Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Elvis Kwiatkowski a prisoner at HMP Long Lartin on 5 August 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

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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 Elvis Kwiatkowski died on 5 August 2018 after making a cut to his arm and suffering severe blood loss at HMP Long Lartin. He was 39 years old. I offer my condolences to Mr Kwiatkowski's family and friends.

Mr Kwiatkowski received regular support from mental health services throughout his time in prison. However, the investigation found there were deficiencies in how the Care Programme Approach, which is used to support those with complex mental health needs, was managed.

We were also concerned that mental health staff may have placed too much emphasis on their perceptions of Mr Kwiatkowski's state of mind, and not enough emphasis on his known risk factors.

In addition, an opportunity to share information about Mr Kwiatkowski's risk with prison staff was missed.

There was a delay in the emergency response. While it did not affect the outcome for Mr Kwiatkowski, the Governor must ensure that this does not happen in future.

Sue McAllister CB
Prisons and Probation Ombudsman **July 2019**

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Summary

Events

1. On 3 May 2014, Mr Elvis Kwiatkowski was remanded in prison custody charged with murder. He was sentenced to life imprisonment on 15 April 2015, and moved to HMP Long Lartin on 23 December 2015.

2. Mr Kwiatkowski had a long history of alcohol misuse before he entered prison and was diagnosed with schizophrenia, which was well managed with medication.

3. In July 2016, Mr Kwiatkowski was supported under suicide and self-harm prevention procedures (known as ACCT) after he told staff he was feeling suicidal. In August 2016, Mr Kwiatkowski disclosed that he was using psychoactive substances (PS) and had accrued a drug debt. He was moved to the Vulnerable Prisoner Unit. There is no other record of him using illicit substances in prison.

4. In the months before he died, Mr Kwiatkowski's behaviour changed and he was placed on violence reduction measures as he had made threats towards Muslim prisoners. Mr Kwiatkowski told healthcare staff that he was having alcohol cravings, but declined to be referred to the substance misuse services.

5. On 12 July, Mr Kwiatkowski asked to see a mental health nurse and told her he was at 'breaking point' and 'did not want to be there' when he woke in the mornings. She assessed that he was not actively suicidal and decided that Prison Service suicide and self-harm prevention measures (known as ACCT) were not necessary.

6. At around 5.42am on 5 August, an operational support grade (OSG) was carrying out a roll check when he saw Mr Kwiatkowski on the floor of his cell in a large pool of blood. He immediately called a medical emergency code but was unable to enter the cell because he did not hold a key. Prison and healthcare staff responded and a custodial manager gained access to the cell. He told the control room that an ambulance was required.

7. Staff tried to resuscitate Mr Kwiatkowski but when the ambulance paramedics arrived, they assessed that he had been dead for some time and recorded his death at 6.22am.

8. The post-mortem examination showed that Mr Kwiatkowski died from severe blood loss. Toxicology tests showed that he had taken PS before he died.

Findings

9. We are concerned that the mental health nurse who saw Mr Kwiatkowski on 12 July, did not consider all Mr Kwiatkowski's risk factors when she concluded that he did not require ACCT monitoring at that time.

10. We are also concerned that she did not share information about his risk with wing staff, particularly as she was about to go on holiday, and that she did not arrange for him to be seen again by mental health staff in the three weeks before he died.

11. We found some shortcomings in the way Mr Kwiatkowski's Care Programme Approach (CPA – used to support those with complex mental health needs) was managed.

12. There was an unacceptable seven-minute delay in the control room calling an ambulance after the medical emergency code was called, although it made no difference in this case as Mr Kwiatkowski was already dead when he was found.

13. Resuscitation should not have been attempted given Mr Kwiatkowski was clearly dead when found.

14. Healthcare staff did not receive adequate support following Mr Kwiatkowski's death.

Recommendations

- The Head of Healthcare should ensure that all healthcare staff understand that when assessing a prisoner's risk of suicide and self-harm, evidence of known risk factors should be fully considered and balanced against how the prisoner presents themselves and staff perceptions of the prisoner's state of mind.

- The Governor and Head of Healthcare should ensure that all staff are reminded of the importance of sharing information about a prisoner's risk of suicide and self-harm, including any changes in behaviour that may indicate an increased risk.

- The Head of Healthcare should ensure that the current system for identifying those who require management under the CPA is reviewed and that:
    - all those identified as needing the CPA are subject to an appropriate care plan;
    - CPA is applied consistently;
    - risk assessments which include possible triggers, protective factors and coping strategies are completed as part of care planning;
    - care plans are recovery focused and include the prisoner; and
    - where appropriate, care plans are shared with prison staff.

- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

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

- The Governor should ensure all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.

The Investigation Process

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

16. The investigator visited Long Lartin on 13 August 2018. She obtained copies of relevant extracts from Mr Kwiatkowski's prison and medical records and visited B Wing where she spoke to staff and prisoners.

17. The investigator interviewed six members of staff and two prisoners at Long Lartin on 3 and 4 September. In addition, she interviewed two members of staff by telephone in October.

