Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Uziel Mendoza-Sillerico, a prisoner at HMP Lowdham Grange, on 18 November 2024

A report by the Prisons and Probation Ombudsman

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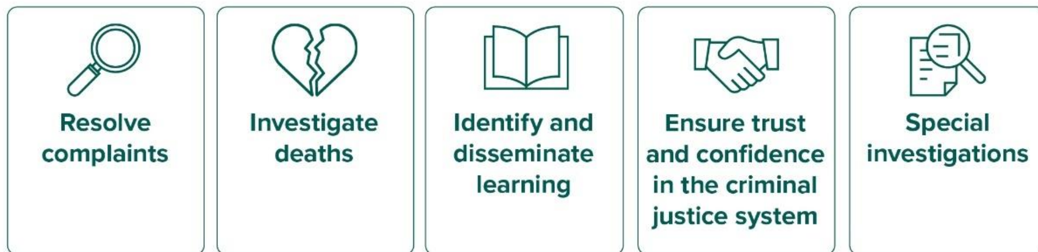
OUR VISION

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

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Summary

1. 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.

2. 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.

3. Mr Uziel Mendoza-Sillerico, a Bolivian national, died in hospital from sigmoid perforation (a hole or tear in the sigmoid colon, part of the large intestine) on 18 November 2024, while a prisoner at HMP Lowdham Grange. This was caused by disseminated tuberculosis (TB – a serious bacterial infection that spread from his lungs to other parts of his body). He was 32 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Mendoza-Sillerico received at Lowdham Grange was poor and was not equivalent to that which he could have expected to receive in the community. Healthcare staff did not investigate his significant weight loss, failed to follow up missed appointments and did not escalate concerns about his deteriorating condition.

5. We found that there was a poor working relationship between prison and healthcare staff, despite Mr Mendoza-Sillerico being under Prison Service suicide and self-harm procedures, known as ACCT. Key information about his isolation, missed appointments and worsening health was not shared promptly, leading to missed opportunities for intervention.

6. We have other serious concerns about Mr Mendoza-Sillerico's care. He was intermittently restrained while in hospital despite being critically ill and having limited mobility. The use of restraints was not proportionate to the actual risk he presented.

7. We also found that language barriers may have impacted Mr Mendoza-Sillerico's access to health information, including TB screening letters provided only in English. Following his death, interpretation support was delayed for his sister and the family liaison officer lacked clear guidance on repatriation procedures.

8. This is a troubling case. We consider that there is significant learning from this investigation and urgent action is required to ensure that the serious omissions we have identified are addressed. Similar shocking failings occurred in a death at Lowdham Grange four months after that of Mr Mendoza-Sillerico, which reinforces the need for systemic change.

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Recommendations

- The Governor and Head of Healthcare should ensure that prison and healthcare staff are fully informed of the procedures for monitoring food and fluid intake. This includes completing the necessary documentation and ensuring that all relevant information is effectively communicated to healthcare staff.
- The Head of Healthcare should ensure that all electronic tasks are regularly monitored, with a documented plan in place to track actions and escalate concerns promptly.
- The Head of Healthcare should implement structured multi-disciplinary safety huddles and ensure all complex cases are discussed and minuted with entries recorded in the medical records.
- The Governor and Head of Healthcare should establish a formal process for sharing information about missed appointments and safeguarding concerns between prison and healthcare teams.
- The Head of Healthcare should ensure that, where concerns regarding mental capacity arise, staff undertake a formal two-stage mental capacity assessment.
- The Head of Healthcare, in collaboration with the UK Health Security Agency (UKHSA), should ensure that translated letters are provided for all prison-wide health concerns and screening initiatives.
- The Governor and Head of Healthcare should ensure that Lowdham Grange's Isolator Regime Strategy (2025) is being consistently applied to all isolating prisoners and that there is a robust quality assurance process to monitor this.
- The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position and that assessments fully consider the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor and Head of Healthcare should ensure that restraint risk assessments are documented and retained whenever there is a change in a prisoner's restraints.
- The Governor should ensure family liaison officers receive training and guidance on bereavement procedures, including support for families with limited English. Family liaison officers should offer repatriation and funeral options in line with policy and use professional interpretation services where appropriate.

The Investigation Process

9. HMPPS notified us of Mr Mendoza-Sillerico's death on 18 November 2024.

10. NHS England commissioned an independent clinical reviewer to review Mr Mendoza-Sillerico's clinical care at HMP Lowdham Grange. The clinical review was attached as Annex 1.

11. The PPO investigator investigated the non-clinical issues relating to Mr Mendoza-Sillerico's care. She interviewed two prison staff in April and May 2025 via Microsoft Teams. The investigator, the clinical reviewer and an Assistant Ombudsman jointly interviewed two prison and four healthcare staff by Microsoft Teams between April and June 2025.

12. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The Coroner gave us the cause of death. There was no post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's office contacted Mr Mendoza-Sillerico's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

14. The initial report was shared with HM Prison and Probation Service (HMPPS) and the prison's healthcare provider, Northamptonshire Healthcare NHS Foundation Trust. HMPPS pointed out three factual inaccuracies. These have been reviewed and the information contained within this report has been confirmed as accurate so no changes have been made. The action plan has been annexed to this report.

    Mr Mendoza-Sillerico's family received a copy of the draft report. They did not make any comments.

Previous deaths at HMP Lowdham Grange

15. Mr Mendoza-Sillerico was the tenth prisoner to die at Lowdham Grange since November 2021. Of the previous deaths, two were due to natural causes, two were drug related and five prisoners took their own lives. There are no similarities between the findings in our investigation into Mr Mendoza-Sillerico's death and those from our investigations into previous deaths.

16. Since Mr Mendoza-Sillerico's death up to mid-November 2025, there have been a further eight deaths. Two of these died of natural causes, five are suspected to be drug related and the cause of the remaining death is unascertained at present. We identified similar issues in a death at Lowdham Grange four months after Mr Mendoza-Sillerico, where significant weight loss was not investigated and missed appointments were not followed up.

Assessment, Care in Custody and Teamwork (ACCT)

17. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

18. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan 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. When Mr Mendoza-Sillerico was at Lowdham Grange, guidance on ACCT procedures was initially set out in the Prison Service Instruction 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.

Key Events

19. On 1 February 2018, Mr Uziel Mendoza-Sillerico was remanded to prison and taken to HMP Thameside, charged with murder. Mr Mendoza-Sillerico was from Bolivia, having moved to the UK in 2014. English was not his first language but prison staff told the investigator that he could understand and communicate in English. On 1 March, Mr Mendoza-Sillerico transferred to HMP Belmarsh.

20. On 30 January 2019, Mr Mendoza-Sillerico was convicted and sentenced to life imprisonment with a minimum tariff of 17 years. (This is the minimum time he had to serve in prison before being considered for release by the Parole Board.)

21. On 20 January 2021, Mr Mendoza-Sillerico transferred to HMP Lowdham Grange, where he remained until 7 October 2025. When Mr Mendoza-Sillerico arrived at Lowdham Grange in January 2021, he weighed 72.2kg, which is 0.2kg over a healthy weight on the body mass index (BMI)

22. During his first reception screening, a nurse recorded a full set of clinical observations (temperature, blood pressure, pulse and respiratory rate), all of which were within the normal range. The nurse also recorded his height and weight, which were within a healthy range. Mr Mendoza-Sillerico disclosed previous cannabis use.

23. A nurse asked Mr Mendoza-Sillerico the standard tuberculosis (TB) screening questions during his reception screening. He answered ‘no’ to all questions. These questions include whether the person has travelled abroad, had TB previously, been in contact with someone with TB in the past year, or has symptoms such as persistent cough, fever, night sweats, or unexplained weight loss. If a prisoner answers ‘yes’, healthcare staff must refer them to the GP.

24. On 30 November 2021, staff issued letters to all prisoners, including Mr Mendoza-Sillerico, informing them of a TB outbreak at Lowdham Grange, where three cases had been confirmed. The letter invited prisoners to opt in or out of voluntary TB screening, which included a blood test and chest X-ray. The letter was only made available in English. Mr Mendoza-Sillerico did not respond to the letter and staff did not screen him for TB.

25. On 2 March 2022, Mr Mendoza-Sillerico reported feeling hot. A nurse observed him through the cell observation panel, as cells were locked, gave him paracetamol and later took a COVID-19 swab. The test confirmed that Mr Mendoza-Sillerico tested positive for COVID-19. There is no evidence of any further health problems over the following months.

26. On 4 April, during a key work session, Mr Mendoza-Sillerico told the officer that he was employed as a wing cleaner, having waited several months for a job and enjoyed the role. (Key workers provide prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address.)

27. On 9 June, during a key work session, Mr Mendoza-Sillerico told the officer that he had no issues or concerns. The officer observed that he appeared safe and happy on the wing, got along well with other prisoners and often socialised throughout the day. He enjoyed playing snooker and cutting other prisoners’ hair.

28. On 17 August, staff found fermented liquid (a substance made by fermenting fruit or other items, often referred to as ‘hooch’ in prisons) in Mr Mendoza-Sillerico’s cell. The following day, staff issued him warnings for missing education sessions. On 27 August, during a key work session, an officer confirmed that he had been made unemployed.

29. On 18 August, Mr Mendoza-Sillerico told a substance misuse worker that he had no problems with alcohol and only drank when he was stressed because he missed his children. He declined substance misuse support and the referral was closed.

30. On 14 December, Mr Mendoza-Sillerico told the officer that he was employed in the industrial units but preferred working on the wing. On 24 December, officers found him in possession of fermented liquid and gave him a disciplinary warning but allowed him to continue working.

