

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Piotr Jarosz a prisoner at HMP Leicester on 22 October 2017

A report by the Prisons and Probation Ombudsman

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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 Piotr Jarosz died at HMP Leicester on 22 October 2017 after he was found hanged in his cell. He was 47 years old. I offer my condolences to his family and friends.

Mr Jarosz found it difficult to cope in prison because of the breakdown of his relationship, his lack of contact with his children and the prospect of being deported. Although staff at Leicester identified that Mr Jarosz was at risk of suicide and self-harm, there were deficiencies in the way they monitored his risk and the way information about his immigration status was shared.

The Governor of Leicester has previously accepted our recommendations to improve suicide and self-harm prevention procedures. I am concerned that I have to repeat these recommendations and the Prisons Group Director of Midlands prisons will wish to assure herself that meaningful action is now taken to address these concerns.

I am also concerned that there was no procedure in place to monitor prisoners who failed to collect their medication.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

October 2018

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Summary

Events

1. Mr Piotr Jarosz was a 47 year old Polish national. He was remanded to HMP Leicester on 20 June 2017 for possession of an offensive weapon and affray. He had a history of suicide and self-harm, chronic back pain and depression. On 8 August, Mr Jarosz was released from prison. He was returned to Leicester on 14 August 2017 for breaching a restraining order.
2. While at Leicester, the mental health team assessed Mr Jarosz and concluded that he had depression. The prison GP prescribed him antidepressants and pain relief for an ongoing back problem.
3. Mr Jarosz was twice monitored under suicide and self-harm procedures (known as ACCT) during his first stay at Leicester and twice during his second admission to Leicester. He was not subject to ACCT procedures at the time of his death. Mr Jarosz twice asked to see a mental health nurse and was referred for emotional support, but no one saw him.
4. Mr Jarosz's prison sentence ended on 22 September 2017, but he was detained in prison under immigration powers and was due to be deported to Poland. Mr Jarosz was concerned about his immigration status, did not want to remain in prison after his sentence had expired and repeatedly asked to be transferred to an immigration removal centre. On 17 October, an immigration officer told Mr Jarosz that he had been assessed as not suitable for transfer to an immigration removal centre. Wing staff were unaware of this.
5. Around 9.00am on 22 October, staff failed to unlock Mr Jarosz to collect his medication. At 11.49am, an officer found Mr Jarosz hanging by a bed sheet, tied to the window in his cell and radioed an emergency code. Prison staff began resuscitation. A nurse arrived and told staff to continue resuscitation efforts although rigor mortis was present. Paramedics arrived and pronounced Mr Jarosz dead at 12.06pm.

Findings

Management of risk of suicide and self-harm

6. Staff appropriately assessed Mr Jarosz as at risk of suicide and self-harm on two occasions. While they monitored him under ACCT procedures, there were a number of deficiencies in the way they did so and failures to comply with Prison Service policy. No-one from the healthcare or mental healthcare team attended the ACCT review and closure on 15 August 2017 or 30 September 2017. Staff stopped ACCT monitoring on 30 September, even though concerns identified in Mr Jarosz's ACCT assessment had not been addressed.
7. There was no system in place between the prison and Home Office immigration staff to ensure that wing staff were informed of any potential changes to the immigration status of foreign national prisoners and how this might affect their risk of suicide and self-harm.

Unlocking of prisoners for medication

8. No one unlocked Mr Jarosz's cell on the morning of 22 October 2017 to collect his medication, as should have happened.

Resuscitation

9. Attempts to resuscitate Mr Jarosz despite the presence of rigor mortis were inappropriate.

Contact with next of kin

10. There was a short delay in notifying Mr Jarosz's next of kin of his death and face-to-face contact did not take place until the next day.

Clinical care

11. The clinical reviewer found that Mr Jarosz's clinical care was not equivalent to that which he could have expected to receive in the community. Healthcare staff did not contribute to the management of Mr Jarosz's risk of suicide and self-harm on more than one occasion or act upon mental health referrals.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
 - Staff have a clear understanding of their responsibilities and the need to record relevant information about risk.
 - Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.
 - Prison and healthcare staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review.
 - Staff Hold multidisciplinary ACCT reviews, with continuity of case management and involving all staff who can contribute to a prisoner's care.
 - Case managers complete caremaps at the first ACCT case review, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.
- The Prisons Group Director, Midlands Prisons, should satisfy herself that effective action is taken to implement these recommendations.
- The Governor and the UK Visa and Immigration Service should develop and implement a system to ensure that wing staff are informed of any potential changes to the immigration status of foreign national prisoners and that wing staff consider whether this might affect their risk of suicide and self-harm.
- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate, in line with NHS

England and HM Prisons and Probation Service's resuscitation policy issued in September 2016.

- 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 Head of Healthcare should review the management of the mental health waiting lists on SystemOne to ensure that referrals are not lost on the system.
- The Governor and Head of Healthcare should review the case for provision of psychosocial interventions as part of the primary mental health care service offered at HMP Leicester.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Leicester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator visited Leicester on 27 October 2017. He obtained copies of relevant extracts from Mr Jarosz's prison and medical records.
14. The investigator interviewed 14 members of staff and one prisoner at Leicester in November and December 2017.
15. NHS England commissioned a clinical reviewer to review Mr Jarosz's clinical care at the prison.
16. We informed HM Coroner for Leicester City and South Leicestershire 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 Jarosz's ex-partner and cousin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked if Mr Jarosz had written a suicide note.
18. Mr Jarosz's ex-partner was informed that the initial report was available, but did not respond.

