Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammed Irfann Afzal, a prisoner at HMP Leeds, on 4 August 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 Mohammed Irfaan Afzal died in hospital from bronchopneumonia on 4 August 2019, after being found unresponsive in his cell at HMP Leeds earlier that day. He was 22 years old. I offer my condolences to Mr Afzal's family and friends.

The circumstances of Mr Afzal's death are shocking. Mr Afzal was a healthy weight when he arrived at Leeds, but over the next 48 days, he lost three stone, almost one third of his body weight, and became very underweight. The pathologist noted that Mr Afzal was emaciated and that his poor nutritional state would have increased the risk of him developing a chest infection.

Mr Afzal appeared confused throughout his time at Leeds. Prison staff suspected that he may have a learning disability or mental health issues. Although they repeatedly raised concerns, I am very concerned that Mr Afzal was never seen by the learning disability nurse and never received a full mental health assessment.

The clinical reviewer found that the mental health care Mr Afzal received at Leeds was not equivalent to that he could have expected to receive in the community. This is the sixth death at Leeds in two years, where my investigations have reached that conclusion. This is extremely concerning and needs to be addressed urgently.

Although there were signs that Mr Afzal was not eating or drinking, neither prison or healthcare staff appeared to pay much attention until a few days before his death, by which time his weight had dropped alarmingly. I am concerned that there was insufficient staff engagement with this vulnerable young man and that, as a result, opportunities were missed to put food monitoring procedures in place and to support Mr Afzal to increase his food and fluid intake.

I also share the clinical reviewer's concerns about the response from healthcare staff when Mr Afzal collapsed two days before he died. He was not assessed as fully as he should have been, was not sent to hospital, and was not monitored. This was a missed opportunity to identify how physically unwell Mr Afzal had become.

Poor communication between prison and healthcare staff also played a part in these missed opportunities to recognise and address Mr Afzal's issues. This also needs to be addressed urgently.

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 **February 2021**

Contents

Summary

Events

1. On 17 June 2019, Mr Mohammed Irfaan Afzal was remanded in prison custody, charged with assault and breach of a Community Order, and taken to HMP Leeds.

2. Mr Afzal weighed 65kg (10st 3lb), a healthy weight for a man of his height, when he arrived at Leeds. When he died, he weighed 46kg (7st 3lb), a loss of three stone, almost one third of his body weight, in 48 days.

3. Mr Afzal appeared confused throughout his time at Leeds. Staff described him as bewildered and child-like. He appeared unable to pay attention and listen to what staff told him, to follow simple commands or to communicate with staff. There were numerous records of odd behaviour.

4. Prison staff suspected that he might have a learning disability or mental health issues and repeatedly contacted healthcare about him. He received an initial assessment by a mental health nurse but was never seen for a full assessment. He was never seen by the learning disability nurse, despite the need for a referral being noted several times. He was prescribed antidepressant medication but never collected it.

5. On 2 August, prison staff found Mr Afzal slumped in a chair and called a medical emergency code. A nurse attended and staff told her that Mr Afzal had not been eating or drinking. She took Mr Afzal's clinical observations, which were all normal, and assessed that he did not need to go to hospital so she cancelled the ambulance that had been called.

6. The next day, prison staff realised that Mr Afzal had a large quantity of uneaten food in his cell.

7. On 4 August at around 9.18am, an officer found Mr Afzal lying on his bed unresponsive. Staff and paramedics resuscitated him and he was taken to hospital. However, Mr Afzal did not regain consciousness and at 10.50am, he was pronounced dead.

8. The post-mortem report concluded that Mr Afzal died from acute bronchopneumonia (inflammation of the lungs). The pathologist noted that Mr Afzal was emaciated and that his poor nutritional state would have increased his susceptibility to a chest infection.

Findings

9. It is not clear why Mr Afzal was never referred to the learning disability nurse for assessment, despite several references to a referral being needed.

10. An initial mental health assessment was conducted but a full assessment was never done.

11. Mr Afzal was discussed at a complex case meeting on 16 July, at which it was agreed that he should be referred to the learning disability nurse and to a psychiatrist. These decisions were not recorded and were never actioned.

12. The clinical reviewer found that the standard of mental health care Mr Afzal received at Leeds was not equivalent to that he could have expected to receive in the community. This is a recurring theme at Leeds and this is the sixth death in two years where we have found that mental health care was not equivalent to the care that could be expected in the community.

13. The clinical reviewer also found that the standard of Mr Afzal's clinical care was not equivalent to that he could have expected to receive in the community.

14. From early July, there were indications that Mr Afzal was not eating. This was not picked up by prison or healthcare staff. Opportunities were missed to put food monitoring measures in place and to provide support to Mr Afzal to increase his food and fluid intake.

15. There is little evidence that staff engaged with Mr Afzal. There was also a delay in allocating him a key worker. Once a key worker was allocated, she met with him only once, on 2 August, and said he ignored her and did not engage. She had no concerns about him, even though she noted he was thin and his cell was very messy. An effective key worker relationship could have identified and addressed Mr Afzal's issues much earlier.

16. When the nurse took Mr Afzal's clinical observations on 2 August, she took his blood pressure reading over his clothes. This is not best practice and if she had taken the reading using Mr Afzal's bare arm, she would have realised how thin he was. The nurse failed to take a complete set of observations or to assess for clinical deterioration, and failed to arrange for Mr Afzal to be monitored over the weekend.

17. We are also concerned that the Custodial Manager (CM) and Supervising Officer (SO) responsible for Mr Afzal's wing did not arrange for staff to monitor him after he collapsed on 2 August, and that the SO took no action when staff told him on 3 August that Mr Afzal was very weak and appeared not to be eating.

18. Mr Afzal was placed on the basic level of the Incentives and Earned Privileges (IEP) scheme, after he pulled an officer's hair. There is no evidence that any consideration was given to Mr Afzal's potential learning disability or mental health issues, or of meaningful interaction to help him progress to the standard regime.

Recommendations

- The Head of Healthcare should ensure that:
    - referrals for learning disability assessments are actioned and followed up promptly;
    - referrals for mental health assessments are actioned and any followed up promptly;

    - discussions and decisions made at multidisciplinary meetings on complex cases are accurately recorded in medical records and all actions are followed up; and
    - staff adhere to the policy on medication refusal.

- The NHS Director of Commissioning for North East and Yorkshire Region should write to the Ombudsman setting out how he intends to improve mental health care provision at Leeds.

- The Head of Healthcare should ensure that where prisoners are unwell, but do not require hospital admission, staff:

    - take a full set of clinical observations and calculate and record the National Early Warning Score (NEWS);
    - follow the correct procedures for taking blood pressure readings;
    - take additional observations/interventions where appropriate; and
    - follow up with documented clinical welfare checks.

- The Governor and Head of Healthcare should ensure all staff are aware of how to formally monitor and record food and fluid intake if there are concerns about a prisoner not eating or drinking.

- The Head of Healthcare should remind all healthcare staff that formal mental health assessments should be completed in private and separately from the ACCT process.

- The Governor should ensure that staff engage with all the prisoners in their care and make regular entries in their prison record, especially about any concerns.