31. Mr Mendoza-Sillerico attended dental appointments over the next 18 months. No other healthcare appointments were documented in his medical record until August 2024.

32. On 6 March 2023, during a key work session, Mr Mendoza-Sillerico told the officer that he was settled on the wing and no longer receiving negative behaviour warnings. He said he enjoyed working full-time and making new friends.

33. On 6 June, an officer described Mr Mendoza-Sillerico as a ‘model prisoner’ because of his positive behaviour. All key work sessions throughout 2023 reported no concerns or issues regarding his safety or behaviour on the wing.

34. On 8 February 2024, officers found fermented liquid in Mr Mendoza-Sillerico’s cell. Further incidents involving fermented substances were recorded on 2 May and 18 May, after which he was placed on a basic regime, meaning he lost some of his privileges. On 28 May, Mr Mendoza-Sillerico tested positive for cannabis in a mandatory drug test.

35. On 26 August, Mr Mendoza-Sillerico told an officer that he was under threat on the wing. The officer recorded that Mr Mendoza-Sillerico believed his life was in danger and that these threats were affecting his mental health. The officer later told the investigator that Mr Mendoza-Sillerico did not provide further details about the threat. Mr Mendoza-Sillerico requested to speak to a prison manager, who authorised his transfer from Houseblock 2 to Houseblock 5 the same day.

36. On 29 August, Mr Mendoza-Sillerico did not attend an appointment with a nurse for concerns about weight loss. Healthcare staff rebooked the appointment for 30 September. It is unclear who had initially requested the appointment or noted the weight loss as this was not recorded in his medical records.

12 September – 5 October 2024

37. On 12 September, an officer started Prison Service suicide and self-harm monitoring procedures, known as ACCT. Mr Mendoza-Sillerico reported feeling low in mood and believed he was under threat from prisoners on his previous wing.

38. On 13 September, an officer completed an ACCT assessment. He noted that Mr Mendoza-Sillerico appeared very low in mood and cried when asked if he was okay.

He told the officer that he felt unsafe on the wing because other prisoners had false information about his conviction. The officer recorded that Mr Mendoza-Sillerico was isolating and wanted to continue isolating for his own safety. He offered him a move to L wing, which was for isolators. Mr Mendoza-Sillerico said he would think about it but later declined the offer. He told the officer he had no thoughts of suicide or self-harm and had never self-harmed before. Staff placed him on hourly checks and three conversations daily.

39. On 15 September, Mr Mendoza-Sillerico was suspended from work after telling staff that he was under threat and unable to leave the wing.

40. On 16 September, a Custodial Manager (CM) noted during ACCT checks that Mr Mendoza-Sillerico had not had an ACCT review as he should have done within 25 hours of the ACCT being opened. She checked on Mr Mendoza-Sillerico and told him that a review would take place the following day. This also did not take place and there was no reason recorded for the omission.

41. On 17 September, an officer conducted a key work session with Mr Mendoza-Sillerico. He told her that there were rumours about his sexuality and, as a result, he did not feel safe in the prison. He said he refused to go to work because he had been threatened by prisoners from his previous houseblock.

42. On 18 September, the CM chaired an ACCT case review with Mr Mendoza-Sillerico, an officer and a Supervising Officer (SO). During the review, Mr Mendoza-Sillerico stated that he felt unsafe due to hearing on the staff radio false rumours regarding his sexuality and his belief that he had been labelled as a dangerous prisoner. This account differed from information he had previously provided to staff. He remained on hourly checks and agreed to be referred to the mental health team.

43. Later that day, a nurse recorded in the medical notes that the mental health team had been unable to attend the ACCT review because another review had overrun. He noted that officers had described Mr Mendoza-Sillerico's presentation as 'bizarre' and that he would be assessed by the mental health team before his next ACCT review scheduled for 23 September.

44. On 20 September, Mr Mendoza-Sillerico saw a nurse for a mental health assessment. The nurse recorded that Mr Mendoza-Sillerico denied any history of mental health issues and was not prescribed medication. He noted that Mr Mendoza-Sillerico was isolating in his cell due to fear of being attacked by other prisoners but could not provide a reason why they would target him. This was the third different explanation he had given for feeling under threat. Mr Mendoza-Sillerico also reported a poor appetite and significant weight loss and admitted to using psychoactive substances (PS). The nurse observed that he appeared delusional and paranoid, referred him to the GP regarding his weight loss and planned to refer him to the substance misuse team and a psychiatrist.

45. On 23 September, the CM chaired a second ACCT review, attended by Mr Mendoza-Sillerico, a nurse and an SO. Mr Mendoza-Sillerico told staff that he had started leaving his cell when fewer prisoners were around and had no current thoughts of suicide or self-harm. He confirmed that he was eating meals but remained concerned about his weight loss. The nurse confirmed that he had been

referred to the GP and psychiatrist. The next ACCT review was scheduled for 18 October.

