Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Ziemiecki, a prisoner at HMP Leeds, on 22 April 2023

A report by the Prisons and Probation Ombudsman

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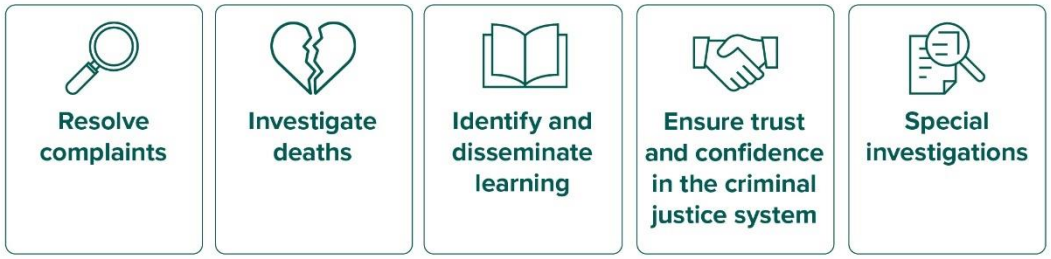
OUR VISION

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

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 Mark Ziemiecki died in hospital on 22 April 2023, the day after he was found with a ligature around his neck in his cell at HMP Leeds. He was 39 years old. I offer my condolences to Mr Ziemiecki's family and friends.

Mr Ziemiecki was the thirteenth prisoner to take their own life at Leeds in three years and the sixth of seven self-inflicted deaths at Leeds between December 2022 and May 2023.

Staff recognised that Mr Ziemiecki was at risk of suicide and self-harm when he arrived at Leeds in January 2023 and supported him using suicide and self-harm prevention procedures (known as ACCT). They restarted ACCT procedures in March and again on the morning of 21 April.

We found that staff managed the ACCT procedures well. The clinical reviewer found that the care Mr Ziemiecki received at Leeds was of a good standard and was equivalent to that which he could have expected to receive in the community.

I make no recommendations.

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 **April 2024**

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Summary

Events

1. On 23 December 2022, Mr Mark Ziemiecki was released on licence to an approved premises (AP).

2. Mr Ziemiecki had a history of mental health and developmental difficulties, including autism and attention deficit hyperactivity disorder (ADHD). This impacted on his behaviour, and he could appear aggressive and make inappropriate comments. His behaviour led to his space at the AP being withdrawn. Mr Ziemiecki's community offender manager (COM) decided that his risk could not be managed safely in the community and so she recalled him to prison.

3. On 10 January 2023, Mr Ziemiecki was arrested and sent to HMP Leeds. Reception staff started suicide and self-harm prevention procedures (known as ACCT) after Mr Ziemiecki said he felt like he would harm himself in custody. He was very unhappy about being recalled. Staff stopped ACCT procedures on 30 January, when Mr Ziemiecki seemed more settled. He had been moved to B Wing at his request and said he was getting on with the staff and had a good support network.

4. Staff reopened ACCT procedures on 11 March, after Mr Ziemiecki said he was going to self-harm after he was downgraded from enhanced status to standard for refusing orders by staff and being abusive. Staff closed the ACCT on 31 March, when Mr Ziemiecki's behaviour had settled again.

5. At around 8.40am on 21 April, an officer saw Mr Ziemiecki receive a pink tablet from another prisoner. When challenged, Mr Ziemiecki put the tablet in his mouth. The officer placed Mr Ziemiecki on report (a disciplinary charge) and locked him in his cell pending his disciplinary hearing. The officer said that he had been given authority to do this by a senior officer, though the senior officer disputed this.

6. Around 20 minutes later, Mr Ziemiecki threatened to cut his throat with a razor blade. Staff persuaded him to hand over the blade and they restarted ACCT procedures.

7. CCTV shows that at 9.21am, the officer who placed Mr Ziemiecki on report was dancing outside his cell. He told the investigator that Mr Ziemiecki was singing an offensive song about him, and he danced to it to show that it was not getting to him. He said that they had a poor relationship and Mr Ziemiecki used to make offensive remarks to him to bait him.

8. Later that morning, Mr Ziemiecki called the COM who had recalled him. He questioned her decision and said that she had not supported him. He asked her if she would support his release and she said she would await the Parole Board to decide the direction. Mr Ziemiecki was agitated by this.

9. At around 2.20pm, a senior probation officer went to Mr Ziemiecki's cell for a prearranged meeting but staff said they would not unlock him given the events earlier. Mr Ziemiecki was frustrated about this. He told the senior probation officer that he had been mistreated by probation staff.

10. At 2.43pm, the officer who had placed Mr Ziemiecki on report responded to his cell bell. The officer said that Mr Ziemiecki was very angry and swore at him about telling the probation officer that he had had a razor blade.

