

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rafal Bozek, a prisoner at HMP Altcourse, on 7 October 2021

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Rafal Bozek was found hanged in his cell at HMP Altcourse on 7 October 2021. He was 36 years old. I offer my condolences to Mr Bozek's family and friends.

Mr Bozek arrived at Altcourse with a fractured shoulder on 15 June 2021. Two months later, staff started suicide and self-harm monitoring (known as ACCT) after Mr Bozek cut his arms because he was in a lot of pain. Staff stopped ACCT monitoring on 17 September. A few days later, Mr Bozek was sentenced to 30 months in prison. Staff extended the ACCT post-closure period after Mr Bozek said he was worried that he would be deported to Poland.

On 29 September, Mr Bozek was transferred to HMP Risley, but he was moved back to Altcourse two days later. He attended an immigration surgery on 6 October and was found hanging the next day.

The investigation found that the ACCT was managed reasonably well initially. However, the post-closure period was managed poorly. The ACCT was not handed over to Risley and no one realised that Mr Bozek was still in the post-closure period when he returned to Altcourse.

The clinical reviewer found that aspects of Mr Bozek's physical healthcare were not equivalent to the care he could have expected to receive in the community.

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

June 2022

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Summary

Events

1. Mr Rafal Bozek was remanded to HMP Altcourse, charged with arson, on 15 June 2021. He was a Polish national but had spent many years in the UK. This was his first time in prison.
2. When he arrived, Mr Bozek complained of shoulder pain following a motorbike accident. He had an X-ray on 28 June, which showed he had fractured his shoulder. On 13 August, a prison GP made an urgent referral to the hospital's fracture clinic.
3. On 24 August, Mr Bozek made cuts to his arms. He told staff he was in a lot of pain and was still waiting to be seen in the fracture clinic. Staff started suicide and self-harm monitoring (known as ACCT).
4. Mr Bozek attended the fracture clinic on 7 September. He subsequently told a prison GP that he was still feeling low so the GP prescribed antidepressants.
5. Staff stopped ACCT procedures on 17 September.
6. Mr Bozek was sentenced to two and a half years imprisonment on 21 September.
7. During a post-closure ACCT review on 24 September, Mr Bozek told the officer that he was worried about being deported to Poland following his conviction. Staff extended the post-closure period to 8 October. The officer noted that they would liaise with the safer custody team and equalities team so they could give Mr Bozek some guidance.
8. On 29 September, while at the medications hatch, Mr Bozek told staff he was going to kill himself. They made a referral to the mental health team. Mr Bozek was transferred to HMP Risley the same day. He returned to Altcourse two days later because of an outstanding court appearance. He was given a 12-week concurrent sentence.
9. Mr Bozek went to an immigration surgery at Altcourse on 6 October. He told the immigration officer he was concerned he might be deported to Poland. The immigration officer said that she had not yet received a notification about him but that in due course, he would receive a letter giving him the opportunity to make representations against deportation.
10. At 5.10am on 7 October, during a roll check, an officer saw Mr Bozek hanging from the top bunk bed. Staff did not try to resuscitate him as he was clearly dead. Paramedics confirmed Mr Bozek's death at 5.32am. Mr Bozek had left a note in his cell to say he was worried he would be deported.

Findings

11. The investigation found that while the ACCT was managed reasonably well from 24 August to 17 September, the post-closure period was managed poorly. Staff failed to reopen the ACCT when Mr Bozek told them he was going to kill himself. Actions identified at the post-closure meeting were not followed up. No one handed over

the ACCT to Risley when Mr Bozek was transferred there, and no one identified that Mr Bozek was still in the post-closure period when he returned to Altcourse two days later.

12. The clinical reviewer found that aspects of Mr Bozek's physical healthcare were not equivalent to that he could have expected to receive in the community.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that they:
 - open an ACCT if they receive information that indicates a prisoner may be at risk of suicide or self-harm;
 - carry out the actions identified to support the prisoner; and
 - handover the case if a prisoner is transferred to another prison during the post-closure period.
- The Head of Healthcare should ensure that staff label blood samples correctly to avoid delaying results.
- The Head of Healthcare should review the process for obtaining hospital blood test results.
- The Head of Healthcare should ensure that electronic tasks and messages sent by prisoners are triaged and actioned promptly.

