

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Pawel Rozanski a prisoner at HMP Maidstone on 28 September 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 Pawel Rozanski was found hanged in his cell at HMP Maidstone on 27 September 2015, and died in hospital the next day. He was 39 years old. I offer my condolences to Mr Rozanski's family and friends.

In June 2015, Mr Rozanski made a serious attempt on his life and was monitored under Prison Service suicide and self-harm prevention procedures until his death. The investigation identified some shortcomings in how staff managed the procedures, including that they did not use interpreting services to ensure Mr Rozanski could fully engage in the process. However, at the time of his death, I consider that it would have been difficult for prison staff to have identified that he was at imminent or high risk of suicide and I do not believe they could have foreseen or prevented his actions.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

June 2016

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Summary

Events

1. In March 2015, Mr Pawel Rozanski was remanded to HMP Chelmsford after assaulting his partner and setting fire to their house while he and his stepdaughter were inside. Mr Rozanski was Polish and did not speak or understand English well. Prison staff monitored him under using Prison Service suicide and self-harm prevention procedures (known as ACCT) for one day. On 24 March, Mr Rozanski was transferred to HMP Norwich.
2. On 27 June, Mr Rozanski attempted suicide by cutting his throat, wrists, and other parts of his body. He spent three days in hospital and staff began ACCT procedures again. When Mr Rozanski returned to Norwich, he was admitted to the prison's inpatient unit and staff constantly supervised him. A psychiatrist assessed him and prescribed antipsychotic and antidepressant medication. Staff held frequent ACCT reviews using interpreting services.
3. On 10 July, Mr Rozanski was sentenced to four years in prison. He told staff that he had expected that length sentence. On 17 July, staff decided that Mr Rozanski no longer needed to be constantly supervised and, on 14 August, he was discharged to a standard wing
4. On 25 August, Mr Rozanski was transferred to HMP Maidstone, a specialist centre for foreign national prisoners. He said he was happy to move and had no thoughts of suicide or self-harm. A psychiatrist reviewed him and increased his medication doses. Staff at Maidstone held frequent ACCT reviews, without using an interpreting service. Mr Rozanski said that he had no thoughts of suicide or self-harm and had settled well at Maidstone.
5. Around 9 September, Mr Rozanski stopped taking his medication regularly. No one spoke to him about this until 22 September, when he saw the psychiatrist again. They discussed his decision to stop taking his medication. He decided he did not want to take antipsychotic medication any longer but agreed to continue taking antidepressants. The psychiatrist referred Mr Rozanski to the GP to review his medication. Staff recorded no concerns about Mr Rozanski in the following days.
6. At about 8.50am on 27 September, an officer unlocked Mr Rozanski's cell and found him hanged. He was taken to hospital but never recovered. He died in hospital the next day.

Findings

7. The investigation found that Mr Rozanski was well supported at Norwich but no one informed his family of his serious suicide attempt in June.
8. Very few of the ACCT case reviews at Maidstone were multidisciplinary. Although Mr Rozanski was receiving support from the mental health in-reach team, a nurse only attended one of his case reviews. The prison could not find some of the ACCT record, so we do not know whether staff at Maidstone reviewed or updated Mr Rozanski's caremap.

9. We are concerned that staff at Maidstone used interpreting services at only one of Mr Rozanski's ACCT reviews. Staff said that he spoke and understood English well enough, but we note that staff at Norwich had used interpreting services at every review. We consider that as Maidstone's specific role is to manage foreign national prisoners, staff should have assessed his proficiency in English and used an interpreting service if necessary.
10. Although some of the ACCT procedures could have been managed better, we are satisfied that staff had no reason to consider Mr Rozanski's risk of suicide had substantially increased in the days before his death or that the frequency of ACCT observations needed to be increased. We do not consider that staff could reasonably have foreseen or prevented Mr Rozanski's actions on 27 September.
11. Mr Rozanski received adequate mental health care at Maidstone, but we are concerned that when he stopped taking his medication regularly, no one followed this up or alerted the psychiatrist.

