Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Piotr Zmijewski, a prisoner at HMP Maidstone, on 9 September 2023

A report by the Prisons and Probation Ombudsman

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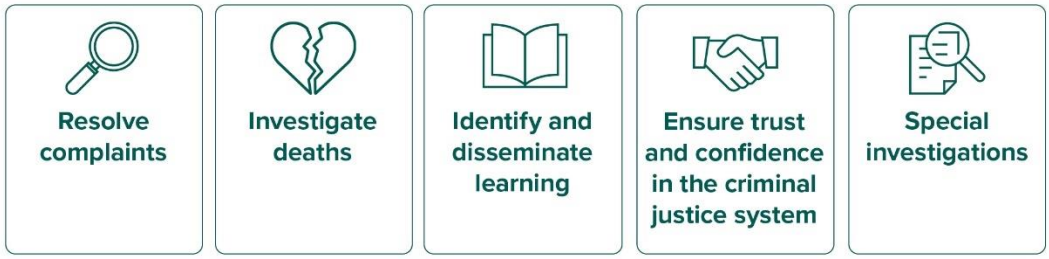
OUR VISION

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 Piotr Zmijewski died after being found in his cell at HMP Maidstone on 9 September 2023 with a ligature tied around his neck. He was 49 years old. I offer my condolences to Mr Zmijewski's family and friends.

I have concluded that Mr Zmijewski gave no obvious indication to staff that he was at risk of suicide. However, in the weeks leading up to his death, Mr Zmijewski chose to self-isolate, meaning he spent periods of the day confined to his cell. I found no evidence that staff attempted to engage in meaningful conversation with him during these periods and, as a result, opportunities to properly assess the risk he posed to himself were missed.

Maidstone has a robust self-isolation policy with clear guidelines on how staff should support a prisoner during periods of self-isolation. However, staff failed to properly implement this policy: they did not review Mr Zmijewski's self-isolation plan regularly or seek input from other professionals who may have been able to provide additional support. However, I also recognise that Mr Zmijewski's self-isolation was inconsistent, and it was difficult for staff to assess the level of threat he genuinely felt.

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 **March 2025**

Contents

Summary

Events

1. In January 2019, Mr Piotr Zmijewski was charged with violent offences and remanded to custody. In October, he was sentenced to 14 years imprisonment. Prison records note that over the next four years, he appeared settled and gave no indication that he was a risk of suicide or self-harm. Having spent time in a number of prisons, on 13 June 2023, Mr Zmijewski transferred to HMP Maidstone.

2. On 27 June, Mr Zmijewski referred himself to the mental health team because he said he was having trouble sleeping, was depressed and was not coping on his wing. Staff booked him an appointment to see a GP on 4 July. He did not attend this appointment. Staff rebooked the appointment but again, he did not attend. Staff did not record the reasons why or offer him a further appointment.

3. On 22 August, Mr Zmijewski was discussed at the weekly SIM (Safety Intervention Meeting), after he reported to wing staff that he felt in danger from other prisoners on the wing. The next day, a member of the chaplaincy team visited him in his cell to discuss his concerns. Mr Zmijewski said he was going to keep himself safe by self-isolating. Staff opened a self-isolation log so they could monitor and support him.

4. Over the next few days, the self-isolation log remained open, however staff also recorded that Mr Zmijewski left his cell at least once a day, unescorted, to access parts of the regime.

5. On 28 August, a supervising officer completed Mr Zmijewski's weekly self-isolation review. This contained limited information but noted that Mr Zmijewski was leaving his cell to access parts of the regime on a regular basis. Despite this, the self-isolation log remained open.

6. On 30 August, an officer took Mr Zmijewski's dinner to him in his cell, as per the self-isolating procedures. Mr Zmijewski asked for his cell to be left unlocked and spent the next hour associating with peers on his wing.