46. On 30 September, Mr Mendoza-Sillerico did not attend his scheduled appointment with a nurse to discuss his weight loss. Staff recorded no reason for the missed appointment.

47. On 1 October, Mr Mendoza-Sillerico did not attend his scheduled dentist appointment. A healthcare assistant noted in the medical records that he had been unlocked for the appointment that morning but chose not to attend.

48. On 2 October, Mr Mendoza-Sillerico told an officer he wanted a healthcare appointment. They advised him to use the kiosk system (a self-service electronic system for submitting appointment requests). Mr Mendoza-Sillerico stated that he had not received a response, so the officer tried to phone healthcare staff but was unable to get through and indicated he would try again the following day. There is no record that the officer spoke to healthcare staff the following day and no entries appear in Mr Mendoza-Sillerico's medical record between 1 October and 6 October, with the next documentation occurring on 6 October.

49. On 3 October, an officer saw Mr Mendoza-Sillerico and asked how he was feeling. He responded with a 50/50 hand gesture. Later that day, staff saw him cleaning his cell, leaving briefly to collect water and accepting the food delivered to his cell.

50. On 4 October, another officer recorded that Mr Mendoza-Sillerico accepted food and voiced no concerns. When asked if he was going to work, he replied 'no.' When asked if he was feeling okay, he said he was fine. On 5 October, Mr Mendoza-Sillerico told an officer that he had not been eating. He asked the officer to fill his water bottle and gave no further verbal responses to questions.

Events of 6 October and 7 October

51. On 6 October, Mr Mendoza-Sillerico stayed in bed all morning. An officer noted that he gave limited responses during morning wellbeing checks, covered his head with a duvet, avoided associating with prisoners and had not eaten well. Later that afternoon, another officer asked Mr Mendoza-Sillerico why he had not been eating, but he did not reply. The officer recorded that Mr Mendoza-Sillerico appeared, "*malnourished, pale and seemed to be on hunger strike*".

52. At 5.34pm, an officer recorded that he spoke with Mr Mendoza-Sillerico during an ACCT check. The officer noted that he had not met Mr Mendoza-Sillerico before. Mr Mendoza-Sillerico said he was not feeling well, felt unsteady on his feet and had lost his appetite. He confirmed he was still eating regularly but in very small amounts and had lost weight. The officer requested healthcare staff assess him.

53. Around 6.00pm, a nurse assessed Mr Mendoza-Sillerico. Prison staff had obtained authorisation from a senior prison manager to unlock his cell after the evening roll check (a standard security procedure to account for all prisoners).

54. The nurse recorded that Mr Mendoza-Sillerico told him he had reduced energy and was not eating as much as he would like but continued ordering food from the prison shop and accepting meals. The nurse observed significant weight loss. The nurse said he would make an urgent mental health referral, add him to the nurse's

list for the next day further assessment, including weight checks, and refer him to the GP for nutritional supplements. Mr Mendoza-Sillerico’s oxygen saturation was 96%, which was within normal range, his temperature was 37.4 degrees Celsius, which was slightly outside the normal range and his heart rate was 98 beats per minute, which was normal.

55. On 7 October, an officer noted in the ACCT document that Mr Mendoza-Sillerico would not respond to any checks and kept covering his face.

56. Around 10.50am, an officer recorded that they had asked healthcare staff to see Mr Mendoza-Sillerico as he said he still felt unwell. At 11.00am, a nurse noted that she attended the wing as he was listed for an urgent review due to weight loss. The nurse observed that he was unsteady on his feet and he reported noticing weight loss over the past two months and experiencing chest pain and shortness of breath for the last month. Mr Mendoza-Sillerico also said he felt too weak to eat. The nurse noted he now weighed 43.2kg. He had lost 29kg during his time at Lowdham Grange and his BMI was now in the severely underweight category.

57. An officer radioed a code blue (which indicates a medical emergency, such as chest pain, difficulty breathing or unconsciousness and requires an ambulance to be called immediately). Control room staff requested an ambulance. Mr Mendoza-Sillerco’s blood pressure was 88/56, which was very low and his oxygen saturation was 91%, which was low. The nurse administered oxygen to him. Mr Mendoza-Sillerico’s temperature was 37.7 degrees Celsius, which was slightly elevated and his heart rate was 166 beats per minute, which was very elevated.

58. Mr Mendoza-Sillerico’s National Early Warning Score was 13, which indicated a high level of risk and required immediate emergency intervention. (NEWS2 – used to determine the level of illness of a patient and whether care needs to be escalated.)

59. Mr Mendoza-Sillerico was taken to hospital by ambulance and restrained with a double cuff (where a prisoner’s hands are cuffed together and a second pair of cuffs is applied, with one cuff attached to the prisoner and the other to an officer). An officer wrote in the ACCT document on 7 October that Mr Mendoza-Sillerico complained that the cuffs were hurting and his whole body ached.