Recommendations

- The Governor of Maidstone should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines with multidisciplinary ACCT case reviews, which include all relevant people involved in a prisoner's care.
- The Governor of Maidstone and Head of Healthcare should ensure that there is an objective assessment of proficiency in English and that professional interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor, particularly in health assessments and when assessing prisoners at risk of suicide and self-harm.
- The Head of Healthcare at Maidstone should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach.
- The Governor of Norwich should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Maidstone informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator visited Maidstone on 2 October. He obtained copies of relevant extracts from Mr Rozanski's prison and medical records and interviewed two prisoners.
14. NHS England commissioned a clinical reviewer to review Mr Rozanski's clinical care at the prison.
15. The investigator interviewed 13 members of staff and one prisoner at Maidstone. The clinical reviewer joined him for the interviews with healthcare staff. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response has been annexed to this report.
16. We informed HM Coroner for Kent of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Rozanski's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Rozanski's mother asked for more information about whether her son was receiving his medication and wanted to know more about his time in prison. She said that no one from Norwich had contacted her when Mr Rozanski attempted suicide in June. Mr Rozanski's family 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 Maidstone

18. HMP Maidstone holds up to 600 foreign national prisoners mostly in single cells. The prison's healthcare unit is open from 8.00am to 6.30pm Monday to Friday. On Saturday and Sunday, and on bank holidays, the healthcare unit is staffed by a single member of staff from 8.00am to 6.00pm. Kent Healthcare Consortium (a joint venture between Oxleas NHS Foundation Trust and the Medical Centre, Maidstone) provides primary healthcare services at Maidstone. Oxleas provide the mental health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Maidstone was in September 2015. Inspectors found that prisoners at risk of suicide and self-harm received generally good care, although the quality of ACCT documents was varied and they were not always sufficiently focussed on the causes of the prisoner's risk. Staff did not always use formal interpreting services to support prisoners in crisis and sometimes other prisoners were used as interpreters in case review meetings. Inspectors reported that the relationships between staff and prisoners were generally courteous and relaxed.
20. Inspectors found good primary and secondary mental health care. Members of the mental health in-reach team attended ACCT case reviews and their planning and progress notes in prisoner's medical records were of a very good standard.

Independent Monitoring Board

21. 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 February 2015, the IMB reported that the process for managing ACCT records and observations had been reviewed and improved.

Previous deaths at HMP Maidstone

22. The last self-inflicted death at Maidstone was in 2013. In that investigation, we were concerned that ACCT case reviews were not multidisciplinary, which we also found in this investigation.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (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.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011