18. NHS England commissioned a clinical reviewer to review Mr Kwiatkowski's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator on 3 September, and in addition obtained written responses from two agency nurses.

19. We informed HM Coroner for Worcestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. The investigator contacted Mr Kwiatkowski's family to explain the investigation and to ask if they had any issues they wanted the investigation to consider. Mr Kwiatkowski's mother wanted to know how her son was discovered, whether he was being appropriately supported and receiving medication for his mental health issues, and if a residential wing was the correct location for him. We have addressed these questions in this report.

21. Mr Kwiatkowski's family received a copy of the initial report, but did not identify any factual inaccuracies.

22. The prison received a copy of the report and identified a minor inaccuracy and misspelt names/roles which we have corrected.

Background Information

HMP Long Lartin

23. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Care UK, with mental healthcare subcontracted to South Staffordshire and Shropshire NHS Foundation Trust Mental Health Team.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that the prison had made very good progress in meeting the Prisons and Probation Ombudsman's recommendations following investigations into three self-inflicted deaths at Long Lartin since 2014. Inspectors noted the management team were competent and effective.

25. Inspectors found relationships between staff and prisoners were confident and respectful. Healthcare was found to be well led and work to support those with mental health needs was responsive and effective; waiting times were short and better than those found in equivalent community services.

26. Inspectors found the violence reduction strategy was extremely comprehensive and violence reduction procedures were very good.

Independent Monitoring Board

27. 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 Long Lartin, for the year to 31 January 2018, the IMB noted the normally settled atmosphere at Long Lartin had been disturbed by periods of tension, including raised levels of violence against staff and prisoners.

28. The Board noted that both mental health and general nursing staff were below the agreed service level and there was no psychologist. They were also concerned prison staff fell significantly behind with data collection, recording and reporting on PNOMIS, the electronic prison record.

Previous deaths at HMP Long Lartin

29. Mr Kwiatkowski was the sixth prisoner to die at Long Lartin since August 2016. Of the previous deaths, four were self-inflicted and one was a homicide. There have been four deaths since, two from natural causes and two self-inflicted.

30. In a report on a previous death, issued in July 2017, we made recommendations about improving staff's understanding of when resuscitation is not appropriate and the importance of holding a hot debrief for all those involved in the emergency response. We have not repeated those recommendations since.

Assessment, Care in Custody and Teamwork

31. 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.

32. 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 (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.

33. 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, *Safer Custody.*

Incentives and Earned Privileges Scheme (IEP)

34. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels: entry, basic, standard and enhanced.

Key Events

35. On 3 May 2014, Mr Elvis Kwiatkowski was remanded in prison custody charged with murder and perverting the course of justice. He was sentenced to life imprisonment on 15 April 2015, with a minimum tariff of 20 years. This was his first time in prison. He spent time at HMP Pentonville, HMP Belmarsh and HMP Thameside before being moved to HMP Long Lartin on 23 December 2015.

36. Mr Kwiatkowski had a long history of substance and alcohol misuse before entering prison. He had been diagnosed with schizophrenia many years earlier, which may have been exacerbated by drug use. He was prescribed an antipsychotic drug (olanzapine) and his symptoms were well managed during his time in prison.

37. Mr Kwiatkowski was also diagnosed with avascular necrosis (the death of bone tissue due to a lack of blood supply which can be as a result long-term use of high-dose steroid medications or excessive alcohol intake). This caused pain in his hip and he was prescribed pain relief medications (tramadol and naproxen) and an anti-depressant to aid his sleep (mirtazapine).

38. Mr Kwiatkowski was aware that he was at risk of heart disease as he had raised cholesterol, high blood pressure, was overweight and did not exercise. Although Mr Kwiatkowski was aware of the risks, he often declined to have his blood pressure checked, sometimes refused to have blood tests and declined the offer of medication that would help to lessen the risk of heart attacks or stroke. Mr Kwiatkowski was also blind in one eye.

39. Over the next few years, Mr Kwiatkowski complied with the prison regime, was noted to be a good worker who was always polite to staff and was an enhanced prisoner under the IEP scheme.

2016

40. Staff supported Mr Kwiatkowski under suicide and self-harm prevention procedures (known as ACCT) from 27 to 30 July 2016, after he told them he was considering suicide and that he did not feel safe because there were too many Muslims at Long Lartin. He also said that he would not take his own life while his mother was still alive.

41. On 28 July, a member of staff from the mental health team completed a support package for Mr Kwiatkowski to be monitored under the Care Programme Approach (CPA - a system for coordinating care for people with serious mental illness).

42. On 1 August, a member of staff from the substance misuse team reviewed Mr Kwiatkowski. He recorded that Mr Kwiatkowski had disclosed he had used ‘Spice’, a psychoactive substance (PS), as a release from the stress he was experiencing, and that he had a craving for alcohol. He told Mr Kwiatkowski about the harmful effects of using PS and discussed other coping strategies. Mr Kwiatkowski said he could not afford to continue using PS as he needed

his money to telephone his mother. Mr Kwiatkowski told him that he felt he could talk to staff or his friends if he needed further support.

