Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Damian Bugno-Swierz, a prisoner at HMP Wandsworth, on 7 November 2023

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

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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Damian Bugno-Swierz was found hanging in his cell at HMP Wandsworth on 7 November 2023. Staff and paramedics tried to resuscitate him but were unsuccessful. Mr Bugno-Swierz was 29 years old. I offer my condolences to his family and friends.

Mr Bugno-Swierz was the fifteenth prisoner to take his own life at Wandsworth in three years. Up to the end of March 2024, there were two further self-inflicted deaths.

Mr Bugno-Swierz had no history of self-harm and gave no indication to staff or fellow prisoners that he was at risk of suicide or self-harm in the lead up to his death. Mr Bugno-Swierz, along with two friends, was caught drinking hooch (illegally brewed alcohol) on the day he died. All three of them were later found with ligatures around their necks but only Mr Bugno-Swierz died.

It appears that the hooch was the trigger for Mr Bugno-Swierz's actions. Wandsworth has an ongoing problem with hooch, however, I am satisfied that the prison has employed good strategies and practices to try to tackle this problem.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

Contents

Summary

Events

1. On 8 April 2021, Mr Damian Bugno-Swierz, a Polish national, was remanded in prison, charged with grievous bodily harm (GBH). On 1 December, he was sentenced to four years and three months in prison. In the meantime, he had attended court and been remanded in custody for separate violent offences and for an extradition case relating to drugs.

2. On 13 July 2023, Mr Bugno-Swierz was moved to HMP Wandsworth.

3. On 7 November, at around 5.00pm, staff discovered that Mr Bugno-Swierz and two friends (his cellmate and another prisoner who had been locked into the cell in error) were drinking illicitly brewed alcohol ('hooch') in Mr Bugno-Swierz's cell. They had also damaged the cell. Staff removed Mr Bugno-Swierz and placed him in a separate cell.

4. At 6.18pm, staff took Mr Bugno-Swierz to the Care and Separation Unit (CSU – the segregation unit) for damaging his cell and being under the influence of alcohol.

5. Shortly before 8.00pm, Mr Bugno-Swierz's two friends joined him in the CSU. Staff escorted them under restraint as they were both non-compliant and under the influence of illicit substances.

6. Within an hour of Mr Bugno-Swierz's friends arriving in the CSU, staff found both with ligatures tied around their necks. They started suicide and self-harm monitoring (known as ACCT).

7. At 11.01pm, an officer went to check on Mr Bugno-Swierz but could not see him through the cell's observation panel. He switched on the cell's emergency light, but it was not working properly. The officer went to get support from other staff.

8. Two officers went to the cell at 11.03pm, looked through the observation panel and then walked away. One of the officers returned a few minutes later and again looked through the observation panel and walked away.

9. At 11.07pm, a supervising officer (SO) arrived at the cell and entered with two officers. They found Mr Bugno-Swierz behind his cell door with a ligature around his neck. They removed the ligature and started CPR. The SO radioed a medical emergency code and the control room called for an ambulance. Healthcare staff arrived and continued CPR.

10. Ambulance paramedics arrived at 11.20pm and took over CPR. They were unable to resuscitate Mr Bugno-Swierz and at 11.59pm, they pronounced that he was dead.

11. Toxicology tests showed the presence of alcohol at twice the level of the legal driving limit. No drugs were found.

Findings

12. Mr Bugno-Swierz gave no indication to staff that he was at risk of suicide or self-harm in the lead up to his death. We are satisfied that staff could not have foreseen his actions.

13. Mr Bugno-Swierz consumed alcohol before he died. Although the hooch problem at Wandsworth is significant and complex, we are satisfied that the prison has employed good strategies and practices to try to manage this problem.

14. We make no recommendations.

The Investigation Process

15. HMPPS notified us of Mr Bugno-Swierz's death on 8 November 2023.

16. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners contacted the investigator as a result.

