Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Piotr Marszalek, a prisoner at HMP Wandsworth, on 8 June 2021

A report by the Prisons and Probation Ombudsman

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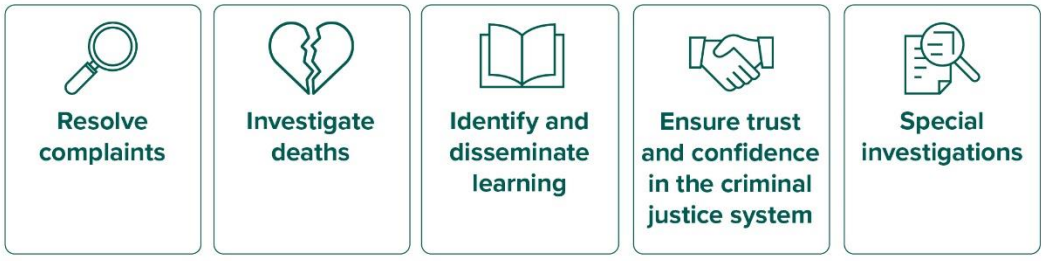
OUR VISION

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

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.

Our 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 Piotr Marszalek died on 8 June 2021, after being found hanging in his cell at HMP Wandsworth. He was 34 years old. I offer my condolences to Mr Marszalek's family and friends.

Mr Marszalek was awaiting extradition to Poland and had been at Wandsworth since October 2019. He was an extremely challenging prisoner to manage and was at high risk of suicide for much of his time at Wandsworth. He was often found under the influence of illicitly brewed alcohol ('hooch') which led to disruptive behaviour. There were reports that if he was unable to access alcohol, he would get depressed.

He was managed under suicide and self-harm procedures (known as ACCT) eight times, after several suicide attempts and incidents of self-harm. Staff started the last period of ACCT monitoring on 29 May 2021. He was being monitored when he died.

I am concerned that staff did not consider managing Mr Marszalek under enhanced ACCT procedures given his repeated suicide attempts and self-harming behaviour. We found failings in the ACCT management, including delays, lack of involvement of healthcare staff and an untrained case manager. On the day he died, Mr Marszalek was not checked every hour as he should have been.

The investigation found that when Mr Marszalek returned from hospital on 30 May, after a suicide attempt, he was not seen by healthcare staff and was placed in a cell he had smashed and flooded the night before. This was unacceptable.

Mr Marszalek was repeatedly disciplined for brewing and using alcohol. He was also referred to the prison's drug and alcohol team but refused to engage. The clinical reviewer considered that more could potentially have been done by the healthcare team to address Mr Marszalek's repeated drunkenness.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **June 2022**

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Summary

Events

1. Mr Piotr Marszalek was recalled to prison in April 2019. In July, after completing his sentence, he was moved to an immigration removal centre (IRC) pending deportation to Poland. Two attempts to remove him from the UK failed because he was disruptive.

2. In October 2019, Mr Marszalek returned to prison custody as the Polish authorities had issued a warrant for his extradition to Poland to face criminal charges. He was sent to HMP Wandsworth.

3. Mr Marszalek was often disruptive and was frequently under the influence of illicit substances, mainly 'hooch' (illegally brewed alcohol). Hooch was regularly found in his cell and as a result he spent time in the segregation unit and on the basic regime. There were reports that he would get depressed if he was unable to access alcohol.

4. Mr Marszalek was monitored under suicide and self-harm procedures (known as ACCT) eight times at Wandsworth. He tried to hang himself several times and also self-harmed by cutting. Following a fight with his cellmate in August 2020, Mr Marszalek became increasingly upset about the appearance of his broken nose and the wait for a hospital appointment to assess and potentially fix it.

5. Staff started the last period of ACCT monitoring on 29 May 2021, after Mr Marszalek cut his arm. Staff noted that he smelt of alcohol. He subsequently smashed up his cell causing it to flood. Staff moved him to another cell. In the early hours of 30 May, staff found Mr Marszalek with a ligature around his neck that was tied to the cell door handle. He appeared to be under the influence of alcohol and was unconscious. Staff brough him round and took him to hospital. He returned to Wandsworth later that morning. Staff took him back to his original cell, which remained damaged. Staff continued ACCT monitoring and set observations at one an hour.

6. At 4.25am on 8 June, an operational support grade (OSG), recorded that Mr Marszalek was watching television and that he spoke to him. At the next check, at 5.40am, the OSG saw Mr Marszalek hanging from a ligature. He radioed for assistance. When officers arrived, they went into the cell and called a medical emergency code. They cut Mr Marszalek down and started cardiopulmonary resuscitation (CPR). Healthcare staff and ambulance paramedics continued resuscitation attempts but Mr Marszalek was pronounced dead at 6.40am.

