Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aron Kuc a prisoner at HMYOI Brinsford on 25 March 2018

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.

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We are:

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Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres. My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Aron Kuc died at HMYOI Brinsford after he was found hanged in his cell on 25 March 2018. He was 19 years old. I offer my condolences to his family and friends.

This was Mr Kuc's first time in prison and he had only been in custody for just over five weeks when he died. He had a number of significant risk factors: he was very young and he had a history of serious self-harm, substance abuse and mental health issues. He found it difficult to cope in prison because, without drugs, he struggled to cope with his emotions when he was alone in his cell and because he was distressed at the lack of contact with his family. He self-harmed on three occasions, began a dirty protest, started to self-isolate and was thought to have tied a ligature round his neck on the morning of his death.

Staff at Brinsford managed Mr Kuc under self-harm and suicide prevention measures (known as ACCT). However, I consider that they failed to take his many risk factors sufficiently into account when assessing and managing his risk, and placed too much reliance on his presentation, and that they did not take effective action to address his key concerns. I am also concerned that they missed opportunities to identify and address his increased risk on the day he died.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2018**

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Summary

Events

1. On 16 February 2018, Mr Aron Kuc was remanded to HMYOI Brinsford for assault and wounding with intent. While he was at court, staff completed a suicide and self-harm warning form because Mr Kuc had self-harmed by cutting his arms when he was arrested, had a history of mental health and substance misuse issues and had taken an overdose of paracetamol 12 months earlier.

2. When he arrived at Brinsford, staff who completed Mr Kuc's reception screening did not use the available information to consider whether to start suicide and self-harm procedures (known as ACCT), and did not note that he had recently harmed himself. Staff did, however, refer him to the substance misuse and mental health teams.

3. On 18 February, Mr Kuc poured boiling water over his hand. Staff immediately began ACCT procedures and he continued to be monitored under ACCT procedures until his death. During this period, staff completed ten ACCT reviews but a member of the mental health team only attended two.

4. Mr Kuc harmed himself again on 14 March, 15 March and he was segregated for a day after starting a dirty protest on 17 March. He often self-isolated and did not collect his meals. He said that he found it difficult being in prison, that he was distressed at having no contact with his family, especially his mother, and that he was struggling to cope with his emotions when he was alone in his cell.

5. On the morning of 25 March, staff suspected that Mr Kuc had tied something around his neck, but he denied it. An ACCT review was completed but did not raise his level of risk or increase the frequency with which he was observed. At around 11.45am, Mr Kuc told staff that he did not want any lunch and refused to leave his cell to collect it. This was not unusual behaviour. At around 12.30pm, staff completed the lunchtime roll check but had no concerns about Mr Kuc. At 3.26pm, an officer found Mr Kuc hanged by a bed sheet which had been tied to a screw in the wall. The officer radioed an emergency code. Prison and healthcare tried to resuscitate Mr Kuc but paramedics pronounced him dead at 4.02pm.

Findings

Management of risk of suicide and self-harm

6. Staff did not appropriately assess Mr Kuc's risk of suicide and self-harm when he arrived at Brinsford.

7. Although staff later monitored Mr Kuc under ACCT procedures, there were some deficiencies in the way they did so which were not in line with national instructions. No one from the healthcare team or the mental health team attended eight out of ten ACCT reviews. The ACCT caremap failed to recognise that the mental health team was supporting Mr Kuc. There was no evidence to indicate whether staff had made any progress in allocating Mr Kuc work or

education activities to reduce the amount of time he had to spend alone in his cell, and no one obtained his mother's contact details.

Clinical care

8. The clinical reviewer found that Mr Kuc's clinical care was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
  - Staff have a clear understanding of their responsibilities and the need to record relevant information about risk.
  - Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.
  - Prison, healthcare and mental health staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review.
  - Staff hold multidisciplinary ACCT reviews, with the same case manager and which involve staff who contribute to a prisoner's care.
  - ACCT case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMYOI Brinsford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator visited Brinsford in March 2018. He obtained copies of relevant extracts from Mr Kuc's prison and medical records.

11. The investigator interviewed nine members of staff and one prisoner at Brinsford in April 2018.

12. NHS England commissioned a clinical reviewer to review Mr Kuc's clinical care at the prison.

13. We informed HM Coroner for South Staffordshire 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 Kuc's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Kuc's family wanted to know as much information as possible about the circumstances leading to Mr Kuc's death.

15. Mr Kuc's father received a copy of the initial report. He did not make any comments.

Background Information

HM Young Offender Institution (YOI) Brinsford

16. HMYOI Brinsford holds up to 473 remanded and sentenced young adults aged 18-21 years, and prisoners aged over 18 years who have been sentenced to less than four years in prison. It offers a resettlement service for young adults and Category C adults who live in Staffordshire and the West Midlands. Prisoners are housed across five residential units. Care UK provide healthcare services.

