reception staff did not use an interpreter when dealing with Mr Gauji. They noted he had self-harm markers on his PER but that they did not consider ACCT monitoring was necessary. They did not complete the defensible decision paperwork to explain how they had reached their decision. (At the time, this was expected where there were suicide and self-harm warnings on a PER, but now a defensible decision is expected for all new receptions at Leeds.)

39. A member of staff in the First Night Centre completed the Care in Custody form. They wrongly recorded that Mr Gauji had no self-harm history. They also ticked that he did not need any help in understanding English. A question about whether Mr Gauji had displayed any behaviour that may prompt concern for his mental health was ticked as yes, but the extra detail did not explain why.

40. Mr Gauji was initially placed on the Induction wing, D wing.

41. On 15 August, a nurse saw Mr Gauji after he had an altercation with another prisoner (he was not injured). She did not use an interpreter and at interview she said that she could not remember the incident, but used Language Line (a telephone interpreting service available to all staff working at Leeds) when she found it to be necessary. That day, another nurse carried out Mr Gauji's second screen. The record does not indicate whether she used an interpreting service.

42. On 18 August, a mental health nurse arrived on the wing to carry out Mr Gauji's triage assessment. The nurse ascertained that Mr Gauji did not speak English and rebooked the appointment for the 21 August so that they could use Language Line.

43. On 21 August, an officer carried out a keyworking session but did not use an interpreter. She recorded in Mr Gauji's prison record that she had explained the role of the keyworker and about the Induction wing. There is no record of anything Mr Gauji said.

44. That day, a nurse carried out the mental health triage using Language Line. He recorded that Mr Gauji suffered from depression, but Mr Gauji said his main concern was that prison officers were putting medicine in his food. The nurse asked him why he thought staff would target him, and he said it was because they wanted to take him back to his country where he feared he would be killed. Mr Gauji said that he was on hunger strike. The nurse reassured him and offered to arrange sealed meals, but Mr Gauji seemed inconsistent about his fears and said that he would only eat food that staff brought to his cell.

45. Mr Gauji said he had not had any prior contact with mental health services and did not want any antidepressant medication. The nurse described him as animated and well kempt, denying any thoughts of self-harm or suicide and was orientated to time and place. There was no evidence of visual or auditory hallucinations and the nurse recorded that no mental health intervention was necessary at that time and discharged Mr Gauji from the mental health team's care. The nurse said at interview that he did not think Mr Gauji's thoughts about food tampering were paranoid. Mr Gauji had had some issues with officers in the past and genuinely thought this was something they might do in retaliation. In addition, the nurse said that fears about being sent back to their country of origin were not unusual for people who have left an unsettled country.

46. On 24 August, an officer asked Officer A to talk to Mr Gauji, as he spoke Arabic. Mr Gauji told the officer that he believed people had been putting medication into his meals. The officer told him that did not happen at Leeds and Mr Gauji agreed he would collect his meals. He said he wanted to speak to Home Office immigration staff and the officer told him that the Foreign National Liaison Officer would come and speak to him. Mr Gauji also said he wanted to go to Friday prayers, and it is noted on the record that the Imam had been to see him, had put him on the list for prayers and was going to get him a new prayer mat and a prayer counter.

47. On 28 August, Officer A carried out another keyworker session. Mr Gauji again expressed concerns that his food was being tampered with and said he was throwing it away. He also reiterated his fears about being removed from the UK. He seemed tired but the officer summed up the session saying Mr Gauji was in great spirits.

48. Later that day, Mr Gauji smashed up his cell. Staff used force to remove him from the cell and placed him on the basic level of the incentives and earned privilege scheme (meaning he had reduced access to some in-cell items and other privileges). There

is no evidence that staff used an interpreter at the disciplinary hearing and or that anyone established why he had smashed his cell up.

49. On 1 September, a Supervising Officer (SO) emailed the mental health team asking someone assess Mr Gauji again. He had been discussed at the Safety Intervention Meeting (SIM- a weekly multi-disciplinary meeting to discuss prisoners who are at risk). The SO said Mr Gauji had exhibited disruptive behaviours such as cell damage and violence and was often seen to be speaking to himself in Arabic.

50. A mental health nurse responded and asked staff to consider referring Mr Gauji to chaplaincy as he may have been engaging in prayer when talking Arabic to himself. She also advised that Mr Gauji had already been assessed and they discharged him on 21 August. She asked for confirmation that Mr Gauji was eating his meals, but it is not clear what the response to that was.