11. At 3.08pm, two officers went to Mr Ziemiecki's cell to take him to collect his medication. Mr Ziemiecki had covered the observation panel of his cell door. One of the officers called to Mr Ziemiecki but got no response. They tried to open the door but felt some resistance behind it. Concerned about their safety, they left to seek guidance and support from a prison custodial manager (CM). At 3.12pm the officers along with the CM returned and entered the cell. They found Mr Ziemiecki sitting on the floor with a ligature around his neck. He had attached the ligature to the medication box on the wall in his cell. Staff cut the ligature and started CPR. An officer radioed a medical emergency code and control room staff called an ambulance.

12. At 3.15pm, healthcare staff arrived and took over CPR. Ambulance paramedics arrived at 3.25pm. Mr Ziemiecki was taken to hospital and placed in an induced coma. He died on 22 April, after his life support machine was turned off.

13. Mr Ziemiecki left a note in his cell which said he had taken his life as an officer was always winding him up. He said he told the officer he was going to take his life and the officer said, "Go on then", and walked off. The officer denied this and none of the prisoners interviewed said they heard the officer say this, though they said he was arrogant and unpopular.

Findings

14. Mr Ziemiecki was very upset about his recall to prison and said that he had been set up to fail. Mr Ziemiecki was originally due to be released to a specialist AP but this did not happen and he was sent to a standard AP instead. It is possible that had Mr Ziemiecki been placed in the specialist AP and had more appropriate support that catered better to his needs, his behaviour might not have deteriorated as it did, and he might not have been recalled. The Probation Service may wish to consider whether there is any learning from this case.

15. During his time at Leeds, staff started ACCT procedures at the appropriate times and they were broadly managed well.

16. The prison carried out an investigation into the actions of the officer who was dancing outside Mr Ziemiecki's cell. The investigating officer concluded that the officer's behaviour was not in line with the Acceptable Behaviours Policy and could be perceived as antagonistic. They also found that authority had not been given to lock Mr Ziemiecki in his cell pending his adjudication. They recommended a disciplinary investigation. However, the Deputy Governor decided not to proceed with this and instead provide the officer with support and mentoring, given he was very new in service.

17. The clinical reviewer found that the care Mr Ziemiecki received at Leeds was of a good standard and was equivalent to that which he could have expected to receive in the community.

18. We make no recommendations.

The Investigation Process

19. HMPPS notified us of Mr Ziemiecki's death on 22 April 2023.

20. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

22. NHS England commissioned an independent clinical reviewer to review Mr Ziemiecki's clinical care at the prison.

23. The investigator interviewed three prisoners at Leeds in May. The interviews were conducted over the telephone.

24. The investigator and clinical reviewer interviewed four members of healthcare staff from Leeds. The interviews were conducted remotely by video in June and July.

25. The investigator interviewed four members of staff at Leeds on 20 July.

26. We informed HM Coroner for West Yorkshire Eastern District of the investigation. We have sent the Coroner a copy of this report.

27. The Ombudsman's family liaison officer contacted Mr Ziemiecki's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Ziemiecki's sister asked for details of how her brother had ended his life. She also raised some issues with the family liaison. She said that she had asked to visit her brother's cell but not heard back and was told that her brother had had no belongings which she found hard to believe. These issues have been addressed in the report.

28. In response to the draft report Mr Ziemecki's mother raised a question which has been answered in a separate letter.

Background Information

HMP Leeds

29. HMP Leeds is a local prison holding up to 1,100 men who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services. Midlands Partnership Trust provides psychosocial substance misuse services.

HM Inspectorate of Prisons

30. The most recent full inspection of HMP Leeds was in June 2022. Inspectors found that Leeds was a well-led prison where leaders and managers were visible on the wings and supportive staff-prisoner relationships were observed. Although levels of self-harm were falling, there had been eight self-inflicted deaths since the last inspection in 2019 but inspectors acknowledged the work that the prison was doing to address this major issue. Inspectors reported reduced levels of violence since the last inspection with significantly fewer prisoners saying that they felt unsafe.

31. Inspectors reported that mental health services were reasonably good, although there were some gaps in non-urgent care. They reported that a 40% vacancy rate had affected the ability to deliver services in 2022 but all vacancies had since been filled. Pharmacy services were safe and effective, but risk assessments were not always followed adequately, including those for some prisons who had daily in-possession medication. Inspectors found that prisoners not attending for medication were usually followed up robustly.

32. Inspectors reported that the availability of key work sessions was better than at other local prisons, with 69% of prisoners saying they had a key worker and 61% saying the sessions were helpful. Inspectors found that most key work sessions were delivered by the same person.

Independent Monitoring Board

33. 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 report covering the period from January 2021 to December 2022, the IMB reported concerns about the standard of accommodation and pressures on mental health services due to severely mentally ill prisoners arriving from the courts. They were also concerned about the impact of staffing levels on the delivery of key work sessions.

