Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michal Netyks a prisoner at HMP Altcourse on 7 December 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michal Netyks died from a head injury on 7 December 2017, after jumping from a first-floor landing at HMP Altcourse. He was 35 years old. I offer my condolences to Mr Netyks' family and friends.

Mr Netyks had been due to be released from prison on the day he died. That morning, he was given Home Office paperwork telling him that he would remain at Altcourse pending deportation to Poland. He jumped to his death a few hours later.

Although there was no obvious indication that Mr Netyks was at imminent risk of suicide or self-harm on the day he died, there are important lessons to be learned about the way in which immigration decisions are communicated to prisoners.

It is troubling that Mr Netyks was told on the morning of his planned release that he was to remain in prison under immigration detention powers. I am particularly concerned that Mr Netyks was given the Home Office paperwork without anyone explaining it and considering the impact on him. More needs to be done to ensure that detention and deportation decisions are communicated to prisoners earlier, and that they are communicated in a considered way to limit any distress caused. The prison should also have assessed Mr Netyks' risk of suicide and self-harm when he was told that he was not going to be released as he had expected. If this had been done, his death might have been avoided.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **August 2018**

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Summary

Events

1. Mr Michal Netyks, a Polish national, was sentenced to 26 weeks imprisonment on 18 September 2017, for breaching a restraining order and assaulting a police officer. He was sent to HMP Altcourse. He was transferred to HMP Risley, but returned to Altcourse on 25 October.

2. While at Risley, Mr Netyks was served with a Home Office notice telling him he was liable to deportation. The notice invited Mr Netyks to set out the reasons why he should not be deported. He sent a response to the Home Office but heard nothing more until 7 December, the day he was due to be released from prison.

3. At around 8.40am that morning, a prison officer gave Mr Netyks Home Office paperwork telling him he would be remaining at Altcourse, detained under immigration powers, pending his deportation to Poland. The officer said he would return later to explain the paperwork.

4. At 12.11pm, after refusing to return to his cell after lunch, Mr Netyks stood on the top railing on the first-floor landing. Staff and prisoners shouted for him to get down and he fell backwards off the rails before standing up again, running to the rails and jumping over them. He landed on his head on the ground floor. Healthcare staff attempted to resuscitate Mr Netyks but were unsuccessful. He was pronounced dead at 12.33pm.

Findings

5. In the weeks before his death, Mr Netyks was anxious about the possibility of deportation. His letters and phone calls to family and friends suggest that his mental health may also have been deteriorating. Prison staff had very little meaningful contact with Mr Netyks during this time and were not aware of his mental state.

6. We found it very troubling that Mr Netyks was not told until the morning of his planned release that he would be remaining at Altcourse under immigration detention powers. The Home Office did not forward the relevant paperwork to Altcourse until late afternoon the day before. This meant that Mr Netyks was not informed of the decision until the morning of his release.

7. It is also troubling that the prison gave Mr Netyks the documentation with no explanation and apparently without considering issues of welfare and potential risk. Prison guidance is clear that the service of immigration detention or deportation papers can raise the risk of suicide or self-harm. We saw no evidence that the impact of the service of the documentation on Mr Netyks was assessed.

8. After Mr Netyks fell from the first floor, an officer called for immediate assistance and the control room called an ambulance. However, an emergency medical code was not called until later. Although it caused no delay in this case, it is

important that the correct emergency procedures are followed so that all staff are clear about the nature of the incident at the outset.

Recommendations

- The Director should ensure that:
    - the prison has arrangements in place to inform prisoners of continuing detention under immigration powers in a way that minimises the prisoner's distress; and
    - when staff serve immigration decisions relating to a prisoner's detention or removal from the UK, they:
        - communicate effectively with the prisoner so that the prisoner understands the implications of the decision; and
        - assess whether the prisoner is at risk of suicide and self-harm as a result.
- The Home Office should ensure that, wherever practicable, prisons are notified of decisions to detain prisoners under immigration powers at least 48 hours prior to the prisoner's release date.
- The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use their radio to communicate the nature of a medical emergency quickly and effectively.

