Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Karar Ali Karar, a prisoner at HMP Leeds, on 5 September 2019

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 I 020 7633 4100
F I 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Karar Ali Karar died in hospital on 5 September 2019, after being found hanging in his cell in the segregation unit at HMP Leeds on 4 September. He was 29 years old. I offer my condolences to Mr Karar's family and friends.

I am concerned that staff under-estimated Mr Karar's risk to himself. Mr Karar had a number of significant risk factors for suicide and self-harm: he was facing a long sentence (a life sentence with a 25-year tariff); he spent 120 days in the prison's segregation unit, over two periods; he had mental health problems; and he spoke only limited English.

In addition, he may have been worried about being deported to Sudan, though I accept that there is no evidence that he explicitly said this to any staff, and I am concerned that prison staff were not aware of this during a failed attempt to transfer him to another prison shortly before he hanged himself.

I am also concerned that aspects of his segregation were not well managed: staff did not create a mental health care plan within 30 days; did not hold an initial case review when there were healthcare reasons not to segregate him; and did not complete certain Initial Segregation Health Screens accurately. Mistakes were also made when the Prison Group Director authorised Mr Karar's segregation beyond 42 and 84 days.

I also consider staff should have used an interpreter during complex discussions with him.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **December 2020**

Contents

Summary

Events

1. On 27 February 2019, Mr Karar Ali Karar, a Sudanese national, was remanded in prison custody, charged with murder, and sent to HMP Leeds.

2. The following day, Mr Karar attacked his cellmate with a kettle and had to be pushed back into the cell by staff when he repeatedly tried to get out. On 3 March, Mr Karar damaged his cell and staff moved him to the segregation unit, where he remained for three months.

3. From 29 March, a locum consultant psychiatrist saw Mr Karar on seven occasions for psychiatric observations. The psychiatrist spoke in Arabic for most of the observations, prescribed Mr Karar anti-psychotic medication and considered that his presentation was suggestive of an adjustment disorder.

4. On 23 May, the psychiatrist completed an urgent referral to consider Mr Karar's transfer to a secure psychiatric hospital. On 13 June, a psychiatrist attempted to complete an assessment, but Mr Karar refused to engage and she decided not to recommend that Mr Karar be transferred to hospital.

5. On 12 June, prison staff moved Mr Karar from the segregation unit to the prison's complex needs unit to try to create some progression for him.

6. On 9 and 14 August, Mr Karar allegedly sexually assaulted, respectively, a nurse and two prisoners.

7. On 15 August, Mr Karar was convicted of murder and sentenced to life imprisonment, with a minimum time to serve of 25 years and 117 days.

8. The following day, Mr Karar assaulted an officer and staff moved him back to the segregation unit.

9. At 8.25am on 4 September, officers tried to escort Mr Karar from the segregation unit to transfer him to HMP Hull but he assaulted an officer in reception. The officers restrained Mr Karar and took him back to the segregation unit.

10. At 9.58am, two nurses tried to check on Mr Karar, but he did not respond. They asked for staff assistance. At 10.01am, three officers entered Mr Karar's cell and found him hanging from a ligature. A nurse called a medical emergency code. They started cardiopulmonary resuscitation (CPR), inserted an airway and gave Mr Karar oxygen.

11. The control room called for an ambulance at 10.03pm. Paramedics took over the resuscitation attempt, found that Mr Karar's radial pulse had returned and took him to hospital. Mr Karar's condition continued to deteriorate and, at 12.40am on 5 September, a hospital doctor declared that he had died.

Findings

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

12. We are concerned that Mr Karar arrived in Leeds with a Suicide/Self-Harm Warning Form but an officer did not start Prison Service suicide and self-harm monitoring (known as ACCT).

13. We consider that staff underestimated Mr Karar's risk to himself during the time he spent in segregation.

14. We are also concerned that healthcare staff had concerns that Mr Karar was anxious about being deported but did not formally record this or share it with other staff, though we accept that there is no evidence that he explicitly said this to any staff. As a result, prison staff were not aware of this when they tried unsuccessfully to move him to another prison shortly before he hanged himself.

Segregation

15. Mr Karar spent 120 days in the segregation unit, over two periods. During the first, staff did not create a mental health care plan that could be shared with prison staff within 30 days, there was a missed opportunity to hold a Medical Recommendations Against Segregation Case Review, and some Initial Segregation Health Screens were inaccurately completed.

16. We are also concerned that the Prison Group Director's (PGD) decisions to authorise Mr Karar's extended segregation referred to non-existent documents, and that extension beyond 84 days was authorised by the Regional Operations Manager, not the PGD, and that she did not sign or date either form.

Use of interpretation services

17. Mr Karar spoke limited English and we consider that staff should have used an interpreter when dealing with complex issues.

Mental health

18. The clinical reviewer considered that the mental health care that Mr Karar received was equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that healthcare staff saw him daily, encouraged him to take his medication and created a mental health care plan.

