Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andirzej Kalicki a prisoner at HMP Elmley on 1 August 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.

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

Mr Andirzej Kalicki was found dead in his cell at HMP Elmley on 1 August 2017. He had died from a heart attack. Mr Kalicki was 56 years old. I offer my condolences to anyone affected by Mr Kalicki's death.

Mr Kalicki had a history of heart problems which were managed with medication. Soon after arriving at Elmley on 11 July, he began refusing food as a protest over an issue with his property. He accepted liquids but declined to attend the healthcare centre. Staff placed him on special monitoring measures. When his cellmate woke on the morning of 1 August, Mr Kalicki was unresponsive. Well-intentioned, albeit inappropriate, attempts to revive him were unsuccessful.

The clinical reviewer found that Mr Kalicki's clinical care was appropriate and equivalent to that which he could have expected to receive in the community. The clinical reviewer also noted that there was no indication that Mr Kalicki's food refusal played a part in his death

However, we are concerned that Elmley did not manage the food refusal in line with guidance. We are also concerned that the use of translation services was patchy and poorly delivered at the prison, although we note that a new system has been introduced since Mr Kalicki's death.

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 **February 2019**

Contents

Summary

Events

1. Mr Andirzej Kalicki was a Polish national. He had been in prison since 2015. He had heart problems for which he was receiving medication. He had self-harmed many years earlier, but had no recent mental health issues or thoughts of self-harm. On a number of occasions while in prison he complained of chest pain. He was taken to hospital, but tests showed no abnormalities. On two occasions, Mr Kalicki refused food but began eating again when he felt issues had been resolved to his satisfaction.

2. Mr Kalicki was sent to HMP Elmley in July 2017. Reception healthcare staff noted his history of heart problems, and the following day a prison doctor confirmed his prescribed medication.

3. On 24 July, Mr Kalicki told a prison officer that he had not eaten for ten days. He said he had not received all his property following his move, and was protesting about this. The prison officer began suicide and self harm monitoring procedures (known as ACCT). A nurse examined Mr Kalicki and the wing manager contacted reception to try to resolve the property issues.

4. The following morning, medical staff assessed Mr Kalicki again and a prison officer took him to the reception area to collect any remaining property. When given his property, Mr Kalicki became angry, emptying it onto the floor and refusing to take it back to his cell.

5. Staff held an ACCT assessment interview and then a review but no healthcare staff attended. Another prisoner, who spoke Polish and English, attended the review as a translator.

6. Healthcare staff continued to assess Mr Kalicki. Comments on the medical file indicate that staff sometimes felt that there were language difficulties. A doctor explained to Mr Kalicki the potential consequences of not eating, including possible effects on his heart condition. She persuaded Mr Kalicki to take a meal replacement drink, but he did not like the taste so he refused to take any more.

7. Mr Kalicki collected meals from the servery on 30 and 31 July, though it is not known whether he ate them. On 31 July, Mr Kalicki and his cellmate retired to their beds before midnight. Neither the cellmate nor the night officer on the wing noted any problems with Mr Kalicki during the night. The night officer conducted ACCT checks and did not detect any problems.

8. Mr Kalicki's cellmate awoke at around 7.20am. After about 15 minutes he became concerned about Mr Kalicki and tried to wake him. He pressed the cell bell and shouted for help. Prison officers went to the cell but were also unable to gain a response from Mr Kalicki, so called an emergency code. They began attempts to resuscitate Mr Kalicki. When healthcare staff arrived, they could see that he was dead. Nevertheless, a prison officer wished to persist, so this continued until paramedics arrived and said that Mr Kalicki had died. Post-mortem reports showed that Mr Kalicki had died of a heart attack.

Findings

Healthcare

9. Healthcare staff were aware of Mr Kalicki's heart condition and, when he complained of pain, he was appropriately treated. He had no mental health concerns while in prison. The clinical reviewer noted that Mr Kalicki's clinical care was appropriate and equivalent to that which he could have expected to receive in the community. Procedurally, the emergency response was correctly managed. However, given the presence of rigor mortis and the clear view of the attending Clinical Nurse Manager that Mr Kalicki had died, resuscitation attempts should not have continued.

Management of Mr Kalicki's food refusal

10. The clinical reviewer found that Mr Kalicki was closely monitored by healthcare staff during the periods he was refusing food. He was seen daily, and no health concerns were noted. The clinical reviewer concluded that there is no indication that Mr Kalicki's food refusal played a part in his death.