Background Information

HMP Leicester

19. HMP Leicester is a local prison that holds 325 men. It primarily serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Leicestershire Partnership NHS Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Leicester was an unannounced visit in January 2018 and is yet to be published. At the last inspection in October 2015, inspectors reported that the level of self-harm was five times that of other local prisons. They found that the quality of ACCT management was not consistently good, care planning was weak and did not contain meaningful objectives for prisoners. Inspectors also reported that mental health nurses spent a significant proportion of their clinic time attending ACCT reviews and responding to mental health crises, leaving little time to manage prisoners on their caseload effectively.

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 January 2017, the IMB reported better management of the Assessment Care in Custody Teamwork (ACCT) process, and very good liaison between the Safer Custody and the Healthcare teams.

Previous deaths at HMP Leicester

22. Mr Jarosz is the fourth prisoner to die at Leicester since January 2015, and the third to take his life. In our investigation into the most recent self-inflicted death, we identified deficiencies in the ACCT process. Since the death of Mr Jarosz, another prisoner took his life in December 2017 and once again, we have concerns about the operation of the ACCT procedures.

Assessment, Care in Custody and Teamwork (ACCT)

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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. 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.

UK Visas and Immigration (UKVI)

24. UKVI is a part of the Home Office. It considers whether deportation is suitable for all foreign national prisoners who are convicted and sentenced. This includes those recommended for deportation by a court and sentenced to 12 months or more in prison and those convicted of drug offences. It is important that UKVI is made aware as early as possible of whether newly arrived prisoners are, or might be, foreign nationals so that their cases can be considered in an efficient and timely manner. Immigration powers permit foreign national prisoners to be held in prison beyond the end of their custodial sentence. Before UKVI makes a final decision about whether to deport a prisoner, the prisoner will have the opportunity to appeal against the decision by submitting written representations.

Key Events

25. Mr Piotr Jarosz was a Polish national who had lived in the UK for 13 years and spoke good English. Mr Jarosz had a long history of attempted suicide and self-harm but there is no evidence that he had self-harmed for a number of years.
26. On 18 June 2017, he was charged with affray and possession of an offensive weapon. The next day at court, Mr Jarosz said that he had thoughts of suicide and self-harm and would kill himself in he was sent to prison. A self-harm warning form and a report to help ensure that those with mental health or substance misuse issues receive the right treatment were completed at court.

HMP Leicester

27. On 20 June, Mr Jarosz was remanded to HMP Leicester. Mr Jarosz's person escort record that accompanied him to Leicester did not note his risk of suicide and self-harm or that a suicide and self-harm warning form had been initiated. During his reception screening prison staff identified no concerns about Mr Jarosz and noted that it was his first time in custody.
28. A nurse saw Mr Jarosz and completed an initial health screen. Mr Jarosz was taking medication for long term back pain (co-codamol) and depression (amitriptyline). The nurse noted that a suicide and self-harm warning form and a court report had been completed on 19 June and added to Mr Jarosz's medical notes before he arrived. Mr Jarosz denied that he had any thoughts to harm himself and denied misusing drugs. The nurse did not start suicide and self-harm procedures, known as ACCT, but referred Mr Jarosz for a mental health assessment and noted that he would confirm his current medication with his community GP.
29. On 21 June, Mr Jarosz's community GP confirmed his medical history, noting that he had been prescribed amitriptyline, co-codamol, lansoprazole (which reduces the amount of stomach acid), naproxen (an anti-inflammatory) and paracetamol. A prison GP prescribed naproxen, paracetamol and codeine (a painkiller) for Mr Jarosz.
30. During the following days, staff recorded in Mr Jarosz's prison records that he had completed his induction and raised no concerns.
31. On 28 June, a prison GP reviewed Mr Jarosz. He said that he had back pain and was unsure if taking amitriptyline had helped his depression. He said that his family did not want to see him and that he had nowhere to live. He described his mood as fluctuating, said he felt depressed and had thoughts of suicide and self-harm. He refused to give any details of how he would take his own life. He said that he had tried to kill himself in the past 15 years by taking an overdose of tablets.
32. A prison GP noted that Mr Jarosz's low mood took priority at this review and agreed to review his backpain problem at their next appointment. He referred Mr Jarosz to the mental health team and started ACCT procedures. He prescribed Mr Jarosz a reducing dosage of amitriptyline, with a view to considering an alternative medication.

