Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Petrut Cristea, a prisoner at HMP Maidstone, on 4 June 2020

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*

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 Petrut Cristea was found hanging in his cell on 1 June 2020 at HMP Maidstone. He was taken to hospital but died on 4 June. He was 26 years old. I offer my condolences to Mr Cristea's family and friends.

Mr Cristea had anger management issues and poor coping strategies when faced with difficulties. He frequently breached prison rules and spent time in segregation and on the basic regime. He found it difficult to cope when he had to spend long periods in his cell, and this was exacerbated during the very restricted regime imposed in response to the COVID-19 pandemic. He often self-harmed, albeit not seriously, and was regularly managed under suicide and self-harm procedures, known as ACCT, during his time at Maidstone.

We are concerned that Mr Cristea's final period under ACCT management, following an act of self-harm, was ended prematurely after only 24 hours. We do not consider that Mr Cristea's risk to himself was fully considered on this occasion and we are concerned that the ACCT was closed without input from the mental health team. He hanged himself two days later.

The clinical reviewer concluded that the physical and mental healthcare Mr Cristea received at Maidstone was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. However, we share the clinical reviewer's concerns that Mr Cristea was not able to receive additional support from the counselling service during the pandemic.

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

Sue McAllister CB
Prisons and Probation Ombudsman **July 2021**

Contents

Summary

Events

1. In July 2018, Mr Petrut Cristea was remanded to prison charged with grievous bodily harm with intent. In January 2019, he was sentenced to seven years imprisonment. Mr Cristea was Romanian and spoke little English. It was his first time in custody in the UK.

2. In March 2019, Mr Cristea transferred to HMP Maidstone, a prison for foreign national prisoners.

3. Mr Cristea's behaviour was often challenging, sometimes fuelled by use of psychoactive substances (PS), and he spent several periods on the basic regime and in the segregation unit during his time at Maidstone. In July 2019, he was assessed by a psychiatrist who noted that he had marked anti-social and emotionally unstable personality traits. He was referred for counselling, but it did not take place.

4. Mr Cristea self-harmed when under stress and cut his arms and was managed under suicide and self-harm procedures (known as ACCT) on three occasions in 2019.

5. In March 2020, a severely restricted regime was introduced in response to the COVID-19 pandemic. Prisoners spent around 23 hours a day in their cell.

6. Mr Cristea was briefly managed under ACCT procedures in March after he threatened to cut his throat. He was then managed under ACCT from 29 March to 29 April after he self-harmed. During this time, his behaviour was described as erratic and staff were concerned that his mental health was deteriorating.

7. On 29 May 2020, ACCT procedures were opened again after Mr Cristea cut his stomach. The ACCT was closed on 30 May, after his mood appeared to improve and he told staff that he was fine.

8. On 1 June, a prisoner spoke to Mr Cristea at about 9.00am. At 9.47am, an officer found Mr Cristea hanging at the back of his cell with a ligature around his neck attached to the window. Staff promptly radioed an emergency medical code for assistance and began CPR. Paramedics arrived and recovered signs of life. Mr Cristea was taken to hospital but died on the morning of 4 June.

Findings

Management of Mr Cristea's risk of suicide and self-harm

9. Mr Cristea had a number of risk factors for suicide and self-harm when he entered prison and staff appropriately opened ACCT procedures when he harmed himself or threatened to do so.

10. Although Mr Cristea was generally well supported when he was managed under ACCT procedures in April 2020, we are concerned that no attempt was made to facilitate contact with his family in Romania, even though lack of contact was identified as one of his key concerns.

11. We are also concerned that the ACCT was closed prematurely on 29 April, by an officer who had not previously been involved in the process, after Mr Cristea said he was feeling "good".

12. We are very concerned that when an ACCT was opened again on 29 May, it was closed the following morning. We consider that this was premature, and that the decision was made without mental health input and on the basis that Mr Cristea said he was "fine", rather than on a consideration of his risk factors.

Clinical Care

13. The clinical reviewer concluded that the care Mr Cristea received at Maidstone was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

14. The clinical reviewer was, however, concerned that although Mr Cristea was repeatedly recommended for counselling, the referral did not take place and he did not therefore receive the support that might have helped him develop coping strategies.

Translation

15. We are concerned that, although Mr Cristea's English was poor, many significant and sensitive discussions, including some ACCT reviews, mental health assessments and key worker sessions took place either without the use of a translation service, or with translation provided by another prisoner.

The key worker scheme

16. We commend Mr Cristea's key worker for the support she provided him from June 2019 to April 2020.

17. Mr Cristea clearly found it difficult to cope with the very restricted pandemic regime. After the key worker scheme was suspended due to COVID, he was listed as requiring 'priority key worker sessions'. We are concerned that after his ACCT was closed on 29 April, he had only three further sessions during the following month, 10, 19 and 31 May. More frequent contact might have been an opportunity to identify any deterioration in his mental state.