Findings

7. Mr Marszalek's behaviour, his suicide attempts, his self-harming and his issues with alcohol made him extremely challenging to manage and meant that he was at high risk of suicide. Despite this, staff did not consider managing Mr Marszalek under enhanced ACCT procedures.

8. We found deficiencies in the prison's management of ACCT procedures, including delays, lack of healthcare input to case reviews and an untrained case manager.

9. Mr Marszalek should have been checked every hour on the day he died but there was a gap of 75 minutes between the final two ACCT checks.

10. Mr Marszalek should have been seen by healthcare staff when he returned from hospital on 30 May. Further, he should not have been placed in a smashed and flooded cell.

11. The clinical reviewer considered that there could have been a clearer plan on managing Mr Marszalek's expectations about his hospital appointment to assess his broken nose. She also had concerns about delays to his dental treatment.

12. The clinical reviewer noted that Mr Marszalek was referred to Change, Grow, Live (CGL - the prison's drug and alcohol team) but he refused to engage. She considered that more could potentially have been done to try to address his repeated drunkenness.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with policy, in particular staff should:
  - consider using enhanced ACCT case management where there has been a pattern of serious self-harm;
  - have had appropriate ACCT training before taking on the role of ACCT case manager;
  - hold the ACCT assessment interview and first case review within 24 hours of the ACCT being opened;
  - invite healthcare staff to the first case review and hold multidisciplinary case reviews where possible;
  - carry out ACCT checks at the agreed frequency, at unpredictable times; and
  - make full, accurate entries in the ongoing record of meaningful interactions rather than just observations.
- The Governor and Head of Healthcare should ensure that when a prisoner returns from hospital:
  - their healthcare needs are assessed if they are in any of the categories at paragraph 4 of Annex D of PSI 07/2015; and
  - escort staff pass on the hospital discharge form to healthcare staff.
- The Governor should ensure that staff are aware of their responsibilities during medical emergencies, including that they should call the appropriate medical emergency code immediately.
- The Governor should ensure that prisoners are not located in cells that are not fit for occupation.

- The Head of Healthcare should consider, in collaboration with CGL and addictions services, how to ensure that a full physical and addictions assessment might be carried out if a prisoner is repeatedly showing signs of drunkenness.
- The Head of Healthcare should ensure that prisoners are kept informed about wait times for significant outpatient appointments and that the risk of extended wait times is managed appropriately.
- The Head of Healthcare should:
  - examine the waiting time in this case with the dental provider and identify any specific issues that led to a delay in this case; and
  - review the current waiting time list for dental appointments with a view to ensuring they are in line with contractual expectations.
- The Head of Healthcare, the lead GP and the lead manager of the mental health service should:
  - review the system for the follow up of patients who do not meet the threshold for input from the mental health team but who continue to be referred; and
  - clarify the GP role and the development of shared care plans in such cases.

The Investigation Process

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

14. The investigator obtained copies of relevant extracts from Mr Marszalek's prison and medical records.

15. NHS England commissioned an independent clinical reviewer to review Mr Marszalek's clinical care at the prison. The clinical reviewer carried out the clinical review on their behalf. The investigator interviewed 16 members of staff. Some interviews were conducted jointly with the clinical reviewer. The interviews were completed by video and telephone due to the restrictions imposed by the COVID-19 pandemic. The clinical reviewer and a PPO colleague visited Wandsworth to interview a prisoner.

16. We informed HM Coroner for Inner West London of the investigation, who sent us a copy of Mr Marszalek's post-mortem and toxicology reports. We have sent the coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Marszalek's family to explain the investigation and ask if they wanted to raise any issues. They asked the following questions:

    - What time did Mr Marszalek die?
    - What checks should have been done?
    - Were checks done when they should have been?
    - Why was Mr Marszalek in a single cell?

    We have addressed these questions in this report.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies.

19. We provided Mr Marszalek'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 Wandsworth

20. HMP Wandsworth is a local Category B prison in London, with a Category C unit. It holds up to 1,452 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. Mental health services are provided by South London and Maudsley NHS Foundation Trust. There is an inpatient unit for up to six prisoners.

HM Inspectorate of Prisons (HMIP)

21. The most recent full inspection of HMP Wandsworth was in March 2018. Inspectors noted that 38 per cent of prisoners were foreign nationals. They found a third of prisoners were receiving psychosocial help for substance misuse problems and prisoners reported that it was easy to obtain illicit drugs. They found that around 450 prisoners were referred to the metal health team each month.

22. HMIP found that Prison Service suicide and self-harm procedures (known as ACCT) had not improved since the previous inspection and that the management of safer custody lacked drive and focus. Prisoners who had been subject to ACCT monitoring told the inspectors that they did not feel supported by staff. The prison had not implemented the learning from the PPO's previous fatal incident investigations.

