Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tomasz Nowosad a prisoner at HMP Manchester on 2 February 2017

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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 Tomasz Nowosad was found hanged in his cell at HMP Manchester on 2 February 2017. He was 27 years old. I offer my condolences to Mr Nowosad's family and friends.

Mr Nowosad, a Polish national with limited English, was managed under suicide and self-harm prevention measures (known as ACCT). However, I am concerned that staff did not consistently use interpretation services to communicate with Mr Nowosad during the ACCT process.

Mr Nowosad took his life the day after he was discharged from the healthcare centre. I am concerned that no staff from the wing to which he was transferred attended the case review held shortly before his discharge. While most of Mr Nowosad's healthcare was satisfactory, I agree with the clinical reviewer that it might have been prudent to keep Mr Nowosad in the healthcare centre until his fears had receded, given he had expressed concerns that moving from the healthcare centre would cause his paranoid thoughts to return.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. On 26 September 2016, Mr Tomasz Nowosad was remanded to HMP Manchester, charged with a violent offence. Mr Nowosad was Polish and spoke limited English. His younger brother was remanded to Manchester on the same day.

2. On arrival at Manchester, Mr Nowosad told a healthcare assistant that he had been diagnosed with paranoid schizophrenia. A consultant psychiatrist prescribed olanzapine (an antipsychotic) and a nurse created a schizophrenia care plan to monitor his mental state and his compliance with his medication. The care plan stated that all examinations required an interpreter.

3. On 9 January 2017, a nurse saw Mr Nowosad for a mental health assessment. He said he had paranoid thoughts and auditory hallucinations about other people wanting to hurt him, so the nurse started Prison Service suicide and self-harm monitoring (known as ACCT). That day, staff moved Mr Nowosad to a safer cell in the healthcare centre.

4. Between 9 January and 30 January, staff held five ACCT reviews and judged that Mr Nowosad's risk of suicide and self-harm had decreased to low. For three of the ACCT reviews there was no evidence that staff used or considered using a telephone interpretation service or a member of staff as an interpreter.

5. On 30 January, a consultant forensic psychiatrist reviewed Mr Nowosad, who said he felt safe on the healthcare centre and was frightened that if he went back to a normal location he might hurt himself or someone else. The psychiatrist considered that Mr Nowosad had improved and that he should not stay on the healthcare centre.

6. At around 3.45pm on 1 February, staff held a sixth ACCT review prior to discharging Mr Nowosad from the healthcare centre. Using a Polish healthcare assistant as an interpreter, a senior officer explained to Mr Nowosad that he would have a 72 hour assessment to determine whether he could be considered a vulnerable prisoner. Mr Nowosad said that he was happy with this and that he had no current thoughts of suicide or self-harm. Less than an hour later, Mr Nowosad moved from the healthcare centre to a cell on the induction wing. No one from the induction wing was present at the ACCT review.

7. During 2 February, two members of staff spoke to Mr Nowosad, who said that he was okay. Mr Nowosad reiterated to one of the officers that he wanted to move to the Vulnerable Prisoners' Unit and the officer said he would talk to the wing manager about this.

8. At around 7.20pm on 2 February, officers went to Mr Nowosad's cell to collect a spare mattress from his cell. Upon entering, an officer saw Mr Nowosad hanging from a ligature attached to the cell window. Officers cut the ligature and called a medical emergency priority one (indicating a prisoner is unconscious, not breathing or having difficulty breathing). A control room operator immediately called an ambulance. Other officers and nurses attended Mr Nowosad's cell and

started cardiopulmonary resuscitation. Paramedics arrived at 7.44pm but they were unable to resuscitate Mr Nowosad and a prison GP confirmed his death at 8.14pm.

Findings

9. Although staff appropriately identified Mr Nowosad's risk of suicide and self-harm and started ACCT procedures, we are concerned about the ACCT management. Staff did not always use interpretation services, no one considered inviting Mr Nowosad's family to ACCT reviews (not least given that his brother was also at HMP Manchester) and no one from the induction wing attended the ACCT review prior to Mr Nowosad's discharge from the healthcare centre. We consider that these actions meant that staff could not fully understand the risks with which Mr Nowosad presented.