60. A hospital nurse told healthcare staff they suspected Mr Mendoza-Sillerico had TB based on his chest X-ray results. Hospital staff admitted him to the respiratory ward. At 8.00pm, an officer wrote in the bedwatch log that the senior prison officer on duty authorised changing Mr Mendoza-Sillerico’s restraint from double cuffs to an escort chain. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.) Staff recorded this was because of his deteriorating health and suspected TB.

61. Following a staff handover, a nurse emailed prison and healthcare managers to inform them that Mr Mendoza-Sillerico had been taken to hospital. He reported that he appeared severely malnourished, with his ribs, hips, collarbone, and spine visible through his skin.

8 October – 18 November

62. On 8 October, Mr Mendoza-Sillerico was diagnosed with TB. During interview, a respiratory consultant and TB specialist told the clinical reviewer that Mr Mendoza-Sillerico was extremely unwell on arrival at hospital and described him as the sickest patient he had seen in five years.

63. On 9 October, Mr Mendoza-Sillerico's condition deteriorated as his oxygen saturation levels declined. He was placed on a ventilator and transferred to the intensive care unit (ICU). A senior prison manager authorised the removal of Mr Mendoza-Sillerico's restraints documenting that he was in intensive care in a serious medical condition, required intensive treatment and had limited physical capability. Later that day, hospital staff placed Mr Mendoza-Sillerico in a medically induced coma.

64. On 16 October, escort staff noted Mr Mendoza-Sillerico was responsive and in and out of sleep. A senior prison manager authorised the use of an escort chain, but by midday he was sedated again, prompting his restraints to be removed.

65. On 18 October, Mr Mendoza-Sillerico was diagnosed with multiple organ failure. He remained in and out of consciousness while hospital staff tried to bring him out of sedation over the following weeks. Mr Mendoza-Sillerico was moved back to the ICU. A senior prison manager authorised removal of the escort chain at 9.30am after confirmation that he required ventilation and was critically ill. (It is not clear from the records when restraints had been reapplied before this). Later that day, Mr Mendoza-Sillerico was placed back in a medically induced coma and escort staff were told to observe from him from outside the hospital room. Hospital staff indicated that, at this stage, they believed Mr Mendoza-Sillerico had approximately 24 hours to live.

66. On 5 November, following management checks, staff reapplied an escort chain. The family liaison officer recorded that a prison manager told her this was because Mr Mendoza-Sillerico was awake and able to communicate with staff. We have not seen any risk assessment to support this decision.

67. On 6 November, a senior prison manager noted that Mr Mendoza-Sillerico could not move or breathe independently and authorised the removal of his restraints. He was not restrained again after this.

68. On 16 November, Mr Mendoza-Sillerico required emergency surgery for a perforated bowel (a hole in the bowel wall, part of the gastrointestinal tract). On 18 November, Mr Mendoza-Sillerico was placed on end-of-life care and hospital doctors withdrew life support. He died at 5.20pm.

Family Liaison

69. A family liaison officer and a deputy was appointed on 7 October. On 9 October, the family liaison officer spoke to Mr Mendoza-Sillerico's mother in Bolivia and was told he had a sister in the UK. Later that day, the family liaison officer visited the hospital to obtain an update on his medical condition and informed his sister. She met his sister during subsequent hospital visits and maintained contact with her. Both the family liaison officer and the deputy family liaison officer supported Mr Mendoza-

Sillerico's sister when his life support was withdrawn and provided information after his death to discuss funeral arrangements. Due to difficulties accessing interpreting services, there was a delay in the family liaison officer being able to discuss funeral arrangements with Mr Mendoza-Sillercio's sister over the phone.

70. Mr Mendoza-Sillerico's mother wanted his body to be repatriated to Bolivia. However, this did not take place and the family liaison officer was not aware of the prison's responsibility to cover repatriation costs.

Cause of death

71. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Mendoza-Sillerico's cause of death as sigmoid perforation (a hole or tear in the sigmoid colon, part of the large intestine). This was caused by disseminated tuberculosis (a serious bacterial infection that spreads from the lungs to other parts of the body).

Actions following TB diagnosis

72. On 11 October 2024, the UK Health Security Agency (UKSHA – the government agency responsible for public health protection and managing infectious disease outbreaks) was notified that Mr Mendoza-Sillerico had been diagnosed with TB.

73. Following Mr Mendoza-Sillerico's diagnosis, the prison and UKHSA took the following actions:

- UKHSA established a multi-agency incident management team to offer mass screenings of all prisoners at Lowdham Grange between 1 June and 8 October 2024. They held question and answer sessions for prisoners and staff.

- Between 9 and 10 December 2024, a TB team offered blood tests to detect TB infection. Approximately 800 prisoners were screened for symptoms such as a persistent cough, night sweats and weight loss. 154 prisoners declined testing.

- The screening identified 31 prisoners with positive blood test results. All prisoners with positive tests had chest X-rays using a mobile X-ray unit brought into the prison.