23. HMIP carried out a Short Scrutiny Visit at Wandsworth in April 2020 to look at how the prison was responding to the COVID-19 pandemic. While time out of cell had been necessarily limited, HMIP considered that good attention had been paid to the provision of in-cell activity, and in-cell telephones were described as a great help for staff to speak to prisoners and prisoners to their families.

24. HMIP reported that primary mental health applications had increased due to prisoners' anxieties about their health and regime restrictions, but these were managed through in-cell assessment forms, work packs and health information leaflets. HMIP found that there was a large number of foreign national prisoners, who were not fluent in English, and not as well informed about pandemic arrangements.

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 31 May 2021, the IMB reported their concern about the availability of illicit substances which seemed to trigger aggressive behaviour. The IMB reported that the effects of the COVID-19 pandemic had impacted on healthcare services delivery.

Previous deaths at HMP Wandsworth

26. Mr Marszalek was the 11th prisoner to die at Wandsworth since June 2019. Of the previous deaths, three were from natural causes, one was drug-related and six were self-inflicted. We have previously raised concerns about Wandsworth's ACCT management.

27. There were seven self-inflicted deaths at Wandsworth within just over six months (December 2020 to June 2021). Mr Marszalek's death was the fifth of these deaths. One of these deaths (in February 2021) involved another Polish prisoner who, like Mr Marszalek, was being held on a European Arrest Warrant and awaiting extradition to Poland.

European Arrest Warrant (EAW)

28. The EAW is a mechanism by which individuals wanted in connection with significant crimes are extradited between EU member states. (From 1 January 2021, it has been replaced by the UK-EU Trade and Co-operation Agreement.) When an EAW is issued, it requires another member state to arrest and transfer a criminal suspect or sentenced person to the issuing state so that the person can be put on trial or complete a detention period.

Assessment, Care in Custody and Teamwork (ACCT)

29. 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. 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.

30. 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. 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.

31. The PSI says that where a prisoner poses a heightened or exceptional risk of self-harm, staff should consider managing them under enhanced ACCT procedures. In such cases, the case review team must be led by a minimum of a Custodial Manager who will chair the case reviews for as long as the risk dictates that the prisoner needs to be supported by an enhanced case review.

Key Events

32. On 6 November 2018, Mr Piotr Marszalek was remanded to HMP Pentonville for theft. He was convicted and released later that month but was recalled to prison in April 2019 as he had not complied with the terms of his licence.

33. On 5 July, after completing his sentence, Mr Marszalek was moved to Heathrow Immigration Removal Centre (IRC), pending deportation to Poland. There were two attempts to remove Mr Marszalek to Poland but both failed after he became disruptive. Mr Marszalek appeared under the influence of illicit substances on occasions, although he denied any substance misuse.

HMP Wandsworth

2019

34. Mr Marszalek was moved to HMP Wandsworth on 7 October 2019, after the Polish authorities issued an arrest warrant for charges of actual bodily harm, theft and driving offences.

35. Between 22 October and 4 November, staff supported Mr Marszalek using suicide and self-harm prevention procedures (known as ACCT) after he cut his abdomen. Mr Marszalek said his mental health was “not good” because he had moved around IRCs and prisons too much. Staff referred him to the mental health team but he refused to engage.

36. In November and December, Mr Marszalek spent time in the segregation unit (known as the Care and Separation Unit (CSU)) due to threatening behaviour and brewing alcohol (hooch).

2020

37. On 21 January 2020, Mr Marszalek was remanded in custody under the Extradition Act 2003 after Poland issued a warrant for his extradition. (Mr Marszalek applied to appeal against his extradition but his application was halted temporarily pending the outcome of a related appeal by another individual. (As far as we know, Mr Marszalek was still awaiting a decision when he died 16 months later.)

38. On 27 February, while in the CSU, Mr Marszalek tried to hang himself. He was breathing when found but was taken to hospital as a precautionary measure. Staff closed the ACCT on 10 March.

39. On 5 May, Mr Marszalek complained of toothache. Only emergency dental treatment was available at the time due to the COVID-19 pandemic. A clinician saw him and found no evidence of infection so gave him paracetamol. On 8 May, Mr Marszalek was taken to the CSU after he had been found intoxicated. He tried to hang himself later that morning. He was breathing but was taken to hospital. Staff began ACCT monitoring. Mr Marszalek told staff he was unhappy about being in the CSU and about not seeing the dentist. On 12 May, a dentist saw Mr Marszalek and prescribed ibuprofen and an antibiotic. Staff closed the ACCT on 22 May.