10. We agree with the clinical reviewer that the majority of care that Mr Nowosad received was largely equivalent to and, in respect of his mental health care, better than he would have received in the community. However, we are concerned that not all healthcare staff used interpretation services during their reviews and that the consultant forensic psychiatrist decided to move Mr Nowosad from the healthcare centre to a standard wing, despite having expressed concern that his suicidal thoughts would return or he would hurt someone if he was moved.

11. We are also concerned about the liaison with Mr Nowosad's family following his death. The prison had not recorded the name and contact details for Mr Nowosad's next of kin, was slow to contact his family and delayed formally appointing a family liaison officer.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:
  - Staff use interpretation services when managing foreign national prisoners with limited English.
  - The residential manager is invited to and attends an ACCT review when a prisoner moves from the healthcare centre to a residential wing.
  - Staff involve the prisoner's family when appropriate.
  - Staff adhere to the frequency of observations set out in the ACCT document and record details of the observations in the ongoing record.
  - Staff set new, specific and meaningful ACCT caremap actions that are aimed at reducing prisoners' risks to themselves.
- The Governor and the Head of Healthcare should ensure that when a prisoner expresses concern about moving wings, the reason for the concern is identified and addressed before the transfer is completed.
- The Governor should ensure that next of kin details are recorded on reception, reviewed regularly and kept up to date, so that the next of kin can be informed of a prisoner's death as soon as possible.

- The Governor should ensure that a family liaison officer or appropriate member of staff is appointed as soon as a prisoner dies and they should inform the prisoner's family promptly, in line with national guidance.

The Investigation Process

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

13. The investigator visited Manchester on 9 February 2017. He obtained copies of relevant extracts from Mr Nowosad's prison and medical records.

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

15. The investigator interviewed five members of staff at Manchester on 22 March, five on 23 March and two on 26 April. He also interviewed one member of staff by telephone on 5 May. The clinical reviewer accompanied the investigator for eight of the interviews on 22 and 23 March, and another of the Ombudsman's investigators accompanied the lead investigator for the interviews on 26 April.

16. The clinical reviewer also interviewed two members of staff by telephone, one on 13 March and the other on 27 March.

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

18. One of the Ombudsman's family liaison officers contacted Mr Nowosad's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Nowosad's family wanted more information about what happened with Mr Nowosad in the run-up to his death and whether it was appropriate that he was moved internally in the prison shortly before he died.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

20. Mr Nowosad's family received a copy of the initial report. They did not make any comments.

21. The clinical reviewer also received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.

Background Information

HMP Manchester

22. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester operates a personal officer scheme (personal officers should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress). Manchester Mental Health and Social Care Trust provide 24 hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Manchester was conducted in November 2014. Inspectors reported good relationships between staff and prisoners. Inspectors found that Manchester focused on preventing self-inflicted deaths and learned lessons from each incident. Levels of self-harm were comparatively low and care for those at risk was good. Vulnerable prisoners generally felt safe, though support for victims of violent incidents needed to be improved. Health provision was generally good but too few prison staff had mental health awareness training. Inspectors noted that there was a high incidence of mental health and substance misuse problems. Provision for most foreign national prisoners was adequate, except for the small minority with limited English who described feeling isolated.

Independent Monitoring Board

24. 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 29 February 2016, the IMB reported that the health and welfare of prisoners was given a high priority. The IMB commented that the main challenges for the prison have been mobile phones, drugs and offence weapons.

Previous deaths at HMP Manchester

25. Mr Nowosad was the fifth person to take his own life at Manchester since January 2016. In a previous investigation, we made a recommendation that staff should ensure that interpretation services are used appropriately to talk to those prisoners with limited or no English.

Assessment, Care in Custody and Teamwork (ACCT)

26. 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.

27. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. 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.

28. 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).

Key Events

29. On 26 September 2016, Mr Tomasz Nowosad was remanded to HMP Manchester, charged with wounding with intent to cause grievous bodily harm and theft. Mr Nowosad was Polish and spoke limited English. This was his first time in custody in the United Kingdom.