43. On 23 August, the member of staff from the substance misuse team reviewed Mr Kwiatkowski, who disclosed that he had continued to use PS, was gambling and had accrued a debt of £650. Mr Kwiatkowski said he felt stressed and anxious and that he felt vulnerable on the wing. The substance misuse worker encouraged Mr Kwiatkowski to speak to his personal officer and he informed wing staff of the situation.

44. On 28 August, Mr Kwiatkowski was moved to B Wing as a 'situational vulnerable prisoner (VP)' (meaning he was vulnerable due to factors other than the nature of his offence).

45. On 8 September, the member of staff from the substance misuse team reviewed Mr Kwiatkowski who said that he had stopped using PS, recognised he needed to stop gambling and as a result felt less stressed and was happier being at Long Lartin.

2017

46. A member of staff from the substance misuse team met Mr Kwiatkowski several times during January 2017, to provide ongoing support and advice about the effect of using illicit substances and the impact on his mental health. Mr Kwiatkowski reported that he had stopped using PS and was more settled, but reflected that when released he would start consuming alcohol again. Mr Kwiatkowski said he did not want to continue contact with the substance misuse services.

47. Towards the end of October, Mr Kwiatkowski's attitude towards prison staff changed. He accused them of being unhelpful and said that they were not helping him address his concerns about missing property and money in his spends account.

48. On 1 November, Mr Kwiatkowski told a nurse that he was struggling to stop smoking and had argued with his family. He asked to be referred to the mental health team. The member of staff from the substance misuse team met with Mr Kwiatkowski on 7 November, when he agreed to re-engage with substance misuse services and access additional support. He met with Mr Kwiatkowski regularly after this.

49. On 20 December, the member of staff from the substance misuse team noted that during their regular session, Mr Kwiatkowski expressed paranoid thoughts and said that he was more agitated since the smoking ban, but agreed to complete work on regulating his emotions.

50. During a counselling session on 22 December, Mr Kwiatkowski disclosed he had thoughts of hurting a named member of staff. The member of staff from the substance misuse team reported this to security, after telling Mr Kwiatkowski that he would have to report it. After this, Mr Kwiatkowski refused to engage with him again, saying he did not trust him.

2018

51. On 26 January 2018, a psychiatrist reviewed Mr Kwiatkowski. He noted that Mr Kwiatkowski said things had deteriorated for him, that he believed officers and the pharmacy were 'trying to set him up', and that he was being warned about his attitude towards staff. Mr Kwiatkowski told him that he was not in debt and had not used illicit substances. He said he was having an internal argument with himself and was angry, but would not harm himself while his mother was alive. The psychiatrist, asked a mental health nurse, to write a care plan to identify the increased risk of suicide and self-harm in the event Mr Kwiatkowski's mother died. Mr Kwiatkowski agreed to engage with support to help him sleep better.

52. On 31 January, a multidisciplinary team discussed Mr Kwiatkowski. The entry in the medical record noted Mr Kwiatkowski was not willing to engage, and just wanted medication, which was not prescribed.

53. On 26 February, a mental health nurse assessed Mr Kwiatkowski. She noted that he spoke at length about being 'dug out' (picked on) by some wing staff and that he felt angry inside. Mr Kwiatkowski told the nurse that the only reason to live was for his mother, but that he wanted to move back onto a standard residential wing and 'let the Muslims do what they want' (meaning attack or kill him). The next day, the nurse completed a mental health care and treatment plan, and concluded that there was no evidence of psychosis or depression, but that Mr Kwiatkowski should be reviewed twice a year by a psychiatrist and she would meet with him again in one month.

54. On 26 March, a mental health nurse met with Mr Kwiatkowski for his planned review. He reported that he was more settled on the wing and as a result had less hassle from prison staff. Mr Kwiatkowski spoke about his concern for his mother's health and that he had been advised his cholesterol was too high. The mental health nurse noted there were no specific issues and arranged to review Mr Kwiatkowski in a further two months.

55. On 5 April, an IT teacher told Mr Kwiatkowski that he would not be starting a new course as he had not yet achieved a sufficient level in his IT or written skills. Mr Kwiatkowski became increasingly aggressive, said he would not complete his current course and deleted all his work. Officers intervened and Mr Kwiatkowski was taken back to B Wing. He was removed from the IT group.

56. On 26 April, Mr Kwiatkowski was seen by a prison GP, following his refusal to have an MRI scan on his hip. Mr Kwiatkowski said that he was 'at the apex of his anger' and concerned that he would kill someone, either staff, prisoners or Muslim prisoners and went on to say that he wanted to kill as many Muslim prisoners as possible and 'go out that way [die]' once his mother had died.

57. A mental health nurse met with Mr Kwiatkowski a short while later, when he reiterated he had thoughts of harming someone. Mr Kwiatkowski explained that it was 'just his way', that he realised he came across as rude to staff but that he did not mean it. The mental health nurse advised Mr Kwiatkowski how

he might control his anger better and told him that he would be reviewed by the psychiatrist on 3 May.