Key Events

26. On 9 March 2015, Mr Pawel Rozanski, a Polish citizen, assaulted his partner and set fire to the house while he and his stepdaughter were inside. The police had to remove Mr Rozanski forcibly from the burning building. They arrested him and charged him with arson with intent to endanger life, assault and threatening behaviour with a bladed article. He spent the next two days in police custody.
27. On 11 March, Mr Rozanski appeared at court. The police completed Mr Rozanski's Person Escort Record (PER), a document that goes with prisoners when they move between police stations, courts, and prisons. They recorded that he had set fire to his home and had refused to leave. Court custody staff completed a suicide and self-harm warning form, noting the same information as the PER and that they had been unable to question Mr Rozanski further about this because of a "language barrier". Mr Rozanski was remanded to HMP Chelmsford. It was his first time in prison.
28. At Mr Rozanski's initial health screen, Nurse A decided to start Prison Service suicide and self-harm monitoring procedures, known as ACCT. She recorded that although Mr Rozanski said he had no thoughts of suicide or self-harm he appeared low and withdrawn. The nurse wrote that Mr Rozanski had limited English. Dr A, a prison GP, recorded that Mr Rozanski seemed calm and pleasant, made good eye contact, and was not suicidal. He did not prescribe any medication.
29. On 12 March, Officer A assessed Mr Rozanski as part of the ACCT process. The officer recorded that Mr Rozanski was in prison for the first time and spoke limited English, but there is no record that the officer used an interpreting service. Mr Rozanski said that he was worried about his son, who lived in Poland. He said that he was in regular contact with his partner and friends in the United Kingdom, and spoke often to his son in Poland. At his first ACCT case review later that day, Mr Rozanski said he had no problems and had no thoughts of suicide or self-harm. Mr Rozanski explained that he had been very drunk when he had set fire to his house and did not know what he was doing. The staff assessed Mr Rozanski as at a low risk of suicide and self-harm (from options of low, raised and high) and decided to end the ACCT monitoring. On 20 March, a supervising officer (SO) met Mr Rozanski for an ACCT post-closure review. Mr Rozanski said that he had no thoughts of suicide or self-harm and the ACCT remained closed.
30. On 24 March, Mr Rozanski transferred to HMP Norwich. Nurse B assessed Mr Rozanski when he arrived, using a telephone interpreting service. Mr Rozanski said he had no thoughts of suicide. The nurse noted that Mr Rozanski had refused to leave a burning building and referred him to the primary care mental health team.
31. On 25 March, Nurse C assessed Mr Rozanski's mental health and asked him why he had refused to leave his house when it was burning. Mr Rozanski told The nurse that he had been drunk and angry at the time, and had not known what he was doing. He said he had not been trying to kill himself. Mr Rozanski told the nurse that he became aggressive when he was drunk but, otherwise, he

was a nice person. The nurse recorded that Mr Rozanski had no previous history of mental health problems. Mr Rozanski said he did not need mental health support but knew how to get help if he needed it. The nurse wrote that Mr Rozanski spoke and understood English well and did not need an interpreter. After the assessment, the nurse recorded that Mr Rozanski's care would be discussed at the next primary care mental health team meeting.

32. On 27 March, Nurse C recorded in Mr Rozanski's medical record that the primary care mental health team had decided to discharge Mr Rozanski from their caseload.
33. At around 8.45am on 27 June, staff found Mr Rozanski sitting upright on his bed in a pool of blood. Mr Rozanski had cut his throat, abdomen, both wrists and shoulder. Mr Rozanski was taken to hospital, where he spent three days in the critical care unit. There is no record that staff at Norwich told his family that he had attempted suicide and was seriously ill in hospital.
34. On 30 June, Nurse D, from the mental health in-reach team, and Dr B, a consultant psychiatrist, visited Mr Rozanski in hospital. The doctor recorded that Mr Rozanski did not want to talk about his current thoughts of self-harm. The doctor concluded that this was Mr Rozanski's second serious act of self-harm, with the first being his refusal to leave his burning house. The doctor decided to prescribe quetiapine, an antipsychotic medication at 25mg a day, and advised staff to supervise Mr Rozanski constantly. The doctor found no evidence that Mr Rozanski was experiencing hallucinations or paranoia but thought that he should be assessed for transfer to a secure psychiatric hospital. The doctor urgently referred Mr Rozanski to Dr C, a consultant forensic psychiatrist at a secure hospital.
35. That afternoon, Mr Rozanski returned to the prison and was admitted to the healthcare inpatient unit. At 4.40pm, a prison manager, Nurse D and Mr Rozanski met for the first ACCT case review, for which they used a telephone interpreting service. Mr Rozanski said he had no issues, but the staff recorded that he was guarded during the review. The staff assessed that Mr Rozanski was at a high risk of suicide and self-harm and should remain in the inpatient unit and be constantly supervised. They recorded one caremap action, for a mental health management plan to be put in place. As well as his mental health medication, Mr Rozanski was prescribed pain relief medication and iron tablets because he had lost a lot of blood.
36. On 1 July, Nurse D assessed Mr Rozanski's mental health again, with an interpreter present. Mr Rozanski said that he wanted to move to a prison closer to his friends. He said that he would not try to harm himself again because he had a young son in Poland. The nurse noted that the mental health care plan was to continue to prescribe quetiapine, for Mr Rozanski to have regular psychiatric reviews, to encourage him to socialise with other prisoners and for staff to monitor his behaviour.
37. Over the next six days, staff held further ACCT reviews, aided by an interpreter, and assessed Mr Rozanski as still at risk of suicide. Staff continued to supervise him constantly.