30. Mr Nowosad's younger brother was remanded to Manchester on the same day and neither brother gave any information about their next of kin when they arrived at the prison.

31. Shortly after arriving at Manchester, a healthcare assistant completed Mr Nowosad's initial health screen. Mr Nowosad said he had been diagnosed with paranoid schizophrenia and had been supported by community mental health services. He denied having any thoughts of suicide or self-harm. She referred him to the mental health in-reach team.

32. On 27 September, a nurse tried to conduct a mental health assessment of Mr Nowosad but was unable to as he did not speak English. She arranged an appointment for Mr Nowosad with a consultant psychiatrist and herself for the following day so that they could use Language Line (a telephone interpretation service).

33. The following day, the consultant psychiatrist and the nurse saw Mr Nowosad and spoke to him via Language Line. The psychiatrist recorded that Mr Nowosad had had two admissions to hospital due to mental health problems. Mr Nowosad said he had been prescribed olanzapine (an antipsychotic) and was due to see a psychiatrist and psychiatric nurse in the community. The psychiatrist re-prescribed olanzapine. The nurse recorded that Mr Nowosad had frequent thoughts of others wanting to harm him, though he denied any thoughts of suicide or self-harm. She noted that he had a poor command of English and that Language Line should be used for future examinations.

34. On 29 September, a nurse created a schizophrenia care plan for Mr Nowosad to monitor his mental state and his compliance with his medication. The care plan specified that staff should use an interpreter during any examinations.

35. On 7 October, a nurse saw Mr Nowosad for a mental health assessment. She felt that Mr Nowosad was able to understand English to a good standard but he asked for Language Line to be used. Mr Nowosad said that his current dose of olanzapine was "too strong" for him, which made him feel dizzy, and that he had a right to refuse to take it. She made an appointment for Mr Nowosad to see the prison GP about his medication.

36. Six days later, the consultant psychiatrist saw Mr Nowosad and spoke to him via Language Line. Mr Nowosad said that he had stopped taking his olanzapine medication, which made him feel better. He also said that he did not want to talk about hearing audio hallucinations or any other symptoms, as he believed this made them worse. Mr Nowosad declined further support so the psychiatrist discharged him.

37. On 26 October, a nurse saw Mr Nowosad for a further mental health assessment. She did not use Language Line, as she felt Mr Nowosad was able to communicate to a good standard. Mr Nowosad said that he was not concerned about his mental health and preferred not to take any prescribed medication. He also said that he was having trouble with other prisoners on his current wing (C wing) and asked her if she could help. She told him it was a matter for prison staff. She recorded that Mr Nowosad's mood appeared stable, and he was much brighter and engaging compared to their previous meeting. He agreed to contact the mental health in-reach team if he needed any support.

38. On 30 October, Mr Nowosad told staff that he and his brother needed to move to another wing, as they were under threat from other Polish prisoners. He did not identify the perpetrators but staff moved both brothers to another wing (G wing).

39. On 10 November, Mr Nowosad applied to see the mental health in-reach team. On the application, he wrote "my is after attack paranoi [sic]". Mr Nowosad's application was not progressed until 30 November.

40. The following day, a nurse saw Mr Nowosad for a mental health assessment. She did not use Language Line because Mr Nowosad did not want to use it and she felt he had a decent understanding of English. During the assessment, Mr Nowosad denied having any psychotic symptoms and said that he felt fine when questioned about his application.

41. On 30 December, Mr Nowosad saw a psychiatrist and told her that he felt fine. Mr Nowosad asked for an interpreter to explain his symptoms but she could not arrange this because she did not know how to use Language Line. She recorded that the interview was very brief though she told him that he would probably get unwell again if he did not take his olanzapine. She recorded that Mr Nowosad said that if he became unwell, he would book a healthcare appointment.