The role of Officer B

18. A prisoner suggested that Officer B had upset Mr Cristea shortly before he hanged himself. We found no evidence that she had acted inappropriately or that she was in any way responsible for Mr Cristea's death.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including in particular that:
    - staff understand the need to consider a prisoner's risk factors when assessing risk and do not rely solely on what the prisoner says or how he presents; and

    - mental health staff should be involved before closing an ACCT on a prisoner who is under the care of the mental health in-reach team.
- The Governor should ensure that staff attempt to facilitate telephone or video contact with prisoners' families during the pandemic.
- The Governor should share this report with SO A and ensure that a senior manager discusses the Ombudsman's findings with him.
- The Head of Healthcare should ensure that:
    - there is a system for monitoring, documenting, and prioritising of referrals to Bradley Therapy Services (BTS); and
    - arrangements are made to allow certain services, such as BTS and substance misuse services, to continue during the pandemic.
- The Governor and Head of Healthcare should ensure that staff use a translation service when discussing sensitive or complex matters with prisoners who do not speak English well.
- The Governor should share this report with Officer A and ensure she is aware of the Ombudsman's findings.
- The Governor should ensure that vulnerable prisoners are identified and have regular and meaningful priority key worker sessions during the restricted pandemic regime.
- The Governor should share this report with Officer B and ensure she is aware of the Ombudsman's findings.

The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Maidstone informing them of the investigation and asking anyone with relevant information to contact her. One member of staff responded.

20. Due to restrictions in response to the COVID-19 pandemic, the investigator was unable to visit Maidstone or view CCTV footage. She obtained copies of Mr Cristea's prison, medical and substance misuse records by email.

21. NHS England commissioned a clinical reviewer to review Mr Cristea's clinical records.

22. The investigator interviewed eleven members of staff and two prisoners between September and December 2020. The clinical reviewer joined her for nine of the interviews. All the interviews were conducted by telephone because of the COVID-19 restrictions. We also apologise for the delay in issuing the initial report and for the additional distress this will have caused his family.

23. We informed HM Coroner for Kent of our investigation. The coroner provided us with a copy of the post-mortem report. We have sent the Coroner a copy of this report.

24. We contacted Mr Cristea's cousin, his nominated next of kin, to explain the investigation (by means of a letter translated into Romanian). She did not raise any matters for the investigation to consider.

25. The initial report was shared with HM Prison and Probation Service (HMPPS) who highlighted two factual inaccuracies, which have been amended in the final report.

Background Information

HMP Maidstone

26. HMP Maidstone is a category C prison that holds up to 600 foreign national prisoners. Healthcare services, including mental health services, are provided by Oxleas NHS Foundation Trust. Substance misuse services are provided by the Forward Trust.

HM Inspectorate of Prisons (HMIP)

27. The most recent full inspection of HMP Maidstone was in October 2018. Inspectors found that relationships between staff and prisoners were generally good, and that a higher than usual proportion of prisoners said they were treated with respect by staff and felt safe. The Safer Custody team had begun to address weaknesses in the ACCT assessments and case reviews, but telephone interpreting was not always used in ACCT reviews and Home Office staff rarely attended them.

28. HMIP also carried out a Short Scrutiny Visit in June 2020 to look at how the prison was responding to the COVID-19 pandemic. Inspectors reported that managers had taken effective measures to contain the spread of COVID-19 and were maintaining regime restrictions. Staff and prisoners were becoming concerned about the impact that such a prolonged restricted regime was having on prisoners' well-being. Inspectors were concerned that there were no systematic welfare checks in place to identify any decline in prisoners' mood and that some prisoners had had no recorded contact at all since lockdown began. Key work for vulnerable and complex prisoners had returned but was inconsistent and had declined since May.

29. Prisoners were unlocked for no more than an hour each day. Managers had considered options to improve the very limited time out of cell but had not felt able to do so due to national guidelines and the concerns of staff associations. The suspension of visits continued to negatively affect many prisoners and HMPPS had still not provided video calling facilities. The failure to make use of additional mobile handsets was a missed opportunity to promote family contact, given the lack of in-cell phones. The Chief Inspector said that, given that the spread of COVID-19 had been well contained, he was disappointed and concerned that at this stage even the most modest local initiatives to increase time out of cell, had, for whatever reason, been frustrated.

30. In addition to these pressures, Maidstone's foreign national population faced additional anxiety about their immigration status. Due to the withdrawal of several agencies, there was too little information or support available to them and not enough had been done to reinforce messages about the regime in languages other than English.

Independent Monitoring Board

31. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2020, the IMB reported

that prisoners were safe and bullying and violence were swiftly addressed. Healthcare provision was generally good, and staff were helpful and supportive. Positive interactions between staff and prisoners were generally commonplace, and the Board had seen examples of good keyworker interactions (although the frequency of sessions was affected by chronic staff shortages). The wing staff were good at identifying vulnerable prisoners and worked well with other agencies to manage them. However, an ongoing concern was that ACCT documents were still not being completed appropriately, both by prison and other staff, despite retraining sessions and efforts from some managers.

32. Although the report was completed prior to the start of the COVID-19 pandemic, the Board added a note that that the prison was applying the restrictions required by HMPPS. They were concerned that for many foreign national prisoners, contact with families outside the UK had been almost impossible.

Previous deaths at HMP Maidstone

33. Mr Cristea's death was the first death at Maidstone since 2015. The previous death was also self-inflicted. There are no similarities between our findings in the investigation into Mr Cristea's death and our findings for the previous death.

Psychoactive Substances (PS)

34. Psychoactive substances are illicit substances which are difficult to detect and can affect users in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with heightened energy levels, a high tolerance of pain and a potential for violence. Besides evidence of damage to physical health, there is potential for worsening the deterioration of mental health with links to suicide or self-harm.