The Investigation Process

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

10. The investigator visited Altcourse on 14 December 2017. She obtained copies of relevant extracts from Mr Netyks' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Netyks' clinical care at the prison. The investigator and the clinical reviewer conducted joint healthcare interviews.

12. The investigator interviewed eight members of staff and two prisoners over three days at Altcourse on 14 December, and 9 and 10 January 2018. She also carried out telephone interviews with three prison custody officers and one prisoner.

13. We informed HM Coroner for Liverpool of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Netyks' brother to explain the investigation and to ask if his family had any matters they wanted the investigation to consider. Mr Netyks' family asked the following questions:

    - Why had Mr Netyks' parents not been informed of their son's death by anyone from Altcourse?
    - What were the circumstances surrounding his death?
    - Was he being bullied?
    - Was Mr Netyks under the care of clinical staff at Altcourse and what medication was he prescribed?
    - Why was there no safety netting between floors?

15. The initial report was shared with HMPPS. HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

16. Mr Netyks' family received a copy the initial report. The solicitors representing Mr Netyks wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitors.

Background Information

HMP Altcourse

17. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young men. G4S manage the prison and provide primary healthcare services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Altcourse was in November 2017. Inspectors noted that there had been three self-inflicted deaths since their previous inspection and the prison had made reasonable progress towards meeting the PPO's recommendations. Levels of self-harm, while still high, were reducing year on year.

19. Inspectors reported that during their inspection, four prisoners were detained under immigration powers after their sentence had ended. They received inadequate help to access independent immigration advice and assistance from support organisations. As at the last inspection, prisoners received notice of their post-sentence detention from the Home Office too late, usually in the last week or sometimes on the day before the end of their sentence, which was unacceptable.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2017, the IMB reported that an increase in staffing numbers had contributed to a reduction in self-harm and violence.

Previous deaths at HMP Altcourse

21. Mr Netyks was the second prisoner to take his own life since 2016. In our previous investigation, we made a recommendation about the emergency response procedures, which we repeat in this case.

Key Events

22. Mr Michal Netyks, a Polish national, was sentenced to 26 weeks imprisonment on 18 September 2017, for breaching a restraining order and assaulting a police officer. He was sent to HMP Altcourse. This was not his first time in a UK prison. Mr Netyks was assessed by a nurse in reception at Altcourse. He told her that he had no thoughts of suicide or self-harm and no mental health issues, but he had issues with alcohol. He agreed to a referral to the substance misuse team but he did not attend his appointment. Mr Netyks was transferred to HMP Risley on 2 October.

23. On 10 October, Mr Netyks was served with a Home Office notice telling him he was liable to deportation. The notice invited Mr Netyks to make any representations against deportation within 20 working days. In a letter to his parents that day, Mr Netyks said that he felt very angry and depressed.

24. Mr Netyks was returned to Altcourse on 25 October. A nurse assessed Mr Netyks in reception. Mr Netyks confirmed that he did not need an interpreter for the assessment (he had not needed an interpreter previously) and said he had no thoughts of suicide or self-harm. The nurse noted that there was a self-harm marker on Mr Netyks' person escort record (PER) stating that he had threatened to take his life when arrested by the police in July. When asked about this, Mr Netyks said that he had been drunk and angry with the police. The nurse noted that Mr Netyks did not display any psychotic symptoms.

25. Mr Netyks was located on Valentines Green Unit, which has a ground floor and first floor. There is no netting between the floors. Staff and prisoners told the investigator that Mr Netyks did not come to their attention much and kept himself to himself. He attended English language classes and seemed quiet and compliant.

26. On 6 November, Mr Netyks wrote to the Home Office setting out the reasons why he thought he should not be deported. He said he was settled in the UK, with employment and close family ties here. (The letter was received by the Home Office on 13 November.)

27. Mr Netyks made several telephone calls to family and friends between October and December, and always spoke in Polish. Telephone calls at Altcourse are randomly checked by staff, but Mr Netyks' calls were not checked, as he was not randomly selected for monitoring and he had not caused any concerns that merited his calls being checked. The investigator arranged for Mr Netyks' telephone calls from 1 December to be translated.