42. On 9 January 2017, a nurse saw Mr Nowosad for a mental health assessment and she spoke to him using Big Word (another telephone interpretation service). She recorded that Mr Nowosad voiced paranoid thoughts and auditory hallucinations about other people wanting to hurt him. She noted that he was unable to communicate in English and considered that this was another indication of how his mental state had deteriorated. During the assessment, Mr Nowosad said that he was scared that prison officers and other prisoners wanted to hurt him. He also said that voices told him to hang himself so that his family could "claim my insurance" and that he used to think his brother wanted to hang him. He denied having any current thoughts of suicide or self-harm. She started Prison Service suicide and self-harm monitoring (known as ACCT). There was no record that any member of staff involved in the ACCT process asked Mr Nowosad to confirm the name and contact details for his next of kin.

43. A Senior Officer (SO) completed an immediate action plan. He decided that staff should observe Mr Nowosad on an hourly basis and that he should be admitted to the healthcare centre as soon as possible.

44. Later that day, Mr Nowosad was admitted to a safer cell in the healthcare centre and a nurse completed a second immediate action plan. She decided that staff should observe Mr Nowosad on an intermittent basis (staff generally observed

him four to five times an hour) and a psychiatrist should complete a medication review by the following day.

45. At 4.20pm that day, an officer assessed Mr Nowosad as part of the ACCT procedures. Mr Nowosad said he was scared to be in prison and reiterated that voices had told him to hang himself. Mr Nowosad said he did not want to die and had not made plans to kill himself. There was no record that the officer used or considered using interpretation services to talk to Mr Nowosad in Polish.

46. Ten minutes later, a SO chaired the first ACCT case review with Mr Nowosad, an officer and two nurses. The SO recorded that Mr Nowosad said he heard voices, which told him he was under threat and to hang himself. Mr Nowosad said he had a lot to live for and did not wish to end his life. He considered that Mr Nowosad was at a raised risk of suicide or self-harm (on a scale of low, raised and high) and decided that observations should continue on an intermittent basis. He scheduled the next ACCT review for 13 January. There is no evidence that staff used or considered using interpretation services to talk to Mr Nowosad in Polish.

47. The SO also completed Mr Nowosad's caremap (designed to identify the main areas of concern and the actions required to reduce risk) and set three actions to address Mr Nowosad's issues: a psychiatrist should see Mr Nowosad for a medication review and to address the decline in his mental health; Mr Nowosad should be moved to the healthcare centre for observation; and Mr Nowosad should be located in a safer cell and observed on an intermittent basis. The second and third actions had been completed before the SO completed the caremap. Neither the SO nor Mr Nowosad signed the caremap and no new actions were added until 1 February.

48. The following day, a prison GP reviewed Mr Nowosad and spoke to him using Language Line. Mr Nowosad said an "inner voice" told him that other prisoners wanted to seriously hurt him, and that he would rather die at his own hand than suffer these injuries. The GP convinced Mr Nowosad to resume taking his olanzapine prescription.

49. On 13 January, the healthcare centre manager held a second ACCT case review with Mr Nowosad, a SO, a nurse and an officer. She recorded that Mr Nowosad said he did not have any current thoughts of suicide or self-harm and that he knew he was safe in the healthcare centre. She assessed that Mr Nowosad's level of risk of suicide or self-harm was low. She decided that observations should no longer be on an intermittent basis, but staff should check him four times during the day and four times at night. She recorded that she reviewed the caremap but did not record any new actions. She scheduled the next case review for 19 January. There is no evidence that staff used or considered using interpretation services.

50. On 15 January, a nurse manager held a third ACCT case review with Mr Nowosad, a SO, an officer and a healthcare assistant. She used Big Word to communicate with Mr Nowosad. She recorded that Mr Nowosad said he felt safe in the healthcare centre and that he had no thoughts of suicide or self-harm. He said he was scared to return to the wing as prisoners there were talking about him. She assessed that Mr Nowosad's level of risk of suicide or self-harm

remained low. She did not record whether she had reviewed the level of observations. She recorded that she reviewed the caremap but did not record any new actions. She scheduled the next case review for 22 January.

51. The following day, a consultant forensic psychiatrist reviewed Mr Nowosad. He described Mr Nowosad as having some residual delusional beliefs and that he should remain in the healthcare centre for further monitoring of his mental state.