- One prisoner had active TB and was immediately isolated, while the remaining prisoners received treatment for latent TB (meaning the infection was present but not causing illness). Treatment options included a six-month treatment plan and follow-up with the TB team.

- UKSHA provided infection control advice including the use of personal protective equipment such as respiratory masks, gloves and aprons for escort officers to reduce the risk of infection.

- Staff were not routinely screened as close contact from TB comes from eight hours of cumulative contact to be deemed a risk.

- In June 2025, UKHSA formally stopped its involvement after all chest X-rays and follow-up tests were completed.

Findings

Clinical care

74. The clinical reviewer concluded that the care Mr Mendoza-Sillerico received at Lowdham Grange was poor and not equivalent to that which he could have expected to receive in the community. She listed several concerns, which are fully considered in the clinical review report. We outline the following concerns related to Mr Mendoza-Sillerico’s death. Some of these issues are the joint responsibility of both prison and healthcare staff.

75. We recognise that when Mr Mendoza-Sillerico was at Lowdham Grange, healthcare staffing levels were very low, with a 40% vacancy rate. The department was very reliant on agency staff with no Head of Healthcare, no Mental or Physical Health Lead and an interim matron who was temporarily promoted. At the time of interview, the situation had improved with a 20% vacancy rate, a new Head of Healthcare and other positions either filled or being advertised.

Management of Mr Mendoza-Sillerico’s weight loss

76. When Mr Mendoza-Sillerico arrived at Lowdham Grange in January 2021, he weighed 72.2kg**.** Staff did not weigh him again until 7 October 2024, when he was 43.2kg**.** He had lost 29kg or 40% of his body weight since his arrival at Lowdham Grange. His BMI had gone from just overweight to severely underweight.

77. In line with national guidance at the time, Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), staff should have taken Mr Mendoza-Sillerico’s decision to refuse food and fluids into account. However, his refusal was not properly recorded or communicated to all relevant staff. There is no evidence that efforts were made to establish the reasons for his refusal or address them. Healthcare staff were not notified immediately, formal monitoring of his food and fluid intake did not commence and multi-disciplinary reviews were not convened as required by policy.

78. There was no documented discussion in Mr Mendoza-Sillerico’s medical records about his significant weight loss and no evidence of accurate monitoring or communication between healthcare and prison staff about his food or fluid intake. Although ACCT entries and daily checks recorded that he continued to collect meals, he said he had a poor appetite and significant weight loss from late September. On 6 October, officers noted he appeared “malnourished, pale and seemed to be on hunger strike.” Despite this, there was no food refusal care plan or daily intake monitoring and escalation to healthcare occurred only later that evening. On 7 October, Mr Mendoza-Sillerico was described as severely malnourished, with ribs, hips, collarbone and spine visible through his skin.

79. In March 2025, another prisoner in his early 30s died of natural causes at Lowdham Grange. We found that his significant weight loss had also not been investigated. It is shocking that, despite the serious failings in Mr Mendoza-Sillerico’s care, learning did not take place and these issues repeated themselves in the months following his death. We issued the report into the previous death in October, recommending improvements in investigating prisoners’ weight loss. At the time of writing this

report, the prison has not yet responded. We do not repeat our previous recommendation but make the following one:

The Governor and Head of Healthcare should ensure that prison and healthcare staff are fully informed of the procedures for monitoring food and fluid intake. This includes completing the necessary documentation and ensuring that all relevant information is effectively communicated to healthcare staff.

Missed healthcare appointments

80. Mr Mendoza-Sillerico did not attend a healthcare appointment on 29 August to investigate his weight loss and this was not followed up. He also missed his rescheduled appointment on 30 September. Mr Mendoza-Sillerico was not reviewed by a GP before his hospital admission.

81. The clinical reviewer found no evidence of escalation or safeguarding action. She noted that follow-up appointments and actions were not properly documented or monitored in electronic tasks. A task created on 20 September to discuss him at the mental health allocations meeting was not actioned. The rescheduled appointment on 30 September was not recorded in his medical records. These delays in communication meant that no urgent intervention occurred.

82. Following Mr Mendoza-Sillerico's death, Lowdham Grange introduced a new process for managing missed healthcare appointments. When a prisoner does not attend an appointment, healthcare staff now call the prisoner in-cell to establish the reason and confirm whether they still want the appointment. If there is no response, healthcare staff contact the wing to check phone access and encourage attendance. This ensures real-time follow-up rather than waiting weeks for rebooking.

83. Following the previous death in March 2025, we also found that missed medical appointments were not followed up. We recommended improvements to this system which the prison has not yet responded to.

84. We acknowledge the improvements introduced at Lowdham Grange to address missed healthcare appointments. However, robust monitoring of electronic tasks remains crucial to prevent delays in care and ensure timely escalation of concerns. We make the following recommendation:

    The Head of Healthcare should ensure that all electronic tasks are regularly monitored, with a documented plan in place to track actions and escalate concerns promptly.