17. The investigator visited Wandsworth on 13 November 2023 and 4 March 2024. He obtained copies of relevant extracts from Mr Bugno-Swierz's prison and medical records, CCTV and body worn video camera (BWVC) footage and a recording of radio transmissions. He also obtained the HMPPS Early Learning Review, and Ambulance Service records.

18. The investigator interviewed one member of staff and the two prisoners who had contacted him at Wandsworth on 13 November 2023 and 4 March 2024. He conducted interviews with a further five members of staff on 20 and 27 March by video call.

19. The investigator obtained further information from the Head of Safety, Head of Drug strategy, Head of Residence, Head of Reducing Reoffending, and the Deputy Head of Security.

20. NHS England commissioned an independent clinical reviewer to review Mr Bugno-Swierz's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with three members of healthcare staff on 2 February by video call.

21. We informed HM Coroner for London Inner West of the investigation. The Coroner gave us the results of the toxicology tests. We have sent the Coroner a copy of this report.

22. We shared our initial report with HMPPS. They pointed out a factual inaccuracy which has been amended in this report.

23. We sent a copy of our initial report to Mr Bugno-Swierz's partner and their solicitor. Mr Bugno-Swierz's partner pointed out some factual inaccuracies which have been amended in the report. Mr Bugno-Swierz's partner raised some other concerns which have been addressed in a separate letter.

Background Information

HMP Wandsworth

24. HMP Wandsworth is a local category B and C prison in London. It holds men in eight residential wings. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison. There is an inpatient unit which accommodates up to six prisoners with physical health needs and up to 12 prisoners with mental health needs.

25. As a result of the number of self-inflicted deaths, Wandsworth is receiving support and monitoring from HMPPS headquarters.

HM Inspectorate of Prisons

26. The most recent full inspection of Wandsworth was in September 2021. Inspectors reported that the prison faced many challenges, including staff shortages and deteriorating buildings. Nearly half of the prisoners at Wandsworth were foreign nationals, many of whom came from eastern Europe. The inspectors found the prison, the education service and, in particular, Home Office staff, were not doing enough to support this group of prisoners.

27. Inspectors found that there was a good strategic approach to tackling drug supply. There had been some improvements to physical security measures, and mandatory drug testing had begun, but more staff training was needed in key areas, such as the gatehouse and the post room, to provide a consistent approach.

28. Inspectors noted that there had been nine self-inflicted deaths and two deaths linked to drug misuse since the previous inspection in 2018. The prison had acted swiftly in response to the recommendations from the Prisons and Probation Ombudsman (PPO) investigation reports received to date. However, inspectors found there was no published overall safety strategy and supporting action plan to make the prison safer.

Independent Monitoring Board

29. 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 May 2023, the IMB highlighted what it termed serious and fundamental concerns. These included staff shortages, the prison not being safe and inhumane conditions.

Previous deaths at HMP Wandsworth

30. Mr Bugno-Swierz was the twentieth prisoner to die at Wandsworth since November 2020. Of the previous deaths, 14 were self-inflicted, three were from natural causes, one was drug related, and in the other, the cause of death was unascertained. Up to the end of March 2024, there were two further self-inflicted deaths.

Key worker scheme

31. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:

    - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
    - Key workers must have completed the required training.
    - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

32. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

33. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

34. On 8 April 2021, Mr Damian Bugno-Swierz was remanded in prison, charged with grievous bodily harm (GBH), and sent to HMP Lincoln. It was not his first time in prison. He moved prisons several times due to court appearances.

35. In November, Mr Bugno-Swierz appeared in court in connection with an extradition case related to drugs and in connection with further violent offences. He was remanded in custody.

36. On 1 December, Mr Bugno-Swierz was sentenced to four years and three months for GBH. Although he was due to be released from prison on 23 May 2023 for this sentence, he continued to be remanded for alleged further violent offences and the extradition case.

37. Mr Bugno-Swierz was a Polish national. He had positive relationships with prison staff and other prisoners and engaged with work and education. However, there was information to suggest that Mr Bugno-Swierz participated in the illicit drug trade in prison.