HM Inspectorate of Prisons

17. The most recent inspection of HMYOI Brinsford was an unannounced visit in November 2017. Inspectors reported that almost half of the prisoners at Brinsford were there for less than three months. Incidents of self-harm had risen significantly, and there had been a self-inflicted death since the last inspection.

Independent Monitoring Board

18. 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 the main issue for the period had been ongoing staffing shortages which had affected the day-to-day running of the prison.

Previous deaths at HMYOI Brinsford

19. Mr Kuc was the second prisoner to die at Brinsford since January 2015. Both prisoners took their own lives. In our investigation into the previous self-inflicted death in 2015, we identified deficiencies in the ACCT process and the emergency response.

Assessment, Care in Custody and Teamwork (ACCT)

20. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

21. Mr Aron Kuc was a 19-year-old Polish national, who had moved to the UK with his parents when he was seven years old. He spoke English well.

22. On the night of 14 February 2018, he was arrested and charged with assault and wounding with intent. When he was arrested, he made deep cuts to his wrist. While in police custody, it was noted that Mr Kuc had self-harmed since he was twelve years old. He said he had taken an overdose of paracetamol 12 months earlier and had misused illicit drugs, including cannabis, MDNA (ecstasy) and psychoactive substances (PS), in the last two days. He said that he heard voices and was paranoid.

23. A psychiatrist and mental health nurse assessed Mr Kuc. They noted that he did not have an acute mental illness but that his psychotic symptoms might put others at risk. They noted that although Mr Kuc denied further plans to harm himself, he was likely to continue to self-harm. (Their assessment was forwarded to HMYOI Brinsford on 19 February.)

24. On 16 February, Mr Kuc was remanded to HMYOI Brinsford. A Person Escort Record (PER) and suicide and self-harm warning form, both completed in police custody, travelled with Mr Kuc to court and Brinsford. The form recorded that Mr Kuc had recently cut his arm, had mental health and substance misuse issues and a history of overdose.

HMYOI Brinsford

25. That day, Officer A, completed Mr Kuc's reception screening interview at Brinsford. He acknowledged receipt of the suicide and self-harm warning form. He emailed the safer custody team to let them know that it was Mr Kuc's first time in prison and that he had a history of self-harm. The officer noted that Mr Kuc was Polish, homeless and dyslexic. He was due to return to court on 19 March. Mr Kuc named his mother as his next of kin, although he was unable to provide any contact details for her.

26. Officer B completed Mr Kuc's first night interview. He noted that Mr Kuc appeared vulnerable and that staff should assess whether he was suitable to live in Residential Unit 1, the Supported Living Unit (for prisoners who require extra help). Mr Kuc raised no concerns. The officer noted that Mr Kuc had self-harmed and tried to kill himself six months earlier. He did not refer to Mr Kuc's recent self-harm which was noted in the PER and the suicide and self-harm warning form with which he arrived. He assessed that Mr Kuc should be located in a single cell.

27. Nurse A (who is no longer employed at Brinsford) completed an initial health screen for Mr Kuc. She noted that it was his first time in prison. Mr Kuc was unable to recall the details of his community GP. He said that he was not taking any medication and admitted to using illicit drugs (amphetamine and cannabis). He said that he had previously taken an overdose of tablets but had no thoughts of suicide or self-harm. The nurse recorded that Mr Kuc had self-harmed in the past 12 months and had visible self-harm scars on his arm. She noted that Mr Kuc presented with no current risks and it was not necessary to start ACCT

procedures. The investigator was unable to confirm whether the nurse had seen the PER or suicide and self-harm warning form. She did not refer to either document in her assessment despite both highlighting Mr Kuc's current risk of self-harm. She referred Mr Kuc to the mental health team (known as the Inclusion Team) and the substance misuse team.

28. Staff took Mr Kuc to the first night centre, where, shortly afterwards, he smashed the sink and observation panel in his cell. Staff issued Mr Kuc with a disciplinary warning.

29. On 17 February, Nurse B completed Mr Kuc's secondary health screen assessment, and noted that he misused alcohol and drugs. Mr Kuc told her that he had self-harmed four months earlier because of stress but he now just felt numb. Mr Kuc said that he had no current thoughts of suicide or self-harm but that his mood was low. He said that he had been hearing voices for about 12 months and wanted to address his mental wellbeing. The nurse noted that Mr Kuc was not fit to hold his own medication in his cell because of his impulsive behaviour. She referred him to the Inclusion Team. She did not refer to Mr Kuc's suicide and self-harm warning form.