34. The Board noted that staff were expected to treat prisoners with care, dignity and respect and, for the most part, this expectation was met, even under the most trying of circumstances. However, there were a significant number of applications received by the IMB which related to the perceived behaviour of staff towards prisoners (e.g., staff being indifferent to their concerns, not responding to requests, speaking to prisoners inappropriately etc.).

35. IMB members had observed staff members swearing both at prisoners and in general conversation. The Board said that this did not set a good example to prisoners and fell short of the stated aim of treating people with respect.

Previous deaths at HMP Leeds

36. Mr Ziemiecki was the 32nd prisoner to die at Leeds since April 2020. Of the previous deaths, 18 were due to natural causes, 12 were self-inflicted and one is awaiting classification. Mr Ziemiecki was the sixth of seven self-inflicted deaths to occur between December 2022 and May 2023. In one of these deaths, the prisoner had also attached the ligature to the medication box in his cell.

Key work scheme

37. The key work 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 system 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.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key work 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.

Assessment, Care in Custody and Teamwork (ACCT)

38. 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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

39. On 23 December 2022, Mr Mark Ziemiecki was released on licence from HMP Full Sutton. He had served seven years and ten months in prison of a 15-year sentence for possession of a firearm with intent to endanger life and conspiracy to supply Class A drugs.

40. Mr Ziemiecki had autism, attention hyperactivity disorder (ADHD), emotionally unstable personality disorder (EUPD) and mixed anxiety and depressive disorder. He had complex needs and had been due to be released to Holbeck House, a Psychologically Informed Planned Environments (PIPE) approved premises (AP). (PIPE APs are designed to support high risk, high harm offenders who are likely to have a personality disorder. Staff who work there are trained and supported to work in a psychologically informed way.) However, a member of staff at Holbeck House knew Mr Ziemiecki personally and so it was decided that it was not a suitable placement for him. Probation service staff considered a PIPE AP outside Leeds for Mr Ziemiecki but concluded that Mr Ziemiecki's resettlement would be more productive if he stayed in Leeds where he had local connections. Mr Ziemiecki was therefore released to a standard AP.

41. Mr Ziemiecki's behaviour at the AP become increasingly disruptive and difficult. This behaviour included making inappropriate sexual comments to a female staff member and being aggressive. He was removed from the AP and became homeless. On 5 January 2023, Mr Ziemiecki's community offender manager (COM) concluded that Mr Ziemiecki's risk could not be safely managed in the community and recalled him to prison.

HMP Leeds

42. Mr Ziemiecki was arrested on 10 January and sent to HMP Leeds.

ACCT – 10 to 30 January

43. When he arrived at Leeds, Mr Ziemiecki said he felt like he would self-harm while in prison. Reception staff noted that Mr Ziemiecki seemed "very hyper" and told them he had mental health issues. Later prison staff noted that Mr Ziemiecki appeared low in mood. They started suicide and self-harm prevention procedures (known as ACCT).

44. A nurse completed Mr Ziemiecki's initial health screen. Mr Ziemiecki was very hyper throughout. He said he had a history of self-harm in prison and the community. The nurse noted that Mr Ziemiecki said he was on medication for anxiety and ADHD but had not taken any medication recently. A GP then saw Mr Ziemiecki and prescribed ADHD and antidepressant medication.

45. Mr Ziemiecki was assessed as high risk for cell sharing and was placed in a single cell on D Wing.

46. On 11 January, Mr Ziemiecki had his first multidisciplinary ACCT review. A supervising officer (SO) chaired the review. The SO noted that Mr Ziemiecki had a long history of self-harm and being on ACCT. (He had been on 14 ACCTs since

2017 after he threatened suicide and self-harm. In the past he had taken an overdose and been found with a ligature around his neck.) The SO noted that Mr Ziemiecki did not know why he had been recalled to prison, did not agree with the recall, and did not know for how long he would be in prison. The SO told Mr Ziemiecki that he would receive this information in his recall pack. Mr Ziemiecki wanted to move to B Wing, as his friend was on that wing. The SO noted that Mr Ziemiecki showed some future planning and was open to working with the Mental Health Team (MHT).

47. A nurse at the review noted that Mr Ziemiecki did not currently have thoughts of suicide and self-harm but had been angry the day before and had head butted and punched walls and metal doors. He noted that Mr Ziemiecki had some slight stammering in his speech. The nurse noted that in the past Mr Ziemiecki had overdosed on paracetamol (58 tablets in total) and said the last time he had self-harmed was eight months ago. Mr Ziemiecki said that he wanted the GP to re-prescribe him quetiapine (an antipsychotic).