11. We do, however, have some concerns. While there were no suggestions that Mr Kalicki had any mental health issues, records do not show that his capacity to make the decision to refuse food was assessed, although a doctor did discuss with him the potential impact not eating could have on his heart condition. Mr Kalicki stressed on more than one occasion that he was refusing food as a protest, not as an attempt to harm himself, and had consciously used food refusal in the past as a means to an end. We are, however, concerned that Mr Kalicki's language difficulties could have masked a problem and that the prison did not assess Mr Kalicki's mental health more thoroughly.

12. In addition, staff did not follow the local policy for managing food refusal, and it is unclear from records when Mr Kalicki did not collect his meals. He collected them on some days, and his cellmate told police that he sometimes gave Mr Kalicki food.

Use of translation services

13. Records show that, on occasions, staff had difficulty communicating with Mr Kalicki. Despite this, there is no evidence that they used translation services. Another, bi-lingual, prisoner was used to translate in ACCT reviews.

Mr Kalicki's ACCT

14. Despite his history of using food refusal as a means to an end, staff rightly began monitoring Mr Kalicki under ACCT procedures. Interviews, assessments and checks were conducted correctly. There was, however, no healthcare representation at reviews. Nor did staff use translation services.

Recommendations

- The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with guidance and the local food and fluid refusal policy.
- The Governor and Head of Healthcare should ensure that staff use appropriate interpretation services when managing prisoners with limited English language skills.
- The Governor and Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:
    - ensuring that healthcare staff, including mental health staff if appropriate, attend case reviews; and
    - ensuring that appropriate translation services are used where necessary.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

The Investigation Process

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

16. The investigator visited Elmley and obtained copies of relevant extracts from Mr Kalicki's prison and medical records. The investigator interviewed one member of staff at Elmley. He remained in ongoing contact with the police officer in charge of the police investigation and had access to police witness statements from staff and from Mr Kalicki's cellmate. Elmley was unable to provide recordings of staff radio traffic and, due to a technical fault, was also unable to provide CCTV footage.

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

18. We informed HM Coroner for Mid-Kent and Medway of the investigation and he sent us the results of the post-mortem examination. We have given the coroner a copy of this report.

19. Neither the prison nor the police were able to trace any next of kin for Mr Kalicki.

Background Information

HM Prison Elmley

20. HMP Elmley serves the courts in Kent and holds up to 1,252 men, remanded and sentenced, in six houseblocks, with a mixture of single, double and triple cells. The healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Elmley was conducted in October and November 2015. Inspectors reported that the prison had greatly improved, with a higher degree of safety and stability. Healthcare had improved since the last inspection. Risk assessment processes on arrival were regarded as sound, and incidents of self-harm had reduced by about a third.

Independent Monitoring Board

22. 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 31 October 2017, the IMB reported that while the prison had improved, there were still problems with staffing levels. Induction arrangements were good, as were mental health services, although they worked under considerable pressure.

Previous deaths at HMP Elmley

23. Mr Kalicki was the seventh prisoner to die in Elmley in 2017. There have since been a further three. There are no significant similarities between these deaths and that of Mr Kalicki.

Assessment, Care in Custody and Teamwork (ACCT)

24. 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 multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody).*

26. PSI 64/2011 states that ACCT case reviews must be multidisciplinary where possible. It is mandatory that a member of healthcare staff attend at least the

first ACCT case review. Where there are ongoing healthcare issues we would expect consistent healthcare attendance at further reviews.

Key Events

27. Mr Andirzej Kalicki, a Polish national, had been living in the United Kingdom since 2009. In 2015, he was sentenced to 78 months imprisonment for causing grievous bodily harm. At his reception screening, Mr Kalicki said that he had had three heart attacks and had a stent fitted. He reported ischaemic heart disease, for which he took prescribed medication. He said that he had no mental health issues. The nurse identified some scarring on his arms, which Mr Kalicki said were a result of self-harm when he was a young man but that he had no recent or current thoughts of self-harm.

28. In December 2015, Mr Kalicki complained of chest pain and had to attend hospital. In January 2016, he again complained of chest pain and in March was taken to hospital after suffering further pain. Hospital tests on his heart function proved normal. In July 2016, Mr Kalicki moved to HMP The Mount. He told reception staff that he could read and write English well. The following month he complained of chest pains and was taken to hospital, but tests once again showed no abnormalities.