30. On 18 February, staff started ACCT procedures after Mr Kuc poured hot water from his kettle over his left hand. He told staff that he wanted to feel the pain and die and that he self-harmed to stop himself from having thoughts of killing someone. Nurse C treated Mr Kuc's burns. She described his behaviour as erratic – he was sitting down and standing up throughout. She said that he had a laceration and dry blood on his right hand. Custodial Manager (CM) A placed Mr Kuc on hourly (irregular) observations until his ACCT assessment.

31. On the morning of 19 February, Officer C completed Mr Kuc's ACCT assessment and noted that he appeared happy. Mr Kuc said that he self-harmed because he liked the feeling of pain and had been doing so for years. He said that when he last self-harmed (on the day of his arrest), he had wanted to die. He said that he was unsure how he currently felt but talked about self-harming again. He described his mood as fluctuating and said that he felt angry. He said that he wanted to contact his mother and half-brother but could not speak to them because he did not have their phone numbers. He talked about his step-father but said that he felt too embarrassed to speak to him. The officer noted Mr Kuc's main concerns were to establish contact with his family; to complete a skills assessment; and to see a member of the Inclusion Team.

32. Afterwards, Supervising Officer (SO) A completed Mr Kuc's first ACCT review. Officer C, SO B (from the Safer Custody Team) and Nurse D (from the Inclusion and the Substance Misuse Team) attended. Mr Kuc said that he self-harmed as a coping mechanism when his mood was low. He said that he had misused drugs significantly until he arrived in custody. He said that he had no current suicidal thoughts and wanted to take part in activities that would keep him occupied.

33. The panel noted that Mr Kuc engaged well despite his erratic behaviour. They agreed to maintain his ACCT observations at hourly intervals, noted that his risk level was raised, referred him to the Inclusion Team and scheduled the next ACCT review for 26 February. Staff recorded in the ACCT caremap that

attempts would be made to find a contact number for Mr Kuc's mother and to find him some purposeful activity, possibly for him to attend the gym or library. They did not update the caremap to reflect that he had been referred to the Inclusion Team.

34. That afternoon, Mr Kuc moved from the first night centre to Residential Unit 3, the induction wing. Staff recorded that he was in a good mood, was mixing with other prisoners and raised no concerns.

35. On 26 February, SO A completed an ACCT review. SO C attended and Nurse D provided input by telephone (although this was not recorded in Mr Kuc's medical records). They noted that Mr Kuc engaged well. He said that he felt settled on Residential Unit 3 and wanted to attend activities. The SO told Mr Kuc that he had contacted the hostel where he had lived and obtained his step-father's phone number. However, Mr Kuc said that he did not want to speak to his step-father. SO A said that he would contact the hostel again to see if they had any other contact numbers for members of Mr Kuc's family. The panel assessed that Mr Kuc's risk of suicide and self-harm was low. They lowered his scheduled ACCT observations to five conversations during the day and five observations at night. The next ACCT review was scheduled for 5 March. SO A updated Mr Kuc's caremap, and noted that he had contacted the Works Allocation Team to ask them to find an activity for Mr Kuc.

36. On 27 February, Mr Kuc completed his induction and moved to a cell on Residential Unit 4. Staff raised no concerns about him but noted that he appeared in a good mood and had asked a member of staff to post a letter for him.

37. The next day, Nurse D and a psychosocial recovery practitioner for substance misuse, saw Mr Kuc and completed a mental health assessment. The nurse noted that this was the second time that she had seen him and noted that he showed no signs of having any acute psychotic illnesses. She considered that his presentation had improved. Mr Kuc agreed to take part in interventions to address his emotional dysregulation and substance misuse. The nurse agreed to review Mr Kuc again on 19 March.

38. Staff recorded on 1 March that Mr Kuc refused to have a shower or attend exercise, and preferred to remain in his cell. Mr Kuc told staff that it was too cold and he was tired.

39. On the evening on 5 March, CM B, a custodial manager in the Safer Custody Team, completed an ACCT review. SO D attended. No member of the healthcare team or Inclusion Team attended. They noted that Mr Kuc engaged well despite stating that he still had some thoughts of suicide and self-harm. Mr Kuc said that he was looking forward to working or participating in education in prison. His solicitor was also trying to facilitate contact with his mother for him. It was agreed that his observation levels and caremap actions would remain the same.

40. On 7 March, Mr Kuc's offender supervisor introduced herself to Mr Kuc as his offender supervisor and gave him information about how she could support him. Mr Kuc said that he was okay.