28. They showed that Mr Netyks was worried that he had not heard from the Home Office and that he might not be released on 7 December as planned. He also thought other prisoners were watching him and collecting information about him. In a telephone call to a friend on 1 December, he said, "I am feeling so very low", "there is something bad going on" and "I have started having these thoughts to do something". During a call to a friend on 3 December, Mr Netyks said, "I've

been thinking about the rope", but did not elaborate. In an earlier call, he also appeared to be frightened that something might happen to him after his release and said, "I am so scared, I have lots of very bad thoughts". Neither he, nor anyone he spoke to, raised any concerns with the prison.

29. Mr Netyks' family, via their legal representative, sent the investigator a number of letters that Mr Netyks had written, some of which were undated. The investigator had the letters translated from Polish to English. The letters suggested that Mr Netyks was not sure what would happen to him at the end of his sentence, but thought he might be deported. Mr Netyks said he felt like doing very little, that something had happened to change him, and that sometimes he felt like he had lost his strength and was broken down. Mr Netyks said that he did not leave his cell anymore, had retreated into himself and did not interact with other prisoners.

30. In a letter dated 26 November, written to his parents, Mr Netyks said he was very worried what would happen to him on 7 December, but remembered he wanted to return to Poland "a long time ago" and spoke about his cellmate who was "lucky" as he was returning to Poland soon. He wrote that he had some weird thoughts, was very worried and scared and wanted to apologise for his past actions.

31. Staff at Altcourse said they telephoned the Home Office during the morning of 5 December, to inform them that Mr Netyks was due for release in two days time. They telephoned again twice on 6 December, and at 3.42pm, the Home Office emailed an authority to detain (IS91) notice to the prison, to be served on Mr Netyks. (Further paperwork was emailed from the same immigration caseworker at 11.50am on 7 December, but Mr Netyks did not receive it.)

32. Officer A said he found out when he arrived on duty on Valentines Green Unit on 7 December that Mr Netyks was not going to be released that morning as expected, and that Officer B would come to the unit to give Mr Netyks the immigration paperwork.

33. Officer B saw Mr Netyks in his cell at approximately 8.40am. He told him that the Home Office had decided to detain him under immigration powers. He gave him the paperwork, along with an application form for bail, and told him he would return at lunchtime to discuss it further. Mr Netyks asked why he was being detained but did not get angry or upset. He walked away shaking his head.

34. Officer A recalled that after he had been given the paperwork, Mr Netyks asked him about bail and whether his PINphone number would be restored (access to the PINphone system is turned off and a prisoner's account is closed the night before their release). Officer A said somebody would speak to him about it later that day. Staff and prisoners on the unit did not recall Mr Netyks collecting his lunch, but Officer A saw him standing at the telephone on the unit. Mr Netyks would not have been able to make a call because he did not have access to the PINphone system. Officer A told him it was time to return to his cell as the unit was being locked up for the lunchtime period.

35. Officer A next saw Mr Netyks standing on the landing on the Valentines Green Unit and told him again to go into his cell. At 12.04 pm, CCTV showed Mr Netyks pacing the floor of the landing, looking over the railings, and rubbing and shaking

his head. He continued to do this until 12.11pm. Shortly afterwards, Officer A went onto the landing to carry out a roll check and saw that Mr Netyks was still out of his cell. Officer A said he asked him three times to go into his cell and, as he walked towards him, Mr Netyks stood on the top railing. CCTV showed Officer A standing a few feet away from Mr Netyks.

36. Officer C had heard raised voices as he was walking onto the unit, and saw Mr Netyks standing on the rail. He shouted for him to get down, as did Officer A and some prisoners who were still unlocked, and Mr Netyks toppled backwards onto the landing floor. Officer A took a step forward and within five seconds, Mr Netyks got up from the floor, ran to the rails and jumped over them. CCTV showed Mr Netyks falling and landing on his head.