38. In February 2022, while at HMP Pentonville, Mr Bugno-Swierz was caught with a mobile phone and charger. In October 2022, he was identified as being part of an Organised Crime Group (OCG).

39. On 22 November, prison staff noted that Mr Bugno-Swierz was told by his partner that his brother had been murdered in Poland.

40. On 13 July 2023, Mr Bugno-Swierz was sent to HMP Wandsworth.

41. He told reception staff that he had no history of substance misuse. (Mr Bugno-Swierz had a history of cocaine and alcohol use and completed alcohol and drugs courses at Lincoln.) Mr Bugno-Swierz had no known history of attempted suicide or self-harm.

42. On 1 November, an officer noted that an intelligence led search was conducted on the cell of Mr Bugno-Swierz and his cellmate. Prison staff found an iPhone and charger, improvised tools, and alcohol brewing equipment. Mr Bugno-Swierz and his cellmate were both placed on report (a disciplinary charge).

Events of 7 November

43. On 7 November, Mr Bugno-Swierz spoke to his partner twice. They spoke for around five minutes. (The investigator was unable to listen to the call as Wandsworth could not provide the recording as, despite requests to provide it, they had deleted it from their system.) Mr Bugno-Swierz's partner told us that Mr Bugno-Swierz was cheerful. She said they talked about the renovation of their home, and about their son.

44. At evening lock up, at around 5.00pm, another prisoner was mistakenly locked into the cell Mr Bugno-Swierz shared with his cellmate. The prisoner told the

investigator that the three of them were having a party with hooch supplied by Mr Bugno-Swierz.

45. Shortly afterwards, staff realised that there were three people in the cell. They also noted that the cell had been damaged. They then mistakenly removed Mr Bugno-Swierz and placed him in a separate cell.

46. At 6.18pm, staff took Mr Bugno-Swierz to the Care and Separation Unit (CSU – the segregation unit). Body Worn Video Camera (BWVC) footage shows that Mr Bugno-Swierz was in handcuffs but walked compliantly to the CSU. At times he appeared slightly unsteady on his feet. (Mr Bugno-Swierz was taken to the CSU for being under the influence and for damaging his cell, both of which are breaches of prison rules.)

47. Staff searched Mr Bugno-Swierz when he arrived at the CSU. A nurse saw Mr Bugno-Swierz as he left the searching cell. She assessed that Mr Bugno-Swierz was fit to be held in the CSU. She noted that he was coherent, swaying a little on his feet and there was no aggression or hostility from him.

48. At 6.23pm, staff took Mr Bugno-Swierz to a CSU cell. At 6.37pm, Mr Bugno-Swierz activated his emergency cell bell (ECB). CCTV footage shows that at 6.45pm, an officer went to Mr Bugno-Swierz's cell and spoke with him for around 40 seconds.

49. At 6.49pm, Mr Bungo-Swierz again activated his ECB. CCTV footage shows that at 7.01pm, the officer went to Mr Bugno-Swierz's cell and appeared to speak with him again.

50. At 7.10pm, Mr Bugno-Swierz activated his ECB again. CCTV footage shows that the officer responded at 7.24pm and appeared to speak to Mr Bugno-Swierz. The officer told the investigator that Mr Bugno-Swierz asked him how long he would be in the CSU. He said he told Mr Bugno-Swierz that he was on Rule 53, which meant that he could be held in segregation from the time he was charged with an alleged offence to the adjudication hearing. He said Mr Bugno-Swierz was calm during their interactions.

51. Meanwhile, at around 7.20pm, staff removed two prisoners from Mr Bugno-Swierz's original cell after they had further damaged and flooded the cell. They escorted both prisoners under restraint to the CSU. BWVC and Video Camera (VC) footage shows that both prisoners were non-compliant during the move and appeared to be under the influence of illicit substances. One prisoner arrived in the CSU at 7.51pm and the other arrived at 7.59pm.