48. The case review team kept the ACCT open with one observation every two hours.

49. On 12 January, an officer saw Mr Ziemiecki for his first key work session. Mr Ziemiecki told the officer he was struggling with his medication, as he needed to collect it in the morning but he was not always let out in time.

50. On 16 January, Mr Ziemiecki had his second ACCT review. The SO noted that the review was to speak to Mr Ziemiecki about moving wings. Mr Ziemiecki was still happy to move to B Wing. The SO said that Mr Ziemiecki had not self-harmed or indicated he would and was aware of the support available. The SO noted staff had remarked at the improvement they had seen in his behaviour. Staff kept the ACCT open with the same level of observations. Mr Ziemiecki was moved to B Wing.

51. On 19 January, the Neurodiversity Lead saw Mr Ziemiecki. He noted that Mr Ziemiecki had complex issues and needed a lot of support. He said Mr Ziemiecki was erratic due to his ADHD, which could be perceived as being aggressive by someone who did not know about Mr Ziemiecki's conditions. He noted that Mr Ziemiecki was fixated on the AP he had been recalled from, saying that he was set up to fail.

52. The Neurodiversity Lead noted that Mr Ziemiecki would not give eye contact and stated that he would make comments about people's appearance, whether good or bad, because he did not like to lie. He considered that B Wing was not the best place for Mr Ziemiecki at that time due to his sensory needs and referred him to the Learning Disability (LD) nurse and Complex Needs Unit (CNU).

53. On 20 January, Mr Ziemiecki had his third ACCT review. Mr Ziemiecki had received his recall pack with a sentence expiry of 2030. He was aware he needed to show good behaviour in custody to be considered for parole. Mr Ziemiecki was appealing his recall and would speak with his prison offender manager (POM) and his COM. Staff kept the ACCT open.

54. On 24 January, an officer saw Mr Ziemiecki for a key work session. Mr Ziemiecki told him he was stressed, and wanted some paperwork back from his POM before a letter was sent to probation.

55. On 30 January, Mr Ziemiecki had his fourth ACCT review. The SO noted that Mr Ziemiecki said he had been doing better. Mr Ziemiecki said the reasons for his recall were not valid but accepted he could not change them. He was aware that he might not be eligible for parole for some time but was confident he would be released. Mr Ziemiecki said he was getting along with staff on the wing, had a good support network and wanted to remain at Leeds while waiting for his parole. The case review team agreed that the ACCT should be closed.

February to March

56. On 1 February, staff discussed Mr Ziemiecki at the Safety Intervention Meeting and the CNU referral. They noted that Mr Ziemiecki's close friend was also on B Wing and was a good influence on him. They decided that it would be more beneficial for Mr Ziemiecki to remain on B Wing.

57. On 6 February, the SO saw Mr Ziemiecki for his ACCT post closure review. The SO noted that Mr Ziemiecki was in good spirits. He had not self-harmed since coming into custody and had no thoughts to do so. Mr Ziemiecki said he had good support on the wing and spoke regularly to his partner. Mr Ziemiecki said he was happy on B Wing and had built a good rapport with the staff. He was feeling better on his current medication and raised no issues with his mental health.

58. On 9 February, the Neurodiversity Lead made an entry on Mr Ziemiecki's electronic prison record which he noted was information for staff. It said that Mr Ziemiecki had complex needs, and needed a little bit more time when being spoken to so that he could process the information being given to him. It said that Mr Ziemiecki may come across as aggressive, but this was not always the case and that staff should not rush their interactions with him.

59. On 16 February, a GP saw Mr Ziemiecki who said that he was struggling with sleep and was awake all night. The GP agreed to prescribe zopiclone (a sleeping aid). Mr Ziemiecki said that he needed to feel things and touch them, had a sensitivity to smell, and the ability to draw and see colours. The GP noted that Mr Ziemiecki had elements of sensory processing disorder (SPD).

60. Mr Ziemiecki told the GP that his behaviour was getting better as wing staff understood that he had little impulse control, and the effort of controlling his impulses sent his mood crashing down. The GP noted that Mr Ziemiecki was keen to be prescribed quetiapine.

61. On 22 February, a nurse completed an initial mental health assessment. Mr Ziemiecki did not display any urgent concerns with regards to his risk to himself or others.

62. The nurse noted that Mr Ziemiecki did not really want to engage in the assessment when she told him she could not prescribe zopiclone or quetiapine. She said there was no evidence of suicidal thoughts or self-harm. The nurse referred him to the consultant psychiatrist.

63. On 3 March, a member of the offender management unit (OMU) noted that Mr Ziemiecki was due to be transferred to another category B prison. She spoke to his POM and they agreed that given Mr Ziemiecki had worked hard and was due to be

re-categorised to category C that month, a move to another category B prison would not be beneficial.