37. Officer C used the telephone on the unit to request immediate help and then went to check Mr Netyks. He put him in the recovery position as he thought he could feel a faint pulse and then used his radio to request urgent assistance. At some point Officer C radioed an emergency code blue call (indicating that a prisoner is unconscious or having trouble breathing and ensuring that an ambulance is automatically called), but staff in the control room had already called for an ambulance, as they had heard the first request for assistance.

38. Five nurses arrived on the unit at 12.15pm and attended to Mr Netyks immediately. He was lying on his right side and nursing staff placed him on his back. They could not detect a pulse and noted Mr Netyks appeared cyanosed (his skin was a bluish colour). Nurses described Mr Netyks as having a catastrophic blood loss and that bleeding was evident from his nose, eyes, mouth and ears. Healthcare staff continued to carry out cardiopulmonary resuscitation (CPR) and administered oxygen and chest compressions. Healthcare staff applied a defibrillator (a device that can give the heart an electric shock in some cases of cardiac arrest) but it advised a shock was not required. A nurse noted a large open wound to the side of Mr Netyks' head and that his pupils were fixed, dilated and unresponsive.

39. Paramedics arrived on the unit at 12.26pm, and assessed Mr Netyks while healthcare staff continued CPR. Paramedics pronounced Mr Netyks' death at 12.33pm.

Contact with Mr Netyks' family

40. Mr Netyks had appointed a friend as his next of kin, and Altcourse's Director and a family liaison officer visited his home at 3.50pm on 7 December, to break the news of his death.

41. The prison contributed to Mr Netyks' funeral, in line with national guidance.

Support for prisoners and staff

42. The Director chaired a debrief on 8 December, for 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.

43. The prison posted notices informing other prisoners of Mr Netyks' death, and offering support. Staff spoke to all prisoners on the unit about what had

happened, and reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Netyks' death.

Post-mortem report

44. Mr Netyks' post-mortem examination concluded he had died as a result of a blunt force head injury. His toxicology report was clear.

Findings

Assessment of Mr Netyks' risk

45. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and triggers that might increase a prisoner's risk of suicide and self-harm. It says that all staff who have contact with prisoners must be aware of these risk factors and triggers, so that they can identify prisoners at risk of suicide and self-harm and take appropriate action. The PSI says that when a foreign national prisoner is, or is about to be detained under immigration powers, or is close to deportation, this can be a trigger for suicide or self-harm.

46. Mr Netyks' custodial sentence was due to end on 7 December, but he knew it was possible he could be deported to Poland. Officer B told the investigator that when he gave Mr Netyks the Home Office paperwork telling him that he was being detained under immigration powers, he did not appear particularly upset and that he had no concerns for Mr Netyks' welfare.

47. The content of Mr Netyks' telephone calls and letters indicate that there may have been a deterioration in his mental health, and that he was also anxious about what would happen to him at the end of his sentence. He did not speak to staff about this so they were unaware. We accept that he never gave staff any cause for concern. We consider that staff could not, on the evidence available to them, have predicted that Mr Netyks was about to take the action he did on the morning of 7 December.

48. However, we do consider that there are lessons to be learned about the way in which prisoners at risk of deportation are monitored and about how important decisions about a prisoner's continued detention or removal from the UK are communicated to them.

49. Mr Netyks was told on 10 October, while he was at Risley, that that he was liable for deportation at the end of his sentence. There is no evidence that prison staff considered at the time whether this might have increased Mr Netyks' risk of suicide or self-harm.

50. When he returned to Altcourse on 25 October, there is nothing to suggest that staff took the potential deportation into account in assessing Mr Netyks' risk to himself. Staff told the investigator that Mr Netyks kept himself to himself on the wing, and Mr Netyks said in letters to his family that he stayed in his cell and that he was depressed and thought other prisoners were watching him. We would have expected that staff would have been keeping an eye of Mr Netyks in the light of his immigration position, but there is very little evidence that staff tried to interact with Mr Netyks during this time. If they had done so, it is possible that they might have picked up on Mr Netyks' mental state and how he felt about his potential deportation.

