

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Marcin Mazurek a prisoner at HMP Garth on 8 August 2015

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



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Marcin Mazurek was found hanged in his cell at HMP Garth on 8 August 2015. He was 32 years old. I offer my condolences to his family and friends.

While it might have been difficult for prison staff to have identified that Mr Mazurek was at immediate and high risk of suicide at the time of his death, the investigation found that he did not get the support he needed through Prison Service suicide and self-harm prevention procedures. Monitoring ended a few weeks before his death, before his identified problems had been resolved. He had harmed himself shortly afterwards, but monitoring did not begin again. Mr Mazurek was segregated at his own request, but without the safeguards that should have applied when he was assessed as at risk of suicide and self-harm and he did not get the level of mental health support I would expect to see. Although it would not have affected the outcome for Mr Mazurek, no one called an ambulance as soon as Mr Mazurek was found hanged. It also took too long to notify Mr Mazurek's family of his death.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**May 2016**

## Contents

Summary .....	1
Events.....	1
Findings .....	2
The Investigation Process.....	4
Background Information.....	5
Key Events.....	6

# Summary

## Events

1. Mr Marcin Mazurek, who was Polish, arrived in the UK in 2005. In December 2012, he was remanded to prison for the attempted murder of his ex-partner and her aunt. In May 2013, he was sentenced to 30 years in prison.
2. Mr Mazurek had been at HMP Garth since June 2013. When he arrived he said he was upset about the length of his sentence. He did not want to be referred to the mental health team for support, but a GP prescribed an antidepressant. Mr Mazurek stopped taking the antidepressant later in 2013, as he said it did not agree with him. He had little contact with healthcare staff for the next two years.
3. In May 2015, Mr Mazurek passed two notes to a prison officer in which he said he felt unsafe. He later said that a prisoner he had known from his previous prison had told other prisoners he was a rapist and as a result he was receiving threats. He did not give any names and his allegations were not fully investigated. He asked to move to the segregation unit for his own protection. Initially he was segregated on his wing and then moved to a segregation overspill unit.
4. On 17 June, Mr Mazurek damaged property in his cell and told officers that prisoners were bullying him. Officers kept an eye on his cell but found no evidence of this. On 18 June, he was moved to the segregation unit. On 30 June, Mr Mazurek cut his wrist and staff began suicide and self-harm prevention procedures (known as ACCT). On 4 July, a supervising officer, acting alone, ended ACCT procedures. Mr Mazurek cut himself again on 6 July, but no one began ACCT monitoring again. An officer did not note this further self-harm at an ACCT post-closure review on 11 July.
5. On 2 July, Mr Mazurek had asked to see someone from the mental health team but no one went to see him until 5 August. A mental health nurse said he would not engage, so she was unable to assess him properly. She did not consider he was a suicide risk. Mr Mazurek said that he wanted to be left alone and go back to Poland for the rest of his sentence.
6. On 7 August, Mr Mazurek declined to see immigration staff about his transfer because he had stomach ache. The next day, for the same reason, he said he was unable to see his brother, who had travelled a long way to see him. That night, at around 8.20pm, a night patrol officer found Mr Mazurek hanged in his cell. He radioed a code blue emergency and went into the cell immediately. He and another officer cut the ligature and lowered Mr Mazurek to the bed. A nurse arrived quickly, but noted signs of rigor mortis and concluded that Mr Mazurek had died and it would not be appropriate to try to resuscitate him. At 8.45pm, the night manager asked control room staff to call an ambulance. Paramedics assessed Mr Mazurek and considered he had died. A doctor later recorded his death.

## Findings

7. It is not clear whether Mr Mazurek's allegations of bullying were real or imagined, and a friend of his suggested they were result of paranoia. However, we do not consider that officers investigated his concerns fully, in line with the prison's violence reduction procedures or consider whether this raised his risk of suicide or self-harm.
8. When staff began ACCT procedures they did not consider whether there were exceptional circumstances for him to remain in the segregation unit, and he did not have an urgent mental health assessment as he should have done. The ACCT was closed prematurely, by a manager acting alone and without any healthcare input into the ACCT process. Caremap actions to address his risk were not specific and time bound and did not address some of his concerns. The ACCT case managers did not attend segregation reviews, as they should have done.
9. We do not consider that Mr Mazurek received appropriate mental health support. As well as not having an urgent mental health assessment after he harmed himself in the segregation unit, he later waited a month before someone from the mental health team went to see him at his request. He did not engage at the time and there was no further follow up.
10. The officer who found Mr Mazurek hanged in cell radioed a code blue medical emergency but control room staff did not call an ambulance immediately, as national instructions require. It took too long to inform Mr Mazurek's brother of his death.