52. On 22 January, the healthcare centre manager held a fourth ACCT case review with Mr Nowosad, a nurse and two officers. She recorded that Mr Nowosad said he had no current thoughts of suicide or self-harm but he still had delusional thoughts about his family wanting to harm him. Mr Nowosad said that he felt safe in the healthcare centre. She assessed that Mr Nowosad's level of risk of suicide or self-harm remained low and that the level of observations should not change. She recorded that she reviewed the caremap but did not record any new actions. She scheduled the next case review for 30 January. Again, during this case review, there was no evidence that staff used or considered using interpretation services.

53. The following day, the consultant forensic psychiatrist reviewed Mr Nowosad, using a telephone interpreter. Mr Nowosad said that he felt better but he still had residual concerns that people meant him harm. He increased Mr Nowosad's olanzapine dosage and stated that he should remain in the healthcare centre for another week for support.

54. During the afternoon of 28 January, a healthcare assistant recorded in Mr Nowosad's medical record that he asked him how he was and Mr Nowosad smiled and said "I am okay I am just bored". Mr Nowosad then played pool with two officers.

55. During the afternoon of 29 January, a Polish healthcare assistant recorded in Mr Nowosad's medical record that he had spoken to him while issuing medication. Mr Nowosad spoke about the facilities in Polish prisons, his family and made a few jokes.

56. During the morning of 30 January, the nurse manager held a fifth ACCT case review with Mr Nowosad, a SO and two healthcare assistants. She used Big Word to communicate with Mr Nowosad. She recorded that Mr Nowosad said he felt safe in the healthcare centre and he had no thoughts of suicide or self-harm, though, if he returned to the wing, he would develop suicidal thoughts. Mr Nowosad said he still had thoughts that people there were trying to harm him. She assessed that Mr Nowosad's level of risk of suicide or self-harm remained low. She decided that the level of observations should remain the same. She recorded that she reviewed the caremap but did not record any new actions. She scheduled the next case review for 6 February.

57. Later that afternoon, the consultant forensic psychiatrist reviewed Mr Nowosad, using a telephone interpreter. He considered that Mr Nowosad's mental state had improved due to antipsychotic treatment and that a move from the healthcare centre was appropriate. Mr Nowosad told him that he felt safe on the healthcare centre and was frightened that if he went back to normal location he might hurt himself or someone else. The psychiatrist agreed to ask officers to

consider Mr Nowosad as a vulnerable prisoner for his own protection, which could allow him to move to the Vulnerable Prisoners' Unit. In light of this, Mr Nowosad said he was willing to move from the healthcare centre. The psychiatrist discussed this with staff and this action was subsequently added to Mr Nowosad's caremap.

58. On the morning of 31 January, a nurse saw Mr Nowosad and asked whether there was anything he wanted to ask or talk about. Mr Nowosad said "No, I am okay, just tired". The nurse felt that Mr Nowosad was reluctant to engage.

59. Later that day, a senior prison manager reviewed a Main Prisoner to VP Location document and decided that Mr Nowosad should move to A wing (the induction wing) to allow a 72 hour assessment of his suitability to be considered a "situational vulnerable prisoner". There is no record that staff created a separate document to assess Mr Nowosad's suitability.

Events from 1 February 2017

60. At around 10.30am on 1 February, a nurse recorded in Mr Nowosad's medical record that he said he was "okay" when he collected his medication. She recorded that Mr Nowosad was polite, did not express any concerns and declined the opportunity to have a shower.

61. At around 3.45pm, a SO held a sixth ACCT review, listed as a 'review prior to discharge from healthcare', with Mr Nowosad, the nurse manager, the Polish healthcare assistant and two nurses. The Polish healthcare assistant acted as an interpreter. The SO recorded that it was explained to Mr Nowosad that he would have a 72 hour assessment to determine whether he could be considered a vulnerable prisoner. Mr Nowosad said that he was happy with this and that he had no current thoughts of suicide or self-harm. He also said that he was aware of the support mechanisms in place for him. The SO assessed that Mr Nowosad's level of risk of suicide or self-harm remained low. He decided that observations should remain at four observations during the day and four observations at night. He scheduled the next case review for 6 February.