The Investigation Process

13. The investigator issued notices to staff and prisoners at Altcourse, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Bozek's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Bozek's clinical care at the prison.
16. The investigator and clinical reviewer jointly interviewed nine members of staff, and the investigator interviewed an immigration officer. Due to coronavirus restrictions, all interviews were conducted by telephone or video.
17. We informed HM Coroner for Liverpool of the investigation. We have sent the coroner a copy of this report.
18. The Ombudsman's family liaison officer contacted Mr Bozek's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They raised no issues.
19. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified some factual inaccuracies, which have been amended in this report.
20. We provided Mr Bozek's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

HMP Altcourse

21. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside and Cheshire. It holds up to 1,164 remanded and sentenced adults and young men. G4S manage the prison and provide primary healthcare services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Altcourse was in November 2021. Inspectors noted that prisoners' safety was not "sufficiently good" and had deteriorated since the last inspection in 2017. Eight prisoners had taken their own lives; four in the last 12 months.
23. Levels of self-harm remained high and Early Learning Reviews had not been transferred into longer term safety plans. There were issues with some aspects of ACCT management, including observations being reduced without multidisciplinary input, and weaknesses with risk assessment and care plans.
24. Staffing challenges had a detrimental impact on the development of primary and mental health care.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2021, the IMB reported that there was a downward trend of self-harm, and new ACCT procedures had been fully implemented.

Previous deaths at HMP Altcourse

26. Mr Bozek was the 18th prisoner to die at Altcourse since October 2019. Of the previous deaths, 13 were from natural causes and four were self-inflicted. We have previously made recommendations about ACCT management.

Assessment, Care in Custody and Teamwork

27. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.
28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The

ACCT plan should not be closed until all the actions of the caremap have been completed.

29. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

30. On 15 June 2021, Mr Rafal Bozek was remanded in prison custody, charged with arson, and sent to HMP Altcourse. He was a Polish national but had spent many years in the UK. This was his first time in prison.
31. When he arrived, Mr Bozek complained of shoulder pain following a motorbike accident. The next day, a prison GP prescribed him a 28-day supply of paracetamol, to keep in his possession.
32. On 20 June, Mr Bozek told staff he had taken 24 paracetamol tablets because he was in pain. He said this was not a suicide attempt. Healthcare staff took the remaining paracetamol away and gave Mr Bozek charcoal to reduce its toxicity. They took a blood sample and sent it to the hospital for testing but when they called for the result, they were told the sample had been wrongly labelled so had not been processed. Healthcare staff took another blood sample, and the result came back that paracetamol levels were raised. The GP advised no further treatment but asked for repeat blood tests. The paracetamol level was within normal range the next day. Mr Bozek was unable to attend the blood clinic on 22 and 25 June because of a COVID-19 outbreak. There is no record of a rearranged appointment.
33. On 21 June, a nurse saw Mr Bozek for a mental health assessment. Mr Bozek told her he had not taken the tablets to self-harm, but because he was in pain. Mr Bozek said he had never self-harmed and had no thoughts of doing so. She noted in Mr Bozek's medical record that he needed no further input from the mental health team, and he should see the GP again about the pain in his shoulder.
34. Later that afternoon, a prison GP prescribed Mr Bozek with codeine (a painkiller) and diclofenac gel (to reduce pain and inflammation), that he could not keep in his possession. The GP referred Mr Bozek to hospital for an X-ray. Mr Bozek had the X-ray on 28 June.
35. On 27 July, a nurse spoke to Mr Bozek because he had told staff he was concerned about his mental health. Mr Bozek said his mood was quite low and he felt anxious and depressed. He said this was due to the death of his mother (though he said subsequently that she was ill) and his shoulder pain. The nurse referred Mr Bozek for a mental health assessment. Mr Bozek also sent an electronic note to the healthcare department about his deteriorating mental health.
36. Mr Bozek sent another electronic message to the healthcare department on 5 August. He wrote that he had already asked for help, that they did not care, and they wanted to deport him. A nurse saw Mr Bozek on 8 August, and a prison GP asked staff to make an appointment for him to see Mr Bozek.
37. A prison GP saw Mr Bozek on 13 August and told him he had fractured his shoulder. The GP made an urgent referral to the hospital's fracture clinic and re-prescribed codeine.
38. On 24 August, Mr Bozek made some minor cuts to his forearm. He told a nurse it was because he was in a lot of pain and was waiting to be seen in the fracture clinic. Mental health staff discussed Mr Bozek and he was added to a nurse's caseload. Staff started suicide and self-harm monitoring (known as ACCT).

