Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patryk Jalocha, a prisoner at HMP Manchester, on 5 November 2024

A report by the Prisons and Probation Ombudsman

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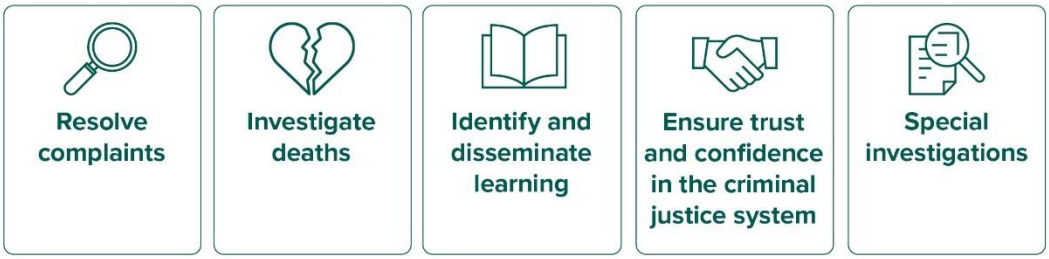
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Patryk Jalocha died after being found hanged in his cell on 5 November 2024 at HMP Manchester. He was 24 years old. I offer my condolences to Mr Jalocha's family and friends.

Mr Jalocha's was the sixth apparently self-inflicted death in three years at Manchester.

Mr Jalocha was on remand and had not been in prison before. The nature of the offences he was charged with meant he was identified as requiring the highest level of security (category A) in prison. As a foreign national he had also received notification that, if found guilty, he may be deported after serving all or part of his sentence. There is some evidence that he was worried about his future and he appeared generally low in mood, bored and frustrated with the limited activities available to him. Wing staff recognised this and managed Mr Jalocha under Prison Service suicide and self-harm monitoring procedures (known as ACCT) for most of the five weeks before his death.

The investigation found some deficiencies in ACCT procedures but, most seriously, an officer did not complete the required ACCT checks immediately before Mr Jalocha was found hanged. The Governor rightly dismissed the officer for gross misconduct but I am conscious that this failure in duty of care will make difficult reading for Mr Jalocha's family.

In October 2024, following an inspection of Manchester, HM Chief Inspector of Prisons issued an urgent notification to the Secretary of State for Justice in relation to a concerning decline in three of the four healthy prison tests. Some of the concerns HM Inspectorate of Prisons identified are relevant to Mr Jalocha including poor ACCT care planning and lack of purposeful activity. As a result the prison has received extra support from national teams and taken some positive steps to improve safety. I therefore make fewer recommendations than I might otherwise have done.

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

Adrian Usher
Prisons and Probation Ombudsman **June 2026**

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Summary

Events

1. Mr Patryk Jalocha was born in Poland and came to the UK aged 15 with his mother and siblings in 2015. On 10 June 2024, Mr Jalocha was convicted of affray, possession of an offensive weapon and possession of cocaine and bailed pending sentence. On 5 August, Mr Jalocha was arrested and charged with attempted murder, possession of a firearm and aggravated burglary.

2. On 6 August, Mr Jalocha was remanded to HMP Birmingham. It was his first time in prison. Mr Jalocha told a nurse during an initial health assessment that he was physically well and had no history of mental illness or substance misuse. He strongly denied any thoughts of suicide and self-harm.

3. On 7 August, Mr Jalocha was identified as a potential category A prisoner (indicating he presented a high risk to the public) due to the nature of his offences. On 12 August, he transferred to HMP Manchester, a high security prison, where he was given a cell on the landing used for younger and more vulnerable category A prisoners away from the main category A wing.

4. On 5 September, Mr Jalocha was sentenced to eight months imprisonment for possessing a firearm and six months imprisonment for the charges relating to the incident on 10 June. Both sentences were to be served concurrently. He remained on remand for attempted murder and aggravated burglary.

5. On 9 September, he was deemed a person of interest to Foreign National Offender Returns Command (FNORC - the branch of Home Office Immigration Enforcement that deals with foreign national offenders) as the nature of his outstanding offences meant it was likely, if found guilty, that he would be sentenced to more than 12 months in prison and would therefore be liable for deportation after serving all or part of his sentence.

6. On 20 September, an officer gave Mr Jalocha a notice of liability to deportation issued by FNORC. Mr Jalocha refused to sign to confirm receipt of this until he had spoken to his solicitor.

7. On 29 September, an officer started Prison Service suicide and self-harm monitoring procedures (known as ACCT) after she noticed that Mr Jalocha had become withdrawn and spent most of his time in his cell asleep.

8. Staff stopped ACCT monitoring on 15 October but re-started this on 26 October when officers noticed superficial scratches on Mr Jalocha’s arm and that he had again become withdrawn. The ACCT case coordinator made some progress towards Mr Jalocha receiving education, obtaining a cleaning job and being allowed access to the main category A unit gym.

9. On 4 and 5 November, two different members of staff noticed graffiti in Mr Jalocha’s cell but did not examine it or question him about it. The graffiti included a drawing of a man hanging.