ACCT – 11 to 31 March

64. On the morning of 11 March, during an incident on the wing, Mr Ziemiecki did not follow instructions and was abusive to staff. Later that morning, Mr Ziemiecki was again abusive when challenged about wearing a hat on the landing and staff walked him back to his cell. As a result of these two incidents, staff downgraded Mr Ziemiecki from enhanced to standard status and removed him from his job as a wing cleaner.

65. At 11.45am, a consultant psychiatrist saw Mr Ziemiecki and reviewed his current mediations and diagnoses. He prescribed quetiapine, to address Mr Ziemiecki's needs around arousal and aggressiveness. He also increased his antidepressant medication.

66. That afternoon, Mr Ziemiecki said that he would self-harm and wanted to go to the segregation unit. A SO noted that Mr Ziemiecki was fixated on what had happened in the morning. She reopened Mr Ziemiecki's ACCT and set observations at three an hour.

67. On 12 March, Mr Ziemiecki had his fifth ACCT review. The SO who reopened the ACCT chaired the review as the SO who usually chaired Mr Ziemiecki's reviews was not on duty. She noted that Mr Ziemiecki said he was alright but was fixated on the previous day's incidents and had lost his job due to these incidents. Mr Ziemiecki said that he had not collected his morning medication, and said he was going to stop taking his medication so he could chill out behind his door. Staff tried to convince Mr Ziemiecki to take his medication, but he did not respond. Mr Ziemiecki told them that when he had said he would self-harm he had felt frustrated and low, and he still felt a bit low. Staff reduced observations to one an hour.

68. On 17 March, Mr Ziemiecki had his sixth ACCT review. The usual SO noted that Mr Ziemiecki's ACCT was reopened after he said he would harm himself, following his very poor and aggressive attitude towards staff and being removed from his job. Mr Ziemiecki did not agree with this and felt he was being "stitched up".

69. Mr Ziemiecki had recently been re-categorised to category C, and said he was happy to transfer to a category C prison. He said he wanted to keep his record positive when looking towards his parole hearings.

70. The SO noted that Mr Ziemiecki was taking his medication (quetiapine) and it appeared to have calmed him down to a certain extent. He was also taking his ADHD medication. The SO said that despite there being very little reason for the ACCT to remain open, Mr Ziemiecki wanted it to stay open based on the fact that he might wake up and his head "might go". Staff kept the ACCT open but reduced observations to four during the night and three conversations a day.

71. On 30 March, the Neurodiversity Lead noted that he saw Mr Ziemiecki and a custodial manager (CM) about getting Mr Ziemiecki's cleaning job back. He noted that the CM was going to speak to the other staff on the wing to let them know how to manage Mr Ziemiecki in the correct way, considering his complex needs.

72. On 31 March, Mr Ziemiecki had his seventh ACCT review. The SO noted that Mr Ziemiecki would get his wing cleaner job back. Mr Ziemiecki's behaviour had settled down. He had been compliant with his medication and said he intended to keep himself to himself and focus on his parole and recall appeal.

73. The SO noted Mr Ziemiecki spent a long time talking about how he thought he was failed by probation and was now working towards his upcoming hearings, in the hope that he could be released. He was aware that this would take time, and he would need to behave while in custody. Mr Ziemiecki said he had no current thoughts or intentions to self-harm. The case review team agreed to close the ACCT.

April

74. On 10 April, the SO saw Mr Ziemiecki for his post closure ACCT review. The SO noted that Mr Ziemiecki was in good spirits and keeping himself busy at work trying to demonstrate how well he could behave for his parole. The SO kept the ACCT closed.

75. On 14 April, Mr Ziemiecki telephoned his partner. He asked her if £30 and £50 had been transferred into her bank. His partner said that only £30 had gone in. Mr Ziemiecki said that the money he sent her was just for her, and he would not ask for it. Mr Ziemiecki said that he got the money from selling "vapes and that". Mr Ziemiecki complained that the prisoner who owed him £50 had been transferred and did not pay him.

76. On 15 April, Mr Ziemiecki telephoned his partner twice. He told her that he had taken a lot of pregabalin (prescribed medication that is widely abused) and smoked cannabis. Mr Ziemiecki told her that he was going to get released and get a new probation officer. His partner said she did not want to be in a relationship with someone who was in jail. Mr Ziemiecki said he was in a "shit place" and felt like he had been "dropped" by his partner. He said he wanted to maintain a friendship with his partner while he was inside and when he got out, they could be together.

77. On 20 April, Mr Ziemiecki telephoned his partner twice. He asked if she missed him, and she responded that she did sometimes. He said that on 25 April, he would have a Member Case Assessment (MCA - the Parole Board determines whether the case can be concluded on the papers or sets out additional steps that are needed for the matter to be determined fairly and swiftly) and would be released. He said he had been told that when he was last released, he had been set up to fail.