7. On 9 September at approximately 1.19pm, an officer went to check on Mr Zmijewski in his cell. He opened the observation panel and saw Mr Zmijewski sitting on the floor with a ligature tied around his neck. The officer immediately entered the cell, pressed the alarm on his radio, and cut through the ligature.

8. Approximately one minute later, additional officers responded to the alarm, entered Mr Zmijewski's cell, and radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff started cardiopulmonary resuscitation (CPR). Two minutes later, healthcare staff arrived and took over Mr Zmijewski's care.

9. At approximately 1.30pm, paramedics arrived and took over resuscitation attempts. At 2.01pm, the paramedics pronounced that Mr Zmijewski had died.

Findings

10. We found that when Mr Zmijewski began self-isolating, staff correctly opened a self-isolation log and spoke with him to understand his motivation for doing so. Mr Zmijewski said that he felt unsafe, but staff had very limited evidence to suggest that there was an actual threat to his safety at Maidstone. We found no further evidence during the course of our investigation. We consider that from this point onwards, the management of his self-isolation was poor, and not taken seriously by staff. There was little evidence of robust case management of his self-isolation log, daily updates and weekly reviews did not take place as they should have done, there was no multidisciplinary input from partner agencies and there was limited information about identified risks and agreed actions to reduce or end isolation. Healthcare staff did not check on him as they should have done.

11. We found that, in the weeks prior to his death, Mr Zmijewski gave no indication to staff that he was at risk of suicide and that they could not have foreseen his actions. However, we consider that staff interactions with Mr Zmijewski during this period were minimal and as a result, opportunities to properly assess the risk he posed to himself were missed.

Recommendations

The Governor and Head of Healthcare should ensure that:

- plans for isolating prisoners contain detailed information about identified risks and agreed actions to reduce or end isolation,
- prison staff regularly review plans and ensure that any changes are recorded and actioned; and
- healthcare staff review and document the mental state of a self-isolating prisoner at least once a week.

The Investigation Process

12. The PPO was notified of Mr Piotr Zmijewski's death on 11 September 2023. The investigator issued notices to staff and prisoners at HMP Maidstone informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

14. NHS England commissioned a clinical reviewer to review Mr Zmijewski's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with eleven members of staff. In April 2024, the investigation was reallocated to another investigator.

15. We informed HM Senior Coroner for Mid Kent & Medway of our investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Zmijewski's daughters to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Zmijewski's daughters wanted to know all the circumstances that led to his death. They said that Mr Zmijewski had told them that he did not feel safe in prison and had been threatened. They said that they had reported this to the prison.

17. Mr Zmijewski's daughters received a copy of the draft report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Maidstone

19. HMP Maidstone is a training prison that holds foreign national prisoners. Almost all the population is of interest to Home Office Immigration Enforcement (HOIE) which has a team, called the In Prison Team (IPT) on site in the prison.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Maidstone was in October 2022. Inspectors reported prisoners' anxiety had increased due to Home Office delays in processing their immigration cases. Self-harm rates were low, although they observed widespread anxiety and distress. Some staff were alert to this, while others were less forthcoming in offering informal support. Records of interactions with prisoners were often missing, and supervisors did not always complete their daily checks. More prisoners than at the previous inspection said they felt unsafe, attributing this to their uncertain immigration status, but others raised concerns about debt and antisocial behaviour.

Independent Monitoring Board

21. 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 2022 to 2023, the IMB reported that mental health issues were made worse because of the additional complications of being a foreign national in a British prison and the stress caused by the way immigration issues were handled. The IMB noted that prison and healthcare staff worked hard to alleviate mental health issues and were noticeably compassionate in the support they provided.

Previous deaths at HMP Maidstone

22. Mr Zmijewski was the fourth prisoner to die at Maidstone since 9 September 2020. One of the previous deaths was self-inflicted, one from natural causes and the other was a homicide. There were no similarities between our findings in these deaths and Mr Zmijewski's death. Up until the end of August 2024, there had been one further death at Maidstone due to natural causes since that of Mr Zmijewski.