10. At about 10.55pm on 5 November, an officer discovered Mr Jalocha hanged in his cell. Prison and healthcare staff attended and began cardiopulmonary resuscitation (CPR). Ambulance paramedics also attended but declared life extinct at 11.45pm.

Findings

11. There were a number of weaknesses in ACCT procedures between 29 September and 15 October including:

    - Mr Jalocha was not assessed by a trained ACCT assessor within 24 hours.
    - Mr Jalocha's ACCT assessment was completed at the same time as a case review and not separately beforehand.
    - No support actions to mitigate and reduce risk were identified.
    - Some sections of the document were left blank or were poorly completed including risks, triggers and protective factors and sources of support.
    - The ACCT was closed without evidence that Mr Jalocha's risk had been reduced.

12. The management of Mr Jalocha's ACCT after it was re-opened on 25 October was significantly better.

13. The night patrol officer did not complete the required ACCT checks immediately before Mr Jalocha was discovered hanging and falsified the ACCT record to say he had done so.

14. The night patrol officer did not radio a code blue emergency when he discovered Mr Jalocha hanging. However, the emergency response was otherwise swift and efficient.

15. Mr Jalocha wrote a number of things on the walls of his cell that should have been explored with him before he died.

16. The prison has brought in a number of measures since Mr Jalocha's death and as a result of an urgent notification from HM Inspector of Prisons (HMIP) in October 2024 to improve ACCT monitoring and increase the number of trained ACCT assessors. As part of this the prison safety team has produced a directory for ACCT case coordinators signposting sources of support for a number of different issues. This is good practice. In April, the prison implemented a system of random CCTV monitoring to ensure staff complete required ACCT checks.

Recommendations

- A fabric check on a cell represents an opportunity to consider wider risk factors. The Governor should ensure that his staff are aware of this fact and take due account of any graffiti, handwritten notes, drawings etc. and take further action where appropriate.

- The Governor should introduce a robust assurance process to satisfy himself that all prison staff understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of an emergency effectively.

The Investigation Process

17. HMPPS notified us of Mr Jalocha's death on 6 November 2024.

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

19. The investigator visited HMP Manchester on 26 November 2024. She obtained copies of relevant extracts from Mr Jalocha's prison and medical records. Further information was obtained from North West Ambulance Service and a member of the HMIP inspection team who inspected the prison in October 2024.

20. The investigator interviewed seven members of staff and one prisoner at Manchester between November 2024 and February 2025.

21. NHS England commissioned a clinical reviewer to review Mr Jalocha's clinical care at the prison. She jointly interviewed healthcare staff with the investigator. Further information was provided by the Head of Healthcare and the Head of the Mental Health Team.

22. We informed HM Coroner for Manchester City of the investigation. The post-mortem report was not available at the time of writing. We have sent the Coroner a copy of this report.

23. The Ombudsman's office contacted Mr Jalocha's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Jalocha's mother said she had no specific questions but wanted to understand all the circumstances around her son's death. We have sent her a copy of this report.

Background Information

HMP Manchester

24. HMP Manchester is a high security training prison which accepts long-term prisoners. There is a category A unit on E Wing for prisoners posing greater security risks. Category A prisoners who are younger or are considered more vulnerable are held on Z landing in the prison's healthcare unit. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour mental and physical healthcare at the prison. Delphi Medical provides substance misuse services.

HM Inspectorate of Prisons

25. The most recent full inspection of HMP Manchester was between 17 September and 3 October 2024. Following this inspection, HM Inspectorate of Prisons issued an urgent notification (UN, a mechanism for the Chief Inspector to raise urgent concerns with the Secretary of State) as a result of their findings. The UN cited the number of weapons and other illicit items found in recent months was amongst the highest of all prisons holding adult men and those testing positive for drug use was very high. Time out of cell was poor and the restricted daily regime left large numbers of prisoners locked in their cells for extended periods of time.

26. Since the last inspection, there had been six self-inflicted deaths and a further three deaths with suspected links to drug abuse. The lack of purposeful activity, drug availability, associated debt and frustration at basic requests not being dealt with had contributed to a steep rise in the rate of self-harm, which was the highest amongst adult male prisons. Too little help was given to men in crisis and few men on suicide and self-harm monitoring were engaged in purposeful activity, which did not help their well-being. There were significant weaknesses in the ACCT process – care plans were often very limited or non-existent and most lacked consistent case management.

Independent Monitoring Board

27. 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. The latest annual report was published in August 2022 and covered the immediate post-pandemic period. Therefore we have not included their findings here.

Previous deaths at HMP Manchester

28. Mr Jalocha was the sixteenth prisoner to die at Manchester since 5 November 2021. Of the previous deaths, six were self-inflicted, six were from natural causes and three were from other causes or drug related. In three of the previous deaths, a code blue emergency (when a prisoner has stopped or is having difficulty breathing) was not called at the earliest opportunity.

29. Up until the end of March 2025, there had been one further self-inflicted death and one from a cause unascertained at the time of writing.