62. The SO also recorded on Mr Nowosad's caremap that he wanted to be signed up for "own protection" status. He recorded that Mr Nowosad would move to the induction wing (A wing) for his 72 hour assessment, though no one from this wing was involved in the ACCT review.

63. The nurse manager recorded in Mr Nowosad's medical record that she told Mr Nowosad that he would be located on A wing for a period of assessment before moving to E or K wing once his vulnerable prisoner status had been determined.

64. At around 4.20pm, Mr Nowosad moved from the healthcare centre to a cell on the induction wing.

65. At 8.15am on 2 February, an officer recorded in Mr Nowosad's ACCT observation record that he said he was okay when he collected his medication. She recorded that there were no signs that he had self-harmed.

66. At 11.40am, an officer recorded that, when Mr Nowosad collected his lunch, he said he was okay and there were no signs that he had self-harmed.

67. At 1.22pm, Officer A recorded that he saw Mr Nowosad on his bed watching television and that he gave the officer a thumbs up. This was the last entry made in Mr Nowosad's ACCT observation record.

68. In his statement, Officer A wrote that he saw Mr Nowosad, at around 4.00pm, in the exercise yard. He wrote that Mr Nowosad was on his own and did not talk with anyone. About 30 minutes later, he spoke to Mr Nowosad on the wing and offered to find other Polish prisoners on other wings to stop him feeling so isolated. Mr Nowosad told him that he wanted to move to the Vulnerable Prisoners' Unit and the officer said he would talk to the wing manager about this.

69. At around 7.20pm, Officer A and Officer B went to Mr Nowosad's cell to collect a spare mattress from the cell. Officer A entered the cell and saw Mr Nowosad hanging from a ligature, made from a bed sheet, attached to the window at the back of the cell. He considered that Mr Nowosad had died because his eyes were fixed open and his skin was bluish-purple.

70. Officer A tried to use his radio to send an urgent message but was unable to get through, left Mr Nowosad's cell to activate a general alarm and shouted for help from other officers. He returned to Mr Nowosad's cell, accompanied by Officer B. Officer B cut Mr Nowosad's ligature and he fell onto the floor. Officer A then was able to use his radio to call a medical emergency priority one (indicating a prisoner is unconscious, not breathing or having difficulty breathing).

71. Various officers responded to the general alarm and started cardiopulmonary resuscitation (CPR). As both Officers A and B were quite distressed they were removed from the cell. An officer collected and fitted a defibrillator (a life saving device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest) but it did not detect a shockable heart rhythm and advised to continue CPR. Two nurses responded to the priority one and assisted with the CPR. One nurse told the investigator that when she arrived at the cell, Mr Nowosad's face was red and his skin was warm but his lips had started to turn blue.

72. The control room received the emergency priority one at 7.23pm and immediately telephoned for an ambulance (Ambulance Service records confirm this). Paramedics arrived at 7.32pm and they took over Mr Nowosad's care. However, they were unable to resuscitate him and a prison GP confirmed that Mr Nowosad had died at 8.14pm.

Contact with Mr Nowosad's family

73. At around 12.30am on 3 February, the duty governor told Mr Nowosad's brother about his death, after receiving permission to do so from the police. A prison chaplain and a custodial manager were both present. The duty governor used Big Word, as Mr Nowosad's brother had limited English. He offered his condolences and asked Mr Nowosad's brother if there were any other family members who should be contacted. Mr Nowosad's brother asked him to contact his sister and provided a contact number for her, though it was incorrect by two digits.

74. At 10.00am that day, a management co-ordinator assumed the role of family liaison officer. At 11.30am, she and the Polish healthcare assistant met Mr Nowosad's brother to offer their condolences and support. Mr Nowosad's brother said that he had not contacted his sister about the death.

75. At 12.20pm that day, the family liaison officer found a telephone number for Mr Nowosad's sister on his telephone account. She telephoned his sister but spoke with his brother-in-law, who spoke English. She broke the news of Mr Nowosad's death and offered her condolences and support. She also arranged for his family to visit the prison on 4 February.