Key worker scheme

23. The key worker scheme was introduced in the men's prison estate in 2018. It provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

24. 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.

Self-isolation

25. Self-isolation is when a prisoner chooses to isolate themselves from the prison's regime and remain locked in their cell for an extended period. Reasons why a prisoner chooses to isolate vary, and staff should discuss the motivation for self-isolation with the prisoner so they can take appropriate action to mitigate any threats and encourage the prisoner to re-engage with the regime.

Key Events

Background

26. On 25 January 2019, Mr Piotr Zmijewski was charged with violent offences and remanded to HMP High Down. Mr Zmijewski was a Polish national, and it was his first time in prison in the UK.

27. On his arrival at High Down, Mr Zmijewski said he had no thoughts of suicide or self-harm. Reception staff noted that he had no history of suicide attempts, self-harm or mental ill-health.

28. On 24 October, Mr Zmijewski was sentenced to 14 years imprisonment. Over the next four years, he was transferred to several prisons including HMP Woodhill, HMP The Mount, HMP Hewell and HMP Wandsworth. Throughout this time, Mr Zmijewski engaged in the prison regime, attended work and gained some basic literacy and numeracy qualifications. His ability to speak English improved and in some instances he became able to communicate with staff without an interpreter. Prison records show that he appeared settled and gave no indication that he was at risk of self-harm or suicide.

HMP Maidstone

29. On 13 June 2023, Mr Zmijewski transferred to HMP Maidstone. Both first and second reception screenings were unremarkable and consistent with those from other prisons. There was no known or disclosed drug, alcohol or mental health history. Mr Zmijewski was of interest to Home Office Immigration Enforcement officials.

30. On 27 June, Mr Zmijewski referred himself to the mental health team, saying that he was having trouble sleeping, was depressed, and was not coping on the wing. Staff triaged the referral and made Mr Zmijewski a GP appointment for 4 July. Mr Zmijewski was sent a slip notifying him of this appointment.

31. On 4 July, Mr Zmijewski did not attend his GP appointment. Staff rescheduled the appointment for 7 July, and again sent him a slip to notify him. Mr Zmijewski did not attend this appointment either. The appointment was not rebooked, and staff did not record why he had not attended.

32. On 22 August, staff discussed Mr Zmijewski at the weekly SIM (Safety Intervention Meeting), after he reported to wing staff that he felt in danger from other prisoners on the wing. The next day, a member of the chaplaincy team visited him in his cell to discuss his concerns. Mr Zmijewski said that a prisoner had been to his cell door and told him that he was “dead”. He said that he believed this was due to previous issues he had with prisoners while at The Mount, and that prisoners thought he was an informer (a prisoner who covertly gives security information to staff). Maidstone checked Mr Zmijewski’s prison records before speaking to staff at The Mount who said he had not been an informer there. Mr Zmijewski said he was going to keep himself safe by self-isolating in his cell.

33. Later that day, staff opened a prisoner self-isolation log and spoke to Mr Zmijewski about why he was self-isolating. Mr Zmijewski said that he had been threatened by another prisoner but could not name them and said he would not feel safe in any other wings at Maidstone. Mr Zmijewski said that he would like to be transferred to another foreign national prison.

34. A few hours later, Mr Zmijewski's daughter rang the prison to tell them he had been threatened and that she was worried for his safety. An officer from the safer custody team assured her that they were aware of the situation and that they were looking at ways to support him.

35. On 24 August, Mr Zmijewski attended a routine appointment in healthcare. Despite self-isolating, he told an officer he did not need escorting to his appointment.

36. Over the next few days, Mr Zmijewski's self-isolation log remained open. However, staff recorded that Mr Zmijewski left his cell at least once a day, unescorted, to access parts of the regime. This included attending the chapel and collecting his meals. An entry in the self-isolation log stated that Mr Zmijewski may have been self-isolating in an attempt to obtain a transfer to another prison, closer to his family. There is, however, no record of this being discussed with him.