Assessment, Care in Custody and Teamwork (ACCT)

30. 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 decide the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After a first 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 predicting when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

31. 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. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which goes with the prisoner as they move around the prison. When Mr Jalocha was at Manchester, guidance on ACCT procedures was set out in PSI 64/2011. From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Foreign national offenders (FNOs)

32. Home Office Immigration Enforcement automatically considers all foreign national offenders sentenced to 12 months or more for deportation. Remand prisoners are identified as persons of interest and served with a notice of liability to deportation once they are sentenced. Under the Early Removal Scheme, prisoners with a determinate sentence can be removed from prison earlier than their half-way point of sentence, to allow their deportation or removal from the UK. The scheme is mandatory; all determinate sentenced foreign national prisoners who are liable to removal must be considered. The rules do not apply to prisoners who receive life sentences (indeterminate sentences). Prisoners who receive extended determinate sentences can be deported once they have served a third of their sentence.

Key Events

33. Mr Patryk Jalocha was born in Poland and came to the UK aged 15 with his mother and siblings in 2015. Mr Jalocha completed his education and then gained employment. In 2022, his GP prescribed him citalopram (antidepressant) after he told her he felt sad and lacking in motivation. However, he had since stopped taking this medication.

34. On 10 June 2024, Mr Jalocha was convicted of affray, possession of an offensive weapon and possession of cocaine and bailed pending sentence. As part of the conditions of his bail he was required to wear an electronic tag.

35. On 5 August, Mr Jalocha was arrested and charged with attempted murder, possession of a firearm and aggravated burglary. The victim was a woman unknown to him.

HMP Birmingham 6 -12 August 2024

36. On 6 August, Mr Jalocha was remanded to HMP Birmingham. It was his first time in prison.

37. Mr Jalocha told a nurse during an initial health assessment that he was not on any medication and had no history of mental illness or substance misuse. She noted on his clinical record that he strongly denied any thoughts of suicide and self-harm, appeared mentally stable, polite, coherent and calm. She did not use a translation service and noted that Mr Jalocha spoke English, although his main language was Polish.

38. On 7 August, Mr Jalocha was identified as a potential category A prisoner (indicating he presented a high risk to the public) due to the nature of his offences. According to local security policy he was moved to the Care and Separation Unit (CSU – segregation unit) pending transfer to a higher security prison. On 9 August, Mr Jalocha told staff he was sleeping a lot due to being bored. He said he was still trying to process what had happened to him. The next day he said he had problems sleeping and a GP prescribed him promethazine (an antihistamine used in prison instead of more addictive and tradeable sleeping tablets) for three days.

HMP Manchester 12 August – 4 November 2024

39. On 12 August, Mr Jalocha transferred to HMP Manchester. He told a nurse at an initial health assessment that he had no long-term health conditions. He denied any history of or current thoughts of suicide or self-harm. Mr Jalocha said he had used cocaine once a week in the community and denied any addiction issues.

40. A mental health nurse also assessed Mr Jalocha as part of his initial health assessment. He said it was difficult to establish rapport with Mr Jalocha and he spoke very little. He noted that it was Mr Jalocha's first time in prison and he did not have access to any of his community records to confirm his history. Mr Jalocha denied any mental health issues, substance misuse issues or suicidal thoughts. She referred Mr Jalocha to the mental health team. He explained at interview that it

was prison policy to automatically refer category A prisoners for a mental health assessment.

41. The next day on 13 August, Mr Jalocha told an officer that he had no concerns about being in Manchester. A member of the drug and alcohol team visited him for a standard triage assessment and he told them he was not interested in working with them. Mr Jalocha was allocated to Z landing, a landing located in the prison healthcare department on M Wing and used for young (under-21) or vulnerable category A prisoners.

42. On 14 August, a nurse completed a full mental health assessment with Mr Jalocha. The nurse said Mr Jalocha's English was very good and he spoke openly about his childhood in Poland and his employment prior to his arrest. He noted Mr Jalocha was not known to mental health services and was not on any medication. Mr Jalocha said he used alcohol and cocaine socially but denied any addiction issues. He also denied any suicidal thoughts or history of self-harm and said he did not understand people who self-harmed.

43. Around this time, an officer on Mr Jalocha's landing asked Healthcare Assistant (HCA) a Polish speaker, to speak to Mr Jalocha because he seemed to be confused about how long he was likely to be in prison. The HCA said he had a conversation with Mr Jalocha in Polish about why he was in prison and explained that he might be there for some time pending his trial. He said he advised Mr Jalocha to speak to his solicitor about his situation. He said Mr Jalocha seemed calm but a little confused because it was his first time in prison.

44. The HCA said he did not know how much English Mr Jalocha understood because they only spoke in Polish. He said he saw him quite regularly because Z landing was in the same wing as healthcare and noticed him interacting with officers in English. The HCA said Mr Jalocha was not very talkative and the fact that they spoke in Polish did not seem to make a difference to how much he communicated.

45. On 5 September, Mr Jalocha was sentenced via videolink to eight months in prison for possessing a firearm and six months for the charges relating to the incident on 10 June. Both sentences were to be served concurrently. He remained on remand for attempted murder and aggravated burglary. On 9 September, he was deemed a person of interest to Foreign National Offender Returns Command (FNORC - the branch of Home Office Immigration Enforcement that deals with foreign national offenders) as the nature of his outstanding offences meant it was likely, if found guilty, that he would be sentenced to more than 12 months in prison and would therefore be liable for deportation after serving all or part of his sentence.