- The Governor should ensure that:

    - all prisoners are allocated a key worker in line with Prison Service policy;
    - staff are scheduled adequate time to perform the key worker role; and
    - key workers understand that their role is to engage, motivate and support the prisoners allocated to them.

- The Governor should write to the Ombudsman setting out what he is doing to address the uncaring culture displayed by some officers and managers in their dealings with Mr Afzal.

- The Governor should ensure staff adhere to local policy on the management of those prisoners on the basic IEP regime, including the involvement of key workers, to support prisoners to achieve their targets.

- The Governor and Head of Healthcare should commission a joint review, with senior prison and healthcare managers, into the circumstances surrounding Mr Afzal's death with specific regard to:

    - improving communication between prison and healthcare staff; and
    - developing a clear escalation process when prison staff have concerns about the mental or physical health of a prisoner.

- The Head of Healthcare should ensure that a programme of regular clinical supervision and support is agreed for the nurses involved in Mr Afzal's care: Nurses A, B, C, D and E.
- The Governor should share this report with Officers C, D and E, SO B and CM A, and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

19. 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. One prisoner responded.

20. The investigator visited Leeds on 14 August 2019. She obtained copies of relevant extracts from Mr Afzal's prison and medical records. The investigator visited the wing where Mr Afzal lived. She spoke to staff who had had contact with him and interviewed one prisoner.

21. We suspended our investigation in August 2019, pending the outcome of a police investigation, and resumed it in June 2020, when West Yorkshire Police told us that no criminal charges would be brought.

22. NHS England commissioned a clinical reviewer to review Mr Afzal's clinical care at the prison. Due to the complexity of the investigation, this was a multidisciplinary panel review with a lead reviewer.

23. The investigator accompanied by the clinical reviewer, interviewed 12 members of staff and one prisoner at Leeds in February 2020, and two healthcare staff in March. The investigator also interviewed five members of staff and one prisoner by telephone, and the clinical reviewer interviewed the Head of Healthcare.

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

25. One of the Ombudsman's family liaison officers, wrote to Mr Afzal's parents in September 2019, to explain the investigation. Mr Afzal's father asked for a copy of the investigation report. We did not get a response from Mr Afzal's mother. We made several further attempts to contact Mr Afzal's mother, but received no response.

26. Mr Afzal's family received a copy of the initial report. They did not identify any factual inaccuracies. However, Mr Afzal's family are critical of the prison's response to Mr Afzal's father, who said he was told when he telephoned Leeds that Mr Afzal was 'fine' and it was Mr Afzal's responsibility to maintain contact with his family. Mr Afzal's family reflected that he had the wrong contact details for his father and therefore could not get in touch. Mr Afzal's family do not understand why they were not contacted to provide him additional support due to his mental and physical ill-health, and that he would not have been capable of figuring out how to get the right details to contact his father.

27. The prison also received a copy of the report and corrected the spelling of a surname of a member of staff. An action plan for the recommendations is annexed to the report.

Background Information

HMP Leeds

28. HMP Leeds is a local prison which can hold a maximum of 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including 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 sought to improve safety, security and decency in the prisons involved. The project focused on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

30. The most recent inspection of HMP Leeds was in November/December 2019. Inspectors found that the need for mental health support was high, with 61% of respondents to the HMIP survey saying that they had a mental health problem. However, only 25% of prisoners said that they had received support for a mental health problem in the prison. Access to the mental health team had improved, with urgent referrals being seen within 24 hours and non-urgent within five days. Support for prisoners with primary mental health care needs was underdeveloped, mainly consisting of self-help. A mental health awareness training package had been developed for prison staff but at the time of the inspection, only 63 staff had received it. Inspectors recommended that prison managers and healthcare commissioners should ensure there are sufficient mental health resources to meet unmet need.

31. Only 58% of prisoners reported that they were treated respectfully by most staff, and 47% reported some form of verbal abuse from staff. Inspectors saw some dismissive and potentially intimidating behaviour by staff. Fewer prisoners from both black and Muslim backgrounds said that staff treated them respectfully. Prisoners told inspectors of their frustration about the inexperience of new staff and their inability to answer some basic queries.

32. Inspectors found key working was developing well. All prisoners had a key worker, and staff and prisoners were reasonably positive about its value. Managerial oversight of the IEP scheme was good, and IEP reviews were generally conducted on time. However, too many targets for those on the basic regime were generic, not focusing on the key areas for improvement.

Independent Monitoring Board

33. 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 annual report for the year ending December 2018, the IMB reported that, unlike comparative prisons, Leeds did not have a dedicated mental health facility. Prisoners with significant mental ill health were cared for in the Segregation Unit or the Social Care Facility, often resulting in the disturbance of other prisoners. The IMB considered this was suboptimal care

and urged NHS England to conduct an urgent needs assessment on the provision of and delivery of mental health services at Leeds.

Previous deaths at HMP Leeds

34. Mr Afzal was the 19th prisoner to die at Leeds since August 2017. Of the previous deaths, eight were self-inflicted, eight were from natural causes, one was drug-related and one was a homicide.

35. In five previous investigations, we have identified that the standard of mental health care at Leeds was not equivalent to the standard of care that could have been expected in the community. We have previously recommended that the Governor should work with NHS England to ensure that the provision and delivery of mental health services at Leeds is adequate for the needs of the prison's population. We have also made previous recommendations about the operation of the key worker scheme at Leeds.

Assessment, Care in Custody and Teamwork

36. 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 support the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

37. 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, multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Incentives and Earned Privileges Scheme (IEP)

38. Each prison has an incentives and earned privileges (IEP) 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 wear their own clothes. There are three levels: basic, standard and enhanced.

Key worker scheme

39. HMPPS's policy document, *Managing the Custodial Sentence Policy Framework*, set out the minimum requirements needed to case manage those in custody from reception to the end of post-release supervision. This included the gradual introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:

- All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.
- All prison officers who work on a residential unit will be allocated a maximum of six prisoners. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance so it is important that they are sufficient.

Key Events

40. On 10 March 2019, Mr Mohammed Irfaan Afzal was remanded in prison custody and sent to HMP Leeds. His weight was not recorded in his medical notes, but according to his prison record he weighed 72kg (11st 4lbs). On 18 March, he received a community order and was released.

41. On 17 June, Mr Afzal was again remanded in prison custody, charged with assault and with breaching the community order, and returned to Leeds.

42. A nurse carried out Mr Afzal's initial health screen. He recorded that Mr Afzal was 6 feet 1 inch tall, weighed 65kg (10st 3lbs) and had a body mass index (BMI) of 19.2. (A BMI of 18.5 to 24.9 indicates a healthy weight.) Mr Afzal told the nurse he had been diagnosed with depression but was not prescribed medication. He said he heard the voice of an evil man that gave him commands. He also said he had chest pains. The nurse noted that Mr Afzal had no obvious current psychotic symptoms, but he referred him to the mental health team for assessment.