33. That day, staff completed an ACCT assessment and a multidisciplinary ACCT review. The review panel set ACCT observations at twice an hour, with three conversations a day. Staff recorded in the ACCT caremap that Mr Jarosz's low mood would be treated through medical intervention.
34. On 3 July, staff completed an ACCT review with Mr Jarosz but recorded no concerns. Mr Jarosz disclosed that his family wanted nothing to do with him. He said that he had no thoughts of suicide or self-harm and his antidepressants were having a positive effect on him. At this review, a mental health nurse noted that Mr Jarosz did not present as having any signs of a mood or psychotic disorder. The review panel reduced his ACCT observations. On 6 July, staff closed ACCT procedures. At this review, a mental health nurse noted no current issues with Mr Jarosz.
35. The prison doctor cancelled Mr Jarosz's appointment on 10 July because of a prison emergency incident and rescheduled it for 17 July.
36. On 13 July, Mr Jarosz submitted an application to see the healthcare team. He said that he had depression, back and head pain. He also asked to see a mental health nurse urgently for depression and suicidal thoughts. A mental health support worker received this request and confirmed to Mr Jarosz that he already had an appointment booked to see the GP. She also added him to the mental health team waiting list for an assessment.
37. On 17 July, Mr Jarosz appeared in court by video link. The court adjourned and rescheduled for a later date. On the same day, a prison GP recorded that due to staff resourcing issues, staff were unable to escort Mr Jarosz to attend his GP appointment.
38. A mental health nurse saw Mr Jarosz on the morning of 19 July. Mr Jarosz said that he had received a letter the day before from his ex-partner which said that she wanted nothing to do with him and he should kill himself in prison. He said that he had self-harmed by cutting himself and planned to take his own life. However, Mr Jarosz said that after his court hearing, there was a possibility that he could be released early from prison. She assessed that Mr Jarosz did not have a mental illness and his depression was considered reactive to his situation. She started ACCT procedures, referred Mr Jarosz to the mental health team and noted that he had a rescheduled doctor's appointment for 24 July. She recorded that Mr Jarosz was due in court shortly and might need emotional support afterwards. (An emotional support service is provided at Leicester through the two support workers in the team, which provides a low level of therapy through listening and talking.)
39. On 20 July, staff completed an ACCT assessment and a Supervising Officer (SO) chaired a multidisciplinary ACCT review. Mr Jarosz told staff that he felt broken after reading the letter from his ex-partner. He said that he would wait until his video link court appearance on 24 July before he made any further plans to harm himself. He said that he was homeless and if he were released from prison, he would have nowhere to live and was likely to return to prison.

40. The review panel set ACCT checks at four observations an hour and recorded in Mr Jarosz's ACCT caremap that the mental health team and prison GP would support and review him after his court hearing.
41. Afterwards, a prison GP saw Mr Jarosz, who said his mood was low. The GP prescribed tramadol as an alternative pain relief to naproxen for Mr Jarosz's back pain and agreed to trial fluoxetine (an antidepressant).
42. On 24 July, Mr Jarosz attended his court hearing by video link. The judge adjourned the hearing until August. Staff recorded no concerns in Mr Jarosz's ACCT record.
43. On 27 July, a prison GP saw Mr Jarosz, who said that he was struggling to sleep but spoke positively about the effects of fluoxetine. He still had thoughts of suicide and self-harm but said he would not make any decisions about his life until after his court date. Mr Jarosz said that he no longer wanted the mental health team to support him.
44. An SO chaired ACCT reviews on 28 and 30 July. Mr Jarosz said he had no thoughts of suicide or self-harm and reiterated that he had previously been angry when he had said he would harm himself. His next court hearing was on 7 August. The review panel assessed his risk as low and stopped ACCT monitoring.
45. Mr Jarosz attended his court hearing by video link on 7 August and received an eight-month suspended sentence order. The court imposed a restraining order to prevent Mr Jarosz from contacting his ex-partner and his neighbours. Mr Jarosz was released from prison the next day.

Mr Jarosz's return to HMP Leicester

46. On 14 August, Mr Jarosz was recalled to Leicester after he breached the conditions of his restraining order and bail conditions. Mr Jarosz had only been out of prison for six days. His person escort record recorded all his known risk factors and he arrived at prison with a suicide and self-harm warning form which noted that he had recently taken an overdose. (He had been hospitalised on 12 August after he took an overdose of antidepressants and drank three cans of cider.)
47. During his reception screening, prison staff noted that Mr Jarosz had been recalled to prison and had arrived with a suicide and self-harm warning form. A nurse completed a health screen, started ACCT procedures and referred Mr Jarosz to the prison GP and mental health team.
48. A custodial manager agreed that Mr Jarosz should share a cell and set his ACCT observations at three per hour, with staff required to have three conversations with him each day. Staff reminded Mr Jarosz of the support offered by the Listener service (prisoners trained by the Samaritans). A member of the substance misuse team saw Mr Jarosz and explained how he could access their service, if he required.
49. On 15 August, a SO completed an ACCT assessment. Mr Jarosz said that he had self-harmed (overdosed) to hurt his ex-partner but said he had no current

- thoughts of suicide or self-harm. He wanted to fight to see his children and attend education classes. The assessment recorded Mr Jarosz's main concern as his contact with his children. He told the SO that the court had not properly explained the conditions of his restraining order. The SO noted that Mr Jarosz's offender manager should see him to clarify this.
50. Afterwards, another SO chaired an ACCT review with a colleague. No member of the healthcare team or the assessor attended. The SO noted that Mr Jarosz engaged well and had no thoughts of suicide or self-harm. Mr Jarosz said that he hoped to receive a letter soon containing his son's phone number and reiterated his desire to improve his English. The SO assessed Mr Jarosz's risk of suicide and self-harm as low and stopped ACCT monitoring.
 51. Over the next couple of days, Mr Jarosz completed his prison induction and staff moved him to a shared cell on the third landing.
 52. On 17 August, a prison GP saw Mr Jarosz. He reviewed his medical history and noted his recent overdose. Mr Jarosz said that he had no current thoughts of suicide or self-harm. His back pain had worsened in the last few days because he had stopped taking his medication. The GP agreed to restart prescribing tramadol and would trial sertraline (an antidepressant). He noted that he would review Mr Jarosz in two weeks' time or sooner if his mood deteriorated.
 53. On 29 August, Mr Jarosz submitted an application to see the GP. This was processed by a mental health support worker, who confirmed that Mr Jarosz had an appointment booked for 31 August. At that appointment, the GP reviewed Mr Jarosz's sertraline medication and agreed that it should continue. Mr Jarosz said his mood was still low and he had feelings of aggression but had no thoughts of suicide or self-harm. The GP increased his tramadol dosage as Mr Jarosz continued to complain of back pain.
 54. The next day, Mr Jarosz submitted another application to the healthcare team to see a mental health nurse, stating that he had "big mental problem urgently please". The mental health support worker added him to the mental health triage list.
 55. On 5 September, Mr Jarosz attended a probation drop-in clinic. He told a probation officer that he had mental health problems and wanted a single cell because if he got angry, he might hurt his cellmate. Prison staff reassessed Mr Jarosz's cell sharing risk as high and moved him to a single cell on 8 September.
 56. On 6 September, Mr Jarosz submitted a further application to see the GP, in which he stated, "urgently please, aggression, depression mental problem". A mental health support worker made a GP appointment for Mr Jarosz for 14 September.
 57. On 11 September, Mr Jarosz was sentenced to six months in prison for breaching a restraining order and breaching his suspended sentence. His release date from prison was set for 22 September. As he was given a custodial sentence, the Home Office Criminal Casework immigration team automatically reviewed his immigration status and considered whether he should be deported.