78. Mr Ziemiecki told his partner that he wanted to marry her one day. She sounded unsure about this. After Mr Ziemiecki said he loved his partner, but she did not reciprocate, he became agitated but the call ended amicably.

Events of 21 April

79. CCTV shows that at 8.40am on 21 April, while Mr Ziemiecki was out of his cell on the wing landing, he passed something to another prisoner and appeared to receive something in return.

80. Officer A saw Mr Ziemiecki receive what looked like a pink tablet from another prisoner. Officer A challenged Mr Ziemiecki and tried to recover the tablet but Mr Ziemiecki put it in his mouth. (We have been unable to establish what kind of tablet this was.) Officer A instructed Mr Ziemiecki to return to his cell and placed him on report (a disciplinary charge). Officer A said he asked Oscar One (the senior officer in charge) if he could keep Mr Ziemiecki locked in his cell pending his disciplinary hearing and was told he could. However, the CM, who was Oscar One that day, said that he had told Officer A that if Mr Ziemiecki had been out for his 'domestics', when prisoners can shower, arrange laundry and so on, he could keep him in his cell except to collect meals. He did not give permission to keep Mr Ziemiecki locked up until his hearing.

81. At around 9.00am, Mr Ziemiecki rang his cell bell and Officer A attended. Mr Ziemiecki had a razor blade and was threatening to cut his throat. A nurse arrived at around the same time, as she had been called to check on Mr Ziemiecki in case he had swallowed multiple tablets. She and other staff managed to convince Mr Ziemiecki to hand over the razor blade by pushing it under the door and they then entered the cell and talked to him at length. Staff reopened the ACCT.

82. The nurse noted that after some discussion, Mr Ziemiecki said that he did not have any more razor blades and had not taken an overdose, and that he was only winding the officers up.

83. Mr Ziemiecki rang his cell bell again and Officer A attended at 9.21am. CCTV shows Officer A dancing outside Mr Ziemiecki's cell. Officer A told the investigator that Mr Ziemiecki was singing an offensive song about him which included the line, "I'm Officer A and I'm racist and I'm a bald bastard". Officer A told the investigator that his relationship with Mr Ziemiecki had got off to a bad start as he had asked him to leave the staff office when he had entered during a meeting. Officer A said Mr Ziemiecki seemed hostile towards him and made offensive comments to bait him. However, he said he thought things had got a bit better over time after he tried to make a joke of Mr Ziemiecki's comments and their interactions became half joking rather than hostile.

84. At 10.16am, Mr Ziemiecki's friend on the wing, who was a Listener (a prisoner trained by the Samaritans), entered Mr Ziemiecki's cell and stayed there for around 25 minutes. A CM told the investigator that he had arranged this as he knew that the other prisoner had a close relationship with Mr Ziemiecki.

85. At 10.51am, Mr Ziemiecki telephoned the COM who had initiated his recall. Mr Ziemiecki initially sounded upbeat, and questioned why he was given a full recall. He said he had complex needs, could be loud and had no filter. He said that he was not supported properly by her and questioned why she put him in the hostel that she did. He was concerned about the COM's input into his recall review. Mr Ziemiecki gave his reasons for his behaviour at the approved premises. The COM challenged him saying he was not taking responsibility for his actions that led to his recall. At times, Mr Ziemiecki sounded frustrated and angry.

86. Mr Ziemiecki then apologised for his behaviour at the hostel and listed what work he had done to address his risk. He said he deserved a second chance. He asked the COM whether she had received any emails about him from a senior probation officer.

87. Mr Ziemiecki asked the COM if she was “backing him” to be released. She said she would wait for the Parole Board to decide the direction and then would make a plan of what to do. Mr Ziemiecki was agitated by this. The COM said the conversation was going round in circles and ended the call.

88. Mr Ziemiecki rang his cell bell multiple times that morning. Between 10.43am and 12.00pm, Officer A and other prison staff attended Mr Ziemiecki’s cell ten times.

89. Staff asked Mr Ziemiecki if he wanted to collect his own lunch, but Mr Ziemiecki declined food. At 12.05pm, CCTV footage shows Officer A took lunch to Mr Ziemiecki’s cell. However, Mr Ziemiecki declined the food.

90. At 2.19pm, a senior probation officer went to Mr Ziemiecki’s cell for a prearranged meeting. Officer A had told him that he could not unlock the door due to the razor blade incident earlier so the senior probation officer spoke to him through the cell door.

91. The senior probation officer said Mr Ziemiecki made no reference to the possibility of an adjudication or negative entries but was frustrated that he could not be unlocked to participate in their planned meeting. He said Mr Ziemiecki felt as though he had been mistreated by probation staff in relation to the recall, staff at the approved premises, his previous probation officer and the officer who had refused to unlock him.