38. On 2 July, Dr C assessed Mr Rozanski after Dr B's referral. Dr C concluded that, although Mr Rozanski had made a serious attempt on his life, there was no evidence of any mental illness and he was not suitable for transfer to a secure hospital. Dr C agreed to reassess Mr Rozanski if there was any change in his mental state.
39. On 7 July, Dr D, a prison psychiatrist, assessed Mr Rozanski, using the telephone interpreting service. Mr Rozanski told the doctor that his medication was helping ease his feelings of stress and tension and his poor sleep. Mr Rozanski said he had been feeling very low for some time, but now felt much calmer. He described several triggers to his low mood, including the deaths of several family members, the end of a relationship, increased work stress and that the mother of his child had been diagnosed with a serious illness. The doctor increased the quetiapine dose to 100mgs a day and also prescribed an antidepressant medication, mirtazapine (15mgs a day).
40. On 10 July, Mr Rozanski was sentenced to four years in prison. When he returned from court, he told Nurse E, from the mental health in-reach team, that he had expected that length of sentence. Mr Rozanski said he felt neither good nor bad about it, but said he had no thoughts of suicide or self-harm.
41. At an ACCT case review on 11 July, Mr Rozanski seemed quite positive and told staff he could now focus on his release date. Although the staff considered that he was at a low risk of suicide or self-harm they decided that he should remain subject to constant supervision.
42. On 17 July, at an ACCT case review, Mr Rozanski said that reports of his offence in the local newspaper had upset him, but that he had no thoughts of harming himself. Mr Rozanski said his medication was working well and he was happy to stay in the inpatient unit. He said that he had support from his family and was due a visit the following week. The review reduced the frequency of Mr Rozanski's observations to three each hour.
43. On 21 July, Mr Rozanski told Dr D that his mood had deteriorated over the previous three days and he was not sleeping well. He said that he was working as a wing cleaner and that being busy helped to manage his low mood. Mr Rozanski said he had no thoughts of suicide or self-harm. He described some psychotic symptoms and the doctor increased the dosage of quetiapine to 200mgs per day. The doctor suggested that the ACCT observations should be increased to four an hour, which staff put in place at a review later that day.
44. At an ACCT review on 24 July, Mr Rozanski said he would like to be discharged from the inpatient unit so he could mix with other Polish prisoners. The staff assessed Mr Rozanski as at a low risk of suicide or self-harm and reduced the frequency of observations to one an hour.
45. On 4 August, Mr Rozanski again said he would like to be discharged from the inpatient unit. Staff agreed to consider moving him to a standard wing the next week. They reduced the frequency of the observations to three checks during the morning, afternoon, and evening shift and three observations during the night. They reviewed the caremap and added another action, for Mr Rozanski to be given a job on the wing (which it seems he already had).

46. On 5 August, Mr Rozanski told Dr D that he was feeling and sleeping better. The psychiatrist noted Mr Rozanski was making good progress, but that the mental health team should continue to monitor him closely. Over the next few days, Mr Rozanski continued to talk positively about his future and said he had a good relationship with his partner, who visited him often.
47. On 14 August, Mr Rozanski was discharged from the inpatient unit to a standard wing. A mental health nurse visited him every day to check him. Mr Rozanski seemed to settle well and said he had no thoughts of suicide or self-harm.