39. At the first ACCT review on 25 August chaired by an officer, Mr Bozek said he was frustrated because he was in pain and was not getting appropriate medication. He also said he had a lot on his mind. The case review team agreed that a mental health nurse would see Mr Bozek, and a GP should review his pain medication. They set Mr Bozek's ACCT observations at one a day.
40. On 27 August, Mr Bozek again complained of shoulder pain and threatened to jump from the landing if he did not see a doctor or get stronger painkillers.
41. A mental health nurse met Mr Bozek on 28 August for a mental health assessment. Mr Bozek said he was struggling due to his shoulder pain and felt agitated and frustrated. Mr Bozek said he could not cope with the pain he was in. The nurse said she would ask a GP to review his pain relief, and to assess his low mood. Mr Bozek seemed happy with this and said he had no thoughts of suicide or self-harm. She noted Mr Bozek showed no signs of psychosis. A GP prescribed Mr Bozek stronger pain relief and the nurse added Mr Bozek to her mental health caseload.
42. At the ACCT review on 31 August, Mr Bozek said he felt he was now appropriately medicated, which had helped with the pain and sleeping.
43. At the next ACCT review on 3 September, Mr Bozek told staff that he had thoughts about harming himself. They increased observations to two a day.
44. A prison GP saw Mr Bozek on 8 September. He noted that Mr Bozek had seen a specialist the previous day who had told him his fracture was healing nicely. The GP added him to the physiotherapy list. They then discussed Mr Bozek's low mood. Mr Bozek said since being in prison he had started overthinking and felt stressed about life in general but had no thoughts of suicide or self-harm. The GP prescribed fluoxetine (antidepressant) and propranolol (for anxiety).
45. During his fourth ACCT review on 10 September, Mr Bozek said his shoulder was 70% healed and he was taking antidepressants which had had a positive effect. He said he was looking to the future after his next court appearance but was concerned about his mother's health. Staff reduced observations to one a day.
46. The mental health nurse met Mr Bozek on 13 September. They discussed how Mr Bozek was feeling and coping mechanisms. They agreed a care plan.
47. At his fifth ACCT review on 17 September, Mr Bozek said he had no thoughts of suicide or self-harm and was thinking about his future. Staff closed the ACCT, but Mr Bozek remained on the mental health team's caseload.
48. The mental health nurse saw Mr Bozek on 20 September, because he had sent a message to the healthcare department to say he had not seen a member of the mental health team for months. She reminded him they had met three days earlier at the ACCT review.
49. On 21 September, Mr Bozek was sentenced to two years and six months imprisonment for arson.
50. Mr Bozek did not attend a physiotherapy appointment on 22 September. The reason for this was not recorded, but another appointment was made. The next day he sent a message to the healthcare department to ask when he would be seen for his stress.

51. During an ACCT post-closure review with an officer on 24 September, Mr Bozek said he was worried about being deported to Poland, and he would have nothing if he returned there. She extended Mr Bozek's post-closure period and scheduled a review for 8 October. She noted that she would speak with safer custody and the equalities department to give him some guidance. There were no further records about this.
52. The mental health nurse met Mr Bozek again on 25 September. He said he had been speaking to other prisoners and was worried he would be deported after living in this country for 17 years. Mr Bozek said he had been sentenced to two and a half years so would soon be released. He said he did not understand why he was considered high risk as he would rather share a cell. (A prisoner with an arson offence is generally considered to be high risk for cell sharing.) Mr Bozek said he had no thoughts of suicide or self-harm. The nurse put Mr Bozek on a waiting list for an anxiety workshop with a healthcare assistant. She also asked wing staff to monitor Mr Bozek.
53. On 29 September, Mr Bozek collected his medication at the medication hatch. He seemed agitated and said he was going to kill himself, so healthcare staff sent an electronic message to the mental health team asking for him to be seen.
54. Mr Bozek was moved to HMP Risley later that day. Mr Bozek appeared agitated but told reception staff he had no thoughts of harming himself. A mental health nurse met Mr Bozek on 30 September, to assess his mental health. Mr Bozek said he felt anxious and stressed about his mother who was in hospital in Poland and was worried about being deported.
55. Mr Bozek returned to Altcourse on 1 October. He had an outstanding court appearance by videolink which could not be facilitated at Risley.
56. A nurse carried out Mr Bozek's reception health screen. She noted that Mr Bozek said he was happy to be back at Altcourse, had no thoughts of suicide or self-harm and no history of self-harm. The mental health nurse arranged for Mr Bozek to return to her caseload.
57. On 4 October, Mr Bozek was sentenced by videolink to 12 weeks imprisonment for racial aggression. This was to be served concurrently and therefore did not affect his release date of December 2023.
58. The same day, Mr Bozek sent a message to the healthcare department to say he had returned to Altcourse and wanted to see a member of the mental health team. This was arranged for 7 October.
59. On 6 October, at an immigration surgery at the prison, Mr Bozek told an immigration officer that he was concerned that his sentence length meant he would be deported. She told him that she had not yet received any notification for him but that in due course, an immigration caseworker would issue him with a letter giving him the opportunity to make representations against deportation. She said they were not yet at that stage. Mr Bozek said his mother in Poland was ill and he had a sister there and was initially intending to return but had changed his mind. She told the investigator that Mr Bozek had seemed fine.