92. The senior probation officer noted that after speaking with Mr Ziemiecki, he calmed and the conversation was forward planning, briefly discussing the opportunity to appeal, the parole process and agreeing to meet the following week to discuss a plan designed to work towards release. He spoke with Mr Ziemiecki for around 15 minutes.

93. At 2.43pm, Officer A responded to Mr Ziemiecki’s cell bell and CCTV shows him standing at the cell door for a few seconds. In his statement, Officer A said that Mr Ziemiecki’s face was pressed against the glass of the observation panel in his cell door and he shouted at him, “Why the fuck did you tell him [the senior probation officer] I had a razor blade?” and “Why the fuck tell him you couldn’t open the door?” Officer A said he responded with, “Because it is true Mark”. He said that Mr Ziemiecki was screaming at him and he stood there for a while before walking away.

94. At 3.08pm, Officer B and Officer C went to Mr Ziemiecki’s cell to take him to the medications hatch. They found that Mr Ziemiecki had covered his observation panel. They called out to him but he did not respond. Officer B opened the door slightly to look in but could not see anything as the cell was dark. He was nervous given the razor blade incident earlier so he closed the cell again and decided to contact the CM.

95. Officer B radioed the CM and asked him to attend B Wing. The CM said he was in his office on the 2s landing on B Wing so Officer B and Officer C went there. Officer A is then seen walking up the landing and standing outside Mr Ziemiecki’s cell.

96. At 3.12pm, Officer B, Officer C and the CM returned and entered Mr Ziemiecki’s cell. Officer B said he shouted for Mr Ziemiecki, unlocked the door and tried to push

it open. He said there was some resistance behind the door, and so he looked round the door but could not see Mr Ziemiecki on the bed or the toilet. Officer B noted he then looked down behind the door and saw Mr Ziemiecki in a seated position with a bed sheet tied around his neck and attached to the medications box (which is attached to the wall). He then forced the door open, and the CM shouted for staff support. Officer B tried to remove the ligature with his fingers but it was too tight and so he cut it with his anti-ligature knife. Mr Ziemiecki was unresponsive, so staff started CPR.

97. At 3.13pm, Officer A radioed a medical emergency code blue. At 3.14pm, the control room called an ambulance. At 3.15pm, a nurse and other healthcare staff attend the cell and took over CPR. At 3.25pm, ambulance paramedics arrived and took over CPR.

98. Mr Ziemiecki was taken to Leeds hospital and placed in the Intensive Care Unit (ICU). He was sedated and put on a ventilator. Hospital doctors said that Mr Ziemiecki had showed signs of a significant brain injury.

99. At 1.10pm on 22 April, after discussions with Mr Ziemiecki's family, hospital staff removed life support. Mr Ziemiecki died with his family by his side.

100. Mr Ziemiecki left a note in his cell which said that Officer A had been winding him up all the time and he had had enough. He said that he had told Officer A that he was going to kill himself and that Officer A had said "Go on then".

Contact with Mr Ziemiecki's family

101. On 21 April, the prison appointed a family liaison officer. She telephoned Mr Ziemiecki's family that afternoon and eventually made contact in the early evening. She and a prison manager attended the hospital to support Mr Ziemiecki's family.

102. The prison offered for the family to see Mr Ziemiecki's cell but they initially declined. They later said they would like to see it but by then, it had been reallocated to another prisoner. Mr Ziemiecki's belongings were returned to the family but the prison was unable to locate his property card so we were unable to check what items he had in his cell when he died.

103. Another officer subsequently took over the family liaison role.

104. The prison contributed to the costs of Mr Ziemiecki's funeral in line with national policy.

Support for prisoners and staff

105. 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.

106. After Mr Ziemiecki was taken to hospital, a prison 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. The local Samaritans team attended the prison on 24 April to provide support to staff and prisoners. Additional support was provided to Mr Ziemiecki's friend.

107. The prison posted notices informing other prisoners of Mr Ziemiecki'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 Ziemiecki's death.

Post-mortem report

108. No post-mortem examination was undertaken. The Coroner's office told the investigator that the cause of death would be determined at inquest.

Findings

Recall to prison

109. Mr Ziemiecki was very unhappy about the decision to recall him to prison and said that he had been set up to fail when he was released to a standard AP. We note that Mr Ziemiecki was not released to a PIPE AP as planned and it is possible that had he been, his behaviour would not have deteriorated as it did. The Probation Service may wish to consider whether there is any learning from this case.

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

110. Prison Service Instruction (PSI) 64/2011, Managing prisoners at risk of harm from self, from others and to others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.

111. When Mr Ziemiecki arrived at Leeds in January 2023, he had several risk factors for suicide and self-harm. He had just been recalled to prison, told staff he would self-harm and had done so in the past, had a long history of mental health problems, and presented as low in mood. Reception staff considered these factors and appropriately started ACCT procedures.