52. At 8.19pm, Mr Bugno-Swierz activated his ECB again.

53. CCTV footage shows that staff escorted Prisoner A past Mr Bugno-Swierz's cell at 8.20pm.

54. CCTV footage shows that at 8.26 pm, two officers went to Mr Bugno-Swierz's cell. They opened his observation panel for a moment and then turned off the ECB activation light outside the cell. One officer told the investigator that when he opened the observation panel, Mr Bugno-Swierz shouted at him aggressively. He said that as Mr Bugno-Swierz was intoxicated, he thought that talking to him would further antagonise him.

55. At 8.27pm, Mr Bugno-Swierz activated his ECB again.

56. At around 8.37pm, staff found Prisoner A with a ligature around his neck. They removed the ligature, called an ambulance and administered oxygen. He had recovered by the time paramedics arrived. Staff started suicide and self-harm monitoring (known as ACCT).

57. At 8.38pm, an officer went to Mr Bugno-Swierz's cell, turned off the ECB activation light and looked through the observation panel for around ten seconds. He told the investigator Mr Bugno-Swierz was standing in the middle of the cell and did not respond when he tried to talk to him.

58. At around 8.45pm, staff found Prisoner B with a ligature around his neck. He appeared intoxicated but was responsive. Staff removed the ligature and restarted ACCT procedures (staff had stopped ACCT monitoring for Prisoner B a week before).

59. At 9.20pm, an officer went to Mr Bugno-Swierz's cell and looked into the cell for around 13 seconds. He told the investigator that he saw Mr Bugno-Swierz lying on his bed.

60. At 9.45pm, an officer went to Mr Bugno-Swierz's cell and looked through the observation panel.

61. At 9.59pm, an officer returned to Mr Bugno-Swierz's cell and looked through the observation panel for around five seconds. He told the investigator that he saw Mr Bugno-Swierz lying on his bed.

62. In the CSU prisoners are subject to standard hourly checks unless more frequent checks are directed. Mr Bugno-Swierz was checked at least hourly for most of the evening. At 11.01pm, Officer A went to Mr Bugno-Swierz's cell, looked through the observation panel and turned on the emergency light (which was not working properly as it was flickering). He told the investigator he could not see Mr Bugno-Swierz. He said his radio had run out of battery, so he asked two other officers to check the cell while he went to speak with a Supervising Officer (SO) (Oscar 2 – the second most senior officer in charge at night) to explain the situation and change his radio battery.

63. At 11.03pm, both officers went to Mr Bugno-Swierz's cell. Officer C looked through the observation panel. Both officers then left. In interview, Officer C said that he switched on the emergency light but that it was flickering so he could not see clearly into the cell (officers are unable to turn on the main cell light from outside the cell). He said he then went to find a torch but was unsuccessful.

64. At 11.06pm, Officer C returned to Mr Bugno-Swierz's cell, looked through the observation panel briefly and then walked away.

65. At 11.07pm, the SO, Officer A and Officer C arrived at the cell. After looking through the observation panel they entered. Officer A told the investigator that as they entered, he saw that Mr Bugno-Swierz was behind and to the side of the door with a ligature, made from bedding, around his neck and tied to the corner of the emergency light. He said he and the SO cut the ligature and the SO started CPR.

66. A Custodial Manager (CM) (Oscar 1 – the senior officer in charge) arrived seconds later and radioed a code blue medical emergency. Control room staff called an ambulance. More prison staff arrived.

67. At 11.09pm, a nurse arrived at the cell, followed at 11.10pm by another nurse. The nurses took over CPR.

68. At 11.20pm, an ambulance crew arrived at the cell and took over CPR.

69. BWVC footage recorded paramedics saying Mr Bugno-Swierz had a cut and that when prison staff removed the ligature "they smacked his head". The paramedic said the cut was not bleeding. (Mr Bugno-Swierz's partner provided post-mortem photographs to the investigator that showed two cuts on Mr Bugno-Swierz's eyebrow and head.)