Recording and communication of information

85. The clinical reviewer and investigator identified a clear lack of joint working between prison and healthcare staff, alongside poor communication about Mr Mendoza-Sillerico's deteriorating condition. Key information including his isolation, repeated missed appointments and escalating vulnerabilities was not shared promptly. Despite him being on an ACCT, there were no multi-disciplinary safety huddles, multi-agency meetings, or documented discussions involving primary care or the GP to address his physical and mental health needs.

86. These were serious missed opportunities to share information which would have allowed staff to assess, escalate and safeguard Mr Mendoza-Sillerico. This contributed to delays in care planning, assessment and treatment. We make the following recommendations:

The Head of Healthcare should implement structured multi-disciplinary safety huddles and ensure all complex cases are discussed and minuted with entries recorded in the medical records.

The Governor and Head of Healthcare should establish a formal process for sharing information about missed appointments and safeguarding concerns between prison and healthcare teams.

Mental capacity assessment

87. The clinical reviewer noted that there was no documented mental capacity assessment in accordance with the Mental Capacity Act 2005, despite mental health staff noting concerns about his delusional and paranoid presentation. We make the following recommendation:

The Head of Healthcare should ensure that, where concerns regarding mental capacity arise, staff undertake a formal two-stage mental capacity assessment.

Language barriers and access to health information

88. Mr Mendoza-Sillerico’s first language was not English. While staff reported that he could understand English, key health-related communications including a letter about TB screenings were provided only in English. Given the complexity and importance of this information, it is unclear whether he fully understood the content or its implications. This may have affected his engagement with screening and healthcare services.

89. UK Health Security Agency confirmed that they have template letters in different languages, if needed. We make the following recommendation:

The Head of Healthcare, in collaboration with the UK Health Security Agency (UKHSA), should ensure that translated letters are provided for all prison-wide health concerns and screening initiatives.

Management of isolating prisoners

90. At the time of Mr Mendoza-Sillerico’s death, Lowdham Grange’s Safer Prison Operating Policy (issued in March 2023) required prison staff to refer isolators to Safer Custody and discuss them at weekly safety intervention meetings. However, it did not require healthcare involvement or provide a system for proactive reviews and there was no clinic for prisoners unwilling to leave their cell.

91. Mr Mendoza-Sillerico isolated from late August 2024, missed two healthcare appointments for weight loss and declined a move to a wing for isolating prisoners. Despite signs of deterioration, healthcare staff did not assess him until 6 October.

92. Lowdham Grange has since introduced the Isolator Regime Strategy (2025), which includes formal management plans, regular reviews, daily welfare checks and multi-disciplinary input. The Head of Healthcare told the investigator that an isolator clinic has been introduced to bring isolators to healthcare when other prisoners are not around, isolators are flagged on daily briefings and care plans and in-cell checks are now provided to prevent missed appointments.

93. During interview, the Physical Healthcare Clinical Lead told us when discussing the new strategy for managing isolating prisoners that she is not routinely notified when prisoners are isolating. She said healthcare involvement remains largely ad hoc, occurring at the request of prison staff rather than through a standardised process. This could lead to an inconsistent and uncoordinated approach to supporting isolating individuals.

94. We found that national guidance for staff on managing isolated individuals places significant emphasis on encouraging engagement with others and increasing participation in the regime. However, this approach may not fully address the healthcare needs of those in isolation.

95. Following a death at another prison, we recently made a national recommendation to update staff guidance on isolating prisoners including a mandatory instruction to consult prison healthcare staff when formulating individual isolator plans. HMPPS Safety Group are currently in the process of reviewing national staff guidance on isolated prisoners. However, in the meantime, Lowdham Grange has a clear local strategy which we are not convinced is being consistently applied. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that Lowdham Grange's Isolator Regime Strategy (2025) is being consistently applied to all isolating prisoners and that there is a robust quality assurance process to monitor this.

Management of Mr Mendoza-Sillerico's risk to himself

96. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, (in place when Mr Mendoza-Sillerico was in prison) lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making. In January 2025, this PSI was replaced with *The Prison Safety Framework* but the guidance remains the same.

97. Staff opened an ACCT for Mr Mendoza-Sillerico on 12 September 2024 due to concerns about his low mood and his perceived threats from other prisoners. The ACCT remained open until his emergency transfer to hospital on 7 October 2024.

98. We have the following concerns about the management of this ACCT:

- The first case review took place six days after the ACCT had been opened, on 18 September, rather than within the required 25 hours.
- Healthcare staff were unaware an ACCT had been opened until 18 September.
- Healthcare staff were not present at the initial ACCT case review or the review on 18 September.
- Healthcare staff did not provide a written contribution when they were unable to attend reviews.
- The ACCT care plan did not reflect physical health concerns or actions, even after a referral for weight loss was made and despite Mr Mendoza-Sillerico not being reviewed by a GP.
- Overall, the ACCT process lacked consistent multi-disciplinary involvement and did not incorporate physical health concerns into the action plan, despite a referral for weight loss being made by the mental health nurse on 20 September.