ACCT: 18 to 20 June

43. On 18 June, a Healthcare Assistant (HCA) completed Mr Afzal's secondary health screen. He started Prison Service suicide and self-harm prevention measures (known as ACCT) because Mr Afzal told him that he had thoughts of suicide and self-harm. The HCA recorded on the ACCT concern and keep safe form that Mr Afzal had poor eye contact and appeared vulnerable. A Supervising Officer (SO) completed the immediate action plan and set observations at two an hour.

44. Later that day, a prison GP saw Mr Afzal. The prison GP noted that Mr Afzal felt low, had thoughts of suicide and thought he should not be in prison. Mr Afzal said he thought the prison was unhygienic, that he felt vulnerable as his cellmate had mental health issues, and that he was developing a chesty cough. The prison GP recorded that although Mr Afzal had some thoughts of suicide and self-harm, he had no active plans. He prescribed an antidepressant (to be collected each day from the medication hatch). He referred Mr Afzal for an urgent mental health assessment, noting that he was a vulnerable adult. The prison GP also requested a full set of blood tests (booked for 1 July).

45. Nurse A recorded on Mr Afzal's medical record that the referral for a mental health assessment had been received and would be done during the ACCT review.

46. Prison staff noted on the ACCT ongoing record that Mr Afzal had to be told several times throughout the day to return to his cell and that he appeared not to listen or understand instructions.

47. That evening, an officer completed the ACCT assessment and Mr Afzal told her that he suffered from depression and anxiety and thought he should be in a secure mental health unit and not prison. Mr Afzal said he had never self-harmed but had suicidal thoughts 'from time to time'. He said he wanted vitamins from the prison doctor, but that healthcare staff had been 'no help'. He

said he was eating and sleeping okay, but that staff would not help him, although he did not elaborate. The officer recorded that Mr Afzal's main concerns were his mental health problems and money that he said had gone missing.

48. On the morning of 19 June, a SO attempted to carry out the first ACCT review with an officer and Nurse B from the mental health team. Mr Afzal refused to engage with the ACCT review or to leave his (shared) cell. Staff assessed that Mr Afzal's risk of suicide and self-harm remained raised and kept observations at two an hour.

49. That evening, Mr Afzal was moved from the First Night Centre to the induction unit. An officer recorded that Mr Afzal had been warned not to misuse his emergency cell bell.

50. On the morning of 20 June, a SO chaired the ACCT review which was attended by Nurse B and Nurse C from the mental health team, and Mr Afzal. The SO noted that Mr Afzal initially refused to engage again but the review took place in his cell. Mr Afzal said he had no thoughts of suicide or self-harm and that he had only said he had such thoughts earlier because he had wanted to be taken to hospital and not kept in prison. The SO noted that Mr Afzal often appeared 'child-like' and that she and Nurse C thought he may have learning difficulties and that they had referred him to a nurse the Learning Disability (LD) nurse. She also noted that Nurse C thought Mr Afzal may have some mental health issues if he did not have learning difficulties, so this would be reviewed once the nurse had seen him.

51. The SO completed the caremap with four issues: possible learning difficulties and refer for assessment; possible mental health issues and engage with assessment; being in custody and to understand why; and to speak to family for support. She updated the caremap to show that referrals had been made to the mental health team and to the nurse for a learning disability assessment (although there is no evidence that a referral for the latter was made). The SO also recorded that Mr Afzal understood the reason why he was in prison and that he said he had spoken to his family and was waiting for a visit. (In fact, Mr Afzal had not used the PIN telephone system and did not make any calls, or receive a visit, while he was at Leeds.)

52. Staff at the review considered that all the caremap actions had been completed and that Mr Afzal's risk of suicide and self-harm was low, so they stopped ACCT procedures. A post-closure review was scheduled for 27 June. (A SO wrote in his police statement that he completed the post-closure review, but the prison was unable to provide a copy of the review.)

53. That afternoon, staff noted that Mr Afzal did not go to work because he had 'mental health issues', and that had been warned about misusing his emergency cell bell on three separate occasions during the day.

B Wing: 21 June to 23 July

54. On 21 June, Mr Afzal was moved from the induction unit to B Wing, a standard residential wing.

55. On 24 June, Mr Afzal was due to appear in court by videolink, but he refused to attend.

56. On 26 June, a pharmacy technician noted that she had asked Mr Afzal why he had not been collecting his antidepressant medication and he said he did not know he had medication to collect. She asked Mr Afzal to collect his medication each morning when he was unlocked for association.

57. On 27 June, an officer noted in Mr Afzal's prison record that he seemed unable to pay attention when spoken to, and he did not seem to understand the prison regime as he kept using his cell bell to ask to be let out. She had moved him to another cell as his previous cellmate did not get on with him because Mr Afzal seemed paranoid and unable to trust anyone. She noted that the mental health team had been contacted but they said they could not do much as he was not in crisis. She also noted that Mr Afzal had not collected his medication because he said he did not need it.

58. Later that day, an officer warned Mr Afzal about his constant use of the emergency cell bell.

59. On 28 June at 2.53pm, a HCA from the mental health team recorded in Mr Afzal's medical record that he had refused to come out of his cell for a wellbeing assessment and just shook his head when she spoke to him. Mr Afzal's cellmate told the HCA that he wanted to move out of the cell because of Mr Afzal's odd behaviour and that he had not slept because he was scared of him. The HCA spoke to a wing officer who told her that Mr Afzal's cellmate was being moved later that day and that she had contacted the mental health team 'on numerous occasions' about Mr Afzal's behaviour.

60. The HCA recorded that she spoke to Nurse B on her return to the healthcare unit and that she had made Mr Afzal a 'red flag' task for the mental health team (high priority messaging on the electronic medical record for an urgent referral). She noted that Nurse B said she and Nurse A would assess Mr Afzal during their weekend shift (29 and 30 June). There is no evidence that this was done.

61. On 30 June, an officer noted in Mr Afzal's prison record that he had walked around the wing with a razor in his hand during the meal time, despite being told not to.

62. On 1 July, an officer noted in Mr Afzal's prison record that he still seemed intimidated by others, that his old cellmate had been trying to encourage him to come out on association and keep his cell clean, but that he was still not going for medication and still seemed to not understand the prison regime. She noted that Mr Afzal was being given his meals but she was unsure whether he had been eating as he often said he felt that everywhere was unclean and he could not stay there.

63. Later that day, a prison GP recorded that Mr Afzal had been discussed at the multidisciplinary team meeting (MDT) because of his bizarre behaviour on the wing. He noted that Mr Afzal was due to be assessed by the mental health team.

64. Also on 1 July, a nurse recorded that she had received a message from the HCA that Mr Afzal was not collecting his medication and that he was not well enough to complete the wellbeing assessment. A nurse noted that Mr Afzal had been given a new appointment for the wellbeing assessment on 4 July. Later that day, there is an entry in Mr Afzal's medical record that he did not attend for blood tests; no reason is recorded. The appointment was rescheduled for 16 July.