58. On 27 April at 2.50pm, a Custodial Manager (CM) and a Senior Officer (SO) spoke with Mr Kwiatkowski about his recent aggressive behaviour and intelligence that he planned to return to a standard wing and ‘kill as many Muslims as he could, until they killed him’. Mr Kwiatkowski said he had no specific problem with the Muslim prisoners located on B Wing, but told the CM and SO that he was a racist. Staff started violence reduction measures as a result of these threats towards Muslim prisoners and Mr Kwiatkowski was downgraded to standard IEP and flagged as a bully.

59. On 3 May, a psychiatrist and the mental health nurse met with Mr Kwiatkowski. He said that he was frustrated that he could not work in a workshop because of the problems with his hip, and that he had been downgraded to standard IEP because of his comments about Muslim prisoners. Mr Kwiatkowski said he had had thoughts of self-harming as a form of release, but no thoughts of suicide. They concluded that Mr Kwiatkowski’s medication should remain the same, that he was not delusional, but that the mental health nurse would contact wing staff to arrange for him to work on the wing, rather than in a workshop. They agreed to review him again in three months. Later that day, the mental health service manager recorded that Mr Kwiatkowski had been discussed at the MDT meeting, and had presented as stressed and paranoid.

60. On 4 May, a SO reviewed Mr Kwiatkowski’s violence reduction (VR) file and noted that he was abrasive and had blamed others for his situation. The SO told Mr Kwiatkowski that his behaviour and attitude towards staff needed to improve.

61. On 11 May, a SO reviewed Mr Kwiatkowski’s VR file. He recorded that on advice from wing staff, the VR file should remain open for a further week, and scheduled a review for 18 May. Later at 2.33pm, it was noted in Mr Kwiatkowski’s medical record that he had been discharged from the CPA, but that the mental health service manager, would complete a care plan.

62. On 18 May, a SO reviewed Mr Kwiatkowski’s VR file and recorded that there had been no issues and it would be reviewed in a week. Shortly afterwards, SO Scott recorded in Mr Kwiatkowski’s prison record that he had sworn and been aggressive to staff in the wing office and when challenged, tried to justify his behaviour. The SO noted that Mr Kwiatkowski had later returned to the office and apologised for his behaviour.

63. On 21 May, the mental health nurse was informed by the pharmacy that Mr Kwiatkowski had asked to stop his antipsychotic medication (olanzapine) and had thrown away the medication he was given and the mental health nurse met with Mr Kwiatkowski who described having what appeared to be a hallucination since stopping his medication. She noted that he appeared tearful at times, and said that when his mother died he would have nothing to live for. Mr Kwiatkowski reiterated that he would not harm himself while she was alive and that being on an ACCT had a negative impact on him. She assessed that an ACCT was not necessary. She recorded that Mr Kwiatkowski had agreed to speak to her if he felt worse and that she would

ask wing staff about employment on the wing as being locked in his cell most of the day was having a detrimental effect on his mental health.

64. On 25 May, the psychiatrist and the mental health nurse met with Mr Kwiatkowski to review his mental health under the CPA (despite it being recorded that he had been removed from the CPA on 11 May). Mr Kwiatkowski said he had experienced visual and auditory hallucinations for five to ten minutes the day after he stopped taking his antipsychotic medication. Mr Kwiatkowski told them he had stopped taking his medication in protest at how one of the senior officers was treating him (telling him off for swearing) and that he was still concerned about his mother's health. Mr Kwiatkowski said he had no thoughts of suicide or self-harm. Mr Kwiatkowski agreed to restart his medication and that the mental health nurse would assist him with securing employment. The psychiatrist, noted that the CPA plan would be reviewed and arranged to see Mr Kwiatkowski in two weeks.

65. Later that day, a SO reviewed Mr Kwiatkowski's VR file and recorded that although his behaviour had been better, he would remain subject to monitoring for another week, because of the recent incident when he was aggressive to staff.

66. On 1 June, a SO reviewed Mr Kwiatkowski's VR file. He noted that Mr Kwiatkowski was employed as a wing cleaner, that there had been no further issues with his behaviour, but that he still held racist beliefs which were unlikely to change. He closed the VR file.

67. On 15 June, the mental health nurse reviewed Mr Kwiatkowski and recorded that he looked brighter and had secured employment as a cleaner on the wing. Mr Kwiatkowski said that he felt better having restarted his antipsychotic medication, but that he still had cravings for alcohol. She noted he had no thoughts of suicide or self-harm.

68. On 17 June, Mr Kwiatkowski told an Officer that he wanted to legally change his name. The officer said Mr Kwiatkowski was concerned that other prisoners would think he was foreign and he provided him with the information on how to make this application.

69. On 22 June, the psychiatrist and the mental health service manager, met with Mr Kwiatkowski to review his mental health. Mr Kwiatkowski said he had not experienced any auditory hallucinations since restarting his medication, had no thoughts of suicide or self-harm, but still had cravings for alcohol.