51. That day, Mr Gauji was discussed at a multi-disciplinary team meeting. Afterwards, the mental health nurse went to see him and recorded that he used hand gestures and simple language to communicate. He described his mood as “so-so” but then “normal”. He responded positively when asked if he was ok and agreed to be weighed. He had only lost half a kilogram since his admission and the landing officer said he had been attending the servery and collecting his meals. The nurse closed the referral as she considered Mr Gauji did not need any further input. She sent a task to the primary care team who booked him for weekly weight monitoring.

52. On 18 September, Mr Gauji moved to B wing.

53. On 26 September, an officer carried out a keyworker session. She recorded that the conversation was sometimes limited and difficult but there is no evidence that she tried to use an interpreter. Her note implied that Mr Gauji had not understood the results of a previous disciplinary hearing. She also noted he told her he had maintained family ties and felt supported. There is no record Mr Gauji made any telephone calls or received any visits while at Leeds.

54. On 30 September, Mr Gauji was moved to the segregation unit after smashing his observation panel and causing other damage to his cell. He had also thrown food over his head while shouting in Arabic.

55. A nurse completed the Initial Segregation Health Screen (ISHS) and recorded that English was not Mr Gauji’s first language, so she was unsure how much he had understood. There are facilities to use Language Line in the segregation unit, but evidence indicates that she did not use it.

56. Health care staff assessed Mr Gauji regularly during his stay in the segregation unit. They considered him suitable for that location but never used an interpreter or interpreting services.

57. On 15 October, Mr Gauji refused to move to another cell in the segregation unit. Staff suspected that he had a weapon and they searched him and the cell. Staff used force to remove him and they removed his clothes under a modesty sheet during the search. This was a planned event but there is no record that staff used an interpreter to explain the procedures beforehand.

58. On 16 October, Mr Gauji was added to the Viper List – Viper is a violence predictor tool. Staff noted he was waiting for a place on an ESOL course (English for Speakers of Other Languages) and the Viper record said a member of the psychology team needed to see him (no further information about this was recorded). Officer A would help with communications because of the language barrier and also take over as his keyworker. A Custodial Manager (CM) would produce a full behavioural update and someone in the Offender Management Unit would find out about upcoming court dates. The target date for all these tasks to be completed was 1 November.

59. On 19 October 2023, Mr Gauji moved to a single occupancy cell on A wing on the basic IEP level. Officer A went to see Mr Gauji, who had some property questions.

60. On 20 October, a SO carried out Mr Gauji's use of force debrief. (The purpose of the debrief is to ensure a prisoner understands why force was used, in part to reduce further restraints. It also offers an opportunity to identify any learning that may help staff avoid the need to use force in the future.) The SO noted that segregation staff had told her that he understood more English than he let on. She noted that Mr Gauji would not engage with the debrief.

61. On 24 October, Mr Gauji's incentives level was upgraded to standard.

62. On 25 October, a SIM took place and attendees decided that although Officer A would be Mr Gauji's keyworker, while he was on nights another officer would cover as the keyworker.

Events of 26 October

63. At 11:45am, Mr Gauji went to the servery and returned to his cell at 11:49pm. Other prisoners told the police that Mr Gauji was talking to himself and had said that his head was a mess. Their opinion was that because Mr Gauji did not speak English, he did not understand what the rules and processes were surrounding meals.

64. Mr Gauji also spoke to Officer B, but the officer could not remember what about. At 11:57am, he spoke to Mr Gauji at his door, but again could not remember what about.

65. At 3:13pm, the keyworker went to Mr Gauji's cell to carry out a keywork session. He opened Mr Gauji's observation hatch and saw Mr Gauji hanging from the window bars by a ligature made from bed sheets. Officer B was stood nearby unlocking other prisoners for association (social time). The keyworker exclaimed in shock and Officer B then told him to move away from the door. The officer attempted to return as many prisoners as he could back to their cells and call for help. At 3:13pm, the officer radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties) and staff in the control room called an ambulance.

66. Officer B opened the cell door as soon as he saw other staff approaching and went into the cell with two officers. Officer B used an anti-ligature knife to cut the ligature and another officer supported the weight of Mr Gauji's body. They laid him on the floor and a CM, who had also responded to the code blue, started CPR.

67. At 3.15pm, healthcare staff arrived at the cell and took over compressions and life-saving techniques. Although the suction machine (to clear vomit from Mr Gauji's airway) was not working, staff used a manual technique to overcome this. A defibrillator advised there was no shockable rhythm.