37. On 28 August, a Supervising Officer (SO) completed Mr Zmijewski's weekly self-isolation review. The review contained little information and it is not clear if Mr Zmijewski was present. The SO recorded that Mr Zmijewski was leaving his cell to access parts of the regime on a regular basis. Despite this, the self-isolation log remained open.

38. On 30 August, an officer took Mr Zmijewski's dinner to him in his cell, as per the self-isolating procedures. Mr Zmijewski asked for his cell to be left unlocked and spent the next hour associating with peers on his wing. He remained unlocked until the evening routine check, two hours later. There are no further entries in the self-isolation log from this date, nor are there any recorded entries on Mr Zmijewski's prison or healthcare records until the day of his death.

39. Mr Zmijewski made daily calls to his daughters from his prison phone. The last call he made was on 6 September (he had sufficient funds to make calls after this date). The investigator received translations of these calls and there was nothing that indicated Mr Zmijewski was a risk to himself. Mr Zmijewski also received regular visits from his family. The last visit he received was on 3 September, and he had a visit scheduled with his daughter for the day after his death.

Events of Saturday 9 September

40. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio communications from 9 September. She also obtained information from the Southeast Coast Ambulance Service. The following account has been taken from all sources.

41. At approximately 11.45am, an officer went to Mr Zmijewski's cell to give him his lunch. At interview, he told us that he unlocked the door, gave Mr Zmijewski his lunch, and asked him if he was okay. Mr Zmijewski said "I'm okay" before taking his lunch and being locked back into his cell. He described Mr Zmijewski as looking

"worried" but said that this was not different to how he usually looked, and he was not concerned.

42. At approximately 1.15pm, an officer began unlocking the cells for afternoon activities. He did not unlock Mr Zmijewski's cell as he believed he was still self-isolating. At 1.19pm, he went to check on Mr Zmijewski in his cell. He opened the observation panel and saw Mr Zmijewski sitting on the floor with a ligature tied around his neck and secured to his cabinet. He immediately opened the cell door, pressed the alarm button on his radio, and asked a prisoner who was standing nearby to press the general alarm. Upon entering the cell, he cut through the ligature and the prisoner helped him put Mr Zmijewski into the recovery position.

43. Approximately one minute later, two officers and a SO responded to the alarm and entered Mr Zmijewski's cell. At 1.21pm, an officer radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Control room staff requested an ambulance immediately.

44. At 1.22pm, the SO checked Mr Zmijewski to see if he had a pulse before moving him onto his back and starting cardiopulmonary resuscitation (CPR). Over the next few minutes, the officers took turns doing CPR and another SO arrived with a defibrillator (a device that gives shocks to the heart to restore a normal heartbeat).

45. At 1.24pm, a nurse and a healthcare assistant arrived and staff moved Mr Zmijewski to the corridor where there was more room. Healthcare staff applied the defibrillator and continued resuscitation attempts.

46. At approximately 1.30pm, paramedics arrived and took over resuscitation attempts. At 2.01pm, the paramedics pronounced that Mr Zmijewski had died.

Contact with Mr Zmijewski's family

47. At 2.45pm, the prison appointed two family liaison officers. At 3.40pm, they left the prison and travelled to Mr Zmijewski's daughter's home address. At 5.45pm, they arrived at the address but found that Mr Zmijewski's daughter no longer lived there. As a result, they agreed to visit the home address of Mr Zmijewski's second daughter. Upon arrival, they found both of Mr Zmijewski's daughters were there and so, at 6.15pm, one FLO informed them of the death of their father and offered his condolences.

48. Maidstone contributed to Mr Zmijewski's funeral costs in line with national guidance.

Support for prisoners and staff

49. 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 to identify prisoners most affected by the death.