65. On 2 July, Nurse B completed a mental health assessment for Mr Afzal. Mr Afzal said that he had used cannabis in the past and was stressed and anxious about being in prison. He said his mood was 'not good' and that he had stopped taking his antidepressant medication as he felt he was getting better and 'can make himself well'. Nurse B advised Mr Afzal it was unwise to stop medication without discussion with healthcare staff. Mr Afzal said he was sleeping but not eating as he did not like the prison food. He said he had no thoughts of suicide or self-harm but that he needed help with his mental health. Nurse B noted that Mr Afzal was experiencing situational anxiety and depression and encouraged him to take his prescribed medication. She concluded that Mr Afzal needed a full mental health assessment and noted 'booked to clinic'.

66. The next day Mr Afzal failed to attend an appointment with a prison GP; no reason is recorded.

67. On 4 July, an officer recorded that Mr Afzal had repeatedly used his emergency cell bell but then just stared at him when he answered it. The officer noted that Mr Afzal seemed to struggle to communicate and that he would contact the mental health team to see if they were aware.

68. Later that morning, a Custodial Manager (CM) emailed Nurse A saying she was concerned that Mr Afzal had a learning disability because he did not understand the regime or what was expected of him. She asked if the LD nurse could look at him. Nurse A replied that Mr Afzal had been seen by Nurse B who had no immediate concerns about his mental health but had booked a further assessment, and that she had asked Nurse B to speak with a CM so that all concerns were shared. She added that the LD nurse would try and catch Mr Afzal on the wing or do a joint assessment next week. A nurse told the investigator that she never received a referral for a learning disability assessment.

69. On 5 July, an officer encouraged Mr Afzal to clean his cell and provided him with cleaning products, but she recorded that he did not seem to understand. Other prisoners cleaned Mr Afzal's cell. and staff moved him to a single cell. The CM noted that there were concerns about Mr Afzal's behaviour and mental health that left him at risk from others.

70. That evening, an officer issued a negative IEP warning to Mr Afzal for constant misuse of his emergency cell bell. He noted, 'When I get to his door he just stands staring.'

71. On 7 July, a member of staff recorded in Mr Afzal's medical record that he had come to the medication hatch and had declined his antidepressant medication but asked for two plastic cups. When she gave them to him, he refused them and insisted she give him two from the middle of the pile. She noted that the skin around Mr Afzal's eyes 'looked very dry and grey in colour'. She sent a task to the mental health team raising her concern that Mr Afzal was not taking his medication. On 9 July, a nurse's responded and said Mr Afzal had been booked for a mental health assessment the next day. However, Mr Afzal refused to attend on 10 July.

72. On 11 July, an officer noted that Mr Afzal had been escorted back to his cell after he ran past officers and sprinted up a staircase while they were responding to a general alarm.

73. On 12 July, a member of staff prescribed aqueous cream for Mr Afzal's dry skin. An officer noted that, after going to the medication hatch, Mr Afzal stood at the end of B Wing trying to get off the wing. The officer knew that Mr Afzal had run off the wing up the stairs the previous day and gave him several direct orders to return to his cell, which Mr Afzal ignored. He and another officer then used an approved guiding hold to walk Mr Afzal back to his cell.

74. Later that morning, an officer recorded that she had contacted the mental health team to see if they were aware of Mr Afzal and they had told her that they were, but that he had failed to attend his appointment on 10 July. The officer told the (unnamed) nurse that Mr Afzal's behaviour was bizarre and that there were numerous similar entries on his prison record. She noted that the nurse said they would see him when possible.

75. That afternoon, a Nurse C and Nurse 'BW' (no name recorded) went to the wing to assess Mr Afzal. Nurse C recorded in Mr Afzal's medical record that he 'appeared bewildered in presentation, if not frightened', and they were not able to engage him in conversation. Nurse C spoke to a CM who said that Mr Afzal had run off the landing several times, but that she had seen Mr Afzal collect his meals and that he had no reported loss of appetite. At interview, Nurse C said that, although Mr Afzal was slim, he did not appear malnourished and his skin did not look dry. She recorded that she had handed the information over to the MDT team and that Nurse B would visit Mr Afzal later the same day.

76. Nurse B went to the wing to see Mr Afzal shortly afterwards and spoke with the CM. Mr Afzal told Nurse B that he had run off the wing to attend prayers and that he had not attended his appointments with the mental health team because he was afraid of being around large groups of people. Nurse B noted that Mr Afzal's mental health had deteriorated since she last saw him and, although he was dressed appropriately, his cell was smelly. She recorded that Mr Afzal would have a full mental health assessment on the wing.

77. On 14 July, an officer recorded that Mr Afzal had been warned about constantly misusing his emergency cell bell.

78. On 15 July, a nurse and Nurse B went to the wing to complete a full mental health assessment. The nurse noted that Mr Afzal accused an officer of stealing his money and called her 'a bitch'. He said he only wanted to speak to Nurse B, but then refused to do so. The nurse noted that Mr Afzal appeared confused. His mouth was very dry but when offered a drink he said he would only drink mineral water. Prison staff said that Mr Afzal had been collecting his meals and had no concerns about him eating or drinking. The nurse noted that Mr Afzal would be discussed at the next MDT meeting with a view to him being assessed by the prison psychiatrist as soon as possible. She, incorrectly, recorded that Mr Afzal was 'currently on CSIP /and to consider opening should risk to self escalates'. (Challenge, Support and Intervention Plans (CSIP) are the Prison Service violence reduction measures.)

79. Mr Afzal failed to attend his appointment for blood tests on 16 July. A new appointment was made for 29 July.

80. On 16 July, the Multi-Professionals Complex Case Clinic (MPCCC) discussed Mr Afzal. They agreed that he should be referred to the prison psychiatrist and learning disability nurse for assessment. However, no minutes of the meeting were taken and no one made the referrals.

81. On 17 July, an administrator recorded in Mr Afzal's prison record that he had received a letter from Mr Afzal's father asking to speak to his son. He noted that he had updated Mr Afzal's PIN phone with his father's mobile number and would ask someone from the chaplaincy to give the telephone number and message to Mr Afzal. There is no evidence the chaplaincy team did so.

82. On 19 July, an officer was unlocking prisoners for association when Mr Afzal approached her asking for money he said she owed him. The officer said she explained that she did not have his money but that Mr Afzal swore at her and, as she walked away, he grabbed her hair and pulled her ponytail. Other prisoners intervened and staff placed Mr Afzal back in his cell and put him on a disciplinary charge. A CSIP referral was submitted to the Safer Custody Team.

83. The next day, a prison manager chaired the disciplinary hearing for Mr Afzal's assault on the officer. The prison manager recorded that Mr Afzal understood the charge against him, did not require assistance and that he pleaded not guilty. Mr Afzal did not attend the hearing. The prison manager adjourned the hearing until 2 August when it would be heard by an independent adjudicator.

84. Later that morning, an officer placed Mr Afzal on the basic IEP regime for a minimum of 28 days. The officer noted five targets for Mr Afzal: complete at least 28 days on basic; receive no further IEP warnings; be polite and respectful to prison staff; respect the prison regime; and relocate to the basic 1s/2s landing. An IEP review was scheduled for 27 July, but this did not take place (no reason is recorded).

85. On 21 July, staff gave Mr Afzal another IEP warning as he refused to go back to his cell at the end of association. He was taken back to his cell by another prisoner.