40. On 3 August, Mr Marszalek was involved in a fight with his cellmate. A nurse attended and noted that Mr Marszalek smelt of alcohol and that his nose was bleeding. She took his observations and noted that his blood oxygen level was low. She administered oxygen through a face mask but Mr Marszalek became aggressive and removed the mask. The nurse took observations later and the blood oxygen level was satisfactory.

41. The next day, 4 August, Mr Marszalek went to collect his evening meal and collapsed onto a food trolley. Staff took him to hospital. Hospital staff noticed he smelt of alcohol and prison staff found a bottle of hooch in his cell. Mr Marszalek underwent a scan in hospital but no significant injuries were identified. He returned to prison the same day.

42. On 6 August, Mr Marszalek collapsed in his cell. Staff found more hooch in his cell. He was taken to hospital where a scan showed he had a broken nose. It was noted that it could be an old fracture. Mr Marszalek was concerned about the appearance of his nose and was told that an appointment would be made with the Ear, Nose and Throat (ENT) department.

43. On 14 August, Mr Marszalek cut his stomach. He told staff he was upset about his broken nose and that he had not yet returned to hospital to have it treated. Staff opened an ACCT and requested an urgent mental health assessment. A mental health nurse assessed Mr Marszalek four days later, on 18 August. Mr Marszalek said he had no thoughts of suicide or self-harm. The nurse assessed that no follow up was required.

44. On 19 August, Mr Marszalek tried to hang himself in his cell. He was initially unresponsive but came round. Staff opened an ACCT. Mr Marszalek said the trigger for harming himself was his nose injury. Staff added a task to Mr Marszalek's electronic medical record (SystmOne) to chase up his hospital appointment (this was not actioned).

45. On 24 August, Mr Marszalek flooded his cell and staff moved him to the CSU. Mr Marszalek said he would kill himself and showed staff cuts on his abdomen. Staff assessed that Mr Marszalek was not suitable to remain in the CSU, so moved him to a wing where he continued to be monitored under ACCT.

46. On 26 August, staff added another task to SystmOne to chase up Mr Marszalek's hospital appointment, which was actioned the same day. Mr Marszalek had a telephone consultation on 4 September. Hospital staff told him he had been added to the rhinoplasty clinic, but he might have to wait six months for an appointment. Staff closed the ACCT the same day.

47. On 1 October, Mr Marszalek was suspected of being under the influence of psychoactive substances (PS, also known as 'Spice'). On 12 October, he cut his stomach with a razor blade. Staff from Change, Grow, Live (CGL, the prison's drug and alcohol team) met Mr Marszalek the next day for the first time. They saw him a further five times and gave him a hooch in-cell information pack. Mr Marszalek initially refused to engage, but eventually agreed to be referred to the Hooch Support Group. There is no evidence that he attended this (possibly because the prison was still subject to a restricted regime due to COVID-19).

48. On 31 December, Mr Marszalek cut his chest. The nurse who saw him thought he was intoxicated with alcohol. Staff moved him to the CSU for observation, as no constant observation cells were available. During an ACCT review, Mr Marszalek said he had harmed himself because it was the anniversary of his grandfather's death. He was offered but declined talking therapy. He requested medication to help him sleep, but the doctor refused to prescribe anything as Mr Marszalek was under the influence of an illicit substance.

2021

49. Mr Marszalek returned to A Wing on 1 January 2021. On 4 January, he tried to hang himself. A nurse noted that officers had told her that Mr Marszalek drank alcohol and that when he could not get hold of any, he got depressed.

50. The same day, a dentist saw Mr Marszalek. The dentist provided some immediate treatment and a plan for fillings and root canal treatment when the situation allowed (treatment was still restricted due to COVID-19).

51. On 11 January, a psychiatrist saw Mr Marszalek. Mr Marszalek said he self-harmed, particularly by cutting, when he felt frustrated. The psychiatrist noted Mr Marszalek had borderline personality disorder (a condition characterised by emotional instability, distorted patterns of thinking and impulsive behaviour) and was at high risk of suicide, due to his impulsiveness. Mr Marszalek said he did not want to engage with any talking therapy or any form of mental health treatment.

52. The psychiatrist asked the prison to consider moving Mr Marszalek from a single cell, so he had a cellmate. A member of the mental health team emailed safer custody to ask for this to be considered. The safer custody team reviewed Mr Marszalek's Cell Sharing Risk Assessment (CSRA) but they assessed that he was still too high risk to share a cell because of his disruptive behaviour and previous fights.

53. On 21 January, prison staff asked a nurse to assess Mr Marszalek, who seemed under the influence of an illicit substance, but he refused to engage. The next day, 22 January, staff found Mr Marszalek unresponsive on his cell floor. He gradually regained consciousness and staff suspected he was under the influence of alcohol. He was seen again an hour later, when he seemed much more alert, but still smelled of alcohol. Later that night, Mr Marszalek smashed a chair in his cell and burst a pipe, flooding his cell. He also made superficial cuts to his chest. He still smelt of alcohol and was moved to the CSU. Staff found 35 litres of hooch in his cell. He returned to a wing the next day and remained on an ACCT.