70. On 25 June, the mental health service manager, completed a treatment plan for Mr Kwiatkowski. He also spoke with the safer custody team to alert them to the high risk of suicide should Mr Kwiatkowski's mother die. Mr Kwiatkowski was also discussed at the MDT meeting on 28 June, with the risk of suicide flagged in the event of his mother dying.

71. On 6 July, a mental health nurse met with Mr Kwiatkowski who told her that he was in a 'bad place and feeling edgy'. (Although this was a planned meeting, Mr Kwiatkowski had also asked to see her.) Mr Kwiatkowski said he had disowned his mother and asked for any letters from her to be stopped and said

that he did not want any visits. Mr Kwiatkowski said he felt pressured when he spoke to his mother on the telephone and that he could not see a life without alcohol. He said there was no illicit alcohol (known as 'hooch') on the wing, but that it would be very dangerous for him if there was.

72. The mental health nurse recorded that Mr Kwiatkowski felt 'on the edge' and was waiting for an excuse to 'kick off'. Mr Kwiatkowski dismissed the benefits of working with the substance misuse team, but agreed to engage with psychology as the psychiatrist, had previously suggested. She noted Mr Kwiatkowski was less agitated at the end of their meeting and he agreed that she could contact his mother, as she felt any breakdown in their relationship would increase his risk. She said she would also contact the GP to see if they could prescribe medication for his alcohol cravings.

73. On the morning of 12 July, the mental health nurse met with Mr Kwiatkowski at his request. He described being at 'breaking point' and said that he woke every day wishing he was not here. He said he had to make himself get up and start work so his mind was on other things. Mr Kwiatkowski said he had spoken to his mother and had tried to resolve their issues. He said he was struggling with the pain in his hip and with his cravings for alcohol. She informed him that there was no medication to stop his cravings for alcohol, and Mr Kwiatkowski said he was close to taking something illicit, although he did not want to get into debt again. Mr Kwiatkowski declined to speak to the substance misuse team. She noted that she did not consider an ACCT was necessary as Mr Kwiatkowski was not actively suicidal. She booked him an appointment with a GP to discuss pain relief and his concerns about bleeding from his back passage. This was the last contact Mr Kwiatkowski had with the mental health team.

74. On 18 July, an officer recorded that Mr Kwiatkowski had not had any issues on the wing and was happy working as a wing cleaner. This was the last entry on his prison record.

75. On 26 July, a prison GP saw Mr Kwiatkowski and recorded that he had refused to have his blood pressure monitored as he said he wanted to die. Mr Kwiatkowski said his main concern was the pain in his hip and asked for his tramadol prescription to be increased, but the prison GP refused as Mr Kwiatkowski was already on the maximum recommended dose. He noted that Mr Kwiatkowski was awaiting a MRI scan on his hip, but that he thought he might refuse to attend again when the appointment came through.

76. On 4 August, Closed Circuit Television (CCTV) shows Mr Kwiatkowski returning to his cell at 4.15pm with a bottle of water. At 4.45pm, an officer locked his cell. Prisoners on B Wing can request to be let out of their cells to use the toilet during the night state, which started at 6pm, but Mr Kwiatkowski did not ask to use the toilet and did not leave his cell after 4.45pm.

77. At around 8.00pm, an officer reported to the communications room that he had completed a roll check (a count of prisoners). However, CCTV shows that he did not carry out this check.

Sunday 5 August

78. CCTV shows an operational support grade (OSG), started his roll check at 5.41am and arrived at Mr Kwiatkowski's cell at 5.42am. CCTV shows the OSG looked through the observation panel several times while shining his torch. He told the investigator that he could not see Mr Kwiatkowski on his bed so he looked to the other side of the cell but still could not see him. Then he realised he was on the cell floor, face down with a pool of blood around his stomach area. He immediately called a medical emergency code red (used to indicate severe blood loss) over his radio. He then carried on with his checks because he knew other staff would be on their way and he did not have the authority to gain access to the cell (which are unlocked centrally using an electronic system).

79. At 5.44am, three officers responded to the code red and arrived outside Mr Kwiatkowski's cell. They called his name but got no response. A minute later, a SO arrived followed by another SO and a CM, who was the night operational manager. Two nurses arrived a few seconds later. The CM instructed the control room to open the lock on Mr Kwiatkowski's cell and confirmed that an ambulance was required.

80. At 5.46am, staff entered the cell and found Mr Kwiatkowski face down on the floor, covered in blood. An officer and a nurse turned Mr Kwiatkowski over and started cardiopulmonary resuscitation (CPR). The nurse collected the defibrillator, attached it to Mr Kwiatkowski and staff continued CPR until ambulance paramedics arrived. An officer described Mr Kwiatkowski as being very cold, that his skin colour had changed and his limbs were stiff. The officer said due to the amount of blood on Mr Kwiatkowski, the cut to his left arm was not immediately apparent.

81. West Midlands Ambulance Service records show they received a request for an emergency ambulance at 5.49am. CCTV shows paramedics arrived at Mr Kwiatkowski's cell at 6.14am. They assessed Mr Kwiatkowski, noted that rigor mortis and blood pooling were present and at 6.22am, they recorded he was dead.