29. On 7 December 2016, Mr Kalicki transferred to HMP Maidstone. In January 2017, he again reported chest pain. After reporting chest pain in April, he was again taken to hospital, but further tests returned normal results.

30. On 5 May, Mr Kalicki asked to be located in a single cell. When informed he might have to wait a few days, he replied that he would refuse food until he got what he wanted. He denied any intention to harm himself or to take his own life, but staff began to monitor him under ACCT procedures. He continued to take fluids and medical staff also monitored him. He was moved to a single cell on 10 May and on 14 May began eating again. ACCT monitoring ended on 17 May.

31. On 3 June, Mr Kalicki complained of chest pain. His medical record noted that the pain was different from previous incidences of chest pain. Tests at hospital indicated no abnormal activity.

32. On 16 June, during a cell check, a prison officer told Mr Kalicki that he had to remove certain symbols he had on display in his cell, including swastikas and pictures of Hitler. When he was charged under the Prison Rules (a disciplinary measure) for failing to do so, Mr Kalicki began to refuse food in protest. Staff began ACCT procedures on 18 June. On 19 June, Mr Kalicki refused to attend the adjudication hearing and, in his absence, was given 21 days cellular confinement as punishment and recategorised as a higher security, category B prisoner. He refused to go to the segregation unit, and had to be restrained and taken there pending transfer to a category B prison.

33. While in the segregation unit, healthcare staff tried to assess him daily, although Mr Kalicki would not always cooperate, sometimes refusing his medication. Staff offered him the use of the interpretation service Language Line during ACCT reviews but Mr Kalicki declined, saying he was able to understand. ACCT monitoring was ended on 26 June.

34. On 11 July, Mr Kalicki was transferred to HMP Elmley. A nurse carried out a reception health screening. She noted that he had heart disease and was

prescribed related medication. The medical record notes show that Mr Kalicki had a poor grasp of English and the nurse used Google Translate to help during the consultation.

35. Prisoners arriving in Elmley from segregation units are initially housed in Elmley's segregation unit (known as the care and separation unit) for a period of 24 hours. On 12 July, a prison GP went to see Mr Kalicki there. He noted that Mr Kalicki had not had his medication that day or the previous day, so the GP represcribed them. Mr Kalicki then moved to Houseblock One, the induction wing. After a secondary health screening on 14 July, Mr Kalicki moved to Houseblock Two.

36. On 24 July, Mr Kalicki said that he had not been eating for about ten days. He was upset that he had not been allowed to take all his property with him from reception. An officer began ACCT procedures. Mr Kalicki said that he would refuse to eat until he was able to collect all his property. That evening a supervising officer contacted reception. They told him that Mr Kalicki had had all property he was entitled to, and there was nothing left to arrive from Maidstone.

37. A nurse assessed Mr Kalicki and took medical observations. Mr Kalicki said he would not eat until he had retrieved all his property from reception. A supervising officer told Mr Kalicki that he would be taken to reception to collect any remaining property in the morning. The nurse noted that Mr Kalicki was content with this plan.

38. On the morning of 25 July, Mr Kalicki attended the healthcare centre for further assessment. Results were all within clinically acceptable levels. An officer then took Mr Kalicki to the reception area to collect any remaining property he was allowed to have. Mr Kalicki emptied his bags onto the floor and pushed and kicked the contents around, refusing to pick them up. He was eventually persuaded to pick them up but he refused to take them back to the wing.

39. At 11.35am, an officer conducted an ACCT assessment interview. Mr Kalicki said that he had not eaten for two days and would not do so until he had a positive outcome with his property, describing his altercation with reception staff earlier that morning. Mr Kalicki said that he did not wish to die; he was making a protest. The note of the interview said that due to language difficulties, the officer was unable to ascertain exactly what support network was available to Mr Kalicki.

40. Another officer then chaired an ACCT case review. A prison chaplain attended, along with Mr A, a Polish-speaking prisoner who acted as translator. The note of the review said that the underlying issue was solely about property and that Mr Kalicki had no intention of harming himself. The note said that the wing manager would contact reception in order to resolve the issue. Mr Kalicki was judged to be a low risk of harming himself. Staff were to have a conversation with him at least once in the morning, afternoon and evening, and to check on him at least three times during the night.