54. During an ACCT review, Mr Marszalek told staff his main reason for harming himself was the issue with his nose. Healthcare chased his hospital appointment again and were advised to check again in four weeks.

55. On 7 and 11 March, staff suspected Mr Marszalek had drunk alcohol. They searched his cell and found a bottle of hooch.

56. Mr Marszalek was again monitored under ACCT between 5 and 16 April after he cut his chest. At an ACCT review he mentioned the issue with his nose again.

57. Healthcare staff noted Mr Marszalek had a hospital appointment for 23 July. They told Mr Marszalek a hospital appointment had been arranged but could not give him the exact date for security reasons.

29 May - 7 June 2021

58. On the evening of 29 May, Mr Marszalek cut his arm. Staff opened an ACCT and took him to the treatment room where healthcare staff treated his wounds. Staff noted he smelt of alcohol and searched his cell, where they found hooch. Mr Marszalek told them he had self-harmed because of his nose and was crying about his appearance. Soon afterwards, Mr Marszalek said he wanted to sleep and asked to go back to his cell. Staff checked again for alcohol, and then Mr Marszalek returned. Shortly afterwards, he smashed and flooded the cell, and seemed even more intoxicated.

59. A prison manager decided to move Mr Marszalek to the CSU, but when they arrived there, they found there were no free cells. While waiting in a holding cell, Mr Marszalek banged his head on the wall. The prison manager decided to move Mr Marszalek to a cell on D Wing, usually used as a constant observation cell. While they were getting the cell ready, Mr Marszalek again banged his head on a wall. The prison manager instructed two officers to sit with him and they all chatted. An officer noted in the ACCT ongoing record that Mr Marszalek seemed much calmer at 2.30am, and at 3.00am his belongings from his cell on A Wing were brought to him. Mr Marszalek remained upset about the injury to his nose. At 3.37am, Mr Marszalek started to fall asleep. The prison manager withdrew the staff from the cell and asked them to check Mr Marszalek every 30 minutes.

60. At 4.03am, a member of staff on duty on D Wing checked Mr Marszalek and saw he had tied a ligature around his neck to the cell door handle. Mr Marszalek gained consciousness quickly and did not need any medical intervention, but when the paramedics arrived it was decided that Mr Marszalek should go to hospital. They were concerned that he seemed under the influence of alcohol and had lost consciousness briefly.

61. Mr Marszalek returned to Wandsworth at 10.15am that morning. He remained on two ACCT checks an hour. Staff took him back to his cell on A Wing, which he had smashed and flooded the night before. The escorting staff did not tell healthcare staff Mr Marszalek had returned and did not pass the hospital discharge note to them. They remained unaware he had returned from hospital until night duty staff (who had been on the wing the night before) returned to work.

62. A nurse tried to assess Mr Marszalek's cut arm later that night, but he would not let her. He seemed in a low mood, and the nurse noted she would refer him to the mental health team and ask about Mr Marszalek having a cellmate.

63. The duty governor checked Mr Marszalek's ACCT document on the afternoon of 30 May. He noted, "*The document in poor order…no assessment (still in time) and no first review. The entrys [sic] in the past 24 hours appear to be observations only and there is no evidence of quality engagement.*" (The ACCT assessment and first case review should be held within 24 hours of the ACCT being opened.)

64. Shortly after 9.00am on 30 May, an officer carried out the ACCT assessment interview with Mr Marszalek. A Supervising Officer (SO) held the first case review

straight afterwards, with an officer. Mr Marszalek continued to be concerned about his nose and when he would have a hospital appointment. The SO told him that an appointment had been arranged. The SO reduced observations to hourly.

65. On 1 June, a mental health nurse assessed Mr Marszalek in his cell. Mr Marszalek said he did not want her to see his face because it was "messed up" and hid under a blanket. The mental health nurse continued with the assessment. She tried to discuss Mr Marszalek's drinking, but he refused to engage with her apart from saying he had no mental health problems. She completed a risk assessment for Mr Marszalek. She noted his impulsivity and anger and that he had refused any further engagement with CGL. She assessed that no further input from the mental health team was required, as Mr Marszalek did not seem to have a serious mental health condition.

66. The healthcare team received a letter on 3 June, which said that Mr Marszalek's hospital appointment had been rescheduled from 23 July to 24 September. Mr Marszalek refused to allow healthcare staff to assess the wounds on his arm or have his dressing changed.