58. On 14 September, a prison GP reviewed Mr Jarosz, who said that he cried a lot when he thought about his family but had no thoughts of suicide or self-harm. He had difficulties sleeping due to his back pain. The GP increased his tramadol and sertraline medication and agreed to review Mr Jarosz again in two weeks' time. He referred Mr Jarosz for emotional support by adding his name to the emotional support waiting list. Mr Jarosz did not receive an appointment for this service. Healthcare staff subsequently told the investigator that prisoners can inadvertently be "lost" from the waiting lists if the wrong entry is made in the medical records.
59. On 18 September, a prison resettlement officer met Mr Jarosz. She recorded on NOMIS that she spoke to Mr Jarosz about various housing options available to him on release from prison. She also noted that the Home Office (UK Visas and Immigration) were reviewing his immigration status and it was possible that he might not be released from prison on 22 September.
60. On 19 September, Mr Jarosz attended a probation drop-in clinic. A probation officer recorded in Mr Jarosz's prison records that he had asked whether he could be held in prison after his sentence release date. She told him that UKVI could prevent his release and detain him in prison pending a decision to deport him. Mr Jarosz was unhappy about this and asked to see an immigration officer. She emailed an immigration officer who regularly attended the prison.
61. The next day, the immigration officer served immigration deportation papers on Mr Jarosz and explained that the Home Office intended to deport him to Poland. He told him that he would not be released from prison on 22 September (his sentence expiry date) but would remain in prison pending a final decision. He explained to Mr Jarosz that he could submit written representations to the Home Office casework team (who are responsible for immigration decisions) within 20 days, giving the reasons why he should not be deported.
62. The immigration officer told the investigator that although Mr Jarosz was not happy about this decision, he had no concerns about his wellbeing. Mr Jarosz said that he would submit written representations.
63. On 21 September, the Home Office criminal casework team emailed the healthcare team at Leicester and asked for Mr Jarosz's medical information and known risks as they were considering his detention. On the same day, Mr Jarosz attended a probation drop-in clinic. A probation officer recorded that she assisted Mr Jarosz to complete immigration written representation forms.
64. A SO visited Mr Jarosz in his cell on the morning of 22 September and served him with an IS91 Home Office notice of intended deportation. Mr Jarosz confirmed that he understood that he was not being released from prison and that he was being detained by the Home Office. The SO said he was calm and signed the notice without raising any issues.
65. The Chief Immigration Officer told the investigator that on the same day the Home Office completed a risk assessment for Mr Jarosz's suitability to be located in an immigration removal centre until his deportation. The assessment concluded that Mr Jarosz was unsuitable because he had breached a restraining order more than once. The immigration officer told the investigator that he had

shared this information with Mr Jarosz during a visit to the prison shortly after the decision had been made. However, prison staff told the investigator that they were unaware that Mr Jarosz was not eligible to transfer to an immigration removal centre and there is no evidence in Mr Jarosz's prison records about this.

66. On 26 September, Mr Jarosz attended a probation drop-in clinic. He told a probation officer that he was upset that he was still in prison after he had served his sentence. He said that another prisoner had threatened him on the wing but gave no further details. He asked her if she would contact the Polish Consulate on his behalf as he did not have any phone credit. She facilitated a phone call to the consulate team and Mr Jarosz spoke to them. She said that she also told an unknown prison officer that Mr Jarosz said that he was being threatened and asked staff keep an eye on him.
67. A member of the Polish Consular team phoned the probation officer that day to ask about Mr Jarosz's status in prison. Unable to answer these questions, she said that she would ask Mr Jarosz to call them. She gave the consulate team the contact details for the Offender Management Unit (OMU) and emailed the immigration officer.
68. On 28 September, Mr Jarosz attended the probation drop-in clinic. He told a probation officer that he wanted to be transferred to an immigration removal centre. He said that he was struggling, had been threatened by other prisoners and intended to go on hunger strike or end his life. She recorded in his prison records that she had submitted an intelligence report about her conversation with Mr Jarosz. She emailed the immigration officer with this information so that it could be given to Mr Jarosz's Home Office immigration case worker. She did not start ACCT procedures despite Mr Jarosz saying that he might take his life.
69. On the same day, a prison GP reviewed Mr Jarosz. He noted that Mr Jarosz was tearful but he denied thoughts of suicide or self-harm. Mr Jarosz said that deporting him to Poland was like giving him a death sentence. He said that he was waiting to be transferred to an immigration removal centre and wanted to see his children before he was deported. He said that he was struggling to sleep due to his anxieties about deportation and so the GP prescribed sleeping tablets (zopiclone) for three nights.

