

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Krzysztof Woskowiak, a prisoner at HMP Bullingdon on 6 May 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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, including any apparent suicides and natural causes, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Woskowiak was found hanged in his cell at HMP Bullingdon on 6 May 2015. He was 41 years old. I offer my condolences to Mr Woskowiak's family and friends.

Prison staff did not assess Mr Woskowiak as at risk of suicide and self-harm, when he arrived at Bullingdon on 19 March, although he had a number of known risk factors. Mr Woskowiak spoke and understood little English but reception staff did not use a professional interpretation service. I therefore do not consider they could have made an informed decision about his risk or given him important information he needed to know. Mr Woskowiak received little meaningful support from wing officers and relied entirely on a Polish speaking cellmate to interpret and translate for him. He hanged himself on the day his cellmate was transferred to another prison.

Overall, I am concerned by the lack of support provided by the prison to a vulnerable foreign national such as Mr Woskowiak. I am also concerned that the emergency response was chaotic and family liaison deficient. The Governor will need to ensure the lessons from this investigation are learned.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**November 2015**

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# Summary

## Events

1. Mr Krzysztof Woskowiak was remanded to HMP Bullingdon on 19 March 2015. He was Polish and spoke and understood very little English. Despite this, no one in reception, including a nurse who completed a health screen, used a telephone interpreting service. Mr Woskowiak was charged with a violent offence against his wife and was in prison for the first time. These are factors that increase the risk of suicide, but no one identified him as at risk.
2. Mr Woskowiak shared a cell with a Polish-speaking prisoner, who he relied on to interpret and translate for him. He did not attend a scheduled education induction assessment in April and no one referred him for English classes. Mr Woskowiak's cellmate told us that Mr Woskowiak had found it difficult to cope with being in prison. His cellmate did not speak to prison staff about this.
3. On 6 May, Mr Woskowiak's cellmate learnt that he was being transferred to another prison that morning. His cellmate said that Mr Woskowiak had been scared and concerned for the future when he heard about this. No one spoke to Mr Woskowiak about what would happen after his cellmate had gone.
4. At around 11.30am, another prisoner found that Mr Woskowiak had hanged himself. He alerted an officer, who asked the prisoner to press an alarm bell. It is not clear how quickly the alarm was pressed and the officer was in the cell on his own for several minutes. He did not summon emergency help. Eventually, other staff were alerted some minutes later, by an alarm bell. Healthcare staff arrived and a supervising officer radioed a code blue emergency, which led the control room to call an ambulance. Paramedics arrived and pronounced Mr Woskowiak dead.
5. Prison staff broke the news of Mr Woskowiak's death to his wife later that day, but did not contact her again for another two weeks.

## Findings

6. Prison staff should have used professional interpreting services when they assessed Mr Woskowiak and we are concerned that they did not identify his vulnerability when he arrived. Mr Woskowiak relied entirely on his cellmate to interpret for him and no one referred him to English classes, which might have helped prevent his isolation. A number of provisions of Bullingdon's local policy for foreign national prisoners, including holding regular forums to support such prisoners, were not met. Wing staff had little meaningful contact with Mr Woskowiak and no one considered the impact that his cellmate's transfer might have on him. There was some confusion when Mr Woskowiak was found hanged and an emergency alarm was not raised quickly or in line with expected procedures. Contact with Mr Woskowiak's wife in the two weeks after his death was very poor.