46. The same day, Mr Jalocha received an email from his mother via the Email a Prisoner scheme. He did not send a reply.

47. On 20 September, an officer the equalities officer in the safer custody department, gave Mr Jalocha a notice of liability to deportation issued by FNORC. Mr Jalocha refused to sign to confirm receipt of this until he had spoken to his solicitor.

48. On 29 September, an officer began Prison Service suicide and self-harm monitoring procedures (known as ACCT) after she noticed that Mr Jalocha had completely withdrawn from daily prison activities and had stopped speaking to staff. She said

Mr Jalocha spent most of the day in bed and told her that he was struggling in prison and worried about being deported to Poland. He said he had not spoken to his family or friends since being in custody because he did not know what to tell them. The officer said Mr Jalocha denied feeling suicidal but she was concerned that his risk was raised and thought he needed extra support.

49. A Supervising Officer (SO) completed the immediate action plan. She instructed staff to check Mr Jalocha five times an hour and record three conversations with him a day pending assessment by a trained ACCT assessor.

50. The next day on 30 September, a SO held an ACCT review, with a nurse from the inpatient unit, in the association room on M Wing. The SO noted Mr Jalocha had not been assessed by an ACCT assessor within 24 hours of ACCT procedures starting as none were available. At interview, he said that the assigned ACCT assessor for that day had gone home unexpectedly for personal reasons and there was no one else available. The SO offered Mr Jalocha an interpreter using a telephone interpreting service (The Big Word) but Mr Jalocha said he did not need one. The SO told the investigator that Mr Jalocha was not a talkative prisoner but he would respond when asked questions and he was satisfied that Mr Jalocha understood what he was saying to him.

51. Mr Jalocha said he was concerned about being deported to Poland and the SO said he would contact the Offender Management Unit (OMU – the department in prison that deals with courts and sentence planning) for him. He reduced the frequency of checks to three per hour and the number of daily conversations with staff to two. Staff did not complete a care plan with actions to support Mr Jalocha.

52. On 1 October, Mr Jalocha's ACCT record showed he played pool with wing staff and they had a conversation about Mr Jalocha's place of birth and his interest in martial arts. The next day, Mr Jalocha spoke to HMIP as part of their inspection for 45 minutes with an interpreter. HMIP noted in his ACCT record that she had spoken to Mr Jalocha about his experiences of the prison's OMU. HMIP said he seemed calm and had laughed with her and said it was nice speaking his own language. HMIP provided some further information for the investigator. She said in her professional opinion, Mr Jalocha had not been distressed when they spoke but she had concluded that he had not had any contact with anyone from OMU at that stage and had therefore not been afforded the opportunity to ask questions regarding his sentence or pending court case.

53. On 3, 5 and 6 October Mr Jalocha's ACCT record showed he played pool with wing staff and was looking forward to the X-Box in the association room being repaired.

54. On 7 October, a SO noted that Mr Jalocha was due for an ACCT review but that he had still not had an ACCT assessment and there were no assessors available that day. She postponed the review to the following day to ensure the ACCT assessment took place.

55. On 8 October, the SO held a second ACCT review with Mr Jalocha, an officer and a member of staff from the Chaplaincy team. The officer was the assigned ACCT assessor but he did not complete the assessment before the review as he should have done. Mr Jalocha said he had no thoughts of suicide or self-harm but just wanted to "chill" in his cell and watch TV. The staff member from the Chaplaincy

team asked him about his family and Mr Jalocha said he had not spoken to them since being in prison and did not want to speak to them. He said he was frustrated about the charges he was remanded for and "overthought" his pending court case. He said he was in touch with his solicitor via videolink. He said he only wanted to watch TV or go to the main prison gym as the gym on the healthcare unit was not very good. After discussion about Mr Jalocha's presentation, the staff present decided to increase Mr Jalocha's observations to five every hour and the number of daily conversations with staff to three.

56. The officer completed the ACCT assessment paperwork after the review. He noted that an interpreter was not needed as Mr Jalocha understood English. He said Mr Jalocha was polite but quiet and withdrawn when asked about his family and said he did not want to contact them. He said he just wanted to watch TV. He said he was confused about the charges against him as he thought they did not represent what he had done. The officer said he thought Mr Jalocha should contact his family for support. Mr Jalocha said he did not want a well-being plan.

57. Between 9 and 15 October, Mr Jalocha's ACCT record showed he came out of his cell for showers, exercise and social time and often attended the landing gym. He also often played pool with his peers. On one recorded occasion, he laughed and joked with staff and taught them some Polish words. He appeared to sleep well and was only noted to be awake at two of the five nightly ACCT checks in this period.

58. On 15 October, the SO held a third ACCT review with staff from the prison chaplaincy team. Mr Jalocha said he still did not wish to contact his family. He said he had no thoughts of suicide and did not want to be on an ACCT. He said he was "good" and just liked watching TV. The SO and staff from the prison chaplaincy decided to stop ACCT monitoring and set a post-closure review for 22 October.