68. Paramedics arrived at 3.25pm and took over care. They declared Mr Gauji's death at 3.59pm.

69. A police report said that the cell was extremely cold, and Mr Gauji was wearing two pairs of tracksuit bottoms, a pair of jeans and three jumpers. He did not leave a note.

Contact with Mr Gauji's family

70. On 27 October, the prison appointed a family liaison officer. Mr Gauji did not have a next of kin listed and staff had been trying to locate one since Mr Gauji's death, including by contacting the Home Office for any information but they were unable to help.

71. On 30 October, Officer A and the prison Imam, who both spoke Arabic, visited Bradford, where Mr Gauji had last lived, to try and track down anyone from his community who could help. They were able to locate his cousin, who wanted to break the news to Mr Gauji's mother who lived abroad.

72. Staff stayed in touch with the family, with the help of the Imam, and paid for the repatriation of Mr Gauji's body to Morocco.

Support for prisoners and staff

73. After Mr Gauji'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.

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

Post-mortem report

75. The post-mortem report concluded Mr Gauji died by hanging from a neck ligature. Toxicology examinations were not carried out.

Findings

Assessment of Mr Gauji's risk of suicide and self-harm

76. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm

77. When Mr Gauji arrived at Leeds, he had risk factors indicating he was at risk of suicide and self-harm. He had a history of self-harm and monitoring under ACCT procedures in prison, including up until 17 days before he moved to Leeds. His behaviour was sometimes volatile and violent and he displayed some signs of mental ill health.

78. Reception staff did not consider that he needed to be monitored under ACCT procedures on his arrival. We note that the HMPPS Early Learning Review carried out after Mr Gauji's death highlighted that staff should have completed a defensible decision log to explain how they reached that decision.

79. After that point, staff did not record any concerns about Mr Gauji's risk of suicide or self-harm. He was discussed in two SIMs but the primary concern appeared to be about his unpredictable and sometimes violent behaviour.

80. However, the extent to which Mr Gauji spoke and understood English is inconsistent across his records. We consider that there is sufficient evidence to indicate that he did not have a good level of English. Staff recorded that he used hand gestures and was limited to basic conversation and it is evident from the records that when the telephone interpreting service was used or he spoke to Arabic-speaking staff, his answers were fulsome and provided insight into his concerns that was simply not obtained when the exchange was in English. Given that staff rarely used the interpreting service we consider it would have been very difficult for them to have properly assessed his risk. We conclude that there was little evidence that Mr Gauji was at increased risk of suicide before his death but that was largely due to the failure to recognise the importance of using interpreting services.

81. Mr Gauji made no phone calls and received no visits in prison. He was known to talk Arabic to himself. We consider it quite likely that he felt isolated during his time at Leeds.

82. The investigator spoke to the Head of Safety and Equalities and the Head of Healthcare. Both agreed that use of the interpreting service could be improved. The Head of Healthcare had begun work to assess healthcare staff's confidence in using Language Line and whether they perceived any barriers to using it. She noted that recent audits had shown that the reception nurse had used Language Line in the past with other prisoners.

83. The Head of Safety and Equalities said the prison had ordered more telephone handsets and information packs to assist staff using Language Line. He said they

also planned to appoint a language lead whose responsibility would include creating and maintaining a log of all the languages staff in the establishment spoke

84. We note that managers had recognised that Mr Gauji would benefit from a keyworker who could speak Arabic. It is unfortunate that Officer A was on nights at the time Mr Gauji was in crisis.

85. Given the actions the prison is taking to address this issue, we do not make a recommendation.

86. We have raised the inconsistent use of interpreting services in a number of investigations into the self-inflicted deaths of foreign national prisoners. We have previously urged HMPPS to introduce a standard assessment of English so that it was not left to unqualified staff to judge a prisoner's ability to speak and comprehend sometimes complex processes and procedures.

Clinical care

87. The clinical reviewer concluded that the standard of care Mr Gauji received at Leeds was equivalent to that he could have expected to receive in the community. However, she noted that staffs' inconsistent use of interpreter services made it difficult to assess whether Mr Gauji required more help at certain points.

Good Practice

88. The prison Imam and Officer A went above and beyond to trace members of Mr Gauji's family. They visited his last home area and after speaking to members of the community obtained his cousin's details. The Governor will wish to recognise their efforts.

Inquest

89. At the inquest, held on 13 October 2025, the medical cause of death was determined to be hanging. A jury concluded the death was suicide.

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