99. Following the internal investigation, Lowdham Grange introduced several measures to improve ACCT management and healthcare integration. These include daily multi-disciplinary safety huddles to ensure ACCT cases are discussed and actions agreed, an enhanced ACCT attendance protocol requiring healthcare staff to attend reviews or provide written input if unable to attend and improved quality assurance processes for ACCT documentation.

100. Senior prison managers now provide additional support to ACCT case managers and healthcare staff receive daily notifications of scheduled reviews to ensure attendance or written contributions. Mental health staff have been reminded of the requirement to assess and document mental capacity where concerns arise.

101. We are satisfied that Lowdham Grange has put clear measures in place to address improve the management and assessment of ACCT procedures and healthcare attendance at reviews. We therefore make no recommendation.

Restraints, security and escorts

102. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner’s health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner’s risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner’s risk when suffering from a serious medical condition. It said that medical opinion about the prisoner’s ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

103. During Mr Mendoza-Sillerico's hospital admission, he was restrained while receiving critical care. On several occasions, staff applied restraints while Mr Mendoza-Sillerico was sedated and physically unable to move.

104. During her interview, the Head of Security said that Lowdham Grange's default position was that all Category B prisoners were taken to hospital in double-cuffs as per the External Escorts Policy Framework, unless there was a medical reason why that should not happen. Healthcare staff were expected to complete a section of the risk assessment to list medical conditions that might affect the level of restraint. The Head of Security explained that decisions should balance escape risk and public safety against medical considerations.

105. It is difficult to understand how the decision to apply restraints could be justified when Mr Mendoza-Sillerico was critically ill, bed-bound and unable to move. Restraints were applied while he was extremely unwell and required oxygen to breathe. This was not proportionate to his perceived risk at the time, given his frail and deteriorating condition. The absence of documented risk assessments underlying some of these decisions means we do not know how they were reached. Based on the information available, the use of restraints during his hospital admission appears to have been excessively precautionary and inappropriate. We therefore make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position and that assessments fully consider the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Governor and Head of Healthcare should ensure that restraint risk assessments are documented and retained whenever there is a change in a prisoner's restraints.

Support for next of kin and repatriation procedures

106. After Mr Mendoza-Sillerico's death, his sister told the family liaison officer that, in line with their mother's wishes, she wanted him to be repatriated to Bolivia. Over the following weeks, Mr Mendoza-Sillerico's sister expressed that she had no experience with funeral arrangements and did not know what steps to take. The family liaison officer told the investigator that communication was difficult because she spoke very limited English and relied on a friend to interpret. The family liaison officer told the investigator she experienced difficulties using interpreting services over the phone when speaking with his sister.

107. Interpretation was arranged on 10 December, when an officer explained funeral and repatriation options. During this call, conducted in Spanish, the officer advised that funeral directors would manage the repatriation.

108. The family liaison officer provided some guidance, but Mr Mendoza-Sillerico's sister seemed uncertain about what was happening or what she was required to do. On 20 December, the family liaison officer noted that she had received the funeral director's details. The family chose a direct cremation with no service. It is unclear whether this decision was fully informed, as she had previously expressed

uncertainty about options and costs. The family liaison officer had not dealt with repatriation before, did not know the prison must offer to pay repatriation costs and lacked support and guidance.

109. PSI 64/2011 states that prisons must offer to pay reasonable repatriation costs of the body or ashes of a foreign national prisoner. It also states that translation should be considered. This would have helped the family understand options, costs and the prison's contribution in line with policy. Further support for staff in managing this process, along with an information pack and access to translation services would help ensure families are better supported and aware of the options available. We make the following recommendation:

The Governor should ensure family liaison officers receive training and guidance on bereavement procedures, including support for families with limited English. Family liaison officers should offer repatriation and funeral options in line with policy and use professional interpretation services where appropriate.

Governor and Head of Healthcare to note

Delays to our investigation

110. It was incredibly difficult to arrange both prison and healthcare interviews for this investigation. The PPO investigator and clinical reviewer offered numerous potential dates for interviews. In addition, some staff did not attend the scheduled interviews or assist with providing alternate dates. This impacted the timeliness of our investigation. The Governor and Head of Healthcare will want to ensure that sufficient priority is given to our investigations in future.

Inquest

111. The inquest into Mr Mendoza-Sillerico's death concluded on 29 April 2026 and returned a verdict of natural causes. It concluded that he died from sigmoid perforation caused by disseminated tuberculosis. The Coroner found that there were missed opportunities to identify potential medical issues that could have enabled earlier identification and treatment for tuberculosis. The inquest found that these missed opportunities might have contributed to Mr Mendoza-Sillerico's death.

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

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