60. Officer A saw Mr Bozek at approximately 7.50pm, during a wing welfare check. She told the investigator that Mr Bozek was lying on his bed and waved at her. They did not speak.

7 October

61. At 5.10am on 7 October, during a roll check, Officer A saw that Mr Bozek had tied a belt around his neck and attached it to the top bunk bed. He was leaning forward, and she could tell from his position and the colour of him that he had been there for some time. She immediately radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). She said she considered going straight into the cell but was told over the radio to wait for assistance. She was debating what to do when two other officers arrived and they all then entered the cell.
62. Officer B held Mr Bozek while Officer A cut the ligature. Mr Bozek fell towards them and the officers laid him on the floor. Officer A said this was difficult as he felt extremely stiff, and a lot of fluid was coming out of his mouth. The officers did not start cardiopulmonary resuscitation (CPR) as it was clear Mr Bozek was dead.
63. The only nurse on duty that night arrived at the cell at 5.13am. She applied defibrillator pads to Mr Bozek's chest, but it did not register an output and the nurse said Mr Bozek must have died four or five hours earlier and CPR would not be appropriate.
64. Officer A stayed with Mr Bozek until the paramedics arrived at 5.32am. They confirmed Mr Bozek had died.
65. Mr Bozek left a note in his cell which said he did not want to be deported to Poland as he had nothing there and that he had lived in this country for 16 years.

Contact with Mr Bozek's family

66. The Deputy Director telephoned Mr Bozek's mother in Poland to tell her that her son had died. The prison maintained contact with Mr Bozek's family through the Polish Consulate.
67. Mr Bozek was repatriated to Poland. The prison contributed to the cost of Mr Bozek's repatriation and funeral, in line with national guidelines.

Support for prisoners and staff

68. After Mr Bozek's death, the Deputy Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
69. The prison posted notices informing other prisoners of Mr Bozek's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Bozek's death.

Post-mortem report

70. Mr Bozek's post-mortem and toxicology reports were not available at the time of issuing this report.

Findings

Assessing Mr Bozek's risk of suicide or self-harm

Risk assessment in reception

71. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures for identifying, managing and supporting prisoners at risk of suicide and self-harm using the ACCT process.
72. Staff monitored Mr Bozek using ACCT between 24 August and 17 September. We consider that the ACCT was managed reasonably well. Staff arranged for Mr Bozek's pain medication to be reviewed and he received support with his mental health issues. By 17 September, his risk appeared to have reduced, though he remained on the mental health team's caseload.
73. However, between then and the ACCT post-closure review meeting on 24 September, Mr Bozek was sentenced to two and a half years in prison. At the post-closure review meeting he said he was worried about being deported to Poland. An officer extended the post-closure period to 8 October and noted that she would speak to the safer custody team and the equalities team who could give guidance. There is no record that this was done or that anyone from either team spoke with Mr Bozek.
74. On 29 September, Mr Bozek told a member of healthcare staff at the medications hatch that he was going to kill himself. Healthcare staff sent a message to the mental health team, but no one reopened the ACCT. We consider they should have done.
75. Mr Bozek was moved to Risley later that day. Even though staff had not reopened the ACCT, he was still in the post-closure period. PSI 64/2011 says that where a prisoner transfers while in the post-closure period, the receiving prison must be made aware of the ACCT and a case coordinator should be allocated. This did not happen. Nor did staff at Altcourse identify that he was still in post-closure when he returned there on 1 October.
76. We recommend:

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

- open an ACCT if they receive information that indicates a prisoner may be at risk of suicide or self-harm;
- carry out the actions identified to support the prisoner; and
- handover the case if a prisoner is transferred to another prison during the post-closure period.

Clinical care

77. The clinical reviewer found that aspects of Mr Bozek's physical healthcare were not equivalent to that he could have expected to receive in the community.
78. Blood samples were incorrectly labelled which caused a delay in getting the blood test results after Mr Bozek took excessive paracetamol. There was also no record of monitoring his missed appointments for the blood clinic and physiotherapy.
79. We recommend:

The Head of Healthcare should ensure that staff label blood samples correctly to avoid delaying results.

The Head of Healthcare should review the process for obtaining hospital blood test results.

The Head of Healthcare should ensure that electronic tasks and messages sent by prisoners are triaged and actioned promptly.

Inquest

80. The inquest, held from 5 to 12 February 2024, concluded that Mr Bozek died by suicide.

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