Assessment, Care in Custody and Teamwork (ACCT)

35. 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.

36. 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 made at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

37. 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.

Key Events

38. On 14 July 2018, Mr Petrut Cristea was remanded into prison custody charged with grievous bodily harm. He was taken to HMP Pentonville.

39. Mr Cristea was assessed in reception by a nurse and no health issues were identified. He was Romanian and spoke little English, but staff recorded that they were able to communicate with him in Romanian, Spanish and Italian.

40. On 4 January 2019, Mr Cristea was sentenced to seven years imprisonment.

41. On 15 March, Mr Cristea was transferred to HMP Maidstone, a prison exclusively for foreign national prisoners. On arrival he was assessed as not having any physical or mental health issues.

42. In May, a worker with Forward Trust, the substance misuse service, referred Mr Cristea to the mental health in-reach team. No reason is recorded.

43. Also, in May, Mr Cristea was placed on the basic regime under the Incentives and Earned Privileges (IEP) scheme (which rewards prisoners with access to more facilities depending on their custodial behaviour) after breaching prison rules and failing a Mandatory Drugs Test (MDT).

44. Later that month, an officer referred Mr Cristea for support by safer custody peer support workers because of concerns that he was at risk of getting into debt after borrowing vapes (e-cigarettes). The officer noted that it was difficult to get Mr Cristea to understand what he was saying.

ACCT: 30 – 31 May 2019

45. On 29 May, Mr Cristea was placed on a disciplinary charge for fighting with another prisoner and on 30 May, ACCT procedures were started after he made cuts to his arms. Mr Cristea said, with translation assistance from another Romanian prisoner, that he had been silly and realised he should not have harmed himself. The ACCT was closed after a case review on 31 May.

46. In early June, Mr Cristea told a safer custody officer that he owed a prisoner money for psychoactive substances (PS). The officer discussed ways in which Mr Cristea could repay the debt and to avoid confrontation, but recorded that Mr Cristea seemed to have no inclination to do so and said he was “happy to fight”. As a result, Mr Cristea was removed from his employment (to avoid contact with the other prisoner) and given another job.

47. On 13 June, Officer A had her first key worker session with Mr Cristea. She recorded that he said he could not understand her and needed a friend to translate, but that wing officers told her that Mr Cristea could speak English and they had had many conversations with him. When she confronted Mr Cristea with this information, he laughed and said it was just her he could not understand. When she saw him again a week later, Mr Cristea told her he did not like his wing and had not made friends there.

48. On 14 June, Mr Cristea was seen by a mental health nurse in response to the earlier Forward Trust referral. Mr Cristea declined to engage. The nurse

recorded that she observed no psychotic symptoms and discharged him from the care of the in-reach team.

49. Later that month, Mr Cristea was referred to be managed under a Challenge, Support and Intervention Plan (CSIP), a case management model for working with violent prisoners, after he assaulted another prisoner and was dismissed from his workshop after becoming aggressive to the instructor.

ACCT: 26 – 27 June 2019

50. On 26 June, an ACCT was opened after Mr Cristea was found with a noose round his neck. He threatened to kill an officer and said he would cut his own throat. He was segregated after being assessed as medically fit. ACCT procedures were closed after a case review the following day when Mr Cristea said he was frustrated at being on the basic regime but did not intend to self-harm because he "had a family".

51. On 2 July, he was seen by the mental health nurse again. He said that he had no mental health issues or concerns. She told him that he could access the services of the in-reach team at any time.

ACCT: 8 July – 22 July 2019

52. On 8 July, ACCT procedures were opened again after Mr Cristea made superficial cuts to his arm and said he had swallowed 25 paracetamol tablets. He was taken to hospital where he received treatment. He was discharged from hospital that evening with a letter asking that he have a mental health assessment.

53. On 10 July, a mental health nurse saw Mr Cristea. She recorded that he did not want to use the telephone interpreting service and that he asked another prisoner to interpret for him. He told the nurse that he had anger management issues and that he had harmed himself deliberately but had no plans to take his life. She referred him to Bradley Therapy Services (BTS), a psychological counselling service. There is no evidence in Mr Cristea's medical notes that he received counselling.

54. On 12 July, Mr Cristea was moved to the segregation unit after making a noose, smashing the observation panel in his cell door and not engaging with staff. He told a senior manager that he was frustrated because he had been on the basic regime for over a week and had no TV, kettle or radio and had not had a shower for three days. She arranged for him to return to a new wing for a fresh start, and the following day he was given a radio and a new job. Staff recorded that he seemed settled on his new wing, was interacting with other Romanian prisoners and that he said he had stopped "smoking drugs".

55. On 15 July, Mr Cristea was seen by a mental health nurse for a mental health review. She noted no psychotic features but recorded that he had anger management issues and acted impulsively when he was angry. He discussed childhood trauma and she noted that he would "benefit a lot" from counselling by BTS. She noted that his risk of self-harm was high.

56. On 22 July, an ACCT review was held, attended by a mental health nurse, and Mr Cristea said he was much happier on his new wing. The ACCT was closed, and he was returned to the standard regime.

57. On 30 July, Mr Cristea was prescribed sertraline, an antidepressant, and there was another reference to referring him to BTS for counselling. In early August, he was seen by a psychiatrist. She noted that he had marked antisocial and emotionally unstable personality traits against a background of substance misuse problems. She also noted that he had difficulty managing his impulsive behaviour and that his long-term risk of self-harm and suicide remained high. She advised him against using PS and said he should be referred to BTS.