HMP Maidstone

48. On 25 August, Mr Rozanski transferred to HMP Maidstone, a specialist centre for foreign national prisoners. Nurse F saw Mr Rozanski when he arrived and noted that he had no thoughts of suicide or self-harm. The nurse recorded that the mental health team would assess him once he had settled at Maidstone. Mr Rozanski was given a single cell on Weald Wing, the induction unit.
49. The next day, 26 August, a nurse from Norwich's mental health team briefed a member of the mental health in-reach team at Maidstone about Mr Rozanski's mental health.
50. Later on 26 August, SO A, another SO from the offender management unit and Mr Rozanski met for an ACCT case review. No member of healthcare staff attended, but SO A told the investigator that, before the case review, she had spoken to someone from the healthcare department who said they had seen Mr Rozanski the day before and that someone from the in-reach team would see him again later that day. SO A said that she asked Mr Rozanski if he wanted to use an interpreting service, but he said he did not need this. SO A said that he could communicate well without one and she had no concerns about his level of understanding.
51. Mr Rozanski seemed to be in high spirits. He said he was happy to be at Maidstone and wanted to attend education classes. The staff assessed him as a raised risk of suicide and self-harm because he had only just arrived at Maidstone and they did not know him yet. They changed the frequency of checks to one conversation in the morning and afternoon, and once an hour when he was locked in his cell. SO A said that she added one action to the caremap, to make sure that he was able to make international phone calls to his son. The caremap in Mr Rozanski's ACCT plan contains no entries from his time at Maidstone. The prison could not find some pages of Mr Rozanski's ACCT document. We do not know if later pages of the caremap are also missing, or whether staff at Maidstone added any actions.
52. Dr E, a psychiatrist from the mental health in-reach team, assessed Mr Rozanski that afternoon. Again, Mr Rozanski said that he did not want to use an interpreter. The doctor recorded in Mr Rozanski's medical record that he seemed a little low when talking about his experiences of bereavement but, otherwise, he was not depressed. The doctor considered that, although Mr Rozanski's mood had improved, he still had ongoing issues, which might have contributed to his suicide attempt. The doctor recommended that ACCT monitoring should continue while Mr Rozanski was settling in at Maidstone and

- being assessed. She increased the dose of mirtazapine to 30mg a day and the quetiapine dose to 220mg a day. Mr Rozanski continued to receive iron tablets.
53. On 31 August, Mr Rozanski asked to see an immigration officer about returning to Poland after his sentence. An immigration officer, saw Mr Rozanski the next day, and recorded that Mr Rozanski wanted to sign the relevant deportation documents in February 2016.
 54. Later on 1 September, SO B chaired an ACCT review, with someone, from the mental health in-reach team, an officer, and an interpreter present. Mr Rozanski engaged well and said he was happy to be at Maidstone. The staff assessed Mr Rozanski as at a low risk of suicide or self-harm and reduced the level of observations to one recorded conversation in the morning and afternoon and six checks during the night. The person from the mental health in-reach recorded in Mr Rozanski's medical record that he seemed stable and said he had no thoughts of suicide or self-harm. She wrote that he had said he did not want to die and was happy to go back to Poland at the end of his sentence.
 55. On 7 September, Mr Rozanski's offender supervisor recorded that a contact restriction order had been put in place. This meant that Mr Rozanski was not allowed to contact his stepdaughter (who had been present when he set fire to his house) but could still speak to his son in Poland. SO A decided to bring forward Mr Rozanski's ACCT case review so that they could discuss this in a supportive environment. A member of staff, from the offender management unit, and a prison chaplain, attended the case review. The SO did not invite a member of healthcare staff to attend the review. She said this was because she had arranged the review in a hurry and did not think about this. The SO recorded that Mr Rozanski took the news of the contact restrictions well and that they had given him the forms to apply for them to be lifted. Mr Rozanski said he had no thoughts of suicide or self-harm. His level of risk and frequency of observations remained unchanged.
 56. On 8 September, Mr Rozanski told Dr E that he now felt more settled at Maidstone, had made friends, and was engaging in activities, like playing pool and going to the gym. Mr Rozanski told the doctor that he had no thoughts of suicide or self-harm, that his appetite was good and he was sleeping. Mr Rozanski agreed to continue with his current medication regime and to consider bereavement counselling. The doctor wrote that the mental health in-reach team should continue to monitor him.
 57. On 12 September, Officer B recorded in Mr Rozanski's case notes that he had completed an application for a job as a wing cleaner and said he was happy at Maidstone. Mr Rozanski told the officer that since he had been at Maidstone he had had no thoughts of suicide or self-harm and had found staff more approachable than at his previous prisons.
 58. On 14 September, SO C, SO D, and a wing officer, held an ACCT case review. SO C could not recall whether he had invited anyone or sought a contribution from either the general healthcare team or mental health in-reach team. SO C told the investigator that Mr Rozanski spoke English well enough and they did not need to use an interpreting service. Mr Rozanski seemed in good spirits and they discussed him working as a cleaner on the wing, which staff thought might