67. On 4 June, a SO arranged an ACCT case review for Mr Marszalek, with a manager and a nurse. However, Mr Marszalek appeared under the influence of an illicit substance and could not attend, so it was rearranged for the next day (although for operational reasons, the ACCT review could not be held on 5 June).

68. The SO and a nurse carried out Mr Marszalek's next ACCT review on 6 June. He appeared tired and withdrawn and said he was not in a good place and had not had a drink for two days. Again, he spoke about his nose and that he had not been given a hospital appointment. He was also worried about some missing property from when he moved from his smashed cell, and the SO agreed to check this for him. The nurse told Mr Marszalek that drinking increased his risk of suicide and self-harm. Staff agreed to refer Mr Marszalek to the mental health team and CGL, although he was not keen to engage with them. They kept observations at hourly.

69. On 7 June, a nurse attempted to remove Mr Marszalek's stitches, but he seemed drowsy and unsteady on his feet. She decided to see him later that day. He appeared more alert later but refused to have the stitches removed or his dirty dressing changed. The nurse told wing staff she suspected Mr Marszalek may have taken PS, and they should search his cell. There is no record of this being done. She noted on SystmOne that healthcare staff should try to remove Mr Marszalek's stitches again the next day.

8 June 2021

70. At 4.25am on 8 June, an operational support grade (OSG) carried out Mr Marszalek's hourly ACCT check. He recorded that Mr Marszalek was awake and watching television and that they spoke to each other.

71. At 5.40am, the OSG carried out another ACCT check. He looked through the observation panel and saw Mr Marszalek was suspended from a ligature made from a bed sheet and attached to the ceiling. He radioed for staff assistance.

72. Two officers responded. They went straight into Mr Marszalek's cell and cut the ligature. One of the officers called a code blue and the control room called an

ambulance at 5.43am. They checked for a pulse, but found none, so an officer began chest compressions. He noticed Mr Marszalek looked very pale, and his lips appeared purple. The other officer radioed for healthcare assistance.

73. Two minutes later, at 5.42am, a nurse arrived at the cell. She radioed a message to two other nurses to collect their emergency bags and come to Mr Marszalek's cell. They had heard over the radio that a prisoner had ligatured. The nurses assessed Mr Marszalek. They were unable to find a pulse, noted he was not breathing and he felt cold. An officer continued with chest compressions. A nurse applied a defibrillator (a device to shock a heart into a normal rhythm) but the machine advised no shock. Staff gave Mr Marszalek oxygen and rescue breaths as well as continuing chest compressions. Mr Marszalek remained unresponsive throughout.

74. Paramedics arrived at Mr Marszalek's cell at 6.02am. The ambulance was delayed entering the prison due to a faulty gate, but paramedics left the ambulance and went to the wing on foot. They took over the resuscitation attempt, but pronounced Mr Marszalek's death at 6.40am.

Contact with Mr Marszalek' s family

75. An officer was appointed as the prison's family liaison officer (FLO). He and a member of safer custody staff visited Mr Marszalek' s family at approximately 10.30am on 8 June to tell them he had died.

76. The prison contributed to the cost of Mr Marszalek's funeral, in line with national guidelines.

Support for prisoners and staff

77. After Mr Marszalek's death, a manager 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.

78. The prison posted notices informing other prisoners of Mr Marszalek'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 Marszalek's death.

Post-mortem report

79. The post-mortem report concluded Mr Marszalek died from ligature compression. No drugs were detected.

Findings

Assessment of Mr Marszalek's risk of suicide and self-harm

80. 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 (known as ACCT) that staff should follow when they assess that a prisoner is at risk of suicide and self-harm.

81. Mr Marszalek's behaviour, his suicide attempts, self-harm and drinking meant that he was extremely challenging to manage. During his 19 months at Wandsworth, Mr Marszalek tried to hang himself several times and also self-harmed by cutting. He was managed under ACCT eight times. Given the severity and frequency of Mr Marszalek's self-harm, we consider that staff should have considered using enhanced ACCT case management (which uses a more senior case review team).

82. We also found that ACCT procedures were not always managed correctly.

83. PSI 64/2011 says that the ACCT assessment interview and first case review should take place within 24 hours of the ACCT being opened. Mr Marszalek's last ACCT was opened on 29 May but the ACCT assessment interview and first case review were not held until 31 May. We note that Mr Marszalek spent time at hospital on the morning of 30 May, but he was back at the prison by 10.15am, so we do not understand why the ACCT assessment and first case review were not held later that day. We are also concerned that a SO, who chaired the case review, had not received ACCT case manager training.

84. We are concerned that Mr Marszalek's ACCT observations were reduced from twice an hour to once an hour at this case review, even though he had cut himself and attempted to hang himself in the previous two days and it is not obvious that anything had changed. We consider this was premature given Mr Marszalek's recent history. He remained on hourly observations until he died.