Incident Report Forms

19. We are concerned that none of the staff involved in the emergency response completed Incident Report Forms.

Recommendations

- The Governor should ensure that staff manage newly arrived prisoners in line with national guidelines, including ensuring that they:
    - assess all prisoners arriving in reception and check all accompanying documents to identify any immediate needs and risks; and

- base their assessment of a prisoner's risk of suicide and self-harm on the prisoner's known risk factors rather than their presentation or statements.

- The Governor and Head of Healthcare should ensure that staff have a clear understanding of their responsibilities and the need to record and share relevant information about a prisoner's risk.

- The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including ensuring that they:
  - create a mental health care plan for all prisoners segregated for more than 30 days;
  - complete Initial Segregation Health Screens accurately and fully;
  - hold a Medical Recommendations Against Segregation or Special Accommodation – Initial Case Review if there are any healthcare reasons not to segregate a prisoner; and
  - set behavioural targets.

- The Director General of Prisons should ensure that the wording of the Initial Segregation Health Screen is amended to remove any uncertainty about whether a prisoner's compliance with medication affects the answer to the question "2. Has the person self-harmed in this period of custody / are they on an open ACCT Plan OR is the person currently taking any anti-psychotic medication?"

- The Prison Group Director for Yorkshire should ensure that reviewing and authorising continued segregation is managed in line with national guidelines, including ensuring that:
  - appropriate documents are obtained from the prison and correctly referred to;
  - any decisions to authorise a prisoner's segregation for more than 84 days are not routinely delegated; and
  - the DDC Review Form is completed fully.

- The Governor and Head of Healthcare should ensure that staff use appropriate interpretation services when managing prisoners with limited English language skills, particularly in health assessments and when deciding when to authorise a prisoner's segregation.

- The Governor and the Head of Healthcare should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that all staff directly involved in an incident complete Incident Report Forms as soon as possible.

The Investigation Process

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

21. The investigator visited Leeds on 12 September 2019. He obtained copies of relevant extracts from Mr Karar's prison and medical records.

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

23. The investigator interviewed 13 members of staff at Leeds on 29 and 30 October, one member of staff at HMP Wetherby on 28 October and one member of staff by telephone on 20 November. The clinical reviewer accompanied him for all the interviews at Leeds.

24. We informed HM Coroner for West Yorkshire (Eastern) of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

25. One of the Ombudsman's family liaison officers contacted Mr Karar's brother and cousin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Neither raised any issues.

26. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

27. Mr Karar's brother and cousin received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Leeds

28. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including clinical substance misuse and mental health services. The prison has 24-hour primary healthcare cover.

29. In August 2018, Leeds was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focussing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

30. The most recent inspection of HMP Leeds was in December 2019, though the results have yet to be published. The most recently published inspection was in October and November 2017. Inspectors reported that segregation was managed reasonably well, that reintegration planning had improved and that prisoners spoke well of the segregation staff.

31. Inspectors reported that the number of self-harm incidents was higher than at similar establishments. They also found that the demand for mental health services was high and a third of prisoners said that their mental health needs were not met. They found that mental health triage clinics were not used effectively.

Independent Monitoring Board

32. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2018, the IMB reported that the segregation unit continued to be busy and was overseen by a dedicated governor.

33. The IMB also reported that prisoners with significant mental health issues were cared for in the segregation unit or social care facility, which often resulted in other prisoners being disturbed. They considered that this resulted in suboptimal mental health care and they urged NHS England to conduct an urgent assessment on the provision of and delivery of mental health services.

Previous deaths at HMP Leeds

34. Mr Karar was the 21st prisoner to die at Leeds since September 2017. Eight of the previous deaths were self-inflicted, one was a homicide, one was drug-related, nine were from natural causes and in one the cause of death is currently unknown. We have previously made recommendations about staff responsibilities during emergency responses.

Segregation units

35. Segregation units are used to keep prisoners apart from other prisoners. This can be 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. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings.

36. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental wellbeing of the prisoners and whether there are any apparent clinical reasons to advise against continuing segregation.

37. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation beyond 42 days and beyond 84 days must be authorised by the Prison Group Director.

Key Events

38. On 25 February 2019, Mr Karar Ali Karar, a Sudanese national, was arrested on suspicion of murder and held in police custody. Mr Karar told the police that he had attempted to hang himself a month before his arrest and that he could get depressed if imprisoned, though he denied any current thoughts of suicide or self-harm.

39. On 27 February, Leeds Crown Court remanded Mr Karar into prison custody and sent him to HMP Leeds. When he arrived, an officer held a first night interview with Mr Karar, who said that he did not have any thoughts of suicide or self-harm and had never hurt himself or attempted suicide. Mr Karar said that a friend's suicide affected him daily and that he had been diagnosed with depression and anxiety. Mr Karar said he did not want to list anyone as his next of kin. There is no record that prison staff completed a reception screening for Mr Karar so they did not review his risk of suicide and self-harm.

40. An officer reviewed a Suicide/Self-Harm Warning (SASH) Form that had accompanied Mr Karar from court. The form noted that Mr Karar had tried to hang himself but the officer said that he did not start Prison Service suicide and self-harm monitoring (known as ACCT) as he said he felt "ok" and that he did not have thoughts of self-harm during his reception interview.