41. On 12 March, CM C and Officer D completed Mr Kuc's fourth ACCT review. No member of the healthcare team or Inclusion Team attended. Mr Kuc said that he had settled in the unit but was unsure if he was under the care of Nurse D from the Inclusion Team. The panel raised no concerns about Mr Kuc and his observation level remained unchanged. Despite the CM noting that he would add Nurse D's name to Mr Kuc's caremap, it was not recorded.

42. On the morning of 14 March, a member of the chaplaincy team, saw Mr Kuc. He noted that Mr Kuc was in good spirits and spoke about contacting his step-father.

43. In the afternoon, Mr Kuc made superficial cuts to his arm. He said that he did this because he no longer had his "vape pen". Nurse E treated Mr Kuc's wounds and referred him to the Inclusion Team.

44. Afterwards, SO A and CM C completed an ACCT review. No one from the healthcare team or the Inclusion Team attended. Mr Kuc said that he had self-harmed because he was bored. He said that he had also lent his vape pen to another prisoner who had now left the unit. The panel increased Mr Kuc's ACCT observations to five conversations during the day and hourly at night, and noted that his risk level was raised. The caremap noted that CM C would contact the activities unit to see if Mr Kuc could be allocated a job.

45. The next day, Mr Kuc again made cuts to his arm. He offered no explanation for his actions. A nurse treated his wounds. CM D and SO A completed an ACCT review but were unable to find out why Mr Kuc had harmed himself. No one from the healthcare team or Inclusion Team attended the review. Mr Kuc said that he wanted to speak to Nurse D, and the SO agreed to contact her. Mr Kuc's observations and caremap remained the same. After the review, the SO took Mr Kuc to the library, where he borrowed books to help keep him occupied.

46. On 16 March, Nurse D saw Mr Kuc and noted that he was tearful at times and his mood was flat. Mr Kuc said that he felt unsure and overwhelmed by his current situation. He said that he had misused illicit substances for a long time and had suppressed his emotions. He said that he now had to spend long periods of time alone in his cell, and without drugs, he was finding it challenging. He felt guilty as he believed that he had let his family down. He wanted to speak to his mother but only had his step-father's phone number. The nurse noted that Mr Kuc had no current thoughts of suicide or self-harm. He said that he had self-harmed on this occasion as an emotional release and wanted something to occupy his time. The nurse discussed distraction techniques with him, gave him some stationery and encouraged him to write to his family. She spoke to CM C who said that Mr Kuc would be offered the opportunity to attend education classes.

47. Staff recorded no concerns about Mr Kuc that evening. He said that he felt better than the previous day and was aware of the support services available to him in prison.

48. On the morning of 17 March, Mr Kuc started a dirty protest. (He smeared excrement around his cell.) He threatened staff and refused to comply with their instructions. Staff used control and restraint techniques to move him from his cell to the segregation unit. Mr Kuc did not explain his behaviour and refused to take

a shower when offered. He was placed on a disciplinary charge. Nurse C assessed that Mr Kuc was fit to be detained in the segregation unit.

49. Afterwards, an operations manager, and CM E completed an ACCT review. Mr Kuc said that he would not kill himself as prison would do it for him. In line with Brinsford's policy, Mr Kuc's scheduled ACCT observations were increased to five an hour while he was in the segregation unit. The panel updated Mr Kuc's caremap and noted that staff would continue to talk to him to try to understand his needs. The next ACCT review was scheduled for 19 March. It was noted that no one from the Inclusion Team was available (as they did not provide a weekend service) but they were to be invited to attend the next review. The CM added that consideration would be given to locating Mr Kuc on Residential Unit 1.

50. That afternoon, staff noted that Mr Kuc stopped his dirty protest and took a shower. A nurse examined his previously self-inflicted wounds.

51. On 18 March, Nurse C saw Mr Kuc during the segregation health check rounds. On the same day, the operations manager conducted a disciplinary hearing on the previous day's disciplinary charge. He found Mr Kuc guilty and imposed a number of sanctions. These included reductions of allowance (of cash to buy canteen), association time, earnings and the removal of his in-cell television for a set period.

52. Afterwards, CM E chaired an ACCT review. CM E and Officer F attended. No one from the healthcare team attended. The panel noted that the operations manager had suspended Mr Kuc's disciplinary sanctions so that he could have a fresh start without loss of privileges on Residential Unit 1, where he would be relocated to later that day. Mr Kuc said that he was happy with this and had no thoughts of self-harm. The panel noted that Mr Kuc's risk level was raised and they reduced his observation level to hourly (at irregular intervals). They noted that the Inclusion Team would be invited to attend his next ACCT review on 20 March. Later that day, staff relocated Mr Kuc to Residential Unit 1.