41. Healthcare staff assessed Mr Kalicki. A nurse noted on his medical record that Mr Kalicki had not been able to read the advice sheet they had offered him as he had not brought his glasses. He said that healthcare staff would see Mr Kalicki again later that day, and would try to get an interpreter. Later that afternoon a prison GP saw Mr Kalicki. He assessed him physically, but noted on the medical

record that he could not speak English and staff should try using online translation.

42. A prison GP saw Mr Kalicki on 27 July. She noted that he had not been communicating much with staff, which could have been due to language barriers, although Mr Kalicki was sometimes able to answer simple questions. The GP tried to encourage Mr Kalicki to drink, and he accepted a glass of warm milk. She did not think he needed to be admitted to the healthcare unit but healthcare staff needed to keep him under observation. Mr Kalicki agreed to take meal replacement drinks, so the doctor arranged for some to be provided.

43. A prison GP saw Mr Kalicki again the following day. He told her that the meal replacement drinks were too sweet and made him feel hungry, so he would not take them any more. His blood tests were all within acceptable levels. The GP noted on the medical record that Mr Kalicki told her what property was missing, including food, clothing and tobacco. He said he had no intention of ending his life, and that he felt well. The GP discussed with him the possible impact of not eating, and said that his heart condition might well deteriorate. He signed a disclaimer refusing medical treatment, and declining admission to the healthcare centre.

44. That day, 28 July, Mr Kalicki moved to a shared cell with Mr A.

45. On 29 July, a supervising officer chaired an ACCT case review. Mr A again attended to act as translator, along with an officer. Mr Kalicki reiterated that he would continue to protest by not eating until his property issues were satisfactorily resolved.

46. Mr Kalicki did collect a meal from the servery on the evening of 30 July. He did so again in the afternoon and evening of 31 July. Mr A told the police that he gave Mr Kalicki an apple, which he ate, but did not see him eat anything else that day.

47. On 31 July, prisoners were locked into their cells at 6.20pm. The night officer on the wing carried out an ACCT check at 8.30pm, noting that Mr Kalicki appeared well and was talking with his cellmate. His cellmate told the police that they watched television until some time before midnight, when they switched off the television and went to sleep. This was their normal practice. He said that Mr Kalicki did not eat or drink anything that evening before they went to their beds. Mr Kalicki's cellmate said that he did not hear Mr Kalicki leave his bed after this.

48. The night officer performed further ACCT checks at 1.15am and 3.05am, and noted on the ACCT document that Mr Kalicki was asleep and that she noted movement and had no concerns. She made a further check at 6.00am, noting he remained asleep, although she did not make a note of having seen any movement.

49. Mr Kalicki's cellmate woke at approximately 7.20am, used the toilet and washed. Mr Kalicki was lying on his bed, his blanket pulled up to his chest. After about 15 minutes, Mr Kalicki's cellmate became concerned and checked on him. He was not breathing. His cellmate touched him and called his name, but got no reaction.

He pressed the cell bell and began to shout and bang on the cell door. Records show that the cell bell was pressed at 8.00am.

50. Prison officers responded and Officer A arrived at the cell at 8.03am. He opened the observation panel, and Mr Kalicki's cellmate told him he could not rouse Mr Kalicki. Officer A called for assistance and as Officer B and Officer C joined him, he opened the cell and went in. Officer B checked Mr Kalicki's breathing and when he was unable to detect any, told Officer C to call a code blue emergency (indicating a prisoner is unconscious or having difficulty breathing). The emergency was called at 8.04am, prompting the control room to request an emergency ambulance automatically. The officers moved Mr Kalicki onto the floor. Officer B noted that his body was rigid. He began to perform cardiopulmonary resuscitation. Officer D attached a defibrillator (a machine used to try to restart the heart) to Mr Kalicki's chest.

51. Medical staff responded to the code blue emergency call. They arrived and assessed Mr Kalicki, who was cold to the touch. Rigor mortis was present and they were unable to open his mouth. The clinical nurse manager realised that Mr Kalicki was dead and told the officer giving compressions to stop which he did and left the cell. Officer E disagreed with the decision and said they needed to carry on until death was verified. The ambulance crew arrived and assessed Mr Kalicki. At 8.37am he was pronounced dead and a prison GP certified death at 9.10am.

Contact with Mr Kalicki's family.

52. A prison chaplain was appointed as family liaison officer. Mr Kalicki had not disclosed any next of kin. His cellmate told the chaplain that Mr Kalicki had told him that his ex-wife and mother had died, and that he had been estranged for years from any remaining family in Poland. His property contained no letters to, or from, him. The chaplain asked the police for assistance in tracing any of Mr Kalicki's family, but the police were unable to locate anybody.