29 September – 20 October

70. On the evening of 29 September, an officer read a letter that Mr Jarosz had submitted in the internal post for OMU. In it, Mr Jarosz said that his prison sentence had ended and he wanted to move to an immigration removal centre. He said that being in prison endangered his life and was not good for his mental health. He said that he had already tried to end his life twice in August.
71. The officer spoke to a custodial manager and started ACCT procedures that night. The custodial manager visited Mr Jarosz in his cell and set hourly observations until staff assessed him under ACCT procedures.
72. On 30 September at 5.10pm, an officer assessed Mr Jarosz under ACCT procedures. Mr Jarosz was angry that he was still in prison and wanted to be transferred to an immigration removal centre. He wanted to remain in the UK,

where his family lived, and said that he would kill himself if he was returned to Poland. She noted that the GP had prescribed Mr Jarosz antidepressant and sleeping aid medication. She explained the ACCT process to Mr Jarosz and noted that his main issue was that he needed to speak to an immigration officer. She added that the sooner he was transferred to a removal centre, the better he would feel and the less angry he would become.

73. Afterwards, a SO chaired Mr Jarosz's first ACCT case review with the officer. No-one from the healthcare team attended. Mr Jarosz said that he had no thoughts of suicide or self-harm but was frustrated that he had not yet been transferred to an immigration removal centre. He was aware that some other foreign national prisoners were in the process of being transferred to Huntercombe Immigration Removal Centre the following week and he wanted to know why he was not being transferred.
74. The SO also discussed with Mr Jarosz his allegation that he was being threatened by other prisoners. Mr Jarosz said that he had had an altercation with another prisoner who had pushed in front of him in the medication queue. He did not disclose any further concerns about the incident or suggest that it was an ongoing problem. The SO noted that Mr Jarosz engaged well during the review and talked about the future, although was unsure what he would do if he was returned to Poland. He spoke about his ex-partner and issues he had had with his neighbours. Overall, the SO assessed Mr Jarosz as positive and took the decision to stop ACCT procedures, noting his risk of self-harm as low. She said that she would speak to the prison transfer clerk about the upcoming moves to Huntingdon.
75. On 2 October, a SO spoke to the transfer clerk who told her that Mr Jarosz did not fit the acceptance criteria for prisoners eligible to be transferred to Huntercombe. Huntercombe only accepted sentenced prisoners, and Mr Jarosz had already completed his sentence. The SO relayed this information to Mr Jarosz, who was annoyed and said he would speak to the immigration officer.
76. On the same day, a member of the IMB saw Mr Jarosz in response to his letter submitted to OMU dated 29 September. Mr Jarosz reiterated that he wanted to transfer to an immigration removal centre. The IMB member said that he spoke to an unknown immigration officer at Leicester who told him that there were no available spaces in the immigration removal centre for Mr Jarosz and therefore that it was legal for him to remain in prison pending his deportation. The immigration officer was unable to give a timescale for Mr Jarosz's move. The IMB member passed this information to Mr Jarosz. Mr Jarosz said that he felt depressed and wanted to transfer soon. The IMB member said that Mr Jarosz gave him no indication that he had thoughts of suicide.
77. In the afternoon, a probation officer saw Mr Jarosz. She passed on the contact details, as he requested, for the member of staff at the Polish Consulate. She noted in Mr Jarosz's prison records that an immigration officer (no name is recorded) had informed her that Mr Jarosz was being detained in prison because there was a shortage of spaces in immigration removal centres.
78. On 4 October, Mr Jarosz attended a probation drop-in clinic. A probation officer recorded in Mr Jarosz's prison records that he wanted to discuss his immigration

concerns. Mr Jarosz confirmed that the Polish Consulate's contact telephone number was now on his prison PIN telephone list.

79. A SO completed the post-closure ACCT review on 5 October. He recorded that Mr Jarosz felt well. Mr Jarosz said that he was still waiting for UKVI to decide his case. The SO did not re-start ACCT monitoring.
80. On 8 October, Mr Jarosz submitted an application to see a member of the mental health team. He said that he had depression and mental health problems, and added that he did not want to see the prison GP. A nurse responded and told Mr Jarosz that the mental health team had assessed him in July and had referred him to the prison GP for treatment. She did not refer or speak to the prison GP about Mr Jarosz.
81. On 10 and 16 October, Mr Jarosz submitted applications to see an immigration officer. An immigration officer spoke to Mr Jarosz on 17 October. He said that they had a general discussion about his unsuitability to be transferred to an immigration removal centre. Mr Jarosz said that he wanted to retrieve his passport and identification documents from his ex-partner's house and that he would give him his ex-partner's phone number so that he could contact her. The immigration officer said that Mr Jarosz's demeanour was calm throughout their conversation and he had no concerns about him. Two days later, Mr Jarosz saw him on the wing and gave him the telephone number for his ex-partner.
82. On Friday 20 October, the Home Officer casework team sent OMU a deportation order to issue to Mr Jarosz, which confirmed that he would be deported to Poland. (Prison staff would have issued the deportation order to Mr Jarosz on Monday 23 October. Deportation normally takes place about three to four weeks after notification.)