70. At 11.59pm, they declared that Mr Bugno-Swierz had died.

Contact with Mr Bugno-Swierz's family

71. Early on 8 November, the prison appointed two family liaison officers (FLOs). Mr Bugno-Swierz's partner lived in Liverpool, so a FLO asked staff at HMP Liverpool to assist.

72. At around 10.00am, two family liaison officers from Liverpool visited Mr Bugno-Swierz's partner and told her of Mr Bugno-Swierz's death.

73. Both FLOs kept in contact with Mr Bugno-Swierz's partner over the following days, offering support and advice.

74. The prison contributed to the costs of Mr Bugno-Swierz's funeral in line with national policy.

Support for prisoners and staff

75. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

76. After Mr Bugno-Swierz's death, two prison managers 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.

77. The prison posted notices informing other prisoners of Mr Bugno-Swierz'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 Bugno-Swierz's death. Prisoners A and B were provided with support.

Post-mortem report

78. We have not yet received the post-mortem report.

79. The toxicology report showed alcohol in Mr Bugno-Swierz's system at the time of his death at twice the legal level for driving. No other illicit substances were detected.

Findings

Assessment of Mr Bugno-Swierz's risk

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 should be followed when a prisoner is identified as being at risk of suicide and self-harm. It sets out the risk factors and triggers that could indicate increased risk.

81. Mr Bugno-Swierz was never supported using ACCT. Mr Bugno-Swierz's friends told us that Mr Bugno-Swierz did not have a history of suicidal thoughts or self-harm, that he told his friends he was due to be released within a month and had been making future plans with his partner and son. We are satisfied that he gave no indication to staff that he was at risk of suicide or self-harm.

82. Mr Bugno-Swierz's death occurred around the anniversary of his brother's murder. We are unable to assess whether the anniversary of his brother's death was a trigger for Mr Bugno-Swierz.

83. Based on the fact that Mr Bugno-Swierz had been drinking hooch with two friends and that they all went on to tie ligatures around their necks while under the influence, it would appear that the hooch was the trigger for Mr Bugno-Swierz's actions. Neither Prisoners A nor B could help to understand why the three men tied ligatures around their necks that night. Both said that they could not remember why they had done so.

Delays in staff finding Mr Bugno-Swierz

84. There were several issues that led to delays in staff realising that Mr Bugno-Swierz was hanging in his cell. Officer A told the investigator that when he went to check on Mr Bugno-Swierz, the emergency light in his cell was not working properly. Due to the vulnerability of prisoners in the CSU, it is vital that safety features such as emergency lights work properly.

85. The prison told us that accommodation fabric checks (AFCs – to assess the security safety of the cell) had been carried out on the cell and no issues were identified. We cannot say for sure whether the emergency light was faulty when the AFCs were conducted but it is possible it was.

86. We also note that Officer A's radio had run out of battery so he had to leave the CSU to change his battery and speak to the SO. Officer C then tried to check on Mr Bugno-Swierz but said he could not see clearly because of the defective emergency light. He said he went to find a torch but could not find one.

87. We consider that these issues indicate that working practices in the CSU are not as good as they should be, and we bring them to the Governor's attention.

Hooch

88. Mr Bugno-Swierz had a history of being involved in the illicit economy in prison. On the day of his death, Mr Bugno-Swierz had a significant amount of hooch in his cell, which he and his friends were drinking.

89. The Deputy Head of Security at Wandsworth told us that data suggested that Eastern European prisoners most frequently used hooch. (Wandsworth has a high number of Eastern European prisoners.) He said that in October and November 2023, there were 15 intelligence reports submitted related to hooch, following accommodation and fabric checks (AFCs) and staff smelling hooch. He said searches found 110 litres of hooch.

90. HM Inspectorate of Prisons (HMIP) found in their 2021 inspection that Wandsworth had a good drugs strategy, which covered illicitly brewed alcohol.