86. On 23 July, a SO from the Safer Custody Team, completed an investigation in response to the CSIP referral. No further action was taken and Mr Afzal was not supported under CSIP measures.

A Wing: 24 July onwards

87. The next day, in accordance with the target in his IEP plan, Mr Afzal moved to A Wing, the incentivised unit. He was moved to a single occupancy cell towards the far end of the wing. CM A said that he met Mr Afzal when he arrived and immediately noticed he was thin and unkempt, his teeth were yellow and he smelled unclean and did not engage. He said he felt that Mr Afzal had mental health problems. He did not make a note of this meeting in Mr Afzal's prison record.

88. On 29 July, Mr Afzal failed to attend for blood tests. No reason was recorded.

Friday 2 August

89. On 2 August, CCTV footage shows an officer going to Mr Afzal's cell at 10.01am to collect him for his disciplinary hearing. He said that when he told Mr Afzal that he was taking him to the segregation unit for his hearing, he did not seem to understand. Mr Afzal did not speak or say anything, but 'looked timid' and stared at the floor. The officer said he had not met Mr Afzal before and he assumed that English may not be his first language. He asked Mr Afzal several times to follow him and took the lack of response as a refusal to attend. He told Mr Afzal that the hearing would probably proceed in his absence and he left the cell.

90. CCTV shows Mr Afzal then came slowly out of his cell, wearing an oversized tracksuit top and bottoms, with a shirt over his sweatshirt, and walked towards the four steps that lead up to the main landing. When Mr Afzal reached the steps, he hesitated before he put his foot on the first step and took nearly four seconds before he could step up, while holding onto the handrail for support. It took nearly 13 seconds for Mr Afzal to climb the four steps; he looked frail and weak. When he reached the top of the steps, Mr Afzal was unsteady on his feet and swayed to the left as he walked towards the wing office. Mr Afzal walked out of the sight of the camera and CCTV stops at 10.02am.

91. At 10.09am, staff called a code blue (a medical emergency code used to indicate a prisoner is unconscious or having breathing difficulties, which alerts healthcare staff and tells the control room to call an ambulance immediately) when they found Mr Afzal slumped in a chair. CM A told the investigator that Mr Afzal was very thin and unkempt and his teeth were yellow. He said that Mr Afzal looked almost like he was having a seizure and just stared straight through him.

92. Nurse D responded to the code blue. She said she had not met Mr Afzal before. She noted that he was uncommunicative, appeared disorientated, had a dry mouth and was 'slightly dehydrated', although he declined water. She said that SO B and CM A told her that Mr Afzal had not been eating or drinking. (CM A told the investigator that he did not know Mr Afzal was not eating or drinking, although he also said that he knew other prisoners were giving Mr Afzal some

of their food because they were concerned that he was not eating, although he did not know if Mr Afzal was eating it or not.)

93. Nurse D noted that Mr Afzal's observations (blood pressure, pulse, respiratory rate and blood sugar) were all within normal ranges. She cancelled the ambulance. She said she observed Mr Afzal from the wing office for about 10 minutes and could see him looking around, which suggested he was aware of where he was. She said other prisoners spoke to him but he did not engage with them.

94. Nurse D sent a task to the healthcare administrator for Mr Afzal to be seen by a GP on Monday 5 August. She did not make any arrangements for him to be reviewed by a nurse over the weekend. She said she told CM A and SO B to contact healthcare if there were any further concerns. CM A said he assumed healthcare staff would monitor Mr Afzal during the rest of the day and so he did not ask wing staff to check on him.

95. CCTV shows that Mr Afzal was escorted back to his cell by prison staff. Officer C and another officer, were either side of Mr Afzal, holding his arms and providing support as he was walked back to his cell. CCTV shows that Mr Afzal was struggling to keep up with the pace of the officers and looked frail.

96. That afternoon, Officer C recorded that she had been to see Mr Afzal for his key worker session but that he did not want to engage. She noted that this was usual behaviour for him. She told the investigator that she had tried to talk to Mr Afzal, but he did not engage and ignored her, which she described as 'just very typical Afzal'. She said wing staff were aware he had 'difficulties' but, although she observed he was 'thin', she did not have any concerns about his physical health, despite the earlier incident. Officer C also said she did not have any concerns that Mr Afzal was not eating or drinking. She said; 'I remember his cell being very messy… but other than that I don't think I took that much notice.'

97. This was the last entry in Mr Afzal's prison record before he died.

Saturday 3 August

98. Officer D unlocked Mr Afzal's cell at around 9.30am to give him his breakfast pack, but he declined it.

99. CCTV shows that at 10.20am, Officer D returned to Mr Afzal's cell. She then used her radio to call her colleague, Officer E, and asked her to come to check on Mr Afzal. Officer D told the investigator that Mr Afzal was still in bed, his mouth was very dry and his cell was very messy. At 10.36am, an unidentified prisoner and Officer D went into Mr Afzal's cell to clean and make it tidier.

100. Officer E arrived at 10.37am. She said she had never met Mr Afzal before and knew nothing about him. She asked a Listener (a prisoner trained by Samaritans to support other prisoners) to assist her. The Listener entered Mr Afzal's cell at 10.40am. At 10.44am, CCTV footage stops.

101. Officer E told the investigator that the Listener offered Mr Afzal a cup of water but he refused, saying it was poisoned. Mr Afzal was in bed covered by the

bedding but she could see he was thin and had dry lips, and she saw that there was a lot of uneaten prison food (packaged food, noodles and crisps) in a pillowcase in the corner of his cell. She removed the surplus food from the cell so that staff could monitor if he was eating. She did not start formal food monitoring measures. She asked another prisoner if he would speak to Mr Afzal to try to encourage him to eat and drink. She thought Mr Afzal might open up to him because he was also a Muslim.

102. The prisoner told the investigator that he had never met Mr Afzal before, but went to his cell around 10.45am, with Officer D, to see if he could help. He said Mr Afzal was lying on the bottom bunk and looked 'very, very, very unwell… very, very, like, lethargic, very unwell' and 'his mouth was very, very dry and it was foamed'. He said Mr Afzal looked as though he had not eaten or drunk for a long time. He gave Mr Afzal some Lucozade which he opened himself. He said he initially thought Mr Afzal had said 'stroke' and assumed that was what was wrong with him, but after a couple of minutes realised he was trying to say 'straw'. A straw was provided to help Mr Afzal drink. The prisoner said he remained with Mr Afzal for around 45 minutes while he had the drink. Officer D said she gave Mr Afzal a sealed packet of Pringles and saw him eat two.

103. The prisoner said Mr Afzal was very weak and not able to hold a conversation. He said his cell was bare and had no television or kettle. The prisoner said he tried to bargain with Mr Afzal to eat, if he was given a television. He said when he asked Officer D about getting a television for Mr Afzal, she said it was beyond her remit but she would try to sort it out. The prisoner said he was locked in his cell at lunchtime and he had no further contact with Mr Afzal.