76. On 6 February, the prison formally appointed a SO as the family liaison officer and she continued to support the family. She arranged for Mr Nowosad's body to be repatriated to Poland, where his funeral took place. The prison contributed to the costs, in line with national guidance.

Support for prisoners and staff

77. After Mr Nowosad's death a custodial manager debriefed the staff involved in the emergency response and the prison's care team offered support.

78. On the morning of 3 February, the Governor issued notices to staff and prisoners informing them of Mr Nowosad's death. Officers and members of the chaplaincy team supported those prisoners affected by Mr Nowosad's death. Staff reviewed all prisoners who had been assessed as at risk of suicide and self-harm, in case they were adversely affected by his death.

Post-mortem report

79. The post-mortem examination concluded that Mr Nowosad died as a result of hanging, and a toxicological assessment found no other substance in his blood, other than a therapeutic level of olanzapine.

Findings

Assessment, care in custody and teamwork (ACCT)

80. PSI 64/2011 sets out the processes that should be followed when an ACCT is opened. These include giving prisoners who do not speak English access to an appropriate interpretation service so they can participate in the ACCT process, giving consideration to involving the prisoner's family in ACCT reviews, setting caremap actions that are tailored to meet the needs of the prisoner and recording conversations between staff and prisoners accurately in the ACCT observation record. The PSI also states that where a prisoner on an ACCT moves from the healthcare centre to a residential unit, the residential manager must be invited to the pre-discharge case review and if they are not able to attend, someone from the residential unit must attend to ensure that all relevant information and risk is shared and understood.

81. Mr Nowosad was a Polish national, who spoke limited English. Although some staff used interpretation services or Polish members of staff as interpreters for some healthcare assessments and ACCT reviews, we are concerned that several ACCT reviews were conducted with Mr Nowosad without the assistance of interpretation services. On 9 January, a nurse noted that Mr Nowosad's use of English had completely deteriorated, but for his initial ACCT assessment and his first, second and fourth ACCT reviews (on 9, 13 and 22 January), there was no record that staff considered using a telephone interpretation service or an interpreter. The Head of Operations confirmed that an absence of suitable phones was not the cause of this problem because conference phones were available in key areas of the prison, including in the healthcare consultation rooms. Therefore, we are concerned that staff failed to always use interpretation services, which meant that Mr Nowosad was not able to express himself fully during his ACCT reviews and that staff could not properly understand his issues to assess his risk. We are also concerned that a prison GP recorded that she did not know how to set up a telephone interpretation service. This may be having an impact on other foreign national prisoners if she and other members of staff cannot access this service.

82. When a nurse started ACCT procedures for Mr Nowosad, he said that he used to believe that his brother wanted to hang him and that other family members wanted him to hang himself. We note that while Mr Nowosad continued to experience delusional thoughts, he tended to refer to threats from other prisoners rather than his brother. There is no record that staff considered including Mr Nowosad's brother, who was still located at Manchester, in the ACCT reviews or that anyone facilitated any other form of contact between them.

83. When a SO started the caremap for Mr Nowosad, two of the three actions had already been completed. While we appreciate that staff had yet to see the impact of these actions, we consider that a caremap should set out new actions to address the prisoner's risk of suicide or self-harm. We also note that neither the SO nor Mr Nowosad signed the caremap.

84. For the sixth ACCT review, prior to Mr Nowosad being discharged from the healthcare centre, all the attendees worked in the healthcare centre, including a

SO. There was no record that the residential manager or another appropriate member of staff from the induction wing was invited to or attended this ACCT review. We are concerned that this meant that staff on the induction wing did not fully appreciate the risks that Mr Nowosad presented and were only partly equipped to understand his difficulties.

85. On the day of Mr Nowosad's death, an officer made two entries, at 8.15am and 11.40am, and Officer A made one entry, at 1.22pm, in Mr Nowosad's ACCT observation record. In his statement, Officer A stated that later in the day he had observed Mr Nowosad on the exercise yard, noting his isolation, and had spoken to him on the wing to discuss ways of addressing it, yet neither of these material events appeared in the observation record. Had this happened it is unlikely to have changed the outcome for Mr Nowosad, but effective and thorough recording of observations is a key element of the ACCT process and could be vital in the future to highlight a prisoner's ongoing risk.