58. On 28 August, Mr Cristea was seen by a mental health nurse. He said he felt fine and had stopped taking the sertraline. She discharged him from the mental health team's caseload but told him he could refer himself again at any time.

59. Over the next few months, Mr Cristea spent several periods in the segregation unit after a series of incidents, smashing his kettle, television and cell observation panels and threatening staff with violence, often after he had used illicit drugs.

60. In September, a Supervising Officer (SO) noted that he had spoken to Mr Cristea after another prisoner expressed concern about him. The SO recorded that Mr Cristea had spent all but one week of the previous three months on the basic regime and that he found it hard to cope locked in his cell. He also noted that Mr Cristea did not speak much English and found it hard to communicate. Mr Cristea said he was very sorry for his behaviour and was keen to make a fresh start.

61. At the beginning of October, Mr Cristea was returned to the standard regime and staff recorded that it had been decided to support him outside the CSIP process and to use his key worker to challenge his behaviour and help him find different ways of dealing with situations that made him angry. He was seen again by the psychiatrist, who noted that he seemed brighter. He told her he was feeling better and did not think he needed much input from mental health.

62. Mr Cristea had regular, roughly weekly, contact with Officer A, his keyworker. Other prisoners usually acted as translators during their sessions. In September, he told her he was "stressed" and that other prisoners thought he was a "terrorist", although he could not explain why. She noted that she would refer him to the mental health team to help with his stress. In late October, he told her he had not used PS "for a while" and she noted that he seemed much more settled and happier. By the end of November, she recorded that he had received a number of positive IEP entries for helpful behaviour on the wing.

63. However, at the beginning of December, Mr Cristea was found under the influence of an illicit substance and was removed from his English language course for being "completely uncooperative".

64. Officer A saw Mr Cristea on 24 December, with translation provided by another prisoner. She recorded that he seemed agitated and said he was disappointed and upset to be in prison at Christmas instead of Romania. The atmosphere was strained, and he said that prisoners on his wing were shouting out of their

windows at night that he was a terrorist. He also said he wanted to move to a new wing as "there were too many snitches" on his wing. She contacted staff on Mr Cristea's wing to let them know what he had said.

2020

65. At the beginning of January, Mr Cristea was moved to a different wing as he said he was being bullied on his previous wing. On 7 January, he was downgraded to the basic regime after he appeared to be under the influence of drugs and refused to take an MDT. On 8 January, he again refused an MDT. Officer A tried to have a keyworker session with him, but he appeared angry, started punching himself in the head and shouting in Romanian, and swore at her.

66. Later that month he was sacked from his job and placed on a disciplinary charge after being found under the influence of an illicit substance. Officer A saw him on 28 January and encouraged him to engage with the Forward Trust to address his drug use, but he refused to see them.

67. In February, Mr Cristea was upgraded to the standard regime and was given a new job. Officer A reported that he was positive and vastly different from her recent sessions with him. His workshop supervisor wrote two positive entries in his case notes about his enthusiasm and work ethic. She told him that if he maintained his good behaviour for three months, he could be put on the enhanced regime.

68. On 17 March, Mr Cristea refused to provide an MDT sample and an illicit mobile phone was found in his cell. He was downgraded to the basic regime. He told Officer A that he felt trapped in a cycle of basic regime and drug misuse. He agreed she should refer him to the Forward Trust.

69. He was placed on a disciplinary charge for the breaches of prison discipline and for threatening staff and on 19 March, he received a punishment of 10 days cellular confinement in the segregation unit. On the same day a Romanian speaking priest told mental health in-reach staff that Mr Cristea was expressing delusional ideas. It was agreed that in-reach staff would monitor him in the segregation unit.

ACCT: 20 March 2020

70. On 20 March, Mr Cristea appeared distressed and told an officer that he would cut his own throat. ACCT procedures were put in place but were closed a few hours later after he said he had been frustrated at being put on a new disciplinary charge for damaging his radio. He said repeatedly that he wanted to go back to Romania where he had children and a large family of siblings and that he did not want to spend any more time in prison.

71. Mr Cristea's Offender Supervisor noted that he appeared to have few coping strategies when faced with difficult situations. She discussed him with the Safer Custody department, and it was agreed that he would benefit from a referral to the Forward Trust as it was possible that substance misuse was underpinning his behaviour.

72. On 26 March, an officer recorded that Mr Cristea's behaviour had been very up and down during his time in the segregation unit: he could be polite and compliant but, more often than not, he was non-compliant and confrontational. The officer recorded that he thought this was partially due to Mr Cristea's poor grasp of English "which means that he cannot understand what is going on and this makes him frustrated".

73. On 27 March, he was given a fresh start on a new wing and staff said that he appeared to be settling down. He was engaging with staff, talking to other prisoners and his mood seemed brighter. However, due to the pandemic, the Forward Trust was unable to continue its rehabilitation work in the prison and counselling did not take place.

ACCT: 29 March – 29 April 2020

74. On 29 March, Mr Cristea cut his arm and then swallowed a razor blade in front of an officer, describing himself as the devil. ACCT procedures were started. During his ACCT assessment with a Custodial Manager (CM), he became very agitated. He said he had been "beaten, raped and tortured" at Maidstone and that he should be released as his sentence had expired. A case review was held immediately after the assessment, attended by the CM and the wing manager. Mr Cristea's behaviour was erratic during the review. He said that other prisoners were taunting him when he was locked in his cell, but there was no evidence of this.