Information obtained after Mr Kwiatkowski's death

82. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to Mr Kwiatkowski's calls made between 29 June and 29 July, when he made his last call. He made 33 calls to his mother, totalling around 90 minutes, during this time.

83. During a call on 12 July at 4.58pm, seven hours after his meeting with the mental health nurse, Mr Kwiatkowski told his mother he was hated by other prisoners, that 'I can't handle it anymore' and that he had stopped all her emails and letters. Mr Kwiatkowski said that he had sold his belongings, and that she was sending him money he could not spend and that he had to talk in riddles as his telephone calls were recorded.

84. The next day Mr Kwiatkowski spoke to his mother at 9.39am. He said that he was 'up to my eyeballs in shit' and that he was in trouble as his debts were doubling up. Mr Kwiatkowski's mother said she was worried he would harm himself, but he reassured her he was trying to sort out his situation and seeing the psychiatrist each week.

85. It was apparent from the telephone calls Mr Kwiatkowski made to his mother over the next two weeks that she was sending money to others on his behalf. On 27 July, Mr Kwiatkowski was frustrated with his mother for getting confused about information he was giving her and reminded her to keep a journal. During the last call on 29 July, Mr Kwiatkowski told his mother he was 'fine' but had no telephone credit so would email her and ended the call by telling her he loved her.

86. Prisoners who knew Mr Kwiatkowski well told the investigator that in the week before he died Mr Kwiatkowski had started drinking an 'alcoholic drink' made from stolen hand sanitiser. They said that Mr Kwiatkowski had also traded his prescription medication (tramadol) for PS, had accrued debts and was not coming out of his cell as often.

87. A prisoner, said that he had seen Mr Kwiatkowski under the influence of illicit alcohol, and that he knew Mr Kwiatkowski used PS after prisoners were locked in their cells for the night. The prisoner said he had never witnessed Mr Kwiatkowski being bullied, and that prisoners would not share information about bullying with officers as it 'was not the done thing'.

88. Another prisoner, said he was aware that Mr Kwiatkowski was in debt, but had never witnessed him being bullied. The prisoner said Mr Kwiatkowski had been quieter in the week or so before he died, but had given no indication that he intended to take his own life. He said he had helped Mr Kwiatkowski financially by purchasing canteen (products from the prison shop) when he had no money, and that Mr Kwiatkowski's mother would repay his partner the money, as they had established a friendship.

89. Neither prisoners would disclose who Mr Kwiatkowski was in debt to as they were concerned for their safety.

90. The investigator was told that information had been submitted after Mr Kwiatkowski's death that a box containing five boxes of hand sanitiser was placed in the wing SO's office, with a sixth box unaccounted for. Staff were unable to say if it had been placed in the sanitiser dispenser. Mr Kwiatkowski was employed as a Wing Support Worker from 1 June, so would potentially have had access to the office.

91. During a search of his cell after his death, staff found numerous bits of correspondence which included letters Mr Kwiatkowski had written which indicated he was not happy with himself or his situation. They also found a vape pen (which had been tampered with to enable the smoking of illicit drugs) and cartridges. When these were tested, traces of ephedrine, often a component of PS, were found.

92. A ‘debtors’ list was discovered on the wing which included the name ‘Elvis… £8’, which was assumed to be a debt Mr Kwiatkowski owed. A prisoner suspected of being involved in the drug culture at Long Lartin was removed from the wing and placed in the segregation unit.

Contact with Mr Kwiatkowski’s family

93. Long Lartin appointed an officer as the family liaison officer (FLO). However, Long Lartin did not have sufficient staff to travel to break the news to Mr Kwiatkowski’s family, so they contacted HMP Woodhill to ask for assistance. An officer from Woodhill, accompanied by an officer from Hertfordshire Police, travelled to the address the prison held for Mr Kwiatkowski’s mother, but she had moved. The officer was given her new address by neighbours, and broke the news of Mr Kwiatkowski’s death at 12.20pm. The FLO contacted Mr Kwiatkowski’s family the next day, and offered his condolences and ongoing support. The prison contributed towards the costs of Mr Kwiatkowski’s funeral, in line with national policy.

Support for prisoners and staff

94. The duty governor held a debrief for prison staff involved in the emergency response, who all said they felt well supported. Healthcare staff did not attend, but said they felt well supported by their colleagues.

95. The prison posted notices informing other prisoners of Mr Kwiatkowski’s death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Kwiatkowski’s death. The prison held a memorial service for Mr Kwiatkowski on 12 September.

Post-mortem report

96. A pathologist concluded that Mr Kwiatkowski had died from exsanguination (severe blood loss) from a wound to the vein in his left arm. This was exacerbated by the presence of coronary artery atheroma (blocked arteries) and cirrhosis (damaged liver). The coronary artery stenosis increased the risk of cardiac ischaemia (lack of blood to the heart) due to blood loss and the cirrhosis would make blood less likely to clot.