86. We make the following recommendation:

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

- **Staff use interpretation services when managing foreign national prisoners with limited English.**
- **The residential manager is invited to and attends an ACCT review when a prisoner moves from the healthcare centre to a residential wing.**
- **Staff involve the prisoner's family when that would be appropriate.**
- **Staff adhere to the frequency of observations set out in the ACCT document and record details of the observations in the ongoing record.**
- **Staff set new, specific and meaningful ACCT caremap actions that are aimed at reducing prisoners' risks to themselves.**

Clinical care

87. We agree with the clinical reviewer that the majority of care that Mr Nowosad received was largely equivalent to and, in respect of his mental health care, better than he would have received in the community.

88. However, as with the management of the ACCT process, the clinical reviewer was concerned that not all healthcare staff used interpretation services during their reviews with Mr Nowosad. The variability in use meant that there was a lack of consistency and continuity in assessing Mr Nowosad's health needs and his risks.

89. With regard to the decision to transfer Mr Nowosad from the healthcare centre to a standard wing, we note that he had said on several occasions that he felt safe in the healthcare centre and he had expressed concern that his suicidal thoughts would return if he was moved. We note that a consultant forensic psychiatrist felt that Mr Nowosad had improved sufficiently to move from the healthcare centre and staff had tried to make his move as safe as possible by assessing his suitability as a vulnerable prisoner, to which he had agreed. However, we agree with the clinical reviewer that it would have been better to have identified the

source of his specific fears and reviewed whether his mental state was as stable as it appeared before healthcare staff discharged him. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that, when a prisoner expresses concern about moving wings, the reason for the concern is identified and addressed before the transfer is completed.

90. The clinical reviewer also made a number of recommendations that we do not repeat, but which the Governor and the Head of Healthcare will need to address.

Family liaison

91. PSI 64/2011 sets out the processes that prisons should follow for informing families after a death in custody. This includes that prisons must record a prisoner's next of kin during their early days in custody, must have a nominated family liaison officer whose role starts when the news of the death is broken and that time is of the essence when breaking the news of a death.

92. When Mr Nowosad arrived at Manchester, there is no record that staff recorded the name and contact details for his next of kin. Nor did they ask his brother, who arrived at the prison on the same day, for these details. At no point during the ACCT process did any member of staff ask Mr Nowosad to confirm his next of kin, despite this being a requirement in the ACCT quality assurance checks.

93. Following Mr Nowosad's death, the duty governor broke the news to his brother and the family liaison officer broke the news to his sister and brother-in-law. However, neither of them kept this role with a SO formally taking on the role on 6 February. We are concerned at the three day delay in formally appointing a family liaison officer and that the chosen person had not been involved in breaking the news of Mr Nowosad's death to any of his family. As the PSI states that the family liaison officer's role starts with breaking the news of the death, we consider that it would have been preferable for the duty governor or the family liaison officer to have remained as the family liaison officer.

94. We also note that Mr Nowosad's sister was not told of her brother's death until 12.20pm on 3 February. While we appreciate that Mr Nowosad's brother had given an incorrect number, the correct number was recorded on Mr Nowosad's telephone account and identifiably the correct version of the number given by Mr Nowosad's brother. We are concerned that there was an unnecessary delay of close to 12 hours in informing Mr Nowosad's sister of her brother's death and that this risked her finding out about the death from another source.

95. While we do not have any concerns about the quality of liaison once Mr Nowosad's family were informed of his death, we are concerned these issues delayed the provision of support and increased the chance that they could have found out about the death from another source. We make the following recommendations:

The Governor should ensure that next of kin details are recorded on reception, reviewed regularly and kept up to date, so that the next of kin can be informed of a prisoner's death as soon as possible.

The Governor should ensure that a family liaison officer or appropriate member of staff is appointed as soon as a prisoner dies and they should inform the prisoner's family promptly, in line with national guidance.

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