## Recommendations

- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular that:
  - Prisoners assessed as at risk of suicide or self-harm are not segregated unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
  - Segregated prisoners assessed at risk of suicide and self-harm have an urgent mental health assessment within 24 hours.
  - There is a multidisciplinary approach for all case reviews, with healthcare staff attending all first case reviews
  - Caremap actions, are specific, meaningful and time bound, aimed at reducing prisoners' risks and reviewed and updated as necessary.
  - Staff re-open an ACCT when a prisoner self-harms or otherwise indicates increased risk.
  - ACCT case managers attend segregation reviews.

- The Governor and Head of Healthcare should ensure that prisoners held in segregated conditions are managed under the provisions and safeguards of PSO 1700, including setting an appropriate frequency of checks, that a member of healthcare staff checks segregated prisoners daily and records this, and that there are careplans for prisoners segregated for more than 30 days.
- The Head of Healthcare should ensure that referrals to the mental health team for prisoners assessed as at risk of suicide and self-harm are actioned promptly and that assessments include plans to mitigate their risk.
- The Governor should ensure that the control room calls an ambulance as soon as an emergency medical code is called.
- The Governor should ensure that when a prisoner dies, a member of Prison Service staff informs the next of kin in person if possible and without undue delay.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator visited Garth on 18 August. She obtained copies of relevant extracts from prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Mazurek's clinical care at the prison.
14. The investigator interviewed 16 members of staff at Garth between August and December 2015. The clinical reviewer and investigator interviewed healthcare staff together.
15. On 3 December, the investigator received a record of a complaint from a prisoner who had not responded directly to the notice of the investigation but had asked officers to see the investigator. The prison said his application had got lost and he subsequently complained. He declined to see the investigator when she visited Garth on 10 December.
16. We informed HM Coroner for Preston 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 Mazurek's brother, to explain the investigation. He had no specific matters for the investigation to take into account.
18. Mr Mazurek's brother received a copy of the initial report. The solicitor representing him wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

# Background Information

## HMP Garth

19. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Lancashire Care Foundation Trust Healthcare provides health services.

## HM Inspectorate of Prisons

20. The most recent inspection of HMP Garth was an unannounced inspection in January 2015. Inspectors reported that support for prisoners at risk of suicide and self-harm ranged from poor to very good. They noted that a high number of prisoners sought moves to the segregation unit for their own protection and that there was no strategy to help them return to a standard wing. Inspectors reported that the conditions in the segregation unit were poor.

## 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 November 2014, the IMB reported that the management of the segregation unit had been weakened by staffing changes, and that it was not possible to operate a full and positive regime.

## Previous deaths at HMP Garth

22. Since 2004, when the Ombudsman began investigating deaths in prisons, there have been three self-inflicted deaths at Garth, including Mr Mazurek. There were no significant similarities with the circumstances of the other deaths.

## 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. Mr Marcin Mazurek was Polish, and had arrived in the UK in 2005. On 19 December 2012, he was remanded to prison charged with the attempted murder of his ex-partner and her aunt. This was his first time in prison. On 24 May 2013, he was convicted and sentenced to 30 years in prison. On 3 June 2013, he moved from HMP Forest Bank to HMP Garth. Prison staff said he spoke and understood English.
27. At an initial health screen at Garth, Mr Mazurek told a nurse that he had been prescribed sertraline for depression. He said he was depressed about the length of his sentence, but had no thoughts of suicide or self-harm. He did not want to be referred to the mental health team. A GP prescribed sertraline, although Mr Mazurek did not always collect it.
28. Mr Mazurek seemed to settle at Garth. Officers noted in Mr Mazurek's prison record that he worked well, over and above what was expected, was polite and participated well in team jobs. He saw healthcare staff for a number of minor complaints and managed to stop smoking.
29. Early in the morning on 15 May 2015, Mr Mazurek gave Officer A a note. It said:

"B-2/6 [his cell number] Important!!! Tomorrow I would like spoke with (PO) or SO. Please don't open my cell, Im not seift!!! Thank you..."
30. Mr Mazurek told Officer A that he was okay and confirmed that when he had written "seift", he meant "safe". Although Mr Mazurek had written that he wanted to speak to a principal officer (now custodial manager) or a supervising officer, the officer took no further action.
31. At 6.00am on 16 May, Mr Mazurek passed another note to Officer A. This time he had written:

"B-2/6 somebody today planning to kill me!!! Or stabbing please don't open cell thank you".
32. Officer A passed this information to managers and later that morning, a Supervising Officer (SO) spoke to Mr Mazurek about his concerns. The SO told the investigator that he had known Mr Mazurek since he had been at Garth, and was confident that he could speak and understand English.
33. Mr Mazurek told him that a prisoner he had known at Forest Bank had recently arrived at Garth and had told other prisoners that he was a rapist. He thought that some prisoners were going to stab him because of this but would not name anyone. The SO said that Mr Mazurek turned down the opportunity to move wings, as he was not sure that he would be safe. Mr Mazurek wrote a statement asking to be moved to the segregation unit for his own safety.
34. The prison's safer custody manager told the investigator that when the segregation unit at Garth was full, they used a landing on D Wing (D2) for prisoners segregated for their own safety. Both the segregation unit and the cells on D2 were full at the time, so Mr Mazurek remained in his cell on B Wing in segregated conditions. (The prison was unable to provide any formal records of

Mr Mazurek's segregation, including the initial authority to segregate, healthcare and other checks.)

35. On 25 May, Mr Mazurek told an officer that he no longer wanted to stay segregated and was willing to sign a disclaimer to say he understood the risks. However, after going out to the exercise yard for a period of time in the open air, he changed his mind. He said that he was still being bullied and while he was out on the exercise yard someone had shouted out at him through a window. He also said that prisoners came to his cell and threatened him. Officers did not investigate further and did not establish who the prisoners involved were.
36. Another Polish prisoner and a friend of Mr Mazurek's told the investigator that he thought Mr Mazurek had mental health problems and had just imagined he was under threat. After Mr Mazurek's death, another Polish friend told a SO that Mr Mazurek had told him that prisoners and night staff were plotting to get him and that prisoners were making racist comments to him at night. He thought that this was not true and was just in Mr Mazurek's mind. He said Mr Mazurek was depressed, paranoid and agitated and probably mentally ill. He said that Mr Mazurek had talked about his long sentence and that he would be 62 before he was released. He said he might as well be dead. He said that he tried to reassure him that he would leave prison before then and would still have his whole life in front of him. (Mr Mazurek would have become eligible for release on parole 19 December 2027, at the half way point of his sentence, when he would have been 44.)
37. In the afternoon of 25 May, Mr Mazurek moved to D2 spur. A nurse completed an initial segregation screen, and recorded that he was fit to be segregated. A risk assessment noted that Mr Mazurek was compliant and that two officers should be present when his cell was unlocked.
38. At a segregation review on 28 May, Mr Mazurek said that he wanted to move to another prison and to transfer to Poland to complete his sentence. According to the record of the review, Mr Mazurek participated well. His offender supervisor contacted seven prisons to see if they would accept him, but none agreed. Mr Mazurek wanted to speak to immigration staff about repatriation. However, he had just missed an immigration clinic for foreign national prisoners and accepted that he would need to wait to discuss this. The next segregation review had been scheduled for 12 June, but did not take place, as Mr Mazurek was no longer segregated. It appears that, in the interim, he had moved to D1 spur, which held prisoners who were in debt or vulnerable on other wings, but not in segregated conditions. There is no record of the date he moved.
39. Mr Mazurek did not raise any further concerns until 14 June, when he spoke to an officer about a personal injury compensation claim he had received from the victims of his offences, which he did not understand. The officer arranged for Mr Mazurek to phone his brother to get help to find a solicitor to deal with the claim. A Polish prisoner told the investigator that Mr Mazurek was very worried in case this meant he would have to stay longer in prison. Mr Mazurek said that he wanted to stay in his cell until he had spoken to a solicitor. He said that he was not under threat on D1 but he asked to move to the segregation unit.