97. A toxicology report found traces of tramadol and olanzapine within a therapeutic range, and also that Mr Kwiatkowski had used PS before he died.

Findings

Assessment of risk of suicide and self-harm

98. Prison Service Instruction (PSI) 64/2011, *Managing prisoners at risk of harm to self, to others and from others* (*Safer Custody)*, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Kwiatkowski had some risk factors. He was serving life imprisonment with a long tariff and was diagnosed with a significant mental health condition. Mr Kwiatkowski did not self-harm while in prison and stated numerous times over the years that he would never harm himself while his mother was still alive.

99. When Mr Kwiatkowski told a member of staff he had suicidal thoughts in July 2016, he was appropriately managed under the ACCT process. However, he was not managed under ACCT in 2018 when it is arguable that his risk factors increased: his behaviour deteriorated, he became increasingly stressed, his relationship with his mother came under strain and he complained of pain in his hip and constant cravings for alcohol.

100. In the months before he died, Mr Kwiatkowski was assessed by the mental health team who emphasised the protective factor of his mother being alive, almost to the exclusion of all else. There is no evidence of a comprehensive risk assessment such as FACE (Functional Analysis of Care Environment) that would have helped to identify triggers, level of risk, strengths and coping methods.

101. On 12 July, Mr Kwiatkowski asked to see a mental health nurse and told her that he was at ‘breaking point’ and that he did not want to be there when he woke up in the mornings. He also said he was close to taking illicit substances to cope with his mental distress. She recorded that she did not start ACCT procedures because Mr Kwiatkowski was ‘not actively suicidal’, he had a negative view of the ACCT process and she was concerned that if she opened an ACCT it might have a negative impact on their working relationship.

102. We are concerned that the mental health nurse may have placed too much emphasis on Mr Kwiatkowski’s assertions that he had no plans to kill himself, and not enough on his risk factors, when she decided that ACCT procedures were not appropriate at that time. She said at interview that she did not know much about Mr Kwiatkowski’s previous substance misuse and debt problems, and we do not therefore consider that she was well placed to make a comprehensive risk assessment in isolation.

103. We recommend that:

The Head of Healthcare should ensure that all healthcare staff understand that when assessing a prisoner’s risk of suicide and self-harm, evidence of known risk factors should be fully considered and balanced against how the prisoner presents themselves and staff perceptions of the prisoner’s state of mind.

104. We are also concerned that the mental health nurse did not share information about Mr Kwiatkowski's state of mind with wing staff, particularly as she was about to go on holiday. In addition, despite the distress he had described on 12 July, she did not make another appointment to see him and as a result he had no further contact with mental health staff for the three weeks before he died.

105. Prison staff would have been unaware of the contact Mr Kwiatkowski had with the mental health team, as they would not have access to his medical records. If the mental health nurse had shared information with wing staff they might have been more alert to his self-isolating behaviour and the signs that he might be using illicit substances and be in debt. At the very least, they might have been able to provide Mr Kwiatkowski with support in the absence of support from the mental health team.

106. We consider that when prisoners present as vulnerable or particularly distressed, information that is relevant should be discussed and shared when appropriate so that the risk of suicide and self-harm can be fully assessed. A single individual may not be aware of all the facts and one of the purposes of opening an ACCT is to enable staff from different disciplines to share information and enable a multidisciplinary assessment of risk. In Mr Kwiatkowski's case, his mental health reviews and his Violence Reduction reviews appear to have taken place in complete isolation and opportunities to make a full assessment of his risk factors and current level of risk were, therefore, missed. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are reminded of the importance of sharing information about a prisoner's risk of suicide and self-harm, including any changes in behaviour that may indicate an increased risk.

Clinical care

Mental health

107. Mr Kwiatkowski was prescribed antipsychotic medication and the clinical reviewer is satisfied that his schizophrenia was well controlled while he was at Long Lartin. As well as prescribed medication, Mr Kwiatkowski had the support of a consultant psychiatrist and a mental health nurse.

108. The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, and review. A comprehensive risk assessment should be part of the CPA. We identified some confusion among the mental health team around the process of placing Mr Kwiatkowski on the CPA and there were times when Mr Kwiatkowski was discharged from the CPA, and then put back on it.

109. Staff produced a CPA care plan in July 2016, which ended in December 2016, even though Mr Kwiatkowski was still being regularly seen by the mental

health team. On 25 May 2018, there was a CPA meeting for Mr Kwiatkowski between a psychiatrist, and the mental health nurse. The notes in Mr Kwiatkowski's medical record suggest that a relapse, trigger and care plan should be written up, to identify circumstances and behaviours that could suggest that Mr Kwiatkowski's mental health was at risk of deteriorating and identify positive coping strategies. On 22 June, the mental health manager, wrote a care plan for Mr Kwiatkowski, even though he did not really know him.