Saturday 21 October

83. At the weekend, the prison runs a limited and split regime for prisoners with sections of prisoners unlocked at staggered intervals in the morning or afternoon to participate in exercise, association and collect medication.
84. In his police statement, a prisoner said that he visited Mr Jarosz in his cell at around 9:15am but had no concerns about him that day. He said that he was aware that in the previous weeks, Mr Jarosz's ex-partner had told him in a letter that she had started a new relationship with another man. Mr Jarosz had also told him that he would kill himself if he was returned to Poland.
85. An officer unlocked Mr Jarosz's cell for him to collect his evening meal. In his police statement, he noted no concerns about Mr Jarosz.
86. At 7.00pm, Officer A completed her roll check on the third landing, where Mr Jarosz lived but raised no concerns. Officer B checked prisoners on the third landing between 7.45pm and 8.00pm. When she looked through Mr Jarosz's observation hatch, she said he was lying in bed, covered by his blanket. At 9.09pm, Officer A completed her roll check but had no concerns.

22 October

87. At 6.06am, Officer B completed the morning roll check. She said she recalled seeing Mr Jarosz, lying on his bed. CCTV footage shows Officer C next checked Mr Jarosz during a roll check at 7.05am. He noted no concerns.
88. Staff scheduled an association and exercise period for prisoners on Mr Jarosz's landing for the afternoon. This meant that the prisoners would remain in their cells until they were unlocked for lunch. The exceptions to this were prisoners who needed to collect prescribed medication or were cleaners, who were unlocked at a similar time to prisoners on other landings. CCTV footage shows that from 8.47am, staff started unlocking prisoners who were required for these specific activities. Prisoners requiring medication should have been unlocked before 9.30am to collect their medication from the hatch.
89. A prisoner went to see Mr Jarosz at around 9:15am. He looked through Mr Jarosz's cell door observation panel but did not see him. However, he noticed part of Mr Jarosz's right leg. It appeared that Mr Jarosz was sitting on the toilet but the rest of his body was obscured by the shower curtain. He shouted Mr Jarosz's name but he did not think that he would have heard because of the loud music on the wing landing. As he did not get a response from Mr Jarosz, he left the landing and went to the gym.
90. Although Mr Jarosz's name was included on the medication list, CCTV footage shows that officers did not unlock his cell door, which meant that he did not attend the medication hatch. The investigator was told by prison staff that this particular role was not the responsibility of any one officer and none of the staff knew who had been assigned this role that day. Until that day, Mr Jarosz had complied with taking his medication.
91. Officer D had been working on the fourth landing all morning. He went down to the third landing later that morning to help his colleagues unlock prisoners for lunch. CCTV footage shows him outside Mr Jarosz's cell door at 11.27am. He told the investigator that when he looked through the observation panel, he did not see Mr Jarosz. He was not concerned about this as he had checked other cells on the landing that were also empty and he presumed that, like these occupants, Mr Jarosz was already out of his cell either participating in an activity or collecting his lunch.
92. Officer C began the roll check on the third landing at around 11.40am. CCTV footage shows that at 11.49am, he arrived at Mr Jarosz's cell. He looked through the observation panel but the cell appeared empty. Knowing that all prisoners should now have returned to their cells, he unlocked the door and went in. When he went in, he saw the blue shower curtain between the two levels of the bunk bed and believed that Mr Jarosz might be on the toilet. He removed the shower curtain and saw Mr Jarosz hanged from a tight ligature around his neck. The ligature had been suspended from a bracket at the ceiling which meant that Mr Jarosz's body was hidden when looking from the cell door. He immediately shouted for assistance from Officer E (who was on the landing) to call an emergency.

Emergency response

93. Officer E radioed a medical emergency code blue (indicating that a prisoner is unconscious or having problems breathing) at 11.49am, and the control room called an ambulance at 11.51am. Officer D joined Officer C in Mr Jarosz's cell. He cut the ligature while Officer C supported Mr Jarosz's weight and they lowered him to the floor. Officer C assessed Mr Jarosz but found no signs of life. He started cardiopulmonary resuscitation (CPR) by doing chest compressions.
94. An officer arrived with other staff. Staff took it in turns to perform cardiopulmonary resuscitation (CPR) under a nurse's direction when she arrived at 11.51am. The Head of Residence collected the defibrillator (a device that monitors heart rhythms and administers an electric shock if required) from the wing and arrived with another nurse, who carried the emergency equipment, at 11.54am. The first nurse said that at first assessment she could not ascertain whether Mr Jarosz's body was stiff although he was cold. However, when she tried to use the medical equipment to assess Mr Jarosz's condition, it was clear that his fingers were stiff. Nonetheless, staff continued with CPR and gave him oxygen. Mr Jarosz showed no signs of life.
95. The paramedics arrived at the cell at 11.59am, followed by a second ambulance crew two minutes later. The paramedics took over Mr Jarosz's care and, after an assessment, pronounced him dead at 12.06pm.
96. Staff found two suicide notes written by Mr Jarosz. One was addressed to his ex-partner and the other to a friend.