59. On 26 October, an officer re-opened Mr Jalocha's ACCT document after he noticed scratches on Mr Jalocha's arm. The officer noted on the concern and keep safe form that Mr Jalocha had been in low mood and had stopped engaging with staff and other prisoners. He said Mr Jalocha told him that the lack of clarity about his future was contributing to his low mood. He refused to see a nurse about his scratches.

60. A SO held an ACCT review the same day with a nurse. Mr Jalocha said his scratches were old and he had not done any recently. He said he had scratched himself out of frustration at not being able to sleep. Mr Jalocha said he had applied to see healthcare staff about his sleeplessness (there is no record that he did this). The SO said they had a long discussion with Mr Jalocha about why he did not want to contact his family. Mr Jalocha told her he was angry about his parents' divorce and said it was the first time he had opened up about his family issues. They discussed whether he had friends he could contact instead and, although Mr Jalocha showed an initial interest in this, he then said he was not bothered.

61. Mr Jalocha said he was bored and that he had been charged with the wrong offence. He asked to see someone from OMU to go through his situation with him. He said he had a TV and books but found it hard to concentrate. He had also applied to start education. The SO noted he was talkative and looked upset when talking about his family. Mr Jalocha said he did not feel suicidal or like harming himself. He said he wanted someone to believe him about his offence. The SO

decided Mr Jalocha should be checked five times a day and five times overnight because she was worried that hourly observations would disturb his sleep.

62. The nurse noted in Mr Jalocha's clinical record that he was low in mood, was unhappy in prison and denied his current charges. He felt let down by his family and did not want to contact them. The nurse said he did not remember the review very well. He remembered Mr Jalocha seemed quite low and did not particularly want to be on ACCT monitoring. He said Mr Jalocha's English was fluent and there was no problem communicating with him. He said Mr Jalocha did not seem to have had much information about his outstanding criminal case and in his experience this was quite common. He said the SO told Mr Jalocha she would liaise with OMU about this.

63. The SO completed a care plan for Mr Jalocha. She said she would email the education department on Mr Jalocha's behalf in an effort to tackle his boredom. She noted Mr Jalocha had agreed to apply for a GP appointment to discuss his sleeplessness.

64. The HCA said he remembered Mr Jalocha complaining about poor sleep when he spoke to him one lunchtime around this time and had advised him to apply to see the GP. He said he did not want to explore why Mr Jalocha was not sleeping because they spoke on the landing and it was not a private conversation.

65. On 28 October, an officer had a key worker session with Mr Jalocha. Mr Jalocha said he was fine but had nothing to do in his cell apart from watch TV. He thought his poor sleep was due to frustration and boredom. The officer offered him books and distraction packs but Mr Jalocha said he already read a lot and was still bored. The officer said he would chase up a GP appointment for Mr Jalocha to discuss his difficulty sleeping. He said he did not want to contact his family. He had seen someone from the education department and was keen to start classes.

66. On 30 October, the SO completed an ACCT review with Mr Jalocha, an officer from OMU and the Imam. She noted that Mr Jalocha was very "smiley" and engaged well with her. The officer explained Mr Jalocha's position regarding his sentence and outstanding charges. Mr Jalocha said he was pleased that he had been accepted for education classes because he wanted more money and to keep busy. TheSO suggested he do a cleaning course so he could be considered for a job as a wing cleaner and Mr Jalocha said he was interested in doing that. He asked for a Polish/English dictionary as he sometimes struggled to understand words when he watched TV. Mr Jalocha agreed to apply to have some of his friends added to his prisoner telephone account. Mr Jalocha said he did not want anyone to visit him. He said he had no thoughts of suicide or self-harm and staff reduced his observations to four a day and four overnight. The SO added actions to the care plan that Mr Jalocha would apply to add a friend to his prisoner telephone account and that she would contact the library to see if she could get a Polish/English dictionary for Mr Jalocha.

67. Later that day Mr Jalocha applied for his mother, stepfather and solicitor's phone numbers to be added to his prison telephone account. The prison correspondence team confirmed that regulation checks on these numbers were completed on 3 November and approved for use on 4 November. Mr Jalocha did not make any calls before he died and he did not receive any visits.

68. According to Mr Jalocha's ACCT ongoing record for the period 26 to 31 October, he came out of his cell for exercise and participated in social time, playing pool and cards with his peers. On 1 and 2 November he did not come out of his cell except to collect his meals and spent the days watching TV or asleep in his cell. On 3 and 4 November, he came out of his cell for meals and a shower. On 4 November, an officer recorded that Mr Jalocha asked for a pen "although he has drawn on the walls". The ongoing record for 1 - 4 November recorded that Mr Jalocha had "settled" nights and was asleep most of the night on 4-5 November.

Events of 5 November 2024

69. On 5 November, a SO completed an ACCT review with Mr Jalocha in the association room. She said she had been allocated to work on another wing that day and had wanted to ensure she completed Mr Jalocha's review and another Z landing prisoner's review first. Other staff were due to join her but did not turn up so she decided it was preferable for her to do the reviews on her own as she knew both prisoners rather than have someone else hold a multi-disciplinary review later or another day.

70. When she collected Mr Jalocha from his cell she noticed graffiti on his wall and told him to stop writing on the walls and that she would provide him with paper. She said she, "saw scrawls everywhere" but only specifically remembered seeing "fuck the magistrate."