51. We are also concerned about the way Altcourse handled the task of communicating the deportation decision to Mr Netyks. We appreciate that the prison had no control over the Home Office's timetable for making the decision.

However, we note that HMIP found that it was not unusual for prisoners at Altcourse to receive notice of their post-sentence detention from the Home Office very late, usually in the last week or sometimes on the day before the end of their sentence. We agree with HMIP that this is unacceptable, but, given that it happens regularly, we would have arrangements in place to communicate these decisions sensitively.

52. In Mr Netyks' case, the Home Office informed the prison that he would be detained under immigration powers at 3.42pm the day before he was due to be released. The prison seems to have given no thought to informing Mr Netyks that afternoon, or to taking practical steps that might have made it easier for him to cope with the news (such as re-instating his PINphone access).

53. Instead, he was told on the morning of his release that he would be staying at Altcourse and detained under immigration powers, and then left him alone to digest what must have been distressing news. He was given immigration paperwork and a bail application, but no one explained to him exactly what these meant or checked that he understood. PSI 64/2011 is clear that the service of immigration detention papers can be a trigger for suicide or self-harm. We consider, therefore, that not only is it important for staff to explain important immigration decisions to prisoners, but also to assess whether the prisoner is at risk of suicide and self-harm as a result of being told that decision.

54. We make the following recommendation:

The Director should ensure that:

- **the prison has arrangements in place to inform prisoners of continuing detention under immigration powers in a way that minimises the prisoner's distress; and**
- **when staff serve immigration decisions relating to a prisoner's detention or removal from the UK, they:**
  - **communicate effectively with the prisoner so that the prisoner understands the implications of the decision; and**
  - **assess whether the prisoner is at risk of suicide and self-harm as a result.**

The role of the Home Office

55. On 10 October, Mr Netyks was served with a notice telling him he was liable to be deported. He made representations in a letter dated 6 November, which the Home Office casework team received on 13 November. He heard nothing further until 7 December, the day he was due to be released from prison custody.

56. On 5 and 6 December, staff at Altcourse chased up the Home Office for a decision, given that Mr Netyks was due to be released on 7 December. The Home Office emailed the detention paperwork to Altcourse at 3.42pm on 6 December. The deportation notices and further documentation were emailed after he had died.

57. It is unclear why it took the Home Office over three weeks to consider Mr Netyks' representations and to make the deportation decision. Unless there were exceptional reasons, we do not consider it acceptable for prisoners to be told, on the day of their expected release, that they are to remain in prison under immigration detention powers. It is also hard for prison staff, who, rather than releasing a prisoner as planned, have to make very quick arrangements to inform the prisoner of the immigration detention decision and deal with any consequences.

58. We have highlighted above why we consider that the decision to detain Mr Netyks was not communicated well to him. This is likely to have been due, in part, to the fact that the prison did not receive the Home Office decision until late afternoon on the day prior to planned release. We make the following recommendation:

The Home Office should ensure that, other than in exceptional circumstances, prisons are notified of decisions to detain prisoners under immigration powers at least 48 hours prior to the prisoner's release date.

Emergency response

59. PSI 03/2013 on Medical Emergency Response Codes states that local protocols must clearly define the nature of a medical emergency with a two code system that distinguishes between a blood injury and all other injuries. The calling of a medical emergency code ensures that staff are alerted to the nature of the emergency and that control room staff call an ambulance immediately. Altcourse's local instruction on emergency response codes (Notice to Staff 57/2015) instructs the use of emergency codes 'red' and 'blue' to comply with PSI 03/2013.

60. When Mr Netyks fell from the first-floor landing, Officer C asked for urgent assistance. He did not call a medical emergency code straightaway as he should have done. We acknowledge that the control room called for an ambulance after hearing the call for urgent assistance, so, in practice, there was no delay. However, it is important that staff follow the correct medical emergency procedures, as set out in the policy, so that control room staff are aware of the nature of the incident and respond appropriately. This is not the first time that we have identified this as a concern, and we repeat a recommendation previously made to Altcourse:

The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use their radio to communicate the nature of a medical emergency quickly and effectively.

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