75. Those present concluded that Mr Cristea's mental health appeared to be deteriorating, but they assessed his risk of harm as low and the likelihood of further risk behaviours as low. They set the observation rate as once an hour and arranged another case review for the following day when a member of the mental health team could attend. The caremap contained three actions: a referral to the mental health in-reach team for possible mental health issues; the issue of a distraction pack to help Mr Cristea cope with boredom; and reassurance by staff in response to his belief that other prisoners were talking about him outside his cell.

76. During the night, Mr Cristea self-harmed by making superficial cuts to his neck.

77. On 30 March, a SO held an ACCT review with an officer and the mental health in-reach team leader. Mr Cristea was distressed and said he wanted to be released immediately and that he would stop eating. He said that when he had cut his neck, "the bad had come out of him", but now that the blood had been cleaned up, he "would suffer". The in-reach team leader considered that Mr Cristea had a personality disorder rather than mental health issues. His risk was assessed as low.

78. On 6 April, Officer A emailed the safer custody team, the Forward Trust and the offender management unit setting out her concerns about Mr Cristea's erratic behaviour and aggressive outbursts. He was not making sense when he spoke to her and other Romanian prisoners had said they were worried about him. She said he was not coping well with the restricted COVID regime and she asked for a more detailed review.

79. At another ACCT review on 14 April, Mr Cristea's risk was assessed as raised. He continued to make superficial cuts to his body and refused to see healthcare staff. Officer A attempted to speak to him twice but recorded that he was very aggressive and appeared to have taken a dislike to her. A few days later, she recorded that he had come towards her on the landing with his fist clenched and that she had feared for her safety.

80. At the ACCT review on 15 April, another action was added to the caremap: to obtain contact details for Mr Cristea's family so he could contact them. (Details were obtained but there is no evidence they were used to enable Mr Cristea to contact his family before his death.)

81. On 20 April, Mr Cristea had a disciplinary hearing for damage to property and threatening behaviour to staff and received a punishment of 10 days cellular confinement in the segregation unit. The Duty Governor considered whether it was appropriate to segregate him while he was on an ACCT and concluded that Mr Cristea could not be safely located on a standard wing because of his threatening behaviour towards a number of female staff. It was also noted that his behaviour towards the telephone service translator used during the adjudication had been "deplorable".

82. On the same day, his offender supervisor submitted a re-categorisation form as staff considered Mr Cristea would be better managed in a higher security prison. She noted that she thought that the mental health in-reach team might be able to help suggest ways of managing him, but that they were not answering their phones.

83. On 22 April, Mr Cristea had a further case review led by a SO and a telephone interpreting service was used. Mr Cristea said that he did not have contact details for his family, but that he was feeling stressed and wanted to go home. Staff explained that this was not possible as he was not eligible for the Early Release Scheme (ERS) until April 2021. He also said that he did not need mental health help as he was not mad but just had a headache and slept standing up.

84. On 27 April, Mr Cristea was moved out of the segregation unit to a standard wing. An ACCT case review was attended by two custodial managers, the mental health in-reach team lead and Mr Cristea, with the assistance of a telephone interpreting service. They explained to Mr Cristea that he would be given a caseworker to help arrange his return to Romania when he was nearer to his early release date. His level of risk remained as raised and his level of observations remained at one an hour.

85. On 29 April, SO A and the mental health in-reach team lead held an ACCT review with Mr Cristea. They did not use a translation service as Mr Cristea said he could understand "okay". He told them he was feeling "good". The SO told the investigator that he knew Mr Cristea well from having supported him through the ACCT process several times and being on his wing. Mr Cristea said that he was happy to be back on the wing, he was sleeping well, and he knew his release date and how to ask for help if he needed it. They concluded that the caremap issues had all been resolved and that the ACCT should be closed. When Mr Cristea was asked how he felt about that, he shrugged his shoulders.

86. On 8 May, Mr Cristea was found in possession of some paper which tested positive for PS. On 17 May, he was visibly under the influence of an illicit substance when he went to collect his meal and had to be walked back to his cell.

ACCT: 29 – 30 May 2020

87. On 29 May, ACCT procedures were opened after Mr Cristea cut his stomach. An officer conducted an ACCT assessment. Mr Cristea began crying on several occasions and the officer described him as looking unkempt and as suffering "extreme amounts of stress due to his sentence and fear". He told the officer that his cell was "haunted" and asked to move to another cell. He said he felt threatened but was not clear who he felt threatened by. He said he was lonely because he could not speak to his family. He also said that he would kill himself but that he did not want to die. The officer noted that Mr Cristea's issues were sentence-related stress, lack of family contact, possible bullying and possible debt/financial issues. Staff moved Mr Cristea to a new cell on a different floor, near to some Romanian prisoners.

88. The next day, SO A, the officer and a general nurse conducted an ACCT case review in the morning using a telephone interpreting service. Mr Cristea said that he had been feeling 'down' the previous day as he did not have a television. He could not say why he had cut himself but said he would not harm himself again as he wanted to go home next April and did not want to die. He asked for a CD player and for batteries to operate his vape pen. The SO said that he would sort out a canteen order form for him. He identified two actions for the caremap: to check Mr Cristea's release date and to move him to another cell as he did not like his cell.