Support for prisoners and staff

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

54. The prison posted notices informing other prisoners of Mr Kalicki's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Kalicki's death.

Post-mortem report

55. The post-mortem report showed that Mr Kalicki died from a heart attack, contributed to by ischaemic heart disease.

Findings

Healthcare

56. Prison healthcare staff were aware of Mr Kalicki's heart disease throughout his prison sentence. When he complained of chest pain, he was taken to hospital for appropriate tests, and his medication was adjusted when thought necessary. He did not complain of any chest pain in the weeks leading up to his death. There had not been any mental health concerns during his time in prison.

57. The clinical reviewer considered that Mr Kalicki's clinical care was appropriate and at least equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that when Mr Kalicki refused food as a protest, he was closely monitored. Blood tests showed no abnormal results, and no health issues were recorded in the days leading up to his death. His cellmate told police that when Mr Kalicki was not eating, he kept asking him whether he felt okay. Mr Kalicki never complained and said he was fine. It is not recorded anywhere that Mr Kalicki complained to anyone of feeling unwell. The clinical reviewer noted that there was no evidence to suggest that Mr Kalicki's food refusal contributed to his death.

Management of Mr Kalicki's food refusal

58. Guidance to staff on prisoners who refuse food is contained in PSI 64/2011, which says:

"Some prisoners may decide to refuse food and/or fluids, or medical treatment for a variety of reasons. These decisions will be valid provided that the prisoner is deemed to have the mental capacity to make the decision. Mental capacity can only be assessed by a healthcare professional."

59. Further guidance is contained in the 2010 Department of Health document "Guidelines for the clinical management of people refusing food in immigration removal centre and prison", which state:

"A thorough assessment of nutritional status should be undertaken at the outset of the fast, including establishing levels of recent food intake and usual body weight and performing a specific nutritional examination. Regular reassessments of a food-refusing individual's physical and mental state should be undertaken within limits dictated by the individual's compliance. Soon after an individual is identified as embarking on a period of refusing food, a case conference should be considered to explore further any ameliorating factors and assist care planning. ….Full documentation of the individual's wishes is essential to demonstrate that the individual is not only refusing all forms of feeding but understands the likely consequences of doing so."

60. The clinical reviewer noted that once it was known that Mr Kalicki was refusing food, he was closely monitored. During Mr Kalicki's regular contacts with healthcare staff, there were no concerns that he did not have capacity to make the decision to refuse food, and he made it clear that it was a protest rather than an attempt to harm himself. Records do not, however, indicate that a full mental capacity assessment was made, which would have been in line with guidance.

61. It is unclear exactly when Mr Kalicki started to refuse food. He also continued to collect his food sporadically, although records do not show whether he ate what he collected. His cellmate told police that he would give Mr Kalicki food from his own plate, which he did eat. A note on Mr Kalicki's electronic prison record of 25 July states that he had been ordering items on his canteen (the system used by prisoners to order items of personal shopping, including food) for sustenance. However, this does not record when, what or whether it was known that he ate them. Financial records show that the last time Mr Kalicki ordered from the canteen was on 20 July, and that was only tobacco.

62. Elmley's food refusal policy at the time stated that when a prisoner refused food, he should present himself at the servery and say that he was refusing food. Staff would then keep a record of this in a food refusal log. Mr Kalicki did not attend the servery, so his food refusal was not documented in the food refusal log. Staff used the ongoing record of his ACCT document as a log of his food refusal, but this does not contain comprehensive notes, only a partial record.

63. It is not clear from the records that Mr Kalicki's food refusal was coherently managed throughout. There is little evidence he suffered any physical detriment, and the extent of his food refusal is uncertain. Records show that Mr Kalicki had previously used food refusal as a bargaining tool to get what he wanted. The clinical reviewer noted that there is no indication that his food refusal played a part in his death. Nonetheless, his food refusal was not managed in line with the local policy that was in place at the time. Elmley's food and fluid refusal policy has been revised and reissued since Mr Kalicki's death. Nevertheless, we make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with guidance and the local food and fluid refusal policy.

Use of translation services

64. Mr Kalicki had lived in the United Kingdom for some years. In his prison record before arriving at Elmley, there were no indications that he had trouble understanding English. At Maidstone, immediately before transferring to Elmley, Mr Kalicki declined the offer of a translator during an ACCT review, saying that he could understand.