91. Wandsworth has since introduced a Psychoactive Substances and Alcohol Strategy – February 2023/24. The strategy focuses on informing prisoners and staff of the risks of alcohol, reducing access, holding those involved in supply and use of alcohol to account, and supporting prisoners who are in the destructive cycle of alcohol misuse. The Head of Reducing Reoffending told us that at Wandsworth, Change Grow Live (CGL) continued to assess all prisoners' substance misuse needs during the second day reception screening, and follow up with assessments and support where needed, including alcohol specific programmes/workshops.

92. She said prison staff have reduced the supply of bread and sugar (key ingredients in hooch brewing) to prisoners. The Head of Reducing Reoffending said staff had continued to focus on AFCs, which included the addition of tamperproof stickers on toilet panels where hooch and hooch brewing equipment are traditionally stored. She said the prison was working closely with the Regional Dog Team who, when onsite, were utilised for hooch specific searches.

93. The Head of Reducing Reoffending said that hooch continues to be a topic of discussion during monthly Drug Strategy Meetings and where intelligence suggests particular wings have a prevalence of hooch, CGL will circulate hooch-specific harm reduction material.

94. It is clear the hooch problem at the Wandsworth is significant and complex. We are, however, satisfied that appropriate strategies and practices are being employed by the prison to address this problem.

Clinical care

95. The clinical reviewer concluded that the care Mr Bugno-Swierz received at Wandsworth for his physical health and substance misuse was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. However, she concluded that the resuscitation attempts were not of the required standard and therefore not equivalent to that which he could have expected to receive in the community.

96. The clinical reviewer watched body worn video camera (BWVC) footage of healthcare staff conducting CPR on Mr Bugno-Swierz. She identified the following concerns:

- The speed and depth of chest compressions conducted by the attending healthcare team were too fast and too shallow.
- Individuals conducting compressions did not rotate frequently (frequent rotation prevents exhaustion and insufficient compressions).
- A pillow was seen under Mr Bugno-Swierz's head during resuscitation efforts, this would have compromised the airway and could result in insufficient ventilations.

97. The clinical reviewer noted that the collective effect of these issues would have resulted in sub-optimal resuscitation.

98. The Head of Healthcare told us that staff involved in the incident had been supported by the prison practice development nurse and Deputy Head of Healthcare. She said staff had been asked to undertake written reflective practice in relation to the incident to identify how they could do something differently in the future.

99. The Head of Healthcare later met with both emergency nurses and discussed the concerns raised about the resuscitation attempt. She noted that she will be providing a supportive learning and development plan for both nurses, and that once this has been completed, they will be able to return to their role of emergency response.

100. We are satisfied by the action of the Head of Healthcare to address the concerns with the resuscitation attempt on Mr Bugno-Swierz. We make no recommendation.

Key work

101. All prisoners in the male closed estate are supposed to receive weekly key worker sessions. However, since arriving at Wandsworth, Mr Bugno-Swierz did not receive any key worker sessions. He had received key worker sessions at previous establishments.

102. The Head of Reducing Reoffending told us that because of staffing levels, and to provide the best regime and access to purposeful activity, key work had been suspended since COVID-19.

103. The Head of Reducing Reoffending said re-introducing keywork had been included in Wandsworth's 2024/25 business plan, but while staffing levels were reduced, only priority prisoners would receive key work. Once staffing levels allowed, all prisoners would receive key work.

104. It is difficult to say whether Mr Bugno-Swierz would have shared any risk related information with a key worker. Mr Bugno-Swierz's friends had no idea that he was a risk of suicide. It is possible therefore that key worker sessions would have made no difference to the outcome for Mr Bugno-Swierz. Nevertheless, key worker sessions

are important in establishing good relationships between prisoners and staff and should be resumed as soon as staffing levels allow.

Inquest

105. At the inquest, held from 31 March to 4 April 2025, the jury concluded that Mr Bugno-Swierz died by suicide. They found that he was under the influence of alcohol which impacted his decision making.

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