89. The staff present at the case review assessed Mr Cristea's risk to himself as low and decided that the ACCT document should be closed because Mr Cristea no longer had thoughts of self-harm and did not have any more issues to resolve. He was reminded to speak to staff for support or ask another prisoner to alert them. A post-closure interview was arranged for 4 June.

90. On the morning of 31 May, an officer spoke to Mr Cristea for a priority key worker session. He recorded that they had a brief chat and Mr Cristea seemed happier than when he had last seen him and said that he "was doing ok". The officer had no concerns about him.

Events of 1 June 2020

91. Prisoner A told the investigator that at about 9.00am he was cleaning the corridor where Mr Cristea's cell was located. Mr Cristea, who was in his cell, called him over and asked him for a vape. He told him that he did not have one as he did not smoke. He said that Mr Cristea then remarked, "An officer pissed me off". He said he assumed Mr Cristea was referring to Officer B, but he did not ask him what he meant, and Mr Cristea did not elaborate.

92. At 9.47am, an officer unlocked Mr Cristea's cell for association. He found him suspended by a ligature around his neck which was tied to the window. He shouted for assistance from two officers who were nearby and radioed a code blue (an emergency medical code indicating that a prisoner is unresponsive or

having breathing difficulties). An ambulance was called immediately by the communications room. The officer entered the cell and supported Mr Cristea's weight while another officer cut the ligature around Mr Cristea's neck. They laid Mr Cristea on the cell floor and an officer began CPR. Two nurses arrived and alternated CPR with the officers.

93. Hospital paramedics arrived and took over Mr Cristea's care. After 35 minutes of CPR, they detected a weak pulse and Mr Cristea was taken to hospital by ambulance.

94. On 3 June, Mr Cristea had a brain scan, which showed that there was no brain activity. His family in Romania were contacted and agreed that his life support machine could be switched off and his organs donated. He died on 4 June.

Contact with Mr Cristea's family

95. Mr Cristea did not have any family in the UK. A prison family liaison officer and a manager contacted Mr Cristea's cousin in Romania, who was named as his next of kin, and broke the news of Mr Cristea's death. The Romanian Embassy assisted with arrangements for his repatriation.

96. The prison contributed to the cost of Mr Cristea's repatriation and funeral, in line with national policy.

Support for prisoners and staff

97. After Mr Cristea was taken to hospital, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team offered support to staff.

98. The prison posted notices informing other prisoners of Mr Cristea's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Cristea's death.

Interview with Officer B

99. In the light of Prisoner A's statement, the investigator asked Officer B why Mr Cristea might have said that she had "pissed him off" shortly before he was found hanging. She said she had not known about Mr Cristea's alleged comment until the investigator raised it and she was adamant she could not think why he would have said that. She said that after Mr Cristea's death, a prisoner told a SO that Prisoner A was saying she was the cause of Mr Cristea's death, but she put this down to the fact that there had been a poor rapport between her and Prisoner A since 2019.

100. Officer B said she did not have much contact with Mr Cristea. She said that when he first arrived on Kent wing in 2019, he told her that she was a racist, but apologised to her later that day. She said she last saw Mr Cristea on 31 May when he completed his list of items he wanted to buy from the canteen (prison shop).

101. Another member of staff said that that Mr Cristea had asked Officer B for a vape on the morning he hanged himself, and that she had declined to give him one (rightly in their view).

102. We note that Officer B made only two brief entries in Mr Cristea's prison record during his time at Maidstone: one in April 2019 recording that an unauthorised radio had been found in his cell, and one on 1 May 2020 recording that he had been misusing his cell bell.

Post-mortem report

103. The post-mortem examination gave Mr Cristea's cause of death as suspension (hanging).

104. No PS or other illicit drugs were detected in his system after his death, but the pathologist noted that no toxicology tests had been done when Mr Cristea was admitted to hospital three days before he died. The possibility that Mr Cristea had taken drugs before he hanged himself cannot, therefore, be ruled out as the substances may have passed through his body before he died.

Findings

Management of Mr Cristea's risk of suicide and self-harm

105. Prison Service Instruction (PSI) 64/2011 gives guidance to staff on how to identify, manage and support prisoners who are at risk of harm to themselves. It sets out the procedures (known as ACCT) that must be followed whenever staff assess that a prisoner is at risk of suicide or self-harm, and requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action.

106. Mr Cristea had a number of risk factors for suicide and self-harm. It was his first time in prison in the UK, he did not have any family in the UK, he harmed himself or threatened to do so several times, and he was known to misuse drugs, which left him vulnerable to debt. He appeared to be struggling to cope in prison and frequently breached prison rules and spent much of his time on the basic regime or in the segregation unit. He was also impulsive and responded to difficulties by self-harming, smashing prison property or becoming aggressive.

107. We are satisfied that ACCT procedures were appropriately opened when Mr Cristea self-harmed, although we are concerned that the procedures were sometimes closed after only a day when Mr Cristea said he had no more thoughts of harming himself and appeared less 'down'.

108. We note that staff and managers recognised that Mr Cristea was impulsive and vulnerable, and he was frequently given a 'fresh start' on a new wing and found new employment after a period of poor behaviour.