65. On arrival at Elmley, however, the nurse who conducted Mr Kalicki's reception health screening noted that his grasp of English was poor, and she used an internet translation tool to assist the consultation. Several notes on his medical file indicated communication difficulties.

66. The officer who undertook the ACCT assessment interview recorded in the notes that they were unable to ascertain what kind of support network Mr Kalicki had because of language difficulties. Staff held two ACCT reviews with Mr Kalicki and on both occasions Mr A attended the reviews as a translator.

67. A new translation service called the Big Word was introduced at Elmley in the last week of July. Before this the prison had been using the Language Line telephone translation service on a non-contractual basis which meant that,

effectively, there was no official translation service in the prison. Staff were, however, able to use Language Line on a case by case basis and instructions on how to use the service were on display in the reception area. Healthcare staff had the equipment to use Language Line in their reception consultation room if they felt it necessary.

68. The various references to communications difficulties suggest that staff did not feel they had ready access to a suitable translation service. The investigator asked Elmley to provide statistics for how often the prison had used Language Line in the months up to Mr Kalicki's death. It has not been able to locate any invoices for translation services.

69. We are not confident that Mr Kalicki understood English well enough to communicate clearly. Using another prisoner as a translator in everyday situations may be reasonable but it is not appropriate in ACCT reviews, which may contain sensitive and personal information, and could discourage the subject from being candid. A number of healthcare staff mentioned communications difficulties, and in circumstances where a prisoner is refusing food, a lack of effective communication is worrying.

70. The new contract for translation services has now been in place for some months. However, Elmley were unable to supply statistics for how frequently the service has been used. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that staff use appropriate interpretation services when managing prisoners with limited English language skills

Managing Mr Kalicki's risk of suicide and self harm

71. Mr Kalicki's history suggested that he used food refusal as a way of trying to manipulate circumstances when he felt that he had a grievance. Nevertheless, when it became apparent that Mr Kalicki was refusing food, staff appropriately began monitoring him under ACCT procedures.

72. Guidance on ACCT reviews is contained in PSI 64/2011. This sets out the processes all staff should follow when a prisoner poses a risk to himself, and the processes that should be followed when an ACCT is opened. This includes that an ACCT assessment must take place within 24 hours; that healthcare staff must attend the first ACCT case review and subsequent reviews should be multidisciplinary where possible; and that the case manager must complete a caremap with actions aimed at reducing the risk of suicide and self-harm.

73. Mr Kalicki's assessment interview was held within the correct timescale. The note of the interview, however, said that because of language difficulties the interviewer was unable to ascertain what support Mr Kalicki had. Mr Kalicki had made it clear in the interview that he had no wish to die, only to protest, but it is still unfortunate that the there were communication difficulties. Neither of the ACCT case reviews included any healthcare staff, which is concerning, given his food refusal, and, as noted above, staff inappropriately used another prisoner as a translator at both reviews. A prison manager recorded on the ACCT document on 30 July that staff should seek a suitable interpreter for the next review. The

lack of healthcare staff in reviews, along with the language difficulties, means that we cannot be sure that Mr Kalicki's mental health was fully assessed. We make the following recommendation:

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

- **ensuring that healthcare staff, including mental health staff if appropriate, attend case reviews, and**
- **ensuring that appropriate translation services are used where necessary.**

Resuscitation attempts

74. Prison officers started cardiopulmonary resuscitation (CPR). When nursing staff arrived, they noted evidence of rigor mortis and said that attempts to resuscitate Mr Kalicki should stop. A prison officer disagreed, and resuscitation attempts continued until paramedics arrived.

75. Guidance to support the decision making process on when not to perform CPR in prison was issued in September 2016. It states: "Resuscitation must be started on all patients who are found not breathing and/or pulseless UNLESS certain conditions exist … In the prison and IRC estate the primary judgment to be made is whether rigor mortis is present. The answer to this will inform the decision about commencing CPR … The ERC guidelines state that in such cases, a non-clinician might be making a diagnosis of death but is not verifying or certifying death. CPR that has no chance of success in terms of survival is pointless and may violate the right for dignity in death."

76. While we appreciate that staff want to make every effort to preserve life, trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. When a clinical nurse manager said that Mr Kalicki was dead and attempts to revive him would be futile, her decision should have been accepted. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

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