41. At his initial health assessment, Mr Karar told the nurse he had not self-harmed or attempted suicide in the last 12 months. The nurse referred Mr Karar to the mental health team.

42. Early on the morning of 28 February, Mr Karar repeatedly rang his cell bell, demanding to go to court, and then attacked his cellmate with a kettle and had to be pushed back into the cell by staff when he repeatedly tried to get out. His cellmate was relocated and Mr Karar remained in the cell on his own.

43. On 1 March, a nurse recorded in Mr Karar's electronic medical record that another nurse had seen him banging his head on his cell wall. She was unable to see him as prison officers said it was unsafe.

44. On 1 and 2 March, prison staff recorded that Mr Karar smashed a chair against the door, rang his cell bell repeatedly, and had to be restrained when he tried to assault the orderly officer.

45. On the morning of 3 March, Mr Karar's key worker recorded that she had tried to introduce herself to Mr Karar but he was smashing up the sink and toilet in his cell and throwing water out of his smashed observation panel onto the landing. She noted that wing staff told her "he talks lots of nonsense about wizards and other various random things" and that because of this "bizarre behaviour", she had referred him to the mental health team for assessment.

Segregation: 3 March to 12 June

46. Staff subsequently moved Mr Karar to the segregation unit because of the damage to his cell and the disruption he was causing on the wing.

47. Later that day, a nurse saw Mr Karar and noted that he appeared clinically fit enough to cope with being segregated. She noted that there was a slight language barrier, though Mr Karar was able to converse if questions were repeated or simplified. He denied any mental health issues and any involvement with mental health services. She also noted that Mr Karar said he heard voices, both his own and others, though he did not elaborate. She noted that this needed to be monitored though she considered they were more pseudo-hallucinations rather than psychotic hallucinations.

48. The nurse also created a segregation unit care plan that required prison GPs and nurses to review Mr Karar daily, for liaison with the mental health team and for any changes in his presentation to be recorded and discussed during biweekly team meetings.

49. On 5 March, a senior prison manager completed the Authority for Initial Segregation and authorised Mr Karar's segregation until 8 March. On the same day, a supervising officer (SO) created a reintegration plan for Mr Karar that gave him seven behavioural targets.

50. That day, a resettlement worker saw Mr Karar to complete his Basic Custody Screen. The resettlement worker noted that Mr Karar's first language was Arabic and that he understood spoken English, though his communication "was poor".

51. On 7 March, an offender supervisor saw Mr Karar and noted on his electronic prison record (known as NOMIS) that he struggled to understand her so had asked for an interpreter.

52. Between 8 March and 11 April, senior prison managers chaired five Segregation Review Boards with mental health staff and segregation staff. Mr Karar attended the first three Review Boards but did not attend the fourth (due to his non-compliance) and the fifth (because he said "he had somewhere else to be"). On each occasion, bar the first, the senior prison managers set Mr Karar some behavioural targets and they authorised his continued segregation.

53. On 8 March, a nurse saw Mr Karar and noted that he displayed bizarre behaviour. He also noted that Mr Karar communicated in broken English and needed to be reassessed using an interpretation service.

54. On 29 March, a locum consultant psychiatrist saw Mr Karar for a psychiatric observation and noted that there were obvious language barriers to completing a thorough assessment. Mr Karar said he had struggled with his mental health in the past but it did not prevent him achieving what he wanted and that he had had no formal contact with mental health services. He could not formally diagnose Mr Karar but thought he might have an adjustment or stress-related disorder. He planned to review Mr Karar in Arabic.

55. On 2 April, a nurse saw Mr Karar in the segregation unit and he denied hearing any voices. She noted that Mr Karar communicated well but that he needed some rephrasing due to his language barrier.

56. On an unspecified date believed to be 12 April, the Regional Operations Manager, who works for the Prison Group Director (PGD) for Yorkshire, completed a Review Form and granted leave for Leeds' Segregation Review

Boards to continue to segregate Mr Karar until 24 May, a maximum of 42 days. She wrote that this would allow Mr Karar's behaviour to stabilise before being moved to a standard location or another establishment, and that the management plan and care plan would be updated. She did not sign or date the decision form.

57. On 18 April, the locum consultant psychiatrist saw Mr Karar for a psychiatric observation and spoke to him in Arabic. Mr Karar said his family had a history of mental health problems. His first impression was that Mr Karar's presentation was suggestive of an adjustment disorder with mixed disturbance of emotions and conduct, though the assessment was limited by a lack of information about his past and how he functioned in the community. He planned a follow-up psychiatric assessment with Mr Karar and prescribed him a 25mg dose of quetiapine (an anti-psychotic drug used in the treatment of schizophrenia and bipolar disorder). He told the investigator that he prescribed quetiapine to treat Mr Karar's depression, low mood, agitation, arousal and any other potential paranoia.

58. On 25 April, a senior prison manager chaired a Segregation Review Board with Mr Karar, a nurse and an officer. He wrote that Mr Karar constantly kicked his door and asked for bizarre things, and that healthcare staff were giving him medication for a stress adjustment disorder. He set Mr Karar two non-timebound behavioural targets and authorised his continued segregation until 9 May.