104. While the prisoner was with Mr Afzal, Officer E used her radio to contact the duty nurse. She said she was concerned about Mr Afzal and that there was a lot of unopened food in his cell. The duty nurse said that she could not attend the wing as she was dealing with another prisoner and told Officer E to contact a HCA. Officer E telephoned a HCA but she said she could not help as she was in reception and was busy completing health screening. She told Officer E to contact the duty nurse (which she had already done).

105. Officer E said she was fed up, so put the phone down. She said it was normal for healthcare to say they would come when they were free. She said she did not think Mr Afzal's condition was life-threatening but she was sufficiently concerned to want someone from healthcare to see him. The duty nurse told the investigator that because she was not contacted again, she assumed the matter had been dealt with. These conversations were not recorded in Mr Afzal's prison or medical notes.

106. Officer D said she got Mr Afzal a halal curry and a sealed drink at lunchtime, and a cheese sandwich in the afternoon, but that although she encouraged Mr Afzal to eat the food, he did not do so.

107. Officer E told the investigator that she saw Nurse A on the wing later in the day and raised her concerns about Mr Afzal. She said Nurse A told her she was aware of Mr Afzal and would see him, but did not give a timescale. This contact is not recorded in either the prison or medical record.

108. Officer E said she subsequently spoke to SO B, the wing SO who was located in the segregation unit (on the landing below Mr Afzal's unit). He told her that healthcare had seen Mr Afzal the day before in response to a code blue and had said that Mr Afzal's clinical observations were 'sufficient for someone who had been eating'.

109. Officer D said prisoners were locked up in their cells for the night around 5.30pm. She said she told an officer of the concerns about Mr Afzal during the day, but did not make an entry in either Mr Afzal's electronic prison record or the wing observation book. Officer E also made no entry about her contact with Mr Afzal.

110. An officer was the night officer and completed a roll check around 8.30pm. He did not know Mr Afzal and had no concerns about him during the night.

Sunday 4 August

111. CCTV shows an officer looked through the observation panel of Mr Afzal's cell at 9.15am. He saw him lying motionless on the bottom bunk of the bed, with his eyes fixed and staring at the bunk above. The officer entered the cell. He could not get a response from Mr Afzal and could not see him breathing.

112. At 9.18am the officer radioed an emergency code blue. He lifted Mr Afzal off his bed and laid him on the floor. An officer responded to the code blue and started cardiopulmonary resuscitation (CPR). A CM arrived and assisted with CPR. A CM and Officers D, E and another officer also responded. They locked other prisoners back into their cells and helped to ensure the ambulance was not delayed entering the prison.

113. A nurse and Nurse E responded to the emergency and arrived at Mr Afzal's cell at 9.20am. They found Mr Afzal lying on the floor unresponsive, with fixed pupils. Prison staff continued CPR. The nurse attached an automatic defibrillator, which indicated that no shock was advisable but that CPR should be continued. Nursing staff recorded that Mr Afzal appeared to be suffering from a cardiac arrest (asystole - the most serious form of cardiac arrest which is usually irreversible). Oxygen was missing from the emergency response bag, but was collected by an officer from a nearby wing. Nurse E described Mr Afzal as appearing 'very emaciated'. She said he had a waxy complexion, was gaunt, pale and that his skin was sunken and stuck to his teeth. None of the prison staff involved in the emergency response activated their body-worn video cameras (BWVCs).

114. Prison and healthcare staff continued CPR until paramedics arrived at 9.26am. The paramedics established a heartbeat about 40 minutes later. While on the stretcher being taken to the ambulance, Mr Afzal had another cardiac arrest but his heart was restarted and he left the prison for Leeds General Infirmary at 10.24am. He was accompanied by two officers but not restrained. Mr Afzal arrived at the hospital at 10.27am. He was pronounced dead at 10.50am.

115. Mr Afzal weighed 46kg (7st 3lbs) when he died, which meant that he was very underweight. The hospital made a referral to the adult safeguarding team and noted neglect and self-neglect.

Contact with Mr Afzal's family

116. The prison appointed a SO as the family liaison officer (FLO) when Mr Afzal was taken to hospital. The FLO, accompanied by an SO, left Leeds at 10.45am, to inform Mr Afzal's family that he was seriously ill in hospital. Before they arrived, they were told that Mr Afzal had died. They went to Mr Afzal's father's address and another family address noted on Mr Afzal's file, but were told that nobody from the family lived there.

117. The FLO contacted the prison and local police to ask for assistance and was provided with Mr Afzal's mother's address. The FLO arrived at the address at 11.50pm and informed Mr Afzal's mother and sisters of his death. Mr Afzal's mother said he had refused to eat for months as he believed food was contaminated and did not believe it was Halal. The family were very angry and said that they felt the prison had allowed him to starve. The FLO left the family home at 12.20pm, and met Mr Afzal's father and other family members at the hospital.

118. The FLO telephoned Mr Afzal's father that evening, and offered ongoing support. The FLO role was taken on by the prison Imam, who continued to liaise with Mr Afzal's family. The prison contributed towards the costs of Mr Afzal's funeral, in line with national policy.

Support for prisoners and staff

119. The operational manager debriefed the prison staff involved in the emergency response and those that escorted Mr Afzal to hospital. Healthcare staff were supported by their healthcare provider.

120. The prison posted notices informing other prisoners of Mr Afzal's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Afzal's death. The prisoner who assisted Mr Afzal the day before he died, said he felt well supported by prison staff. Some other prisoners told the investigator that there was a lot of upset on the wing as nobody from the chaplaincy visited.

Post-mortem report

121. The post-mortem report concluded that Mr Afzal died from acute bronchopneumonia (inflammation of the lungs). The pathologist noted that Mr Afzal was emaciated and that 'bronchopneumonia commonly occurs when a person is debilitated and/or has pre-existing lung disease, and it is recognised that a poor nutritional state will increase a person's susceptibility to developing a chest infection'. The pathologist identified no underlying disease which might explain Mr Afzal's low body weight.

Findings

122. During the 48 days he spent at Leeds, Mr Afzal lost 19kg (3st), a third of his body weight, and he was seriously underweight when he died from bronchopneumonia. The pathologist noted that it was likely that Mr Afzal's poor nutritional state would have increased his susceptibility to a chest infection. We have, therefore, considered how it was possible for him to have lost so much weight in full view of both healthcare and prison staff without any action being taken.

Clinical care

Mental health

123. One key failing was that Mr Afzal's probable learning disability and/or mental health issues were never properly assessed. We are extremely concerned that, although prison staff repeatedly raised concerns with healthcare staff, these were not followed up.

124. Mr Afzal appeared confused throughout his time at Leeds and was described as bewildered and child-like. He appeared unable to pay attention when spoken to and to understand simple commands, often responding to staff either by staring at them or just shaking his head. Although prison staff were concerned that Mr Afzal may have a learning disability, he was never assessed by the learning disability nurse. We have not been able to identify why the learning disability nurse did not see Mr Afzal. Despite it being noted three times in his medical and prison record that he would be referred to her for assessment, there is no evidence that this was ever done and the nurse told us she was not made aware of Mr Afzal.

125. Staff also thought that Mr Afzal's difficulties and bizarre behaviour may have been due to mental health issues. Despite referrals being made, he was never properly assessed by mental health staff.