109. In March 2020, Maidstone, like other prisons, introduced a severely restricted regime in response to the COVID-19 pandemic. Prisoners spent no more than an hour a day out of their cell and opportunities for socialising were severely curtailed. It is clear that Mr Cristea found it very difficult to cope with such a restricted regime, spending so much time alone in his cell.

ACCT: 29 March - 29 April 2020

110. Staff appropriately opened ACCT procedures on 29 March 2020 when Mr Cristea self-harmed. His behaviour over the next few weeks was described as "erratic" and staff expressed concerns that his mental health was deteriorating (for example, he believed that other prisoners were taunting him from outside his cell although there was no evidence that this was happening). He found it difficult to understand why he had to remain in prison and could not be released immediately, and he talked a lot about wanting to speak to his family in Romania.

111. We consider that it was appropriate that he continued to be supported under ACCT for a four-week period. We are, however, concerned that although contact with his family was identified as an issue on the ACCT caremap, there is no evidence that anyone attempted to facilitate contact, even after his family's details had been obtained.

112. We also consider that the ACCT was closed prematurely. Mr Cristea had only moved from the segregation unit back to a standard wing on the morning of 27

April and was still on hourly observations when the ACCT was closed two days later.

113. The final ACCT review was chaired by SO A. Although he recorded that he knew Mr Cristea "very well", we are concerned that he had not been involved in any of the ACCT reviews over the previous month, and that his knowledge of Mr Cristea was therefore not up to date or informed by the many multi-disciplinary discussions that had taken place. He also recorded, incorrectly, that all the caremap issues had been completed, although nothing had been done to facilitate contact with Mr Cristea's family.

114. In addition, SO A's record of the ACCT review suggests that he relied too heavily on the fact that Mr Cristea said he was feeling "good" and would speak to staff if he had any further problems. All the previous evidence suggested that Mr Cristea's moods were very changeable and that when he had concerns or felt distressed, he did not speak to staff but instead self-harmed or behaved aggressively. We think that it would have been preferable to have allowed a little longer to see how Mr Cristea settled on the wing before the ACCT was closed, particularly given the restricted regime that would limit the amount of contact he had with staff.

115. SO A saw Mr Cristea for an ACCT post-closure review on 4 May, when he recorded that Mr Cristea was generally happy to engage. Otherwise, there is very little evidence of staff contact with Mr Cristea during May, apart from a record that he was misusing his cell bell on 1 May, a suspicion that he had been using PS on 8 May, a record that he had been under the influence of drugs on 17 May, and a note of a brief 'priority key worker session' on 19 May when it was recorded that he had just woken up and was "not very forthcoming". In addition, a student nurse made a retrospective entry (after Mr Cristea had been found hanging and taken to hospital) that she had conducted a welfare check on 21 May when Mr Cristea had been "sleepy but welcoming" and had made it clear that he did not need any input from the in-reach team.

116. Mr Cristea was a complex and vulnerable individual who had recently been managed under ACCT for a month and we would have expected to see more welfare checks during this time.

ACCT: 29 – 30 May 2020

117. We are also very concerned that, although an ACCT was opened appropriately when Mr Cristea self-harmed again on 29 May, it was closed the following morning. We consider that this was premature. At the assessment interview immediately after the self-harm incident, Mr Cristea had been distressed and was described as unkempt and suffering extreme amounts of stress. His issues were identified as sentence-related stress, lack of family contact, possible bullying and possible debt/financial issues.

118. We are concerned that at the ACCT review the following morning, SO A once again relied on Mr Cristea's assertions that he had no intention of further self-harm and that he did not want to die. We consider that previous experience had shown that Mr Cristea acted impulsively when he was upset and that his assertions could not therefore be relied upon.

119. We are also concerned that insufficient attention was paid to what may have been a deterioration in Mr Cristea's mental health. Although SO A recorded that Mr Cristea had been moved to a new cell because he did not "like" his previous cell, what Mr Cristea had said was that he thought his previous cell was "haunted". This may have been a sign that he was hearing voices and should have been explored. We are concerned that despite this and Mr Cristea's previous contact with the mental health in-reach team, no one from the in-reach team was involved before the ACCT was closed.

120. In addition, the issues identified during the ACCT assessment were not all reflected in the caremap – including the possibility that Mr Cristea's known recent substance misuse might have meant he was in debt - and there was once again no attempt to facilitate contact with Mr Cristea's family.

121. Given Mr Cristea's complex presentation, his impulsivity, his repeated self-harming behaviour, his mental health issues and the fact that he had recently been managed under ACCT procedures for a month, we consider that SO A's risk assessment was poor and that he placed too much reliance on what Mr Cristea said and how he 'appeared' and gave insufficient weight to his known risk factors and previous history.

122. We make the following recommendations:

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

- **staff understand the need to consider a prisoner's risk factors when assessing risk and do not rely solely on what the prisoner says or how he presents; and**
- **mental health staff should be involved before closing an ACCT on a prisoner who is under the care of the mental health in-reach team.**

The Governor should ensure that staff attempt to facilitate telephone or video contact with prisoners' families during the pandemic.

The Governor should share this report with SO A and ensure that a senior manager discusses the Ombudsman's findings with him.

Clinical care

123. The clinical reviewer concluded that the physical and mental healthcare Mr Cristea received at Maidstone was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

124. She noted that he had no significant physical health conditions and that he was seen appropriately by healthcare staff following injuries and self-harm incidents.