53. On 19 March, staff said they observed Mr Kuc laughing and joking with other prisoners. Staff had scheduled an appointment for Mr Kuc with the Inclusion Team that day but he did not attend despite reminders. Nurse D rescheduled his appointment for 22 March.

54. SO E and Officer G completed Mr Kuc's ninth ACCT review on 20 March in his new unit. Mr Kuc said that he struggled to ask for help. No one from the healthcare team or the Inclusion Team attended. The panel encouraged him to speak to staff if he felt that he was struggling to cope and said that he should try to come out of his cell more frequently to collect his meals and use the shower. They lowered Mr Kuc's risk level to low, and noted that staff should observe him five times during the day and hourly at night.

55. That evening, Officer H recorded that Mr Kuc had refused to collect his evening meal and had said that he was not hungry. The officer brought Mr Kuc's meal to his cell and tried to persuade him to eat something. Initially, Mr Kuc refused but then agreed to try. The officer noted that Mr Kuc appeared okay.

56. On 21 March, Mr Kuc refused to take part in the morning exercise period. He later refused to collect his lunch. Officer H offered to collect it for him but he refused to eat. Staff recorded that Mr Kuc left his cell that evening at around 5.00pm and collected his evening meal.

57. At midnight on the night of 21 to 22 March, Officer I recorded that he spoke to Mr Kuc at his cell door. He said that Mr Kuc asked when his next mental health appointment was. He said that he was struggling because he was over-thinking past issues. The officer discussed distraction techniques with Mr Kuc.

58. At 9.56am on 22 March, staff escorted Mr Kuc to the healthcare unit. Nurse D and Nurse F reviewed Mr Kuc and recorded that he engaged well. Mr Kuc said that he had struggled with his emotions over the weekend and although he had asked staff to see a Listener (a prisoner trained by the Samaritans to offer support to other prisoners), he said he was told to "get over it". (There is no record of this request.) Mr Kuc said that this was the trigger for his outburst (dirty protest) on 17 March. He said that he was not coming out of his cell to mix with the other prisoners or to collect meals but he was drinking fluids. Officers brought his meals to his cell occasionally but he did not have a shower.

59. Nurse D spoke to a member of staff in the prison kitchen and arranged to provide Mr Kuc with a cold food option. Mr Kuc was happy with this. He said that he felt safer locked in his cell and believed other prisoners would call him a "wimp". He said he was not sleeping well and that his mood was low. Mr Kuc admitted that he had fleeting thoughts of self-harm but said he had used distraction techniques which had worked. He had, however, picked at his old self-harm scars. The nurses assessed that Mr Kuc had moderate depression and made an appointment for him to see the prison GP on 26 March.

60. Afterwards, Nurse D gave Mr Kuc some more distraction materials (crosswords and books). She visited Residential Unit 1 and spoke to the supervising officer who said that Mr Kuc was collecting his meals, but inconsistently.

61. On Friday 23 March, Mr Kuc left his left his cell, had a shower and participated in the morning exercise period. Nurse D passed Mr Kuc on the landing on his way to post some letters he had written. Staff later recorded that Mr Kuc collected his lunch. Officer J told the investigator that he had noticed that Mr Kuc was not coming out of his cell much and asked a member of the chaplaincy team to speak to him and offer support.

62. That afternoon, a second member of the chaplaincy team, spoke briefly to Mr Kuc in the unit. Mr Kuc told her that he was not feeling good. The second member of the chaplaincy team made an appointment to return to the unit later that day to speak to him again. Mr Kuc collected his evening meal at around 5.00pm and, when asked, told staff he was okay.

63. The second member of the chaplaincy team returned to the unit at around 6.45pm. She spoke to Mr Kuc for about an hour, and offered support and encouragement. She did not record any concerns about Mr Kuc.

64. At 1.38am on Saturday 24 March, Officer K recorded that Mr Kuc asked to use the Samaritans phone. The officer contacted CM B, the officer in charge, who gave Mr Kuc a phone to use.

65. Later that day, staff noted that Mr Kuc collected his lunch and evening meal. Prisoner A, a prisoner who lived on Residential Unit 1, told the investigator that he spoke to Mr Kuc occasionally. He said that Mr Kuc had told him that afternoon that he had tried to kill himself. He said that he tried to persuade Mr Kuc that he needed support and should see a member of the healthcare team.

Events of Sunday 25 March

66. Officer I checked on Mr Kuc at 4.00am and 5.00am under ACCT procedures, and noticed that he was awake and looking out of his cell window. The officer told the investigator that Mr Kuc was often awake during the night so this was not unusual. He said that Mr Kuc said he was okay but could not sleep.