40. As the segregation unit was full, Mr Mazurek stayed on D1 over the weekend. On 17 June, he smashed some prison property in his cell. An officer noted in Mr Mazurek's record that he had done this because he was stressed, as other prisoners were taunting him through his cell window.
41. Mr Mazurek told the officer that it was not just one person who was bullying him. He said that prisoners were nice to his face, but then called him behind his back. Wing officers decided that Mr Mazurek should stay locked in his cell and they would keep an eye on other prisoners, to identify who might be responsible for threatening him. They did not identify anyone. The officer referred Mr Mazurek to the mental health team in case he had any underlying mental health problems and he stayed in his cell on D1.
42. On 18 June, the Head of Security authorised Mr Mazurek's segregation for his own protection and he moved to the segregation unit. A nurse completed the initial segregation health screen and recorded that there was no medical reason not to segregate Mr Mazurek. He arranged a segregation review for 21 June. This took place as arranged but the record indicates that Mr Mazurek "moved from D1 to B Wing. Move did not work out, wants to go back to D1, although stated he has been bullied on D1". There is no clear record of the date Mr Mazurek moved to B Wing and why this move did not work out. The next review was arranged for 2 July and Mr Mazurek remained in segregated.
43. On 29 June, Mr Mazurek told a mental health nurse doing segregation rounds that he wanted some tablets for stress. She advised him that he needed to see the doctor to arrange this.
44. At 5.36pm on 30 June, during a routine segregation round, a GP noted in Mr Mazurek's medical record that there were "no issues". At 6.30pm, Mr Mazurek made what were described as superficial cuts to his left wrist and a nurse treated them with steri-strips. An officer began ACCT suicide and self-harm prevention procedures. Mr Mazurek told him that he had cut himself because he felt remorseful about his offences and he thought that he had mental health problems.
45. A SO completed an ACCT immediate action plan and decided that Mr Mazurek should stay in his cell and be checked every half an hour until he had been assessed. He noted that Mr Mazurek was aware that he could use a dedicated line to the Samaritans and have access to Listeners. (Prisoners trained by the Samaritans to offer support to other prisoners.)
46. At 12.22pm on 1 July, a healthcare manager saw Mr Mazurek during a routine segregation unit visit. He noted that Mr Mazurek had no current problems or disabilities.
47. At 4.53pm, Officer B assessed Mr Mazurek as part of ACCT procedures. She noted that he wanted to return to Poland to finish his sentence. He told her that he was still concerned that he would be bullied if he went back to an ordinary wing. She did not record anything about his mental health or his fears about bullying as actions to be followed up in the case review.

48. A SO and Officer B held the first ACCT case review at 5.50pm. No member of healthcare staff were present, although this is a mandatory requirement of ACCT procedures. They assessed Mr Mazurek as at low risk of suicide and self-harm and noted two objectives in the ACCT caremap. Firstly, that Mr Mazurek should apply to serve his sentence in Poland, and secondly, for him to remain in segregated conditions on D Wing. There was no record that they considered whether there were exceptional circumstances for Mr Mazurek to remain segregated conditions or whether he should be moved to a safer cell, as they should have done in line with Prison Service Order (PSO) 1700, which covers segregation. He did not have an urgent mental health assessment within 24 hours, as he should have done.
49. A SO arranged the next ACCT case review for 3 July, and recorded that a member of the mental health team should attend. The review set observations at three meaningful conversations during the day and early evening and once an hour at night. He was assessed as at low risk of suicide or self-harm. The SO noted on the caremap that he had reviewed the two actions, and noted that Mr Mazurek should remain segregated on D2.
50. The Head of the prison's Offender Management Unit (OMU), a nurse and a member of the IMB, held a segregation review on 2 July. PSO 1700 requires the ACCT case manager to attend segregation reviews. Two SOs and an officer were listed as case managers on the ACCT document, but none of them attended. Mr Mazurek said he was "not good". He asked again for an application to return to Poland, and to see someone from the mental health team. The nurse (an agency nurse who did not have her own caseload) told the investigator that she had been too busy to see him later that day, so she told her line manager. (Mr Mazurek did not have a mental health assessment until 5 August.) That day, his offender supervisor gave Mr Mazurek papers to apply to transfer to serve his sentence in Poland. She said she would arrange for him to speak to immigration staff at their next monthly surgery, on 7 August. (Although immigration staff would not deal with a transfer between prisons, she said that Mr Mazurek insisted on seeing them. She said that Mr Mazurek standard of English was good.)
51. Mr Mazurek told his offender supervisor that he had harmed himself so that staff would listen to him about wanting to remain segregated. To try to reduce his anxiety, she told him that he would not move back to a wing until he felt safe and wanted to do so. Later, Mr Mazurek asked an officer what he had to do to get back on a normal wing. She told him that he should speak to the duty governor during segregation rounds the next day. The next day, the duty governor noted in the segregation log that Mr Mazurek did not have any concerns.
52. On 4 July, a SO held a second ACCT case review, which had originally been scheduled for the day before. There were no other staff present. The SO said that she had asked an officer who worked on D2 spur how Mr Mazurek had been since his last review, but the officer did not attend the case review and neither did a member of healthcare staff. The SO told the investigator that it was always difficult to get healthcare staff to attend case reviews. She said that during the review, Mr Mazurek was laughing and joking and she did not think that he was likely to harm himself.