Family liaison

97. Mr Jarosz's ex-partner was the victim of his crime and Mr Jarosz's restraining order prevented him from contacting her. The Head of Residence said that he was therefore unsure how information about Mr Jarosz's death would affect her. He was the only senior manager on duty after the incident and he decided to break the news of Mr Jarosz's death to his ex-partner by telephone. He updated a member of the chaplaincy team, who telephoned Mr Jarosz's ex-partner at 3.49pm to break the news to her.
98. A custodial manager and a SO were appointed as the prison's family liaison officers. The SO spoke to Mr Jarosz's ex-partner on the same day at 6.50pm, and offered support. Along with a governor, the SO visited Mr Jarosz's ex-partner the next day to offer support and offered their condolences. Leicester contributed to the cost of Mr Jarosz's funeral in line with national instructions.

Support for prisoners and staff

99. On 19 November, a prison governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Jarosz's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Jarosz's death.

Post-mortem report and toxicology results

100. The post-mortem examination established Mr Jarosz's cause of death as hanging. Toxicology results identified the presence of potentially lethal and toxic levels of sertraline and tramadol. The pathologist noted that this might indicate that Mr Jarosz had taken an overdose of his prescribed medication.

Findings

Management of risk of suicide and self-harm

101. Prison Service Instruction (PSI) 64/2011 (Safer Custody) and PSI 07/2015 (Early Days in Custody) list a number of risk factors and potential triggers for suicide and self-harm. Mr Jarosz had a number of these risks when he arrived at Leicester. It was his first time in custody, he had stated that he intended to take his life, had a history of self-harm and overdose and had depression.
102. Although Mr Jarosz had been identified as at risk of suicide and self-harm on 19 June 2017 as he said he would kill himself if sent to prison, this information was not recorded on his person escort record which meant that reception staff at Leicester were not aware of this. Although the reception nurse had access to this risk information in his medical records, he did not identify that Mr Jarosz was at risk of suicide and self-harm. There is no evidence that he tried to find out more information about Mr Jarosz's risks and share these risk factors with reception staff. This led to a poor quality early assessment of Mr Jarosz's risk of suicide and self-harm.
103. Staff did, however, appropriately start ACCT procedures from 26 June to 7 July and from 19 to 30 July in response to concerns about Mr Jarosz's risk of suicide and self-harm, and healthcare contributed to his care.
104. When Mr Jarosz was recalled to prison on 14 August 2017, staff again started ACCT procedures. PSI 64/2011 requires a multidisciplinary approach for ACCT case reviews and where possible, the ACCT assessor and healthcare staff should attend the first ACCT review. This did not happen despite Mr Jarosz's recent overdose in the community and history of depression.
105. A SO identified Mr Jarosz's main concerns as his lack of contact with his children and that he needed clarification about the restraining order. However, another SO stopped monitoring Mr Jarosz under ACCT procedures at the first review on 15 August as he considered that he was no longer at risk. We are concerned that ACCT procedures were stopped prematurely as it was only 24 hours after ACCT monitoring began and the concerns identified in the ACCT assessment had not yet been addressed. No one referred to the restraining order and Mr Jarosz had not spoken to his offender manager about his concerns, as recommended in the ACCT assessment. The PSI requires that, at the first case review, staff should identify whether a referral for mental health care or drug/alcohol services is needed and make the referral(s). Mr Jarosz had taken an overdose days before returning to custody but no one referred to this at the first case review, and it was a missed opportunity to address his needs.
106. We are concerned that, contrary to PSI 64/2011, no one assessed Mr Jarosz's risk or fully discussed his concerns on 28 September when he threatened to go on hunger strike or take his life.
107. Staff again appropriately started ACCT monitoring on 29 September. At the first review on 30 September, there was no input from the healthcare team. A SO stopped monitoring Mr Jarosz under ACCT procedures as she considered that he was no longer at risk, even though the concerns identified in the assessment

had not been addressed. In addition, Mr Jarosz had been prescribed antidepressant medication since 17 August and there was no input from the mental health team at this first review nor was he referred to them for additional support. This was another missed opportunity to address his needs and we are concerned that ACCT procedures were once again stopped prematurely.

108. Yet again, we are not satisfied that Leicester managed ACCT procedures effectively to support Mr Jarosz and we make the following recommendations:

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

- **Staff have a clear understanding of their responsibilities and the need to record relevant information about risk.**
 - **Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.**
 - **Prison and healthcare staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review.**
 - **Staff Hold multidisciplinary ACCT reviews, with continuity of case management and involving all staff who can contribute to a prisoner's care.**
 - **Case managers complete caremaps at the first ACCT case review, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.**
109. Given that this is not the first time that we have raised concerns about the management of those at risk of suicide and self harm at Leicester, we make the following recommendation:
- **The Prisons Group Director, Midlands Prisons, should satisfy herself that effective action is taken to implement these recommendations.**

Immigration concerns and assessment of risk

110. PSI 64/2011 notes that changes in status for foreign national prisoners who are, or about to be, held under immigration removal powers and for those close to deportation can be triggers for suicide or self-harm. PSI 52/2011 on immigration, repatriation and removal services adds that if, at any point, a detainee is considered to be at risk of self-harm, prisons must inform UKVI immediately.
111. Immigration staff said that they were not aware of staff concerns about Mr Jarosz or that his main wish was to be transferred to an immigration removal centre after his prison sentence had expired, and that this had triggered ACCT monitoring on 29 September. As a result, they had no input into the first ACCT review on 30 September. As Mr Jarosz's immigration status was the underlying cause of his increased risk, UKVI should have been considered a key stakeholder and invited

to contribute to his care. Had this happened, Mr Jarosz's uncertainty about if or when he would be transferred to an immigration removal centre might have reduced. Immigration staff said that they told Mr Jarosz that he was unsuitable to be transferred to an immigration removal centre. However, there is no evidence in Mr Jarosz's prison records to support this and prison and probation staff continued to advise him, wrongly, that he would be transferred when a space became available. Sharing of risk information with all staff and agencies that work in prison establishments is of the utmost importance to enable staff to support prisoners adequately. We make the following recommendation:

The Governor and UK Visa and Immigration service should develop and implement a system to ensure that wing staff are informed of any potential changes to the immigration status of foreign national prisoners and that wing staff consider whether this might affect their risk of suicide and self-harm.