59. That day, the nurse wrote in Mr Karar's electronic medical record that during the Segregation Review Board, he said that he did not feel well and that he felt people were in his space and his cell, though he did not elaborate.

60. On 9 May, a senior prison manager chaired a Segregation Review Board with a nurse and an officer, though Mr Karar did not attend as he was assessed as posing a significant risk if unlocked. The manager wrote that the mental health team were managing Mr Karar's mental health, that a psychiatrist had assessed him and that there were no concerns about him hurting himself. He set Mr Karar six non-timebound behavioural targets and authorised his continued segregation until 23 May.

61. That day, two nurses completed two separate Initial Segregation Health Screens and recorded that there were no clinical reasons to advise against segregating Mr Karar. On both forms the nurses answered 'no' to the question "*Has the person self-harmed in this period of custody / are they on an open ACCT Plan OR is the person currently taking any anti-psychotic medication?*"

62. On 11 May, the locum consultant psychiatrist saw Mr Karar for a psychiatric observation and spoke to him in Arabic. Before the observation, prison staff told the psychiatrist that Mr Karar regularly refused his medication, though he seemed more stable when taking it; that he had not showered for some weeks; and that he had refused to see another psychiatrist who was accompanied by an interpreter. (There is no record of the identity of this psychiatrist or the attempted examination.) The psychiatrist noted that Mr Karar seemed perplexed as he could not recall the name of his solicitor or his next court date. Mr Karar said his mental health was not good but he was unable to describe his thoughts or

feelings. He planned to discuss Mr Karar at the next multidisciplinary team meeting.

63. Four days later, at a multidisciplinary team meeting, the locum consultant psychiatrist agreed to refer Mr Karar for a move to a secure psychiatric hospital.

64. On an unspecified date believed to be 22 May, the Regional Operations Manager completed a second Review Form and granted leave for Leeds' Segregation Review Boards to continue to segregate Mr Karar until 3 July, a maximum of 42 days. She wrote that Mr Karar's care plan and reintegration plan had been considered and that they would be updated. She did not sign or date the decision form.

65. On 23 May, a senior prison manager chaired a Segregation Review Board with a nurse and a SO, though Mr Karar did not attend as he said "he wanted to go to court". The manager wrote that the mental health team were managing Mr Karar's mental health, that a psychiatrist had assessed him and that there were no concerns about him hurting himself. He set Mr Karar seven non-timebound behavioural targets and authorised his continued segregation until 6 June.

66. The nurse also completed an Initial Segregation Health Screen and recorded that there were no clinical reasons to advise against segregating Mr Karar. On the form, the nurse answered 'no' to the anti-psychotic medication question but answered "yes" to the question "*Does the prisoner show signs of being acutely unwell (eg: psychotic/ withdrawal from drugs/ significant physical injury) at the present time?*" The nurse wrote that she had discussed Mr Karar with the locum consultant psychiatrist and decided that, although he was clinically unwell, the segregation unit's low stimulus environment would be better for him. There is no record that a senior prison manager chaired a Medical Recommendations Against Segregation or Special Accommodation – Initial Case Review.

67. That same day, the locum consultant psychiatrist completed an urgent gatekeeping referral to the NHS Specialised Commissioning Team asking them to consider Mr Karar's suitability for a transfer to a medium secure psychiatric hospital. He noted that Mr Karar presented with cognitive, behavioural and emotional disabilities that amounted to a mental disorder, though he was uncertain about his suitability based on the absence of any previous contact with mental health services and his limited use of English to describe psychological processes.

68. On 6 June, a senior prison manager chaired a Segregation Review Board and a Medical Recommendations Against Segregation or Special Accommodation – Initial Case Review with a nurse and an SO, though Mr Karar did not attend as he "wanted to go to Newcastle". The manager wrote that the mental health team were managing Mr Karar's mental health and that there were no concerns about him hurting himself. He decided that it was not safe or decent to keep Mr Karar in any other location in the prison so he overruled healthcare's objection to Mr Karar's continued segregation. He set Mr Karar seven non-timebound behavioural targets and authorised his continued segregation unit 20 June.

69. The nurse also completed an Initial Segregation Health Screen and recorded that there were clinical reasons to advise against segregating Mr Karar. On the form,

the nurse answered 'yes' to the question "*Is the prisoner awaiting transfer to/ being assessed for a bed in an NHS Secure setting?*"

70. The nurse also created a Care Plan for Mr Karar that said he did not have an established mental health diagnosis, that he was not complying with his medication and that there had been no self-harm or suicide attempts in custody or reported in his limited historical documentation. The Care Plan planned for staff to encourage Mr Karar to take his medication and for him to discuss this with the psychiatrist. It also said that Mr Karar was unlikely to tell staff about a deterioration in his mental health so staff needed to recognise his early warning signs, which included talking to himself, banging on his door, being aggressive or abusive towards staff, and being agitated and unsettled in his presentation.