50. The prison posted notices informing other prisoners of Mr Zmijewski'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 his death. Staff checked on the welfare of the prisoner involved in the emergency response and told him about support services available to him at Maidstone, should he need them.

51. After Mr Zmijewski's death, the staff involved in the incident were given the opportunity to discuss any issues arising. They were also offered support by the staff care team and signposted to support services available to them. Arrangements were made for the staff who were directly involved in the incident to be taken home and the Governor contacted them the following day to check on their welfare and offer additional support.

Post-mortem report

52. The post-mortem report recorded Mr Zmijewski's cause of death as hanging.

53. At the inquest held on 3 February 2025, the coroner concluded that Mr Zmijewski died by suicide.

Findings

Assessment of risk

54. Prison Service Instruction (PSI) 64/2011, Safer Custody, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making. Mr Zmijewski had several risk factors including that it was his first time in prison, he was facing extradition proceedings, he felt at risk of harm from other prisoners, he was self-isolating, and he missed his family. However, he had no recorded history of suicidal thoughts or attempts, or self-harm.

55. We found that, in the weeks prior to his death, Mr Zmijewski gave no indication to staff that he was at increased risk of suicide and that they could not have foreseen his actions. However, staff interactions with Mr Zmijewski during this period were minimal and as a result, opportunities to properly assess the risk he posed to himself were missed. These opportunities included self-isolation procedures, key working and mental health support and are discussed further below.

Self-isolation

56. It is essential for staff to recognise the heightened risks associated with specific situations and groups of prisoners, including isolating prisoners. Governors must have a system in place to identify and accurately record details of all isolating individuals within the establishment. Records must include the reasons given for isolating, support offered, and the details of regime being offered and taken. This information must be made available in local SIMs to inform decisions about any subsequent supportive actions or interventions to mitigate the risk of continued isolation.

57. Maidstone's self-isolation policy states that a collaborative approach between prison staff and partner agencies should provide regular and consistent intervention to support prisoners to manage any issues raised. The aim is to provide appropriate support to encourage prisoners to cease self-isolating. The policy instructs that prisoners who self-isolate should be monitored daily by staff with weekly isolation reviews.

58. When Mr Zmijewski began self-isolating, staff correctly opened a self-isolation log and spoke to him to understand his motivation for doing so. Mr Zmijewski said that he feared for his safety at Maidstone due to prisoners believing he had been an informer whilst at The Mount. Initially, Maidstone took appropriate steps to try to investigate his concerns but found no evidence to suggest that Mr Zmijewski had experienced any issues while at The Mount. However, following this, staff made little effort to re-engage with Mr Zmijewski or explore any other possible motives for his self-isolation. An entry in the self-isolation log stated that Mr Zmijewski may

have been self-isolating in an attempt to obtain a transfer to another prison, closer to his family. There is, however, no record of this being discussed with him.

59. Although wing staff were aware that Mr Zmijewski had chosen to self-isolate, he was still attending church services and some appointments without an officer escort, as well as asking to be unlocked from his cell to attend wing association, where he was seen chatting with his peers. It is possible that this contributed to the inconsistent use of the self-isolation log. Staff made no entries in the log after 30 August and the weekly self-isolating review that should have taken place on 4 September did not. A review might have enabled staff to either close the log or further explore his concerns and put in place appropriate measures to support Mr Zmijewski.

60. Mr Zmijewski's self-isolation log should have been overseen by a case manager, who would have been responsible for ensuring that relevant partner agencies were appropriately informed and engaged. Mr Zmijewski's self-isolation was discussed at three weekly SIM meetings. However, the meeting minutes and interviews with staff indicated that little update was given in regard to his condition and other departments such as the mental health team were not appropriately informed or able to offer their support. The Head of Safety could not tell us why more detailed updates were not provided at the SIM. Additionally, the Head of Healthcare told us that he expected healthcare staff to review every isolating prisoner on a daily basis. He was unaware that Mr Zmijewski was self-isolating.