67. At 6.10am, Officer I saw Mr Kuc standing at the end of his table with his back towards the cell door. He thought that Mr Kuc had something tied around his neck, although he said that it was difficult to see what it was because of Mr Kuc's long hair. He said that Mr Kuc refused to turn around and face him although, when asked, he said that he was okay. The officer contacted CM B and raised his concerns.

68. CM B arrived on Residential Unit 1 with Officer L and SO F, and spoke to Mr Kuc in his cell. He said that the television was on and Mr Kuc was sitting on his bed. Mr Kuc did not have anything round his neck. The CM asked Mr Kuc why he had placed something around his neck. Mr Kuc denied that he had done so. The officer asked to see Mr Kuc's neck which was mostly covered by his long hair. The CM noticed a faint, red mark on Mr Kuc's neck which looked like he had strangled himself. Mr Kuc would not show staff his neck but they saw the red marks. Mr Kuc said that they had occurred the previous day.

69. The staff asked Mr Kuc what he had put around his neck as there was no sign of a ligature in his cell. Mr Kuc did not respond. When asked if he had tried to strangle and cut himself the day before, Mr Kuc responded, "If you're not a self-harmer, you wouldn't understand." He added that when he self-harmed, it calmed his mood. He would not say if he had any problems with other prisoners or issues on the unit and he appeared not to be listening to staff at times. CM B reminded Mr Kuc that he should tell staff if he felt low and was struggling. Mr Kuc repeatedly said that he had not done anything.

70. CM B completed an ACCT review for Mr Kuc. He noted that the current observation levels were appropriate and he would ask the healthcare team to review Mr Kuc in the morning. The CM told the investigator that he asked Officer I to complete a form for the healthcare team, which recorded Mr Kuc's injuries. (The investigator found no evidence that this document was completed.)

71. At around 8.00am, prisoner A spoke to Mr Kuc during the morning association period as he saw him sitting alone. Mr Kuc said that he was okay. The prisoner said that he told Mr Kuc not to do "anything silly again". Mr Kuc said that he would not but that when he did, he would succeed. Staff locked prisoners in their

cells at around 8.45am for around 45 minutes before they were again unlocked for association.

72. At 9.30am, Officer H and Officer J spoke to Mr Kuc at his cell door. They noticed bruises on his neck. During their conversation, Mr Kuc said that he felt let down because no one had responded to the letters that he had sent out. Officer H tried to persuade Mr Kuc to speak to a member of the healthcare team (as he knew that the Inclusion Team were not on duty at the weekend). Mr Kuc repeatedly refused.

73. At around 9.45am, prisoner A visited Mr Kuc in his cell to check on his wellbeing. Mr Kuc again said that he was okay.

74. At around 10.00am, Officer H spoke to Mr Kuc about the bruises on his neck. Mr Kuc admitted that he had previously tried to kill himself. He implied that he was more susceptible to self-harm at night and spoke about the lack of contact he had had with his parents, who had not responded to recent letters he had sent them. The officer offered to facilitate a phone call to Mr Kuc's mother, with whom he said he had a strong relationship. Mr Kuc said that he did not have a contact phone number for her. Mr Kuc refused to see a nurse and said that he did not want to talk to anyone. The Officer phoned the healthcare team and asked for a nurse to visit Mr Kuc. He said he was told (although we do not know who told him) that the nurses were busy but would visit the unit that afternoon.

75. The association period ended at 10.30am and staff locked prisoners in their cells. As a cleaner, prisoner A remained out of his cell. At around 10.55am, while cleaning, he looked through Mr Kuc's cell door observation panel. He saw Mr Kuc sitting on a chair at his table, watching television. He had a short conversation with Mr Kuc, who again said that he was okay.

76. Officer H told the investigator that CM F accompanied him to speak to Mr Kuc at around 11.30am because he was concerned about the bruises he had seen around Mr Kuc's neck. Mr Kuc was not as forthcoming as he had been with Officer H previously. Officer H and CM F discussed Mr Kuc. They concluded that as his risk had already been assessed that morning because of the bruises to his neck, there was no need to make any further changes to his observations.

77. Officer M unlocked Mr Kuc for lunch at 11.45am. Mr Kuc said that he was not hungry and did not intend to leave his cell. The officer offered to collect Mr Kuc's lunch for him but he repeated that he was okay. Shortly before the lunch period ended at around 12.15pm, Officer N recorded that he brought Mr Kuc's lunch to his cell. He said that they had a short conversation and Mr Kuc appeared to be okay. All prisoners were locked in their cells after this.