85. PSI 64/2011 says that healthcare staff should always be invited to the first case review and that case reviews should be multidisciplinary where possible. There was no healthcare input to the first case review on 31 May and a number of other case reviews had no healthcare staff in attendance. Given Mr Marszalek's concerns about his nose injury and staff concerns about his substance misuse and the possibility that he was suffering from depression, we would have expected healthcare involvement in every ACCT review.

86. Mr Marszalek should have been checked every hour on 8 June. The OSG checked Mr Marszalek at 4.25am and saw him watching television. He next checked him at 5.40am, 75 minutes later, so well outside the hour.

87. PSI 64/2011 says that ACCT observations should be at unpredictable times. There were occasions when Mr Marszalek's checks were carried out at regular, and therefore predictable, times.

88. We note that when the duty governor carried out a quality assurance check on the ACCT document on 30 May, he found that the entries in the ongoing record were observations only and there was no evidence of quality engagement. It was good

practice to carry out a quality assurance check, but unfortunately there is no evidence that anything changed as a result.

89. We recommend:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with policy, in particular staff should:

- **consider using enhanced ACCT case management where there has been a pattern of serious self-harm;**
- **have had appropriate ACCT training before taking on the role of ACCT case manager;**
- **hold the ACCT assessment interview and first case review within 24 hours of the ACCT being opened;**
- **invite healthcare staff to the first case review and hold multidisciplinary case reviews where possible;**
- **carry out ACCT checks at the agreed frequency at unpredictable times; and**
- **make full, accurate entries in the ongoing record of meaningful interactions rather than just observations.**

Mr Marszalek's return to prison on 30 May

90. Mr Marszalek was not seen by healthcare staff when he returned to Wandsworth from hospital on 30 May. PSI 07/2015, *Early days in custody*, says that prisoners returning after a temporary absence need only be medically assessed if they are in a category that puts them at enhanced risk of suicide and self-harm (as listed at paragraph 4 of Annex D). Given that Mr Marszalek was returning from hospital after a suicide attempt, we consider that he should have been seen by healthcare staff. In addition, the escorting staff did not pass the hospital discharge sheet to a member of healthcare staff. We recommend:

The Governor and Head of Healthcare should ensure that when a prisoner returns from hospital:

- **their healthcare needs are assessed if they are in any of the categories at paragraph 4 of Annex D of PSI 07/2015; and**
- **escort staff pass on the hospital discharge form to healthcare staff.**

91. Mr Marszalek was returned to the cell he had smashed and flooded before being taken to hospital. This was unacceptable. We recommend:

The Governor should ensure that prisoners are not located in cells that are not fit for occupation.

92. The psychiatrist and a nurse thought that Mr Marszalek might self-harm less if he had a cellmate. The prison did consider this, most recently on 19 March 2021, but

Mr Marszalek's behaviour meant his risk to other prisoners was too high to allocate him a shared cell.

Substance misuse

93. Wandsworth recognised that PS and alcohol use was a concern at the prison and issued a PS and alcohol strategy in 2020. The strategy covers educating prisoners about the risk, reducing access, holding those involved to account and offering support.

94. Mr Marszalek was frequently under the influence of illicit substances, mainly hooch. He was managed in line with the local strategy, including being given education on the risks of hooch, being subject to cell searches, being dealt with through the disciplinary process, and being placed on the basic regime. Attempts were also made to get him to engage with the substance misuse service, CGL, but he was unwilling to accept their help.

95. None of the action taken made any difference: Mr Marszalek continued to use hooch throughout his time at Wandsworth. The clinical reviewer noted that Mr Marszalek's drinking was primarily considered as a disciplinary issue. She said that there is no evidence of a clinically focussed discussion with Mr Marszalek about the risks his drinking posed, even though there is evidence that it was affecting his mental health and a nurse told him it increased his risk of self-harm.

96. The clinical reviewer also said that there is no evidence that either CGL or healthcare staff considered asking the local addictions team or a dual diagnosis specialist to see Mr Marszalek. (Dual diagnosis is where there is substance misuse alongside mental health issues.) Mr Marszalek might have refused to engage, but, given the extreme nature of his drinking and the problems it was causing, we agree with the clinical reviewer that this approach should have been considered.

97. We recommend:

The Head of Healthcare should consider, in collaboration with CGL and addictions services, how to ensure that a full physical and addictions assessment might be carried out if a prisoner is repeatedly showing signs of drunkenness.

Mr Marszalek's extradition

98. Impending removal from the UK can be a trigger for self-harm and suicide for foreign national prisoners. PSI 2011/52, *Immigration, Repatriation and Removal Services*, says:

> "Foreign national prisoners can often experience isolation in prison due to language and cultural difficulties and lack of family visits and support. Prison staff should be aware of the heightened risk of self-harm in these cases and particular care should be taken when serving documentation relating to deportation which could cause distress."