help support him. The staff did not change Mr Rozanski's assessed level of risk or the frequency of observations.

59. On 19 September, Officer C recorded in the ACCT record that Mr Rozanski thought his medication was too strong and was making him feel sick. Officer C advised Mr Rozanski to speak to healthcare staff about this but he said he did not feel like speaking to them at that time. From Mr Rozanski's medical record, it seems that he took his medication only sporadically after 9 September. There is no evidence that healthcare staff noted that Mr Rozanski was not taking his medication regularly, or talked to him about this. (The prison was unable to find the ACCT record for the period from after 9.55pm on 20 September until 9.45am on 23 September.)
60. On 21 September, SO E and Officer E held an ACCT case review with Mr Rozanski. SO E did not invite anyone from the healthcare department or any other prison department to attend the case review. He noted that Mr Rozanski seemed to be in a very good mood. He had started work as a wing cleaner and was happy about this. Mr Rozanski told the SO he had stopped taking his medication as it made him feel sick. The SO advised Mr Rozanski to see the doctor who might be able to prescribe alternative medication. The staff did not change Mr Rozanski's assessed level of risk or the frequency of checks and there is no record of any further entries in his caremap. The next review was due on 28 September.
61. On 22 September, Nurse G, from the mental health in-reach team assessed Mr Rozanski. Mr Rozanski said he had no thoughts of suicide or self-harm. He said he had a cleaning job on the wing and that everything was good. The nurse recorded that Mr Rozanski seemed guarded and did not want to discuss how he was dealing with his feelings of loss, and worry about his ex-partner's illness. The nurse noted that the ACCT should remain open and that he would see Mr Rozanski again in two weeks. The nurse did not record anything about Mr Rozanski stopping his medication.
62. Later that afternoon, Dr E saw Mr Rozanski again. The doctor told the investigator that, before seeing Mr Rozanski, she had checked his record and realised that he was not taking his medication. Mr Rozanski told the doctor he was not taking his iron tablets, as they gave him stomach ache, or his quetiapine. The doctor and Mr Rozanski discussed that he might become depressed again, but that Mr Rozanski could decide not to take his medication if he wanted. The doctor stopped the prescription for the quetiapine and referred Mr Rozanski to the prison GP for a medication review. Mr Rozanski agreed to continue taking his antidepressant medication. The doctor recorded in Mr Rozanski's medical record that ACCT monitoring should continue because Mr Rozanski was still at risk of suicide and self-harm. The doctor noted that healthcare staff should monitor his mental health and check he took his antidepressant medication.
63. On 23 September, Officer D recorded in the ACCT record that Mr Rozanski was enjoying his work as a wing cleaner. .
64. On 24 September, Dr F, a prison GP, reviewed Mr Rozanski's medication. Mr Rozanski said that he had been taking his iron tablets. The doctor stopped the

prescription and arranged for Mr Rozanski to have a blood test the following week.

65. At 5.40pm on 26 September, Officer E wrote in the ACCT record that Mr Rozanski had said that he was all right.
66. The night patrol officer on Mr Rozanski's wing on the night of 26/27 September. At 8.00pm, 10.00pm, 11.50pm, and 2.05am noted in the ACCT record that Mr Rozanski was watching television. At 4.00am, when he checked, Mr Rozanski was asleep.