125. She also noted that he was seen regularly by the mental health in-reach team and that a member of the team attended a large number of ACCT reviews, particularly in 2020. The team also undertook comprehensive mental health assessments on referral and following self-harm incidents, and Mr Cristea was also seen twice by a psychiatrist. Follow-ups and welfare checks appeared to be

timely, taking into account the staff shortages during the pandemic. On a number of occasions Mr Cristea refused to engage with the mental health team.

126. The clinical reviewer also noted that Mr Cristea was under the care of the Forward Trust for his substance misuse issues and that prior to the pandemic, he was seen approximately once a month, although he did not always want to engage, and language difficulties limited the work that could be done with him.

127. The clinical reviewer did, however, identify some concerns.

Access to healthcare services during the pandemic

128. The clinical reviewer was concerned that COVID-19 restrictions had a significant impact on the prison's healthcare regime, resulting in reduced services being provided and reduced capacity.

129. Once the COVID-19 regime restrictions were in place from March 2020 onwards, Mr Cristea had only one further brief contact with the Forward Trust, on 23 April. A member of the team also contacted the wing on 11 May for an update on Mr Cristea's progress. However, the clinical reviewer has considered that there was no evidence that Mr Cristea's self-harm was linked to his substance misuse.

130. Mr Cristea was referred to Bradley Therapy Services (BTS) on 12 July 2019 as it was felt he would "benefit a lot" from counselling. This was noted again on 30 July 2019, 7 August 2019 and 6 April 2020. The clinical reviewer considered that psychological counselling could have helped Mr Cristea develop healthier coping strategies and that it could have provided him with support at times of heightened risk.

131. The Head of Healthcare told the investigator that BTS was not able to see prisoners from March 2020 due to the COVID-19 restrictions. However, this does not explain why Mr Cristea was not referred to BTS before March 2020. The clinical reviewer considered that the process for making and monitoring referrals to BTS needs to be improved. She also considered that arrangements should have been made to allow certain key services to continue during the pandemic. We agree and take the view that prisoners need such services more than ever when the regime is severely restricted.

132. We recommend:

The Head of Healthcare should ensure that:

- **there is a system for monitoring, documenting, and prioritising of referrals to Bradley Therapy Services (BTS); and**
- **arrangements are made to allow certain services, such as BTS and substance misuse services, to continue during the pandemic.**

Translation

133. There are repeated references in Mr Cristea's records to his poor English. Although some officers, including SO A, said that it was possible to have a conversation with him, others thought that Mr Cristea did not fully understand what was going on and that this was a cause of frustration for him.

134. We are concerned that some significant interactions with Mr Cristea took place without any translation assistance, most notably the ACCT review on 29 April 2020 and the subsequent post-closure review on 4 May. We do not consider that it was safe to assume that Mr Cristea understood everything that was being said to him or that he would have been able to discuss the complexities of his mood and feelings.

135. We are also concerned that some other significant interactions, including some ACCT reviews, mental health assessments and discussions with his key worker, took place with translation provided by another Romanian prisoner. These should have been confidential discussions at which Mr Cristea was free to talk openly about his concerns. Using other prisoners, even if they appeared to be friends of Mr Cristea's, meant that his vulnerabilities were shared and put him at risk of bullying and exploitation. In addition, there was no guarantee that other prisoners had the vocabulary to translate complex matters or that they translated accurately.

136. We appreciate that Mr Cristea did not always want to use an official translation service and that he was sometimes abusive to the official translators. However, we do not consider it was acceptable to discuss sensitive and private issues with him in the presence of other prisoners.

137. We recommend:

The Governor and Head of Healthcare should ensure that staff use a translation service when discussing sensitive or complex matters with prisoners who do not speak English well.

The key worker scheme

138. We commend Officer A, Mr Cristea's keyworker, for the way she kept frequent contact with him, making regular clear, timely and meaningful observations on his progress or setbacks, and offering support.

139. However, during the pandemic, the key worker scheme was suspended across the Prison Service. Officer A's last key worker session with Mr Cristea was on 17 March 2020 and her last recorded contact with him was on 18 April 2020. This was a pity, as she knew Mr Cristea well and was well placed to identify and report any deterioration in his mood or mental state.

140. We were told that when the key worker scheme was suspended, wing officers at Maidstone made special welfare checks every few days on vulnerable and complex prisoners. These were known as 'priority key worker sessions.'

141. We would have expected Mr Cristea to have been seen regularly to check his well-being after his month-long period on ACCT ended on 29 April 2020. In fact, he was seen only three times, on 10, 19 and 31 May, and all sessions were brief. He was also seen on 21 May by a student nurse who did not know him.

142. We do not consider that this was enough to make meaningful checks on the welfare of such a vulnerable prisoner. This may have been a missed opportunity to identify that Mr Cristea's mood or mental state was deteriorating.

143. We recommend:

The Governor should share this report with Officer A and ensure she is aware of the Ombudsman's findings.

The Governor should ensure that vulnerable prisoners are identified and have regular and meaningful priority key worker sessions during the pandemic.

Officer B's role

144. A prisoner said that Mr Cristea had told him that Officer B had "pissed him off" shortly before he hanged himself on 1 June. We have found no evidence to suggest that the officer acted inappropriately to Mr Cristea or that she was in any way responsible for his death. We recommend:

The Governor should share this report with Officer B and ensure she is aware of the Ombudsman's findings.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141