71. In the review, Mr Jalocha said he was looking forward to starting education but wondered why he had to have so many assessments. The SO explained the education staff needed to work out which level to start him on in each class. She told him he would be starting the cleaning course soon too. Mr Jalocha said he was still struggling to sleep but had a GP appointment on 12 November. The SO kept Mr Jalocha's observations at the same level and planned the next review for 12 November. (The Head of Healthcare confirmed that Mr Jalocha had a GP appointment booked for that date but was unable to find out who had booked it and when.)

72. The SO said Mr Jalocha engaged really well in the review. Overall she said he mixed quite well on the landing and usually came out for exercise and social time. She said he was bored and said a number of times that he needed something to keep him busy. He came across as restless. He was keen to start education and was frustrated at the number of assessments that had to be completed before he could start something. He was unhappy about the small gym on Z landing and this had prompted her to try to get the prisoners on Z landing a session in the main category A unit gym (something she achieved after he died). The SO said she understood that the activity she was able to offer Mr Jalocha was not enough for him.

73. As a category A prisoner, Mr Jalocha was subject to routine cell searches every 28 days and had to move cells every three months. After his ACCT review, he moved from cell MZ-02 to cell MZ-04 on the same landing.

74. The investigator watched CCTV footage from the afternoon and evening of 5 November. CCTV showed Mr Jalocha mixing with other prisoners during social time and going back and forth from his cell. At 4.34pm. he collected his evening meal

and returned to his cell three minutes later. Another prisoner said he offered Mr Jalocha extra food after dinner as there was some left. He said Mr Jalocha accepted the food and seemed his usual self.

75. At 5.13pm, a SO stopped at his door and spoke to him briefly. At interview, the SO said he could not specifically remember speaking to Mr Jalocha that day but nothing in his behaviour had seemed different.

76. CCTV showed that at 7.05pm and 7.30pm, an officer and then a second officer checked Mr Jalocha and recorded their checks on his ACCT document.

77. The second officer also recorded that he had checked Mr Jalocha as required by his ACCT plan at 8.30pm and 10.00pm. CCTV showed that these checks did not take place. At 8.30pm, CCTV showed the officer walked up the landing and refilled his water bottle but did not stop to check Mr Jalocha as he passed his cell. The officer was initially on sick leave and was then suspended from duty during our investigation and was not interviewed.

Emergency response

78. In addition to watching CCTV, the investigator also watched bodyworn video camera (BWVC) footage, listened to staff radio communications and obtained further information from North West Ambulance Service. The following account has been taken from all these sources and interviews with relevant staff.

79. At 10.55pm, an officer looked through Mr Jalocha's observation panel and then ran to the wing office, returning to the cell with two nurses. He radioed "assistance required on healthcare" and a Custodial Manager (CM, who was he night orderly officer (most senior officer on duty), and a SO arrived on the unit within a minute. The CM entered Mr Jalocha's cell and radioed a code blue emergency at 10.57pm. Shortly afterwards at 10.58pm, the control room officer asked the CM if Mr Jalocha was breathing and he said he was not. She rang North West Ambulance Service promptly at 10.59pm and an ambulance was dispatched with the highest priority.

80. BWVC footage showed Mr Jalocha had made a ligature from a pair of trousers, tied it to the frame of the top bunk bed and was slumped in a seated position on the floor. The officer used his anti-ligature knife to cut the ligature and remove it from Mr Jalocha's neck. The CM put Mr Jalocha on the floor and checked for signs of life as the nurses got the emergency equipment ready. A nurse said Mr Jalocha was not breathing and she could not find a pulse but his skin was still warm so they decided to start CPR. Between them, the nurses put a defibrillator on Mr Jalocha and it advised them to start chest compressions. They gave Mr Jalocha oxygen via a bag and mask. The defibrillator continued to analyse Mr Jalocha's heart output and advised staff to continue CPR. It did not advise an electric shock.

81. At 11.14pm, ambulance paramedics arrived and took over CPR with their own equipment. At 11.45pm, they stopped CPR and pronounced life extinct.

Contact with Mr Jalocha's family

82. The prison contacted the reverend shortly after Mr Jalocha was pronounced dead and she arrived at the prison at 1.00am. Mr Jalocha had given a telephone number

but no address for his mother on arrival in prison. The prison contacted the police, but they were unable to find an address for her. The reverend and duty governor, telephoned Mr Jalocha's mother with a Polish speaking officer acting as interpreter and broke the news of his death.

83. At 11.30am on 6 November, the prison appointed an officer as family liaison officer (FLO). a senior manager and the HCA visited Mr Jalocha's mother at her home at 1.30pm. The prison offered a financial contribution to Mr Jalocha's funeral in line with national policy.

Support for prisoners and staff

84. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

85. After Mr Jalocha's death, duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

86. The prison posted notices informing other prisoners of Mr Jalocha'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 Jalocha's death. Listeners attended Mr Jalocha's wing in line with postvention procedures.