Sunday 27 September 2015

67. At about 7.30am on 27 September, Officer D started work and took over from night patrol officer. He checked and noted that Mr Rozanski was sitting on the chair in his cell, watching television and drinking a cup of tea. Mr Rozanski told the officer he was okay. The officer said he had no concerns about Mr Rozanski when he checked him.
68. At around 8.50am, Officer E and Officer F started unlocking cells on the wing. When Officer F unlocked Mr Rozanski's cell he was sitting on the floor with a sheet around his neck, which was tied to a television he had put on the top bunk. Officer F called for help and went into the cell. Officer E arrived at the cell a few seconds later and cut the sheet while Officer F supported Mr Rozanski's weight. Officer E and Officer G also responded to Officer F's call and while Officer D collected the defibrillator, Officer G started cardiopulmonary resuscitation. According to prison logs, at 8.54am, Officer E radioed a code blue medical emergency (indicating a prisoner is unconscious, not breathing or having difficulty breathing).
69. Nurse H heard the code blue and reached Mr Rozanski's cell soon after. She and Officer G (who had been the first aid instructor at Maidstone) continued to attempt to resuscitate Mr Rozanski.
70. According to the ambulance service log, staff in the control room requested an ambulance at 8.56am. The first response paramedic arrived at the prison at 9.00am, reached Mr Rozanski's cell at about 9.05am, and took over his care. An ambulance arrived at 9.10am. The paramedics stabilised Mr Rozanski's condition, and at 10.13am, left for Maidstone General Hospital.
71. At around midday, hospital staff called Nurse H and said Mr Rozanski was on a life support machine. Mr Rozanski did not recover and he died at 11.55am the next day, 28 September.

Contact with Mr Rozanski's family.

72. SO F was the prison's family liaison officer. When Mr Rozanski arrived at the prison, he had not given any contact details for his next of kin and there were no next of kin details recorded in the ACCT documents. SO F found details for his mother, who lived in Poland and, on 27 September, phoned the Polish Embassy for assistance, but it was closed. On the morning of 28 September, the SO spoke to a consular assistant at the Embassy and asked them to help tell his family he was seriously ill in hospital. The Embassy said that they would not tell

his family until he had died. Later that day, after Mr Rozanski had died, the Embassy confirmed that Mr Rozanski's mother had been told of his death.

73. Mr Rozanski's father visited the prison 11 November. In line with national instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

74. The Head of Offender Management debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising. He offered them his support and that of the staff care team.
75. After Mr Rozanski died, staff checked all prisoners subject to ACCT procedures in case they had been adversely affected by Mr Rozanski's death.

Post-mortem report

76. A post-mortem examination recorded Mr Rozanski's death was caused by hanging. The toxicology examinations found no trace of Mr Rozanski's prescribed medication. No other drugs were detected.

Findings

Managing the risk of suicide

77. In February 2015, when Mr Rozanski was remanded to Chelmsford, staff monitored him under ACCT suicide and self-harm prevention procedures for one day because he had set fire to his home and then refused to leave, and he seemed low in mood. In June, while at Norwich, Mr Rozanski attempted suicide by cutting his throat, wrists and other parts of his body, and was subject to ACCT procedures again which remained in place until his death.
78. Mr Rozanski moved to Maidstone one month before he died. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires a multidisciplinary approach for case reviews with relevant people involved in the prisoner's care. At Norwich, someone from the mental health team had attended each of the ACCT case reviews. At Maidstone, only one of the six reviews held involved someone from the mental health team, although Mr Rozanski was receiving mental health care.
79. In our Learning from PPO investigations bulletin covering prisoner mental health, published in January 2016, we highlighted the importance of mental health teams attending and contributing to all ACCT reviews for prisoners under their care and being fully involved in any important decisions about location, observations, and risk. We make the following recommendation:

The Governor of Maidstone should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines with multidisciplinary ACCT case reviews, which include all relevant people involved in a prisoner's care.