61. In the weeks prior to his death, staff interactions with Mr Zmijewski were minimal and, as a result, there were few opportunities to properly assess the risk he posed to himself. No attempts were made to effectively engage with him. The isolation log we reviewed lacked detail and forward planning, contained very few details about the issues that had been identified and it did not address how staff would encourage Mr Zmijewski to end his self-isolation. There was no evidence of collaboration between prison staff and partner agencies, that wing staff contributed to the log on a daily basis, or that a SO reviewed it weekly. Regular, thorough self-isolation reviews, meaningful conversations and documented daily checks may have identified possible risk factors to suicide and self-harm and alerted staff when Mr Zmijewski's risk increased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **plans for isolating prisoners contain detailed information about identified risks and agreed actions to reduce or end isolation,**
- **prison staff regularly review plans and ensure that any changes are recorded and actioned; and**
- **healthcare staff review and document the mental state of a self-isolating prisoner at least once a week.**

Key work

62. In common with many other prisons, the key work scheme is not operating as it should at Maidstone. During the month of Mr Zmijewski's death, 64% of scheduled key worker sessions were completed. However, there was no record of Mr

Zmijewski being offered or attending any key work sessions during the three months he was there. Mr Zmijewski's allocated key worker told us that he had offered Mr Zmijewski key work sessions on three occasions. On two of these, Mr Zmijewski declined the session and the third time, he asked to speak with a SO, which was subsequently actioned. The key worker told us that he did not document any of these as he was a new officer and was not yet familiar with the computer system. He confirmed that he now knows how to navigate the prison system and records all his key worker entries.

63. In addition, the Head of Residence told us since Mr Zmijewski's death, prisoners who are self-isolating are automatically placed on a CSIP (Challenge, Support and Intervention Plan) to provide them with additional support. In light of this change and the key work support Mr Zmijewski was offered, we make no recommendation.

Clinical care

64. The clinical reviewer concluded that Mr Zmijewski's physical healthcare was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. He did however find that the mental healthcare Mr Zmijewski received could have been improved.

65. When Mr Zmijewski self-referred to the mental health team on 27 June, his request was triaged, and an appointment was made for him to see the GP the following week. When Mr Zmijewski failed to attend this appointment, another appointment was made which he again failed to attend. The clinical reviewer found no clear documentation detailing the reason why Mr Zmijewski did not attend these appointments.

66. Although it is always possible that Mr Zmijewski had made an informed decision to decline further engagement with mental health services, the clinical reviewer found that the possibility of his non-attendance being attributable to a deterioration in his mental state could not be excluded. The Head of Healthcare will want to consider the clinical reviewer's recommendation to review local procedures relating to non-attendance, specifically when there is evidence of a mental health related concern.

Emergency response

67. When the officer found Mr Zmijewski ligatured in his cell, he did not radio a code blue, check for signs of life or start CPR. At interview, he explained that, as a new officer, he had recently completed his first aid training and felt competent and comfortable in what he should do in the event of a medical emergency. He said, however, that dealing with a medical emergency in training was very different to experiencing a medical emergency in reality. He said that when he found Mr Zmijewski unresponsive, he was in a state of shock and confusion and, as a result, did not follow correct procedures.

68. We recognise that the officer was faced with an extremely distressing situation and, as a new officer, had likely not been exposed to such difficult situations before. Although prison emergency procedures were not fully followed, we find that he acted with the best intentions while in a heightened state of emotion and shock. He immediately entered the cell, raised the alarm and cut the ligature. Staff responded within a minute and an ambulance was quickly requested so that the delay to Mr

Zmijewski's treatment was minimal. The officer said that he has learnt from the death of Mr Zmijewski and told us what he would do differently should he be faced with a similar emergency situation. The Governor may wish to consider how best to support staff, particularly those who are new, to effectively implement their training in emergency situations.

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