Writing on the walls of Mr Jalocha's cell

87. The prison provided photographs of the graffiti in Mr Jalocha's cell. There were five pieces of writing:

- "Fuck cops"
- "Fuck magistrate"
- "Fuck it I can't"
- "They can lock the locks but can't stop the clock"
- "666"

There were two pictures – one of a stick figure hanging from some gallows and one of a skull and crossbones.

88. After his PPO interview in January 2025, the HCA said he had visited Mr Jalocha's cell after he died and noticed writing in Polish on the walls. He looked at the photographs provided to the investigator but they did not show the writing and the cell had been redecorated by this point so the investigator was unable to see it. The

HCA said he had written down what Mr Jalocha had written at the time. He translated the writing as “People won’t be judging me for something I haven’t done. I’m bored. Fuck.” He said Mr Jalocha had also written “eyes tell you truth”, “eyes” and “reset”.

Prison investigation into falsification of records on 5 November

89. In December 2024, the Governor, commissioned an investigation into whether an officer’s final entries on the ACCT document on the evening of 5 November amounted to making false statements. As a result of the investigation, the Governor held a disciplinary hearing on 11 March 2025. He found the charges proved and dismissed the officer for gross misconduct.

Post-mortem report

90. The post-mortem and toxicology reports were not available at the time of writing in April 2025. Given the circumstances in which Mr Jalocha was found on 5 November and the absence of any evidence to suggest illicit drug use, we have investigated this death as apparently self-inflicted. The cause of Mr Jalocha’s death will be determined at the Coroner’s inquest.

Coroner’s inquest

91. One 1 May 2026, the Coroner’s Inquest concluded that Mr Jalocha died by hanging. The jury returned a narrative verdict and said that at the time he hanged himself it was not possible to determine whether Mr Jalocha had formed the necessary intent.

Findings

Assessment and management of risk of suicide and self-harm

92. At the time of Mr Jalocha's death, Prison Service Instruction (PSI) 64/2011, governed staff responsibilities regarding ACCT suicide and self-harm prevention procedures. It required all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

93. In November 2024, a revised Prison Safety Policy Framework was issued, which was fully implemented on 1 January 2025. It states that all staff have responsibility for ensuring that ACCT procedures are started if they believe a prisoner to be at risk of suicide or self-harm. Both PSI 64/2011 and the Prison Safety Policy Framework contain guidance and mandatory instructions on using ACCT procedures to manage prisoners at risk of suicide and self-harm.

94. Mr Jalocha had a number of risk factors and potential triggers for suicide and self-harm including that it was his first time in prison and he faced the prospect of a significant prison sentence and deportation to a country he had not lived in for many years. He was evidently often low in mood, spent a significant amount of time in his cell and frequently said he was bored and frustrated by a lack of things to do. Despite these risk factors, there is nothing in Mr Jalocha's record to indicate that an ACCT should have been opened before 29 September. On arrival at Manchester, he appeared calm and a full mental health assessment on 14 August did not identify particular concerns. He was allocated to a small wing with a more settled staff group and more regular time out of cell than other wings.

ACCT monitoring, 29 September – 15 October 2024

95. We consider staff opened an ACCT appropriately on 29 September when an officer noticed that Mr Jalocha was withdrawn and was spending most of his time in bed. The officer's actions demonstrate good professional curiosity. However, we have identified a number of deficiencies in the management of Mr Jalocha's ACCT during this period.

96. PSI 64/2011 requires that an assessment is completed by a trained ACCT assessor within 24 hours of the ACCT being opened. While we understand that the designated assessor was called away from the prison suddenly on 30 September, Mr Jalocha had still not received an assessment by 7 October when a SO noticed the omission and arranged one for the next day. This was an unacceptable delay.

97. The assessment eventually took place at the same time as the second case review and was not completed separately beforehand as it should have been. The assessment was missing some sections required under PSI 64/2011 and the Safety Framework including areas of support, and the risks, triggers and protective factors section was only partially completed.

98. The ACCT assessment plays a key part in identifying support actions to mitigate and lower risk that should be set at the first case review. No support actions were

set at the first case review as required by PSI 64/2011 or at any point before the ACCT was closed on 15 October.

99. The identification of support actions to mitigate and reduce is risk is fundamental to the ACCT process. PSI 64/2011 states that an ACCT can be closed when the risk of harm has been reduced to a level where it is no longer considered raised and all support actions have been achieved. It is self-evident that ACCT documents should not be closed without support actions on the care plan.

100. At the reviews on 30 September and 8 October, Mr Jalocha said he was worried about being deported to Poland, "overthought" his pending court case and was confused about his sentence. A SO said on 30 September that he would get someone from OMU to speak to Mr Jalocha, but this did not happen. Mr Jalocha's concerns about potential deportation and his questions about his court case and sentence should have been added to his care plan and addressed before the ACCT was closed. In the absence of identified risks and actions to reduce them, the ACCT process fails in its fundamental purpose and it is understandable why Mr Jalocha saw little point in being on one.

ACCT re-opened 26 October 2024

101. Mr Jalocha's ACCT was appropriately re-opened on 26 October and was very well managed by a SO. She identified support actions and measures to address them within an identified time period. The SO ensured the attendance of a member of OMU to answer Mr Jalocha's questions and put him on the path to attending education classes and obtaining a cleaning job. She also began lobbying for the prisoners on Z Landing to have their own weekly session in the main category A wing gym because Mr Jalocha was keen to use it. Something sadly only achieved after he died.