Complex needs unit: 12 June to 16 August

71. On 12 June, prison staff moved Mr Karar to the complex needs unit, within the healthcare unit, to try to create some progression for him.

72. The following day, a psychiatrist with the Yorkshire Centre for Forensic Psychiatry tried to see Mr Karar with an interpreter to complete the gatekeeping assessment, but he refused to engage as he said he did not want to see any doctors. She tried to explain the purpose of the assessment through the interpreter, but Mr Karar continued to refuse to engage. She noted that Mr Karar's speech was normal and easy to understand, and that he did not appear to be distracted or responding to internal stimuli.

73. The same day, a multidisciplinary team meeting discussed Mr Karar. A senior prison manager created a post-segregation management plan for Mr Karar, which included daily visits from the mental health team while he was in the complex needs unit.

74. On 15 June, the locum consultant psychiatrist saw Mr Karar, who said that he had refused to see the other psychiatrist because he did not understand what was going on. He also said that he had taken his medication, though there was no evidence to support this. The locum consultant psychiatrist noted that Mr Karar seemed less perplexed but absorbed at the time.

75. On 19 June, the psychiatrist wrote to the locum consultant psychiatrist to explain that she did not recommend Mr Karar's transfer to a medium secure hospital as she considered the prison could adequately give further care. She agreed with the locum consultant psychiatrist that Mr Karar could be suffering with an adjustment reaction and that it was unclear whether his antisocial behaviour was caused by a psychotic or affective mental disorder (such as depression, anxiety or bipolar disorder).

76. On 23 June, the locum consultant psychiatrist decided, in light of the psychiatrist's decision, that the mental health team should keep Mr Karar on its caseload until he moved to a standard location.

77. On 3 July, the offender supervisor saw Mr Karar and noted on NOMIS that it was "difficult to ascertain what he understands and how well he is engaging due to language barrier".

78. On 10 July, a nurse saw Mr Karar and noted that staff said that he was doing well in the complex needs unit, including spending time on association and integrating with other prisoners.

79. On 3 August, the locum consultant psychiatrist saw Mr Karar as he wanted to discuss his mental health. Mr Karar said that his mental health changed with the weather, that he was not depressed, and that he wanted to return to a standard location. The psychiatrist decided that healthcare staff should continue to monitor his mental health, though there was no indication that he presented a risk to himself.

80. On 9 August, a nurse saw Mr Karar at the request of an officer who thought that he had deteriorated. Mr Karar said that he was scared and he felt a "pain in his heart". He said that he heard voices and slept to prevent this. The nurse encouraged him to take his medication as it would help improve how he was feeling. She noted that he did not express any paranoia or hallucinatory behaviour. She planned to keep Mr Karar on the mental health caseload.

81. That day and 14 August, Mr Karar allegedly sexually assaulted, respectively, a nurse and two prisoners. Staff placed him on two disciplinary charges, which were referred to the police. The police's investigations were not completed before Mr Karar died.

82. On 15 August, Mr Karar was convicted of murder and sentenced to life imprisonment, with a minimum time to serve of 25 years and 117 days.

83. Later that day, a nurse saw Mr Karar and asked whether he had any feelings of self-harm or suicide. Mr Karar said that he did not, but she was unsure that he understood. He also said he wanted to leave Leeds to do a fishing course.

Segregation from 16 August

84. On 16 August, prison staff tried to move Mr Karar from the complex needs unit to the first night centre but, during the move, he assaulted an officer. Prison staff restrained Mr Karar and took him to the segregation unit.

85. Later that day, a nurse completed an Initial Segregation Health Screen and recorded that there were no clinical reasons to advise against segregating Mr Karar. On the form, she answered 'no' to the anti-psychotic medication question.

86. On 19 August, a nurse completed an Initial Segregation Health Screen and recorded that there were no clinical reasons to advise against segregating Mr Karar. On the form, she answered 'no' to the anti-psychotic medication question. A senior prison manager completed an Authority for Initial Segregation and authorised Mr Karar's segregation until 22 August.

87. On 21 August, the offender supervisor completed an Initial Categorisation for Mr Karar and recommended that his security category be set at category B (meaning that he posed a risk to the public and a risk of escape but did not require maximum security). She ticked a box with the question "*At risk of self-harm, suicide*" and wrote "attempt hanging". She also wrote that Mr Karar spoke Sudanese and "limited English".

88. The following day, a senior prison manager chaired a Segregation Review Board with Mr Karar, a nurse and an officer. Mr Karar said he had assaulted staff because he was angry, though he could not recall why. The manager decided that Mr Karar did not present any urgent mental health issues and that he would be monitored during the mental health rounds. He set Mr Karar six non-timebound behavioural targets and authorised his continued segregation unit 5 September. On the same day, the SO created a reintegration plan for Mr Karar.

89. On 24 August, the locum consultant psychiatrist saw Mr Karar, who said that he had punched an officer because he did not want to leave the complex needs unit and he did not know where he was going. They discussed his medication and the psychiatrist increased Mr Karar's prescription to a 100mg dose of quetiapine.