78. At 1.45pm, staff unlocked prisoner A to continue his cleaning duties. He started mopping the floors and when he arrived at Mr Kuc's cell, he again looked through the observation panel. As the cell was dark and the television was off, he assumed that Mr Kuc was asleep, although he did not see him. Prisoner A continued his cleaning duties and checked Mr Kuc's cell again a few minutes later and saw that nothing had changed.

79. At 3.20pm, Officer O and Officer J started the fabric checks (a safety check of the cells' fabric and furniture) in the unit. When the officer arrived at Mr Kuc's cell, she looked through the observation panel but did not see Mr Kuc on his bed. She unlocked the door and went into the cell. Mr Kuc was slumped to the side of the table, with a ligature made from bed sheets tied around his neck and attached to a screw in the wall.

Emergency response

80. Officer O shouted to Officer J (who was outside of the cell) for help and radioed a medical emergency code blue (indicating that a prisoner is unconscious or having problems breathing) at 3.26pm. Officer J joined Officer O in the cell. Officer O cut the ligature while Officer J supported Mr Kuc, lowered him to the floor and removed the ligature from around his neck. Officer M arrived and assessed Mr Kuc but found no signs of life. He started cardiopulmonary resuscitation (CPR) by doing chest compressions, assisted by the Head of Violence Reduction, who arrived at the cell within 30 seconds. The Head of Violence Reduction said that Mr Kuc was blue around the lips and very grey in colour.

81. Nurse G arrived at 3.28pm, and staff took it in turns to perform CPR under his direction. The nurse attached the defibrillator (a device that monitors the heart's rhythm and administers an electric shock if required) to Mr Kuc. Nurse H arrived within two minutes, with healthcare staff and further emergency equipment. The defibrillator instructed staff to continue CPR and the nursing staff applied oxygen. Mr Kuc showed no signs of life and there was a prominent red mark on his neck.

82. Paramedics arrived at the cell at 3.40pm, followed by a second ambulance crew around eight minutes later. The paramedics took over Mr Kuc's care but pronounced him dead at 4.02pm.

Family liaison

83. SO B was appointed as the prison's family liaison officer. Mr Kuc's mother was identified as his next of kin but Brinsford had no contact details for her. The police tried unsuccessfully to find her contact details. The SO left a telephone message for Mr Kuc's step-father. He later responded and provided contact details for Mr Kuc's mother.

84. SO B visited Mr Kuc's mother, with the police, at 9.58pm to break the news and offer support. Brinsford contributed to the cost of Mr Kuc's funeral in line with national instructions.

Support for prisoners and staff

85. On the same day, the Head of Violence Reduction debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Kuc'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 Kuc's death.

Post-mortem report and toxicology results

86. The post-mortem examination established that Mr Kuc died of cerebral anoxia (a reduced supply of oxygen) as a result of hanging. Toxicology test results were clear of substances, including PS.

Findings

Management of risk of suicide and self-harm

87. Prison Service Instruction (PSI) 64/2011 (Safer Custody) and PSI 07/2015 (Early Days in Custody) list a number of risk factors and potential triggers for suicide and self-harm. Mr Kuc had a number of these risks when he arrived at Brinsford. It was his first time in custody and he had a history of self-harm, mental health issues, overdose and illicit substance misuse.

88. Mr Kuc had been identified as at risk of suicide and self-harm while in police custody. The suicide and self-harm warning form and the person escort record that accompanied him to Brinsford identified that he had recently taken an overdose and self-harmed.

89. Officer B completed Mr Kuc's first night reception screening interview and recorded that he had self-harmed and tried to kill himself six months earlier. Nurse A and Nurse B, who respectively completed Mr Kuc's first and second health screenings, noted that he had self-harmed in the last 12 months. Neither referred to him arriving with a suicide and self-harm warning form or that he had self-harmed recently (as noted in his PER and suicide and self-harm warning form).

90. We are concerned that staff did not find out more information about Mr Kuc's recent self-harm and did not use the available information about his risk as a tool to assess him. This led to a poor quality early assessment of Mr Kuc's risk of suicide and self-harm.

ACCT reviews

91. Staff appropriately started ACCT procedures from 18 February when Mr Kuc self-harmed by pouring boiling water on his hand, and he was then managed on ACCT until his death.

92. However, a number of different prison staff were involved in the ACCT reviews, meaning that there was little continuity, and the majority of the reviews were not multidisciplinary.

93. PSI 64/2011 requires a multidisciplinary approach for ACCT case reviews and, where possible, the ACCT assessor and staff from the healthcare team, including the mental health team (the Inclusion Team at Brinsford) should attend the first ACCT review. Mr Kuc's first ACCT review met these requirements, and included a member of the Inclusion team who referred him for a further mental health assessment.