110. Although the mental health manager said that he was trying to ensure that all those requiring a CPA are now on one, we consider that the process needs to be reviewed to ensure the CPA is appropriately and adequately implemented. We therefore make the following recommendation:

The Head of Healthcare should ensure that the current system for identifying those who require management under the CPA is reviewed and that:

- **all those identified as needing the CPA are subject to an appropriate care plan;**
- **CPA is applied consistently;**
- **risk assessments which include possible triggers, protective factors and coping strategies are completed as part of care planning;**
- **care plans are recovery focused and include the prisoner; and**
- **where appropriate, care plans are shared with prison staff.**

Physical health

111. Although Mr Kwiatkowski often refused to engage with healthcare services, there was a coronary heart disease care plan in place which was reviewed annually.

112. Mr Kwiatkowski's medication for his hip pain was frequently reviewed and updated. Prisoners who knew Mr Kwiatkowski well said that towards the end of his life he was trading his tramadol (pain relief medication) for illicit substances. There is no evidence to support this, although it is possible that his request for an increase in his tramadol prescription was drug-seeking behaviour.

Substance misuse

113. Mr Kwiatkowski had a significant alcohol problem before he went to prison, and he reported to still have cravings, particularly at times of stress. Although staff had no suspicions, prisoners interviewed after Mr Kwiatkowski's death said that in the week before he died he had been drinking illicit alcohol made from hand sanitiser.

114. The investigator was told that an internal investigation by the prison was unable to identify where the sanitiser was stolen from. We understand that the prison no longer uses an alcohol based product.

115. When Mr Kwiatkowski disclosed PS use, and associated debts, in August 2016, he received good support. He received regular support from the

substance misuse team until the end of 2017 when he declined further engagement. (Given the circumstances of Mr Kwiatkowski's index offence, we are satisfied that it was appropriate for a member of staff from the substance misuse team to report that Mr Kwiatkowski had disclosed thoughts of decapitating a named officer.)

116. When he spoke of having strong cravings for alcohol in 2018, and he was offered, but declined, additional support from the substance misuse services.

117. The clinical reviewer concluded that the care Mr Kwiatkowski received for his substance misuse was equivalent to that which he could have expected to receive in the community.

Violence Reduction

118. A PPO publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and violence and the self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013 - 2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly.

119. Long Lartin has a violence reduction (VR) strategy, which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation or violence. Mr Kwiatkowski was monitored under VR measures as a bully after he made threats to harm Muslim prisoners. We found that the process was timely, VR plans were clear and Mr Kwiatkowski was regularly reviewed, in line with the guidelines.

120. There was no evidence before he died that Mr Kwiatkowski was being bullied himself, and prisoners who knew he was using illicit substances and had accrued debts did not inform staff. There was, therefore, no reason for staff to consider VR measures to support him.

Emergency Response

121. PSI 3/2013, *Medical Emergency Response* requires prisons to have a medical emergency response code protocol, which states how staff should communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used. Long Lartin's local protocol is clear that an ambulance should be called immediately when a medical emergency code is radioed, in line with PSI 3/2013.

122. An OSG correctly radioed a code red medical emergency at 5.42am when he saw Mr Kwiatkowski bleeding heavily on the floor of his cell, but an ambulance was not requested until seven minutes later when a CM contacted the control room and confirmed one was needed. We are very concerned about this lengthy delay.

123. Although it would not have changed the outcome for Mr Kwiatkowski, any delay in requesting an ambulance could be crucial, and we make the following recommendation to ensure national guidance is followed:

The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

Resuscitation

124. An officer recorded in his statement that he believed Mr Kwiatkowski was beyond the point of resuscitation when he entered his cell. He described Mr Kwiatkowski as very cold, his skin was a dark purple/black colour, his eyes were fixed and his limbs were stiff. A SO recorded that Mr Kwiatkowski's colouring and the rigidity of his limbs indicated that he had been dead for some time. Nurses who responded to the emergency code said that while the chances of recovery were extremely slim, they decided to attempt resuscitation. Paramedics recorded there were obvious signs of death: dried clotted blood, rigor mortis and blood pooling were all evident.

125. In September 2016, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons and immigration removal centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance is designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile."

126. We understand the wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

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

127. We note that we made this recommendation previously in July 2017 and that the Governor and Head of Healthcare will now need to think carefully about how best to ensure that staff understand when resuscitation is not appropriate.

Support for staff

128. PSI 08/2010, *Post Incident Care*, states: 'The Governor must have a local policy to identify the staff responsible for ensuring access to post incident care.'

129. Healthcare staff did not attend the debrief held after Mr Kwiatkowski died. While most prison staff said they had felt well supported by their colleagues in the period after Mr Kwiatkowski's death, healthcare staff, including the mental health team, did not have the same support from the prison Care Team. We therefore make the following recommendation.

The Governor should ensure all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.

Staff investigation

130. An officer was suspended from duty on 15 August, because he signed for a roll check that CCTV showed he had not completed. Long Lartin have already conducted an investigation into his actions, under the terms of PSI 06/2010, *Conduct and Discipline*, which we would otherwise have recommended. The officer resigned from the Prison Service on 9 January 2019.

Prisons & Probation
Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141