112. Mr Ziemiecki's ACCT was reopened on two occasions, on 11 March and on 21 April, the day of his death. Staff recognised that Mr Ziemiecki's risk had increased and the decisions to restart ACCT procedures were appropriate.

113. We found that the ACCT procedures were broadly managed well. There were frequent case reviews, which were all multidisciplinary and with consistent case management, and records were detailed, with clear explanations for the decisions taken. There was an appropriate care plan and staff tried to address Mr Ziemiecki's needs.

114. Mr Ziemiecki tied the ligature to the medication box in his cell. Two months before that, another prisoner took his life using the same method. We understand that the prison considered whether the medication boxes should be moved but decided that this was not proportionate given that there are other ligature points in standard cells.

Officer A's conduct

115. Mr Ziemiecki left a suicide note which said that he had taken his life because Officer A was always winding him up. He said he told Officer A he was going to kill himself and Officer A had said, "Go on then". Prisoners told the investigator that they did not hear Officer A say this, but they said they disliked Officer A's attitude and behaviour, describing him as arrogant.

116. The prison commissioned an investigation into Officer A's behaviour on the morning of 21 April, when he locked Mr Ziemiecki in his cell pending his adjudication and was later seen dancing outside his cell. The investigating officer concluded that

Officer A's behaviour did not fall within the Acceptable Behaviours Policy and that it could be perceived as antagonistic. He also could not establish where the authority had come from to keep Mr Ziemiecki locked in his cell pending his adjudication. He recommended a formal disciplinary investigation.

117. The Deputy Governor noted that while he accepted that some of Officer A's actions were inappropriate, Officer A was new in service (since March 2023) and was still developing his skills in interacting with prisoners. He noted that managers should aim to deal with issues at the lowest level possible and decided that nothing further would be learned by having a disciplinary investigation. He decided that Officer A should be supported and developed. He set out several actions including that Officer A's line manager should discuss the events with him and guide him on expectations, as well as allocating a mentor. The Governor will want to assure herself that these actions have had the necessary impact.

Key work

118. Mr Ziemiecki had only two key work sessions during his four months at Leeds. His last recorded key work session was on 24 January, three months before he died.

119. The Acting Head of Recovery told us that the prison was addressing key work in several ways:

- Preparing guidance to staff on responding to prisoner non-engagement with key work.
- Carrying out work on the induction unit to improve the provision of key work.
- Rolling out a priority group scheme to ensure that prisoners with specific risk factors, such as high risk cell sharing, were prioritised for key work.
- Trialling a new quality assurance process to provide robust feedback to key workers.
- Monitoring key work compliance. (53% of key work sessions were delivered in June 2023, compared with 20% in December 2022.)

120. As the prison is already taking steps to improve the provision of key work at Leeds, we make no recommendation.

Covered observation panel

121. When Officer B and Officer C went to Mr Ziemiecki's cell to take him to the medications hatch on the afternoon of 21 April, they found his observation panel was covered so they could not see inside the cell. They knocked on his door but got no response. They then tried to open the cell door but had difficulty as they felt resistance behind the door. They tried to look in but the cell was dark. Considering Mr Ziemiecki had been found with a weapon earlier that day, they were concerned about their safety and decided not to enter the cell. We consider that was reasonable in the circumstances.

122. The officers then left the cell to go to the office to fetch the CM and returned with him a few minutes later. The three of them then entered the cell and found Mr Ziemiecki unresponsive with a ligature around his neck.

123. We consider that staff should have remained at Mr Ziemiecki's cell door and radioed for urgent assistance when they found that his observation panel was covered. We asked Leeds for their local policy on dealing with covered observation panels, but they told us that they did not have one. It is important that staff understand what they should do if they find an observation panel covered, especially for prisoners on ACCT. We bring this to the Governor's attention.

Clinical care

124. The clinical reviewer concluded that the care Mr Ziemiecki received at Leeds was of a good standard and was equivalent to that which he could have expected to receive in the community. She noted that Mr Ziemiecki had an extensive and long history of impulsive reactions to certain situations. His needs were complex and combined with his self-harm incidents and impulsive behaviour, the risks of self-harm acts going fatally wrong were high.

125. The clinical reviewer made one recommendation about substance misuse referrals which the Head of Healthcare will want to address.

Good practice

126. Shortly after arriving at Leeds, the Neurodiversity Lead saw Mr Ziemiecki. He identified Mr Ziemiecki's complex needs, provided ongoing personalised support and advised prison staff how best to positively interact with Mr Ziemiecki. The CM at morning briefings also informed B Wing staff of Mr Ziemiecki's needs and how best to manage him. Both evidenced good practice.

Inquest

127. At the inquest, held from 25 October to 1 November 2024, the jury concluded that Mr Ziemiecki died by suicide. The cause of death was recorded as hypoxic brain damage caused by hanging.

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