126. Nurse B and Nurse A agreed they would see him over the weekend of 29 and 30 June, but they did not do so. Nurse B saw Mr Afzal on the wing on 2 July, but said that a full assessment was needed. This never happened.

127. Mr Afzal failed to attend for his mental health assessment on 10 July and then did not engage with the rearranged assessment on 12 July. Nurse B and another nurse saw Mr Afzal on the wing on 15 July, but noted that he was very confused and there is no evidence that a full assessment was completed.

128. The other nurse referred Mr Afzal to the complex case meeting and he was discussed there on 16 July. It was agreed that he should be referred to the prison psychiatrist and for a learning disability assessment, but these decisions were not recorded and were never actioned. The mental health team had no further contact with Mr Afzal before he died on 4 August.

129. Mr Afzal was prescribed antidepressants when he arrived at Leeds but never collected them. Despite pharmacy staff flagging this, Mr Afzal's failure to collect his medication was never followed up.

130. We do not consider that this was an acceptable level of care and we share the clinical reviewer's view that the standard of mental health care Mr Afzal received at Leeds was not equivalent to that he could have expected to receive in the community. We recommend:

The Head of Healthcare should ensure that:

- **referrals for learning disability assessments are actioned and followed up;**
- **referrals for mental health assessments are actioned and any follow ups are actioned promptly;**
- **discussions and decisions made at multidisciplinary meetings on complex cases are accurately recorded in medical records and all actions are followed up; and**
- **staff adhere to the policy on medication refusal.**

131. This is the sixth case in two years where we have found that the standard of mental health care at Leeds was not equivalent to that which could have been expected in the community. In response to a previous recommendation about ensuring the mental health care provision at Leeds met the needs of the prison's population, we were told that NHS England was carrying out a review, due to be completed in April 2020. We recommend:

The NHS Director of Commissioning for North East and Yorkshire Region should write to the Ombudsman setting out how he intends to improve mental health care provision at Leeds.

Physical health

132. A further concern is that although mental health nurses saw Mr Afzal quite frequently, they apparently did not notice the deterioration in his physical health. The only member of healthcare staff who appears to have noticed and expressed concern was the pharmacy technician, although, given her role, there was a limit to what she could do.

133. When Mr Afzal entered prison in March 2019, he weighed 72kg (11st 4lbs) but this was not entered in his medical records. When he returned to prison in June 2019, he weighed 65kg (10st 3lbs), meaning he had lost 7kgs (about a stone) in three months. If his weight had been recorded in his medical notes in March, this weight loss might have been picked up and rung alarm bells when he lost more weight from June onwards.

134. On 2 August, when Nurse D responded to the code blue after Mr Afzal collapsed, she took Mr Afzal's blood pressure over his clothing (a thick sweatshirt and shirt). The clinical reviewer said that this is not good practice as it can give an inaccurate reading. If Nurse D had exposed Mr Afzal's bare arm to take his blood pressure, she would have got a more accurate reading and would also have seen how underweight he was.

135. The clinical reviewer was also concerned that Nurse D did not record Mr Afzal's temperature or National Early Warning Score (NEWS – a tool used to assess clinical deterioration), and did not obtain a urine or blood sample or consider an

electrocardiogram (ECG) to try and understand why Mr Afzal had collapsed. The clinical reviewer considered that, given Mr Afzal's age and presentation, Nurse D should have arranged for him to go to hospital for assessment, and was concerned that she did not even arrange for him to be monitored by healthcare staff over the weekend.

136. The clinical reviewer also considered that Nurse D should have considered monitoring Mr Afzal's food and fluid intake, as prison staff had told her that he had not been eating or drinking.

137. The clinical reviewer concluded that the clinical care Mr Afzal received at Leeds was not equivalent to that he could have expected to receive in the community. We recommend:

The Head of Healthcare should ensure that where prisoners are unwell, but do not require hospital admission, staff:

- **take a full set of clinical observations and calculate and record the National Early Warning Score (NEWS);**
- **follow the correct procedures for taking blood pressure readings;**
- **take additional observations/interventions where appropriate; and**
- **follow up with documented clinical welfare checks.**

Monitoring Mr Afzal's food/drink intake

138. Although prison staff consistently expressed concerns about Mr Afzal's mental health, there is mixed evidence about whether they were aware that he was not eating.

139. Prisoners told the investigator that everyone on the wing, including staff, knew that Mr Afzal was not eating and drinking. An officer recorded her concern that Mr Afzal might not be eating as early as 1 July, and Mr Afzal told Nurse B the next day that he was not eating as he did not like the food. On 7 July, the pharmacy technician, recorded that the skin around Mr Afzal's eyes was dry and grey and on 15 July, a nurse noted that Mr Afzal had a dry mouth and said he would only drink mineral water.

140. On 2 August, when Nurse D responded to the code blue, she said that SO B and CM A told her that Mr Afzal was not eating or drinking and described him as 'just bone'. (We note that CM A told the investigator both that he did not know that Mr Afzal was not eating, and that he knew other prisoners were giving Mr Afzal food because they were concerned he was not eating.)

141. However, on 12 and 15 July, wing staff told nursing staff that Mr Afzal was collecting his meals and that they had no concerns that he was not eating. It was not until 3 August, the day before his death, that staff realised how much uneaten food Mr Afzal had in his cell.

142. We recognise that the baggy prison-issue clothes Mr Afzal wore, and the fact that staff often spoke to him when he was in bed, hid the extent of his weight loss. Staff who witnessed him being given CPR on the day of his death were shocked by how emaciated he was without clothes. The move to a new wing 12

days before his death also helped to obscure his weight loss, since staff on the new wing assumed he had always been thin.

143. However, we consider that there were sufficient grounds for concern for healthcare or wing staff to have considered monitoring whether Mr Afzal was eating the food he was given. We are surprised that the fact that he was apparently stockpiling unopened food in his cell was not identified during the regular cell accommodation and fabric checks, although it is possible that he was disposing of it in the rubbish. We are also concerned that there is no evidence that wing staff raised their concerns about Mr Afzal's eating and drinking with healthcare staff before 2 August.

144. We are particularly concerned by the lack of staff action on 2 and 3 August.

145. The clinical reviewer noted that, although Nurse D was told on 2 August that Mr Afzal was not eating or drinking, she did not do a urine test to determine if he had ketoacidosis (which would have indicated if there was a problem) and did not consider starting food monitoring.

146. The CCTV footage of 2 August shows that Mr Afzal was extremely fail and weak and struggled to walk unsupported. We do not consider that it required medical training to know that this was not normal for a 22-year old and that Mr Afzal was unwell. We are therefore concerned that neither CM A or SO B made arrangements for staff to monitor Mr Afzal for the rest of the day and over the weekend. CM A said he did not do so because he assumed that Nurse D would arrange to monitor him. We are concerned that he made this assumption without checking with Nurse D. We also take the view that CM A and SO B were responsible for Mr Afzal's overall welfare and that they should have exercised this responsibility proactively instead of leaving everything to the nurse.

147. When it became clear on 3 August that Mr Afzal had a lot of uneaten food in his cell, we are concerned that Officer E did not persevere in her attempts to contact healthcare staff for advice, and that neither she or Officer D considered starting food monitoring.