53. The SO assessed Mr Mazurek as a low risk of suicide and self-harm and noted that she had reviewed the problems identified in the caremap. She told the investigator that she closed the ACCT by herself because Mr Mazurek said that he felt a lot better and was happy for the ACCT to close. She scheduled a post-closure review for 11 July.
54. On 6 July, a nurse noted in Mr Mazurek's medical record that she had examined him after he had made a superficial cut to his right arm. She noted that Mr Mazurek was due to see someone from the mental health team the day after. No one re-opened the ACCT, despite his self-harm. The next day, the healthcare manager saw Mr Mazurek and noted in his medical record that Mr Mazurek did not have any issues or concerns.
55. On 8 July, a nurse noted in Mr Mazurek's medical record that he had been discussed at a single point of access meeting and added to the mental health team triage list. A registered mental health nurse saw Mr Mazurek for routine segregation checks between 10 and 12 July on D2. She noted in his medical record that Mr Mazurek had "no comments".
56. On 11 July, Mr Mazurek told an officer at an ACCT post-closure review that his problems were "finished". However, he was still concerned about his sentence and sentence plan, which he said he did not understand. She said that she would contact his offender manager about his transfer, repatriation and sentence plan. He said that he did not have any thoughts of suicide or self-harm. She did not note that he had harmed himself on 6 July, or that he was still waiting for a mental health assessment.
57. On 13 July, Mr Mazurek told a GP that he was feeling stressed, depressed, anxious and nervous. He said that other prisoners had threatened him, that he had self-harmed and was having problems sleeping. He still had thoughts of harming himself and was worried about his sentence. He asked the doctor for some sleeping tablets. The GP prescribed phenergan (a medication that has sedative effects), and re-started him on sertraline, which he had stopped taking in 2013 because he said it made him feel sick. (Mr Mazurek took sertraline until 19 July, when he stopped taking it again.)
58. On 15 July, at a segregation review, Mr Mazurek said that he felt ready to go back to B Wing. He said that he knew that the prisoner who had been threatening him had now moved but, before he moved back, he wanted to see his solicitor, who he was due to see on 17 July.
59. On 17 July, Mr Mazurek's solicitor visited him at Garth. Mr Mazurek's solicitor wrote to the Governor of Garth on 29 July, and said that Mr Mazurek had written four statements about threats against him. He thought that Mr Mazurek's English was poor and asked how he was able to communicate his concerns properly without an interpreter. He said that Mr Mazurek's mental health was deteriorating because he was segregated. The offender supervisor replied to Mr Mazurek's solicitor on 4 August because he had not enclosed a signed disclosure form from Mr Mazurek. The investigator contacted Mr Mazurek's solicitor to discuss his concerns but he did not respond.

60. On 20 July, at another segregation review, Mr Mazurek said he wanted to remain segregated until he had seen his solicitor again. A member of the healthcare team saw Mr Mazurek each day between 13 July and 5 August. He did not raise any issues except that he refused to take his sertraline tablets, which he said made him feel sick.
61. On 4 August, at the next segregation review, Mr Mazurek contributed well and said that he had an appointment letter to see the immigration team about returning to Poland. He said he wanted to remain segregated until then. The next review was arranged for 18 August.
62. On 5 August, a mental health nurse saw Mr Mazurek to carry out a triage assessment arising from the single point of access meeting on 8 July. She told the investigator that he did not engage with her and said that he could not remember, in response to some questions. She asked him about self-harm, but he said that he wanted to be left alone and wanted to return to Poland.
63. The nurse told the investigator that she thought that Mr Mazurek had understood her and she had paraphrased questions when he did not engage. She discharged him from the mental health team caseload but told him to ask if he needed to see them again. She noted in his medical record that Mr Mazurek was a low risk of suicide and had no thoughts of self-harm.
64. Nurses saw Mr Mazurek daily on 5, 6 and 7 August, for segregation checks. They noted “no concerns” on his medical record.
65. On 7 August, the offender supervisor, a SO and an immigration official went to Mr Mazurek’s cell to discuss his repatriation. He said he could not see them, as he was ill with stomach ache. The SO told the investigator that Mr Mazurek did not ask to see anyone from the healthcare team.
66. At 2.00pm the next day, Mr Mazurek’s brother arrived to visit him. Mr Mazurek had gone to the visits hall but then told staff he could not see his brother, as he was ill. On the way back to the wing, he asked to go to the toilet. When he came out, he said that he felt better and would now see his brother. However, the visitor centre staff had already notified Mr Mazurek’s brother that he had refused to attend the visit, so he could not see him.
67. One of Mr Mazurek’s friends told a SO that he had spoken to him before and after the abortive visit with his brother. Before the visit, Mr Mazurek had asked him for some tobacco. His friend said that he would give it to him after his visit. When Mr Mazurek returned from the visits hall, Mr Mazurek told him that he had cancelled it because he did not feel well and had diarrhoea. His friend gave him tobacco and he returned to his cell. He said that earlier in the week, Mr Mazurek had not gone outside to the exercise yard for time in the open air because he had stomach ache.
68. The Head of Safer Prisons and Equality told the investigator that although Mr Mazurek was officially segregated, he was allowed to spend time in the exercise yard with a friend, as they were both Polish, and appeared to be friends. He thought this would be a positive intervention for Mr Mazurek.