Unlocking of prisoners for medication

112. Staff last checked Mr Jarosz during the morning roll check at 7.05am on 22 October. After this, staff were not required to check or unlock prisoners on his landing unless they were subject to ACCT monitoring, had to collect medication or had a wing cleaner role.
113. Mr Jarosz's name was on the list of prisoners to be unlocked from his cell between 9.00am and 9.30am for medication. Prison staff appeared to have overlooked his name and failed to unlock his cell door. Mr Jarosz therefore did not attend the medication hatch and staff missed an opportunity to check on his wellbeing. Healthcare staff noted that Mr Jarosz did not collect his medication but appear not to have taken any active steps to inform prison staff. This meant that Mr Jarosz was not discovered for more than two hours.
114. While we cannot know whether or not the outcome for Mr Jarosz might have been different if he had been found earlier, it is important that prison staff understand that they must check on prisoners' welfare if a prisoner has failed to attend a scheduled activity. Early intervention when a prisoner is found unconscious or in a critical situation might save his life.
115. After the investigator's visit to the prison, the Head of Safer Custody issued instructions in January 2018 to all prison and healthcare staff about the actions to take to follow up on prisoners who do not attend the medication hatch to collect their medications. We therefore make no recommendation.

Resuscitation

116. Prison and healthcare staff responded quickly to the medical emergency code blue on 22 October and an ambulance was called. They conducted CPR and told the investigator that Mr Jarosz was cold and stiff, indicating that rigor mortis was present. We understand the commendable wish to try and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to do so in these circumstances.
117. A nurse told the clinical reviewer that she was not aware of the guidance from the Royal College of Nursing, the Royal College of GPs and HM Prisons and

Probation Service about the circumstances when resuscitation should not be attempted and that it had not been included in her CPR update training. The guidance, which has been in place since September 2016, is designed to support prison healthcare staff to make appropriate decisions in situations where the patient is showing signs of death, and resuscitation would be futile. The guidance has been adopted by the NHS and includes a number of circumstances where resuscitation would be futile, including when rigor mortis is present. We make the following recommendation:

The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate, in line with NHS England and HM Prisons and Probation Service’s resuscitation policy issued in September 2016.

Contact with Mr Jarosz’s next of kin

118. Prison Rule 22 says that when a prisoner dies, the Governor should inform the 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.
119. A governor delivered the news of Mr Jarosz’s death to his ex-partner by telephone at 3.49pm on 22 October at the request of the Head of Residence. There was a delay of over three hours in notifying Mr Jarosz’s ex-partner of his death. The Head of Residence said he was unsure how information about Mr Jarosz’s death would affect his ex-partner, who was the victim of his crime. He was also the only senior manager on duty and was unable to leave the prison as he was managing the incident. We acknowledge that the assigned family liaison officer did speak to Mr Jarosz’s next of kin at 6.50pm, but there was a further delay in staff attending the family home, and a face-to-face meeting did not take place until the next day.
120. While we accept that it can be difficult during weekends to find adequate resources during emergency situations, Leicester should ensure that they have contingency procedures in place to manage the early contact with families following a death in custody. 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.

Clinical care

121. We agree with the clinical reviewer that overall, Mr Jarosz’s care at Leicester was not equivalent to that which he could have expected to receive in the community because of the lack of follow-up care after mental health referrals and the lack of psychosocial therapy support.

Mental health

122. Mental health staff noted that Mr Jarosz had reactive depression and referred him twice to the emotional support service. However, he was not seen by the service.
123. Mr Jarosz also submitted a number of applications to see the healthcare team because he felt depressed and had suicidal thoughts. He submitted an application to see a mental health nurse on 1 September and was not seen, despite his name being added to the mental health waiting list. Staff told the investigator that the mental health team had a weekly allocation meeting, where work is distributed. It is therefore unclear how Mr Jarosz's name was removed from the waiting list.
124. Mr Jarosz asked to see a mental health nurse on 8 October. This was dismissed by a nurse because Mr Jarosz had been assessed by the mental health team in July 2017. The nurse believed that Mr Jarosz's condition was unchanged despite the assessment taking place three months earlier. This was a missed opportunity for the healthcare team to have assessed Mr Jarosz's mental wellbeing and captured his risks and concerns.
125. The clinical reviewer noted that for people with reactive depression, care and treatment would normally be provided through primary mental health, under the leadership of the GP and with support from psychological interventions, such as talking therapies or cognitive behavioural therapy (CBT). These services help people manage their problems by changing the way they think and behave, and are most commonly used to treat anxiety and depression. The clinical reviewer noted that this form of treatment might have better suited Mr Jarosz but Leicester do not have psychosocial services. We make the following recommendations:

The Head of Healthcare should review the management of the mental health waiting lists on SystemOne to ensure that referrals are not lost on the system.

The Governor and Head of Healthcare should review the case for provision of psychosocial interventions as part of the primary mental health care service offered at HMP Leicester.

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