80. Maidstone could not find some pages from Mr Rozanski's ACCT plan and the caremap contains no entries from his time at Maidstone. We do not know whether this is because staff made no entries or the relevant pages are missing.
81. Staff at Maidstone told the investigator that Mr Rozanski's level of English was reasonable and he was able to speak and understand English. However, at almost every ACCT review held at Norwich, staff recorded that they had used an interpreter. At Maidstone, staff used an interpreter for one of Mr Rozanski's reviews. Prisoners who do not speak or understand English well should be given access to an interpretation service so they can fully participate in the ACCT process. It is difficult to know how well Mr Rozanski was able to communicate his feelings in a second language and, without an objective assessment of language skills, we consider that there should be presumption that an interpreter should be used. This is particularly important at a prison like Maidstone, which is a specialist centre for foreign national prisoners. We note HM Inspectorate of Prisons found at an inspection in September 2015 that staff at Maidstone did not always use interpreting services when necessary. We make the following recommendation:

The Governor of Maidstone and Head of Healthcare should ensure that there is an objective assessment of proficiency in English and that professional interpreting services are used for prisoners who do not

understand English well, whenever matters of accuracy or confidentiality are a factor, particularly in health assessments and when assessing prisoners at risk of suicide and self-harm.

82. Mr Rozanski had apparently settled in well at Maidstone and told staff that he was happy to be there and had made friends. We have found nothing to suggest he was having any problems at the prison, or to indicate that his risk of suicide had substantially risen in the days leading to his death. While we have identified a need for some improvement in ACCT procedures, we do not think that staff could reasonably have predicted or prevented his actions.

Clinical care

83. The clinical reviewer reviewed the clinical care Mr Rozanski received at Maidstone and considered that he had good access to the mental health in-reach team. She was satisfied that Mr Rozanski's care was equivalent to what he could have expected to receive in the community.
84. Mr Rozanski had been prescribed both antipsychotic (quetiapine) and antidepressant medication (mirtazapine). However, in September, Mr Rozanski stopped taking his medication. On 22 September, Dr E discussed this with Mr Rozanski and agreed to stop prescribing quetiapine. Mr Rozanski said he would continue to take mirtazapine, but the results of the toxicology tests conducted after his death suggest that Mr Rozanski was not taking any of his prescribed medication.
85. Dr E only found out Mr Rozanski had not been taking his medication when she checked his record. There is no evidence that any member of healthcare staff had noted or followed up with Mr Rozanski why he had stopped taking his prescribed medication before that. We make the following recommendation:

The Head of Healthcare at Maidstone should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach.

Emergency response

86. When Officer F discovered that Mr Rozanski had hanged himself, he shouted for help, but he did not radio a code blue emergency. However, Officer E radioed a code blue when he arrived at the cell, very shortly afterwards.
87. Officer F told the investigator that he knew he should have radioed a code blue, but his priority was to get into the cell and help Mr Rozanski. We consider that there was only a very slight delay in calling the emergency code and that this did not affect the outcome for Mr Rozanski.

Family liaison

88. We are satisfied that there was appropriate family liaison after Mr Rozanski's death. However, Mr Rozanski's mother was concerned that no one had contacted his family when he made a very serious suicide attempt at Norwich in

June 2015. We found that Norwich supported Mr Rozanski very well during this crisis but there is no evidence of any family contact.

89. Prison Rule 22 says that the prison should inform the next of kin of a prisoner if they are seriously ill. PSI 64/2011 says that when prisoners have suffered sudden life-threatening harm, the prisoners' wishes on who they would like to be contacted must be obtained where possible. When Mr Rozanski was taken to hospital on 27 June, he was in a very serious condition and he spent three days in the hospital's critical care unit. There is no record that anyone sought his views about family contact and no one informed them that he was seriously ill in hospital. We make the following recommendation:

The Governor of Norwich should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

**Prisons &
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