90. On 3 September, a nurse saw Mr Karar, who said that he was well and did not need any support from the mental health team. The nurse noted that Mr Karar told her he had no thoughts of self-harm or suicide.

Events from 4 September 2019

91. At 8.25am, a SO and three officers arrived at Mr Karar's cell, to transfer him to HMP Hull, and restrained him with double handcuffs. (This means a prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) At 8.31am, the officers escorted Mr Karar to reception and he complied with all their instructions.

92. At 8.36am, once in reception, Mr Karar attempted to assault one of the officers, so the officers restrained him and moved him onto the van for the journey to Hull. Mr Karar continued to fight with the officers and they were unable to position him safely in the vehicle. The duty manager told the officers to take Mr Karar back to the segregation unit and, at 9.02am, the officers put him back in his cell.

93. At 9.50am, an officer checked on Mr Karar, through the observation panel, as he had stopped kicking his cell door. The officer told the investigator that he could not see Mr Karar at first but he then appeared from the recess and sat on his bed.

94. At 9.58am, an officer asked two nurses to check on Mr Karar. The nurses visited Mr Karar's cell and tried to talk to him but he did not respond. One nurse noticed that Mr Karar's hands were tied behind his back, though the nurses' view was obstructed as Mr Karar had put toothpaste on the observation panel. The nurses walked to the office and asked for staff assistance.

95. At 10.01am, three officers entered Mr Karar's cell and found him hanging from a ligature at the back of the cell. A nurse called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing). The officers cut the ligature, which was made from a torn bed sheet and had been attached to a window bar, and they lowered him to the floor. The nurses started cardiopulmonary resuscitation (CPR), inserted an airway and gave Mr Karar oxygen.

96. The control room daily log sheet noted that they called for an ambulance at 10.03pm. Yorkshire Ambulance Service sent an ambulance and a rapid response vehicle to the prison and they reached Mr Karar at 10.13am and 10.16am respectively. Paramedics took over the resuscitation attempt. At

10.47am, Mr Karar's radial pulse had returned so the paramedics took him to hospital. Officers did not restrain Mr Karar.

97. The ambulance arrived at the hospital at 10.51am and hospital doctors admitted Mr Karar to the critical care unit. Mr Karar's condition deteriorated and, at 12.40am on 5 September, a hospital doctor declared that he had died.

Contact with Mr Karar's family

98. On 4 September, the prison appointed a custodial manager (CM) as the prison's family liaison officer. She reviewed Mr Karar's prison records and noted that he had not listed anyone as his next of kin. She telephoned Mr Karar's solicitor, who gave her an email address for Mr Karar's brother, who lived in the USA. She sent an email to Mr Karar's brother and asked for his telephone number.

99. Following Mr Karar's death, the CM telephoned Mr Karar's brother to break the news of his death and to offer her condolences and support. Later that afternoon, Mr Karar's brother emailed the CM and asked for all future correspondence to be made through Mr Karar's solicitor.

100. On 9 September, after one failed attempt three days earlier, the CM telephoned Mr Karar's solicitor, who said that Mr Karar's cousin, who lived in the UK, would act as the family's representative. She asked the solicitor to contact Mr Karar's cousin and to pass on her contact details.

101. The following day, Mr Karar's cousin emailed the CM and said that he and Mr Karar's brother wanted to learn about the circumstances of Mr Karar's death. On 11 September, the CM spoke to Mr Karar's cousin to provide further information and to offer her support.

102. The CM continued to support Mr Karar's cousin until Mr Karar's funeral, which was held on 29 September. The prison contributed towards the costs of the funeral in line with national instructions.

Support for prisoners and staff

103. After Mr Karar had been taken to hospital, a senior 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.

104. After Mr Karar's death, a senior prison manager debriefed the staff who were with him when he died to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

105. The prison posted notices informing other prisoners of Mr Karar'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 Karar's death.

Post-mortem report

106. The post-mortem report found that the cause of Mr Karar's death was complications of neck compression due to hanging.

107. The toxicology report found the presence of various drugs used to treat Mr Karar but did not find any that he had used any illicit substances.

Findings

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

Reception

108. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, provides a non-exhaustive list of a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. These require staff to take appropriate action, such as starting ACCT procedures or referring prisoners to the mental health team. Staff must identify prisoners at risk of self-harm and suicide. They must also check relevant documents for evidence of risk.

109. PSI 07/2015, *Early Days in Custody*, sets out the processes that should be followed when a prisoner first arrives in prison. This includes that staff should assess a prisoner's risk to themselves by examining all available documentation, including the Person Escort Form and any SASH Form.

110. When Mr Karar arrived at Leeds, a SASH Form noted that he had attempted suicide a month before and that he could get upset and depressed if imprisoned for a long time. Despite this information, an officer decided not to open an ACCT and relied upon Mr Karar's statements that he was "ok". We consider that this was an error of judgement, though we accept that Mr Karar did not take his life in the days or weeks that followed the officer's decision. Another officer did not complete a reception screening document for Mr Karar, which should have happened as he had arrived with the SASH Form.