99. Extradition under a European Arrest Warrant is a criminal justice matter, rather than an immigration matter. This was not one of the cases we sometimes see where immigration officials at the Home Office are responsible for keeping foreign

nationals informed about their possible deportation. In this case it was for the court and Mr Marszalek's own lawyers to keep him updated about his appeal against extradition. However, the effect on Mr Marszalek was likely to be very similar: he apparently did not want to be extradited to Poland and he had spent 19 months waiting to hear whether this was going to happen or not.

100. We are concerned that there is no evidence that anyone at Wandsworth considered whether this might be having an effect on his mental wellbeing, or took any steps to try to obtain an update on when a decision might be made.

Emergency response

101. When the OSG saw Mr Marszalek hanging, he radioed for staff assistance. It was not until two officers arrived that they called an emergency code blue. This resulted in a short delay in healthcare staff attending and in an ambulance being called. We consider that the OSG should have called the code blue as soon as he saw Mr Marszalek hanging. We recommend:

The Governor should ensure that staff are aware of their responsibilities during medical emergencies, including that they should call the appropriate medical emergency code immediately.

Clinical issues

Physical health

102. Mr Marszalek was upset about the appearance of his broken nose and was frustrated about the wait for a hospital appointment. The clinical reviewer noted that there was little evidence that his nose damage was causing Mr Marszalek significant breathing difficulties and therefore he would not have been a priority case for surgery. In addition, the COVID-19 pandemic had led to longer waits for outpatient appointments and non-emergency surgery. There were also delays in Mr Marszalek receiving dental treatment.

103. The clinical reviewer noted that while Mr Marszalek was seen and reviewed many times by healthcare staff, there was no clearly formulated management plan across health and custodial care to manage his expectations and needs. Mr Marszalek may not have responded to such a plan, especially as he become more erratic and drank more heavily, but in terms of trying to coordinate his care and empower staff to manage challenging and distressing behaviour, a clear and shared approach would have been supportive. We recommend:

The Head of Healthcare should ensure that prisoners are kept informed about wait times for significant outpatient appointments and that the risk of extended wait times is managed appropriately.

The Head of Healthcare should:

- **examine the waiting time in this case with the dental provider and identify any specific issues that led to a delay in this case; and**
- **review the current waiting time list for dental appointments with a view to ensuring they are in line with contractual expectations.**

Mental health

104. Mr Marszalek was seen many times by the mental health team and was most recently assessed on 1 June 2021. Staff never identified any evidence of serious mental illness so he was never added to the mental health team's caseload. A psychiatrist assessed that Mr Marszalek may have a personality disorder, characterised by impulsiveness, that put him at increased risk of suicide. However, Mr Marszalek refused to engage with any psychological therapy which may have enabled him to challenge his thinking and reduce his self-harming behaviour.

105. Although Mr Marszalek refused referral to psychology, he did agree to a referral for bereavement counselling in May 2020. However, there is no record that this was taken forward.

106. The clinical reviewer noted that Mr Marszalek reported symptoms and behaviour suggestive of depression and said that he had been given a diagnosis of depression and medication many years earlier. There are also references to Mr Marszalek 'self-medicating' with alcohol. However, there is no evidence of any clinically focussed discussion with a GP to consider the possible introduction of antidepressant medication. The clinical reviewer considered that such a discussion was indicated, even though Mr Marszalek may have refused medication.

107. The clinical reviewer noted that there was no evidence that Mr Marszalek lacked the mental capacity to make the decisions he did.

108. We recommend:

The Head of Healthcare, the lead GP and the lead manager of the mental health service should:

- **review the system for the follow up of patients who do not meet the threshold for input from the mental health team but who continue to be referred; and**
- **clarify the GP role and the development of shared care plans in such cases.**

Inquest

109. The inquest was held from 15 to 26 July 2024. The jury concluded that Mr Marszalek died by suicide and found that:

"A probable cause was his mental health exacerbated by:

1. His injury to his nose and the uncertainty regarding his hospital appointment date possibly heightened by his extradition to Poland.
2. Possibly due to the amount of time spent in a single cell during COVID and lockdown within HMP Wandsworth.
3. Possibly due to frustration caused by loss of property.

A second probable cause being the observations of his cell on 7 and 8 June 2021 establishing a predictable pattern with poor quality engagement. Some observations exceeded the required hourly intervals.

A possible cause was the inadequate communication between prison service and health service.

Another possible cause was the failure to capture accurate and complete information from ACCT review on health care system.

A third probable cause was the inadequate management of risk by not recognising Mr Marszalek's change of behaviour on 6 June 2021 ACCT review."

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