69. Mr Mazurek's brother had been worried about Mr Mazurek not attending the visit and had told the visitor centre staff that he was concerned about him. They asked a chaplain to check on him. He went to see him about 3.00pm. Mr Mazurek told him that he had had stomach ache and had not been feeling well. He offered to call his brother on his behalf, but Mr Mazurek declined. He told the investigator that Mr Mazurek did not seem to be in any distress and he did not look ill, when he saw him. He did not consider that he was likely to harm himself and saw no reason to speak to wing officers about him.
70. An officer took Mr Mazurek's evening meal to him between 5.00pm and 5.30pm. He said that Mr Mazurek seemed fine and was polite to him. He did not give any indication that he intended to harm himself. This was the last time anyone saw Mr Mazurek alive.
71. At 8.20pm on 8 August, a night patrol officer started a roll count on D Wing, to check that all prisoners were present. When he arrived at Mr Mazurek's cell he opened the observation panel and saw him hanging by a ligature made of shoelaces, attached to a screw in the wall. He immediately radioed a code blue medical emergency.
72. At night, for security reasons, officers on wings do not carry standard prison keys but have a cell key in a sealed pouch for use in emergencies. The night patrol officer followed the standard night procedure and got permission from the night manager to open the cell and went in immediately. He held Mr Mazurek's body up until an officer arrived a few seconds later and cut the ligature. They lowered Mr Mazurek to the bed.
73. A nurse, the night manager and other staff then arrived. The nurse brought emergency equipment and assessed Mr Mazurek. She noted that Mr Mazurek was cold and stiff. She found no signs of life and recorded that he had a deep indentation mark around his neck with visible swelling. She assessed that Mr Mazurek had been dead for some time and that it would not be appropriate to try to resuscitate him, as this would be futile and disrespectful. The staff left the cell and the night manager radioed the control room and asked for an ambulance at 8.44pm. The control room had not called an ambulance when the night patrol officer first called the code blue, as they should have done.
74. At 8.56pm, paramedics arrived at the prison. After assessing Mr Mazurek they presumed his death. At 9.45pm, a prison doctor certified Mr Mazurek's death.

#### **Contact with Mr Mazurek's family**

75. On 8 August, the duty governor tried to phone Mr Mazurek's brother, who was listed as Mr Mazurek's next of kin, as the address the prison held for him was some distance away. However, the person who answered the phone said that Mr Mazurek's brother no longer lived there. The duty governor asked the police to try and locate Mr Mazurek's brother, which they did the next morning. As he lived over three hours' drive away, the prison asked the police to notify Mr Mazurek's brother of his death.
76. On 10 August, two days after Mr Mazurek's death, the prison appointed a family liaison officer. He tried to phone Mr Mazurek's brother but did not get an answer.

They spoke the following day. Mr Mazurek's brother visited the prison and saw Mr Mazurek's cell, but did not want any other support or contact from prison staff.

77. Mr Mazurek's body was repatriated to Poland. In line with Prison Service instructions, the prison contributed to the costs of the funeral and repatriation.

#### **Support for prisoners and staff**

78. After Mr Mazurek's death, the night manager debriefed the staff involved in the emergency response and offered his support and that of the staff care team.
79. The prison posted notices informing other prisoners of Mr Mazurek's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by his death.

#### **Post-mortem report**

80. The provisional post-mortem report stated that Mr Mazurek's cause of death was compression of the neck due to hanging.

# Findings

## Possible bullying

81. Garth's violence reduction policy states that verbal abuse, insults or threats will always be taken seriously, that staff should record allegations on the required form and that allegations should be investigated by a senior officer. The policy states that complaints and grievances should be listened to and acted upon, and that there should be an ethos of care, respect and responsibility. Staff should be proactive.
82. In May 2015, Mr Mazurek told staff that he was being threatened and that other prisoners would kill or stab him. He did not name the perpetrators and staff told him that there was little that they could do if he did not name them. He made similar accusations later in May and then on 17 June. Staff said they watched his cell for a while and did not see anyone approaching his cell and threatening him.
83. Prison staff agreed that Mr Mazurek should be segregated for his own safety, but there is no evidence that anyone properly investigated his allegations, in line with the local policy. We do not know whether Mr Mazurek's concerns were genuine or he was suffering from paranoia, as another prisoner suggested, but we consider that his allegations should have been investigated more actively.
84. Bullying is a factor associated with raised risk of suicide and self-harm. In June 2011, a Prisons and Probation Ombudsman's publication found that evidence of bullying and intimidation featured in 20 per cent of self-inflicted deaths we considered. In a follow up report issued in October 2011, on violence reduction, bullying and safety, we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that prisoners who have been victims of bullying are at greater risk of suicide and self-harm.
85. We are not satisfied that Mr Mazurek's concerns were appropriately investigated, as they should have been under Garth's violence reduction policy. We make the following recommendation:

**The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.**

## Management of ACCT procedures

86. We have some concerns about the management of ACCT procedures, after Mr Mazurek was identified as at risk of suicide and self-harm on 30 June. Prison Service Instruction PSI 64/2011 requires that case reviews should be multidisciplinary where possible. There were only two case reviews but neither was multidisciplinary and there were no healthcare staff at the first case review, which is a mandatory requirement of the PSI. A SO held the second ACCT case review and ended ACCT procedures without any other members of staff present, which is poor practice. Even when multidisciplinary attendance is not possible, it

is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff.

87. A custodial manager in the safer custody team told the investigator that since Mr Mazurek's death, the safer custody team circulates a weekly timetable of ACCT reviews. Case managers have been instructed that reviews should be multidisciplinary and that ACCTs should not be closed without the involvement of the mental health team.
88. Officer B did not identify mental health issues or bullying as issues, when she assessed Mr Mazurek. These issues were not discussed at the first case review and there were no caremap actions to address them, although one of the caremap actions was that Mr Mazurek should remain segregated. The other caremap action was about Mr Mazurek wanting to repatriate to Poland, an issue that was not likely to be resolved quickly. A SO decided that both actions had been addressed adequately when she closed the ACCT.
89. We are concerned that no account seems to have been taken of the effect of segregation when Mr Mazurek was assessed as at risk of suicide and self-harm. In a learning lessons bulletin we issued in June 2015, we noted that segregation reduces protective factors against suicide and should be used only in exceptional circumstances for those at risk. PSI 64/2011 recognises this and requires that when a prisoner at risk is held in segregation the exceptional reasons must be documented in the ACCT document and include other options that had been considered but discounted. There is no evidence that anyone considered this. One of the lessons we identified was that lengthy periods of segregation should be avoided, yet the plan for Mr Mazurek was that he should remain segregated rather than any plan to return him to a standard prison wing.
90. Prison Service Order 1700, which covers segregation procedures, requires that segregated prisoners subject to ACCT procedures should have a mental health assessment within 24 hours, but this did not happen. ACCT case managers should attend segregation reviews, but they did not. We are concerned that important safeguards for segregated prisoners at risk of suicide and self-harm were not followed.
91. Two days after ACCT procedures ended, Mr Mazurek cut his wrists again on 6 July, but no one re-opened the ACCT. There was no mention of his further self-harm during the post-closure review on 11 July. PSI 64/2011 says that ACCTs can be re-opened at any point after closure if the risk posed by the prisoner has increased. We consider that a further act of self-harm so shortly after the ACT was closed should have indicated an increase in Mr Mazurek's risk. Healthcare staff who saw him did not record any discussion of his motives for cutting himself.
92. The ACCT was closed a month before Mr Mazurek killed himself and we recognise that at the time immediately before his death, it might have been difficult for staff to have identified that he was at increased and imminent risk of suicide. However, we are concerned that the prison did not operate ACCT procedures in line with national instructions. We do not consider that during the time that Mr Mazurek was managed under ACCT procedures they were managed effectively to ensure that he received appropriate support. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular that:**

- **Prisoners assessed as at risk of suicide or self-harm are not segregated unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.**
- **Segregated prisoners assessed at risk of suicide and self-harm have an urgent mental health assessment within 24 hours.**
- **There is a multidisciplinary approach for all case reviews, with healthcare staff attending all first case reviews**
- **Caremap actions, are specific, meaningful and time bound, aimed at reducing prisoners' risks and reviewed and updated as necessary.**
- **Staff re-open an ACCT when a prisoner self-harms or otherwise indicates increased risk.**
- **ACCT case managers attend segregation reviews.**