102. PSI 64/2011 and the Safety Framework require ACCT reviews to be multi-disciplinary and the fact that the SO held the review on 5 November on her own is not ideal. However, we understand that other staff who were expected did not turn up and we understand her desire as the dedicated case coordinator to complete them herself. On balance, we agree that it was probably better that she undertook them on her own rather than someone unfamiliar with each case.

103. Overall, we are satisfied that there was nothing to indicate to staff that Mr Jalocha was at heightened or imminent risk of suicide on the day he died. At his review, he appeared keen to start education and work as a cleaner and after dinner on 5 November he accepted the offer of extra food from another prisoner.

ACCT checks on the evening of 5 November

104. The officer did not make the required ACCT checks on Mr Jalocha as he should have done and falsified the record to say that he had. While we cannot say that had he made those checks he would have been able to prevent Mr Jalocha's death, this was a serious failure in his duty of care and will be particularly upsetting for the family given the time Mr Jalocha was discovered hanging that night.

105. Had the prison not undertaken an investigation into the officer's conduct we would have recommended they do so. We are satisfied that the Governor has considered the matter and taken appropriate action.

Measures taken by the prison since Mr Jalocha's death

106. We have read the Secretary of State's response to HM Chief Inspector of Prisons' urgent notification and the associated action plan to address the issues identified. The Head of Safer Custody told us that a number of measures had been brought in as a result of issues identified by HMIP and as a result of learning from Mr Jalocha's death. These include:

- Compilation of a local directory of services available in the prison to support prisoners with a variety of issues that ACCT case coordinators can use to ensure care plans are more meaningful and prisoners receive targeted support.
- Intensive support sessions for ACCT case coordinators delivered by the National Safety Team and focussing on recognising risks and triggers and making more effective care plans.
- Recruitment of two supervising officers to act as floor walkers to provide hands-on help for ACCT case coordinators.
- Training of eight more ACCT assessors.
- Implementation of random CCTV monitoring to ensure required ACCT checks are conducted. (At the time of writing this was scheduled for mid-April 2025.)

107. The Head of Safer Custody said that staff had also been reminded to re-visit and update ACCT care plans at every review and that ACCTs should never be closed with no actions on the care plan. He was also in the process of reviewing ACCT assurance models to ensure effective management oversight of the process.

108. In recognition of these measures and the significant amount of support provided to Manchester to improve the standard of ACCT monitoring following the urgent notification we make no recommendation.

Writing on the walls of Mr Jalocha's cell

109. Mr Jalocha wrote a number of things on the walls of his original cell on Z landing in both English and Polish that indicated he was ruminating on his current and future circumstances. Most tellingly he appears to have drawn a figure hanging. The records indicate that the fact he had written on his cell walls was noticed by the officer on 4 November and by a SO on 5 November.

110. Identifying the risk of suicide is extremely difficult and risk assessment is not an exact science. It is therefore vital that all potential indicators of risk are identified and explored. All closed prisons are required to conduct fabric checks to ensure the physical integrity of each cell. Cells in Manchester are checked daily. Fabric checks are necessary for the security of the establishment, for gathering intelligence and

help to ensure cells are kept in a decent state. Graffiti should be identified and steps taken to remove it as part of this process. We are also aware that there was writing on the walls of a self-isolating prisoner who died in March 2025. Closer inspection of Mr Jalocha's walls should have raised concerns about his risk, especially because he was subject to ACCT monitoring. This was a missed opportunity to explore Mr Jalocha's risk to himself. We make the following recommendation:

A fabric check on a cell represents an opportunity to consider wider risk factors. The Governor should ensure that his staff are aware of this fact and take due account of any graffiti, handwritten notes, drawings etc. and take further action where appropriate.

Emergency response

111. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes requires that the Governor must have a medical emergency response code protocol in place which ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.

112. As is usual, Manchester use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

113. When the officer discovered Mr Jalocha hanging he did not radio a code blue. Fortunately the CM was in close proximity to the scene and radioed a code blue one minute 40 seconds later once he had entered Mr Jalocha's cell. We cannot say whether this delay made a difference to the outcome for Mr Jalocha but in cases of hanging the swiftest possible response is necessary. We note that in three of the previous deaths at Manchester since November 2021, the first on scene has not radioed a code blue.

114. In the first of these deaths (in February 2022) we recommended the Governor remind staff of the importance of using emergency codes and in the second and third deaths (in April and July 2024) we have not yet produced our initial reports due to the investigations being suspended pending the results of toxicology tests. Given that Mr Jalocha's was the third death in 2024 in which the first officer on scene did not radio a code blue we make the following recommendation:

The Governor should introduce a robust assurance process to satisfy himself that all prison staff understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of an emergency effectively.

Clinical care

115. The clinical reviewer found that the clinical care that Mr Jalocha received at Manchester was equivalent to that which he could have expected to receive in the community.

Good practice

116. The compilation of a local directory of services available in the prison to support prisoners with a variety of issues that ACCT case coordinators can use to ensure care plans are more meaningful is good practice.

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