111. In a learning lessons bulletin, *Early Days and Weeks in Custody*, published by the Prisons and Probation Ombudsman in February 2016, we identified that too often reception staff make decisions based on a prisoner's presentation and their statements that they do not have any thoughts of suicide or self-harm, rather than relying upon known risk factors, such as previous suicide attempts. We make the following recommendation:

The Governor should ensure that staff manage newly arrived prisoners in line with national guidelines, including ensuring that they:

- **assess all prisoners arriving in reception and check all accompanying documents to identify any immediate needs and risks; and**
- **base their assessment of a prisoner's risk of suicide and self-harm on the prisoner's known risk factors rather than their presentation or statements.**

Segregation

112. With the exception of the SASH Form and a reference to Mr Karar banging his head against a wall on 1 March, there is no record that Mr Karar said that he had any thoughts of suicide or self-harm and there were no self-harm incidents during his time in Leeds. However, he had a number of significant risk factors, including facing a long sentence, spending a long time in segregation, mental ill health and limited English. These factors increased as his segregation continued and we

are concerned that there is limited, documented consideration whether his risk to himself had increased.

113. In addition, during our interview with a nurse, he said he thought that Mr Karar was concerned about being deported to Sudan. The locum consultant psychiatrist experienced a similar concern, though only after Mr Karar had died. Although the nurse felt that this was known to prison staff, there is no evidence that this information was recorded anywhere and prison staff do not appear to have been aware of it.

114. During our interviews with the officers involved in the attempt to transfer Mr Karar to Hull, an officer thought he heard him say, "I not leave, I not leave," though none of the other officers heard Mr Karar say anything.

115. We cannot be sure whether Mr Karar was anxious about being deported, as there is no evidence that he explicitly said this to any staff, or whether he thought that was happening during the attempted transfer to Hull. However, we are concerned that information which affected his risk was not formally recorded and shared among staff. If this had happened, staff may have given Mr Karar more information before the transfer or could have put in additional checks once he had been returned to his cell in the segregation unit. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff have a clear understanding of their responsibilities and the need to record and share relevant information about a prisoner's risk.

Segregation

116. Prison Service Order 1700, *Segregation*, says,

> "Research into the mental health of prisoners held in solitary confinement indicates that for most prisoners, there is a negative effect on their mental wellbeing and that in some cases the effects can be serious."

The PSO sets out the processes that should be followed when a prisoner is segregated. This includes that a care plan to support a prisoner's mental wellbeing should be created if they are segregated for more than 30 days, that healthcare staff must complete an Initial Segregation Health Screen, and that prisoners should be set timebound behavioural targets.

117. An accompanying document, *Reviewing and Authorising Continuing Segregation & Temporary Confinement in Special Accommodation – Amendment to Policy set out in PSO 1700*, sets out the processes that should be followed when a prisoner is segregated for longer than 42 days. This includes that a DDC (Deputy Director of Custody) Review form must be accompanied by all relevant paperwork, that the form must be completed and that the DDC cannot routinely delegate decisions to authorise a prisoner's segregation beyond 84 days. (The DDC role no longer exists and DDCs have been replaced by Prison Group Directors (PGDs).)

118. The Amendment also says,

> "Prisons must be aware of the potential effects of segregation on a vulnerable person's state of mind and begin ACCT procedures if they observe any changes in a prisoner's behaviour or circumstances, which indicate an increase in the risk of suicide and self-harm … A prisoner [in segregation] does not have to have harmed themselves, or even spoken of doing so, for it to be appropriate to open an ACCT. The full range of risk factors, as set out in PSI 64/2011, including significant changes to the prisoner's behaviour or mood should be considered."

119. When Mr Karar initially moved to the segregation unit, a nurse created a care plan for him on 3 March but this was only available to healthcare staff. On 6 June, a nurse created another care plan for Mr Karar and this was available to both prison and healthcare staff. While we note that a care plan was created on 3 March, we are concerned that the prison's segregation staff did not have access to it. We do not, therefore, consider that it was sufficient to meet the obligation in PSO 1700 to create a care plan for all prisoners segregated for more than 30 days, and we consider that one should have been created on or before 2 April, and certainly well in advance of 6 June.

120. On 23 May, a nurse completed an Initial Segregation Health Screen and noted that Mr Karar showed signs of being acutely unwell. Following the Screen's algorithm, this should have meant that there were healthcare reasons not to segregate Mr Karar and that this should have led to a Medical Recommendations Against Segregation or Special Accommodation – Initial Case Review. If such a Case Review had taken place, a senior prison manager would have considered the nurse's concerns and the information provided by the locum consultant psychiatrist and decided whether it was appropriate to segregate Mr Karar. In the absence of this review, we are concerned that there was no multidisciplinary discussion about whether another location could offer a "low stimulus environment" for Mr Karar or whether he needed additional support.

121. From 18 April, the locum consultant psychiatrist prescribed Mr Karar quetiapine, an anti-psychotic drug. While Mr Karar regularly refused his medication, healthcare staff never cancelled the prescription. We are concerned that five out of eight Initial Segregation Health Screens completed during Mr Karar's two periods of segregation, failed to record that Mr Karar had been prescribed an anti-psychotic. We consider that healthcare staff should have included this information so that the senior prison managers had as accurate a picture of Mr Karar's mental wellbeing as possible.