#### **Mr Mazurek's segregation**

93. Mr Mazurek first asked to be segregated for his own protection on 16 May. Apart from a brief period of two weeks at the beginning of June, he was segregated under Prison Rule 45 for the rest of his time at Garth, until his death on 8 August.
94. We are concerned that records for Mr Mazurek's original segregation on B Wing are missing. Although there is some evidence from a record on a summary sheet that his segregation was authorised appropriately, full records are not available to provide assurance that Mr Mazurek was seen as he should have been by members of the healthcare team, senior managers and others as Prison Service Order (PSO) 1700 requires.
95. Managers did not set a required level of checks when Mr Mazurek was segregated. There is no mandatory national instruction setting out the required frequency of checks for prisoners segregated under Prison Rule 45, as Mr Mazurek was, but it is mandatory that all segregated prisoners should be checked at an agreed frequency. PSO 1700, says, "All prisoners located in the segregation unit must be observed by an officer at a frequency which is relevant to the individual's circumstances and will be based upon a case management approach. The observation level should be decided by the person authorising segregation.....All prisoners subject to cellular confinement must be observed at least hourly".
96. The clinical reviewer noted that PSO 1700 requires healthcare staff to see segregated prisoners daily but there is no evidence from Mr Mazurek's medical record that healthcare staff saw him each day. We note the very high number of segregated prisoners at Garth and a GP said that the high numbers meant that he was not always able to see every segregated prisoner in a day, when he was doing segregation rounds.
97. In our June 2015 learning lessons bulletin on segregation, we noted that lengthy periods of segregation should be avoided. Where this is unavoidable,

segregation review boards should assess how well the prisoner is coping, plan their relocation to more appropriate accommodation and develop a careplan to help prevent deterioration in mental health. There is no evidence that review boards considered this. PSO 1700 also requires that “those segregated for more than 30 days should be subject to care plans that detail how their mental well being is to be supported”. There is no record of such a careplan, although Mr Mazurek had been segregated for over two months. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners held in segregated conditions are managed under the provisions and safeguards of PSO 1700, including setting an appropriate frequency of checks, that a member of healthcare staff checks segregated prisoners daily and records this, and that there are careplans for prisoners segregated for more than 30 days.**

### Clinical care

98. The clinical reviewer concluded that there were shortfalls in the standard of care that Mr Mazurek received at Garth. She noted that the quality of medical record keeping needed to be improved and healthcare staff reminded of the importance of their entries as a continuous and full record of the prisoner’s mental and physical health and well being. Where entries need to be made on both SystemOne (the computerised healthcare record) and prison records this needed to be done to ensure that all staff responsible for prisoners’ care had as complete a picture as possible. She also had concerns that there was insufficient follow up when Mr Mazurek stopped taking prescribed antidepressants. In her clinical review, she has made recommendations about these matters, which the Head of Healthcare will need to address.
99. As noted above, as a segregated prisoner on an ACCT, Mr Mazurek should have had a mental health assessment within 24 hours, but this did not happen. The clinical reviewer noted that Mr Mazurek’s behaviour and presentation would have warranted a mental health assessment on several occasions between 15 May 2015 and his death. On 2 July, Mr Mazurek himself asked to see someone from the mental health team. He had been assessed as at risk of suicide and self-harm at the time, but it took over a month, including two episodes of self-harm, before an assessment took place. The clinical reviewer considered that the resulting assessment described his presentation but lacked any focused action plan to reduce or mitigate his risks. We make the following recommendation:

**The Head of Healthcare should ensure that referrals to the mental health team for prisoners assessed as at risk of suicide and self-harm are actioned promptly and that assessments include plans to mitigate their risk.**

### Emergency response

100. PSI 03/2013, Medical Response Codes, requires governors to have a medical emergency response code protocol and states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The instruction states that, when a medical emergency is called,

the control room should call an ambulance immediately and there should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed. Garth has a local protocol in line with PSI 03/2013.

101. The officer who found Mr Mazurek hanged in his cell, radioed a code blue medical emergency code immediately. However, the control room did not call an emergency ambulance in response. Although this did not make a difference for Mr Mazurek, who was clearly dead at the time he was found hanged, the control room staff were not aware of this assessment. We are concerned that such a delay could be crucial in a future emergency. We make the following recommendation:

**The Governor should ensure that the control room calls an ambulance as soon as an emergency medical code is called.**

### Family liaison

102. Prison Rule 22 states that the when a prisoner dies, the governor should inform next of kin “at once”. Prison Service Instruction 64/2011 requires that where possible, the family liaison officer and another member of staff should visit the next of kin in person and that this should be done quickly to ensure that the prisoner’s family does not hear of the death by other means.
103. Mr Mazurek’s brother was not notified of his death until 9 August, by local police. Garth did not consider asking a local prison to visit Mr Mazurek’s brother, and did not appoint a family liaison officer until the next day. The family liaison officer did not manage to speak to Mr Mazurek’s brother, until 11 August, three days after his death. We do not consider that this meets the expectation of the Prison Rule or the Prison Service Instruction. We make the following recommendation:

**The Governor should ensure that when a prisoner dies, a member of Prison Service staff informs the next of kin in person if possible and without undue delay.**