94. Staff completed nine more ACCT reviews before Mr Kuc's death but no one from the Inclusion Team attended any, despite him being under their care. The second ACCT review (on 26 February) noted that a member of the Inclusion Team had contributed by phone but this was not recorded in Mr Kuc's medical records.

95. As a result, there was poor communication between wing staff and healthcare staff and important information was not fully shared. For example, Mr Kuc had

disclosed his low mood and his struggles to cope with his emotions to Nurse D on 16 and 22 March and this should have been taken fully into account in his ACCT reviews.

96. This lack of mental health input into Mr Kuc's ACCT case reviews was a missed opportunity to identify and address his needs using a multidisciplinary approach and we are concerned that ACCT procedures were not correctly operated.

97. In addition, when Mr Kuc told wing staff that he had tried to kill himself in the early hours of the morning on 25 March, there is no evidence that this information was shared with healthcare staff. The nurse in charge said that he had not been told that prison staff had raised concerns about Mr Kuc or that Mr Kuc had asked for a nurse to visit him. There is no evidence that the healthcare team had received this request.

ACCT observations

98. At the time of his death, Mr Kuc was subject to hourly observations at night and five observations during the day. We are concerned that these levels of observations did not adequately reflect the risk Mr Kuc presented on the day of his death.

99. When staff reviewed Mr Kuc's risk at 6.10am on 25 March, we consider they should have identified his increased risk after concerns were raised that he may have tied something around his neck. We are concerned that they simply maintained his observation levels. Later that morning, Mr Kuc told staff that he had previously tried to kill himself and still had thoughts of suicide. Staff immediately offered to take him to see the healthcare team but he refused. This was another missed opportunity for staff to identify and address his increased risk.

100. This incident should have prompted staff to review Mr Kuc's risk of suicide and self-harm. Mr Kuc had a number of risk factors. He was 19 years old; this was his first time in custody; he had a history of self-harm; he was concerned about lack of contact with his mother; in just over five weeks in custody, he had made cuts to his wrists in police custody, poured boiling water on his hand, cut himself more than once, engaged in a dirty protest and put something round his neck which had resulted in red marks and bruising; he was self-isolating and missing meals; and he repeatedly referred to thoughts of self-harm and told staff that he found it difficult to cope with his emotions when he was alone in his cell. In our view staff placed too much reliance on his presentation and should have taken Mr Kuc's risk factors into consideration when assessing his risk.

101. We consider that they should have assessed him as being at increased risk after they suspected he had put a ligature round his neck on the morning of his death and should have increased the frequency of his ACCT observations or identified other possible interventions. As Mr Kuc's observation levels remained unchanged, he went unchecked for over three hours before he was found hanged in his cell. We cannot know whether this might have changed the outcome for Mr Kuc.

Caremaps

102. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment interview. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time bound and say who is responsible for completing the action.

103. Staff failed to update Mr Kuc's caremap, including to say that the Inclusion Team were supporting Mr Kuc. Nothing was recorded in the caremap until 17 March, when it was noted that advice about Mr Kuc's mental health should be sought from the Inclusion Team. The Inclusion Team did not provide any input and were not invited to the majority of Mr Kuc's ACCT reviews.

104. One of Mr Kuc's key concerns was the amount of time he was spending alone in his cell. Although this was recognised as a concern, staff failed to set and record clear and effective caremap actions aimed at addressing this. While they apparently made some efforts to find Mr Kuc employment and education opportunities, they kept no record of their progress. In addition, Mr Kuc repeatedly spoke about his distress at having no contact with his mother. Contact with his mother was appropriately included as one of Mr Kuc's caremap actions, but staff did not obtain contact details for her until after Mr Kuc's death (when they asked his step-father for the information). We make the following recommendation:

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

- **Staff have a clear understanding of their responsibilities and the need to record relevant information about risk.**
- **Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.**
- **Prison and healthcare and/or Inclusion staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review.**
- **Staff hold multidisciplinary ACCT reviews, with the same case manager and which involve staff who contribute to a prisoner's care.**
- **Case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.**

Clinical care

105. The clinical reviewer noted that the clinical care that Mr Kuc received at Brinsford was equivalent to that which he could have expected to receive in the community.

106. Although the healthcare team did not attend the majority of Mr Kuc's ACCT reviews, Inclusion Team staff assessed Mr Kuc on four separate occasions at

Brinsford and concluded that he did not have any significant mental health problems. Although Mr Kuc had a lengthy history of substance misuse in the community, there was no evidence to indicate that he had used drugs at Brinsford.

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