148. We are also very concerned that SO B took no action on 3 August when Officer E told him that Mr Afzal was not eating and was very weak. Although he had been reassured by Nurse D the previous day that Mr Afzal's observations were consistent with him eating, she had advised him to contact healthcare again if there were any further concerns. He should have done so when Officer E spoke to him. Even if Nurse D did not tell him to contact healthcare, we consider that he should have exercised his judgement and done so, as Mr Afzal was clearly not improving and there was now hard evidence that he was not eating. He should also have started food monitoring.

149. We are concerned that there were missed opportunities to put food monitoring and supportive measures in place, but that no one considered doing so. We are also concerned that there was poor communication between prison and healthcare staff about Mr Afzal's food and fluid intake, particularly in the two days before he died. We recommend:

The Governor and Head of Healthcare should ensure all staff know how to formally monitor and record food and fluid intake if there are concerns about a prisoner not eating or drinking.

ACCT

150. The day after Mr Afzal arrived at Leeds, HCA Tye appropriately started ACCT procedures when Mr Afzal told him he had thoughts of suicide. This was good practice.

151. At the first ACCT review on 20 June, a SO added four actions to the caremap including: 'possible learning difficulties and possible mental health'. At the same time, the actions were marked as completed, as referrals had been made. The review considered that Mr Afzal's risk had reduced to low and the ACCT was closed.

152. If the ACCT had remained open, it is possible that this would have helped to ensure that Mr Afzal was properly assessed by the learning disability and mental health nurses. However, we are satisfied that it was not unreasonable for the ACCT to have been closed on the basis that Mr Afzal's risk of suicide and self-harm was low and that mental health and learning disability referrals had been made (although in fact there is no evidence that the learning disability referral was ever made).

153. The purpose of ACCT procedures is to support prisoners who are at risk of suicide or self-harm and at that stage there was no reason to consider that Mr Afzal was at risk. We do not consider that ACCTs should be kept open simply to facilitate mental health referrals. The problem in this case is that healthcare staff did not action mental health referrals promptly or thoroughly. It should not be necessary to keep ACCTs open to ensure that this happens.

154. We do, however, have a concern. Nurse A said that that she would complete a mental health assessment as part of the ACCT review. This is poor practice. Mental health assessments should be completed in private to give prisoners the opportunity to open up in confidence to a medical professional, and should not therefore be conducted as part of an ACCT review. We recommend:

The Head of Healthcare should remind all healthcare staff that formal mental health assessments should be completed in private and separately from the ACCT process.

Staff engagement with Mr Afzal

155. One reason why Mr Afzal's dramatic weight loss may have gone unnoticed is that there is very little evidence that staff had much meaningful contact with him during his 48 days at Leeds.

156. Only two officers, recorded any engagement with Mr Afzal and both contacted healthcare to express their concerns about him. The only other entries in his

prison record are brief negative entries recording warnings given to him for misusing his cell bell.

157. We recognise that Mr Afzal was a difficult prisoner to engage with and that the fact that he was odd, unkempt and smelled bad probably meant that staff did not choose to spend time with him. But he was clearly vulnerable and we are concerned that the wing SOs did not ensure that staff kept an eye on him and identified any concerns.

158. Under the Offender Management in Custody (OMiC) model every prisoner should have a dedicated key worker as their first point of contact to assist with any difficulties. We found no evidence that Mr Afzal was assigned a key worker when he first arrived at Leeds. We are concerned that this was a possible missed opportunity to identify that Mr Afzal was not eating or drinking and that his mental health needs were not being addressed.

159. There is only one record of a key worker session in Mr Afzal's prison record, made by Officer C on 2 August, seven weeks after Mr Afzal arrived at Leeds and two days before he died. Officer C, said she could not remember when she was assigned as Mr Afzal's key worker, but thought it was only shortly before she met him on 2 August – although in that case we would have expected her to have recorded that she had introduced herself to Mr Afzal as his key worker.

160. Officer C told the investigator that she worked on the wing so she was familiar with Mr Afzal. She said she had tried to talk to him on 2 August, but he did not engage and ignored her, which she described as 'just very typical Afzal'. We appreciate that Officer C could not make Mr Afzal talk to her. However, a code blue had been called that morning after Mr Afzal collapsed, and Officer C said she was aware of 'his difficulties'. We are therefore very concerned that Officer C did not make more effort to satisfy herself about Mr Afzal's wellbeing. She said herself, 'I don't think I took that much notice'.

161. We do not consider this was an appropriate attitude for a key worker dealing with a young man who was clearly vulnerable, who was thought to have mental health problems and who had collapsed a few hours earlier. If she had taken some notice and arranged for his 'very messy' cell to be tidied (as Officers D and E did the following day), the unopened food might have been identified earlier. This was another missed opportunity to identify that Mr Afzal was not eating or drinking.

162. We recommend:

The Governor should ensure that staff engage with all the prisoners in their care and make regular entries in their prison record, especially about any concerns.

The Governor should ensure that:

- **all prisoners are allocated a key worker in line with Prison Service policy;**
- **staff are scheduled adequate time to perform the key worker role; and**

- **key workers understand that their role is to engage, motivate and support the prisoners allocated to them.**

The Governor should write to the Ombudsman setting out what he is doing to address the uncaring culture displayed by some officers and managers in their dealings with Mr Afzal.

Incentives and Earned Privileges

163. We have a number of concerns about Mr Afzal being placed on basic for at least 28 days following his assault on an officer by pulling her hair.

164. No account seems to have been taken of the effect on Mr Afzal's mental health of being placed on basic. A review should have been held on 27 July, but this did not happen and there is no explanation recorded. The objectives Mr Afzal was set were very generic and there is no evidence of what, if anything, was done to support him to progress or achieve these objectives, or that Officer C, Mr Afzal's key worker, was involved. If there had been more proactive engagement with Mr Afzal, there may have been an opportunity to identify that he was not eating and how physically unwell he was. We recommend:

The Governor should ensure staff adhere to local policy on the management of those prisoners on the basic IEP regime, including the involvement of key workers, to support prisoners to achieve their targets.

Learning from this report

165. The healthcare provider completed a comprehensive early learning review after Mr Afzal died. An equivalent review was not undertaken by the Prison Service Regional Safer Custody Team as these are usually only undertaken in self-inflicted deaths. We consider it important that staff should learn the lessons from this report. We therefore recommend:

The Governor and Head of Healthcare should commission a joint review, with senior prison and healthcare managers, into the circumstances surrounding Mr Afzal's death, with specific regard to:

- **improving communication between prison and healthcare staff; and**
- **developing a clear escalation process when prison staff have concerns about the mental or physical health of a prisoner.**

The Head of Healthcare should ensure that a programme of regular clinical supervision and support is agreed for the nurses involved in Mr Afzal's care: Nurses A, B, C, D and E.

The Governor should share this report with Officers C, D and E, SO B and CM A, and arrange for a senior manager to discuss the Ombudsman's findings with them.

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 I 020 7633 4100
F I 020 7633 4141