122. Three nurses said at interview that they answered 'no' to the anti-psychotic question because Mr Karar was not taking the medication regularly. One nurse told the investigator that the algorithm was open to perspective and that how many doses a patient took would influence her answer. We had similar answers from the other two nurses. We are concerned that such a crucial question is open to interpretation and we consider that this uncertainty should be removed.

123. Throughout Mr Karar's time in segregation, prison staff gave him numerous behavioural targets. However, we are concerned that the notifications that prison managers created following Mr Karar's Review Boards on 8 March and 4 April, respectively, did not contain any behavioural targets and were missing. We are

concerned that a lack of behavioural targets meant that Mr Karar would not know how to properly demonstrate an improvement in his behaviour, or for how long, and this may have resulted in him being segregated for too long.

124. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including ensuring that they:

- **create a mental health care plan for all prisoners segregated for more than 30 days;**
- **complete Initial Segregation Health Screens accurately and fully;**
- **hold a Medical Recommendations Against Segregation or Special Accommodation – Initial Case Review if there are any healthcare reasons not to segregate a prisoner; and**
- **set behavioural targets.**

The Director General of Prisons should ensure that the wording of the Initial Segregation Health Screen is amended to remove any uncertainty about whether a prisoner's compliance with medication affects the answer to the question "2. Has the person self-harmed in this period of custody / are they on an open ACCT Plan OR is the person currently taking any anti-psychotic medication?"

125. With regard to the DDC Review Forms, we note that the Regional Operations Manager referred to the care plan on both forms and a management plan on the first form. Neither the prison nor the Regional Operations Manager has been able to give us a copy of either plan and Regional Operations Manager told the investigator that she was not referring to the mental health care plan. In any event, this was not created until 6 June after both DDC Review Forms had been completed. We are concerned that her decisions refer to non-existent documents, which brings into question the appropriateness of her decisions.

126. We are also concerned that the Regional Operations Manager completed the second DDC Review Form, which authorised Mr Karar's segregation for more than 84 days, and that she did not sign or date either form. Given the effects of prolonged segregation on a prisoner's wellbeing, the decision to authorise segregation for more than 84 days is an important one. The Amendment to PSO 1700 makes it clear that the DDC (now the PGD) cannot routinely delegate decisions to authorise a prisoner's segregation beyond 84 days unless he or she is absent for an extended period. We are concerned that we have seen nothing to explain why the PGD delegated the decision to the Regional Operations Manager in Mr Karar's case, and that this was contrary to the Amendment. We make the following recommendation:

The Prison Group Director for Yorkshire should ensure that reviewing and authorising continued segregation is managed in line with national guidelines, including ensuring that:

- **appropriate documents are obtained from the prison and correctly referred to;**

- **any decisions to authorise a prisoner's segregation for more than 84 days are not routinely delegated; and**
- **the DDC Review Form is completed fully.**

Use of interpretation services

127. The Prison Service's policy on foreign national prisoners says,

> "Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline."

128. PSI 64/2011 says,

> "All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process."

129. During our interviews with staff, the consensus was that Mr Karar spoke limited English but sufficient to communicate on a day-to-day basis. The locum consultant psychiatrist told the investigator that he wanted to speak to Mr Karar in Arabic to see if he could describe his mental health processes in his first language, although he felt that the Arabic language lacked the terms to describe his depression. We also note that Care UK completed a Significant Incident/ DIC 72 Hour report following Mr Karar's death and noted that he was "not as aggressive, engagement and compliance much improved when not in his cell and interpreter/ own language used".

130. We commend the locum consultant psychiatrist for conducting most of his reviews in Arabic and also that the gatekeeping assessment involved an interpreter. However, we believe that an interpreter should have been used when dealing with other complex issues, such as Mr Karar's other mental health reviews, the Segregation Review Boards and the reasons for his transfer to Hull. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff use appropriate interpretation services when managing prisoners with limited English language skills, particularly in health assessments and when deciding when to authorise a prisoner's segregation.

Mental health

131. The clinical reviewer considered that the mental health care that Mr Karar received was of a reasonable standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that, despite Mr Karar's reluctance to engage with healthcare staff, they saw him daily, tried to build a relationship with him and tried to encourage him to take his medication. She also noted that mental health staff created a mental health care plan for him.

Incident Report Forms

132. PSI 64/2011 sets out the actions that should be taken following a death in custody. This includes that all staff directly involved in an incident, particularly those who were first on scene, must complete Incident Report Forms as soon as possible.

133. As part of the investigation, Leeds provided six statements from the officers involved in the attempt to transfer Mr Karar to Hull. However, none of the prison or healthcare staff involved in the emergency response completed Incident Report Forms. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that all managers follow the national instructions for dealing with a death in custody or serious incident, including that all staff directly involved in an incident complete Incident Report Forms as soon as possible.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T | 020 7633 4100
F | 020 7633 4141