## Recommendations

- The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.
- The Governor should ensure that foreign national prisoners who do not speak or understand English well are referred promptly for English classes.
- The Governor should appoint a foreign national coordinator and ensure that foreign national prisoner forums are held regularly and translated material is available on every residential unit, in line with the local policy.
- The Governor should ensure that reception staff consider and record all the known risk factors of a newly arrived prisoner when determining risk of suicide and self-harm.
- The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.
- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including immediately and efficiently communicating the nature of the emergency so that healthcare staff attend quickly with relevant emergency equipment and that the control room calls an ambulance without delay.
- The Governor should ensure, in line with national instructions, that a family liaison officer is assigned immediately after the death of a prisoner to provide information and ongoing practical support.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator visited Bullingdon on 11 May 2015. He obtained copies of relevant extracts from Mr Woskowiak's prison and medical records and interviewed two prisoners
9. The investigator interviewed eight members of staff at Bullingdon in June. He interviewed Mr Woskowiak's former cellmate by telephone on 9 June.
10. NHS England commissioned a clinical reviewer to review Mr Woskowiak's clinical care at the prison. He interviewed healthcare staff with the investigator in June.
11. We informed HM Coroner for Oxfordshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Woskowiak's wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Woskowiak's wife asked about the medical care Mr Woskowiak had received in prison, particularly whether anyone had assessed his mental health as he had begun to behave erratically. Mr Woskowiak's wife also asked what medication he had received in prison and for details of the emergency response, after he was found hanged
13. Mr Woskowiak's wife received a copy of the initial report. The solicitor representing her wrote to us raising 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.

## Background Information

### HMP Bullingdon

14. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Virgin Healthcare provides healthcare services.

### HM Inspectorate of Prisons

15. The most recent inspection report for HMP Bullingdon in June 2015 is yet to be published. In preliminary inspection feedback, inspectors reported that levels of self-harm were relatively low, partly due to the effective support provided to potentially vulnerable prisoners in the early stages of their imprisonment. Reception staff were aware of a range of possible risk factors for suicide and self-harm. Inspectors noted that staff used the telephone interpretation service only infrequently, and they were concerned about the safety of prisoners who did not speak or understand English.

### Independent Monitoring Board

16. 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 July 2014, the IMB reported that during the year more prisoners had been monitored under ACCT suicide and self-harm prevention procedures. The IMB noted that 13% of the population were foreign nationals with Jamaican, Polish, Irish and Pakistani, the most frequently represented nationalities. A previous independent immigration advice service no longer operated and there were plans for an increased service from Home Office immigration staff.

### Previous deaths at HMP Bullingdon

17. Mr Woskowiak's death was the third self-inflicted death at Bullingdon since January 2014. In our investigation into the death of a man in January 2014, we found that prison staff did not fully recognise his risk of suicide and self-harm when he arrived at Bullingdon.

### Assessment, Care in Custody and Teamwork

18. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

19. On 17 March 2015, Mr Krzysztof Woskowiak was arrested after assaulting his wife. He was Polish and spoke and understood very little English. Mr Woskowiak had no previous convictions and had not registered with a doctor in the United Kingdom. On 18 March, a police doctor noted that Mr Woskowiak was emotional and gave him medication to help him sleep.
20. On 19 March, Mr Woskowiak appeared at Magistrates' Court and was remanded to HMP Bullingdon. Court documents and his Person Escort Record (PER, a document that accompanies prisoners on all journeys to communicate information, including about risk factors) both highlighted that Mr Woskowiak needed a Polish interpreter. The escort record did not indicate any risk of suicide or self-harm.
21. Mr Woskowiak arrived at Bullingdon at 7.45pm. The duty supervising officer (SO) interviewed him. There is a professional telephone interpreting service at Bullingdon, but the SO said that he did not use this as the only dual handset telephone to facilitate such calls in the reception area was in the room that healthcare staff used to screen new prisoners. He said that he usually uses gestures and sign language to communicate with prisoners who do not speak English.
22. The reception SO is expected to complete an 'at-risk' form if they consider a prisoner might be at risk of suicide or self-harm, which they then pass to the reception nurse to consider further. The reception SO can also begin ACCT procedures, but the SO told us that the reception nurse usually does this because they have more time to assess the prisoner. The 'at risk' form highlights criteria that might indicate that a prisoner is at risk. Mr Woskowiak met some of these criteria, including that it was his first time in prison and he had been charged with a violent offence against a family member. The SO said he asks prisoners how they are feeling or, if they do not speak English, assesses their body language. He told us that he did not remember Mr Woskowiak and could not therefore recall whether he considered completing an 'at-risk' form or beginning ACCT procedures.
23. A nurse then assessed Mr Woskowiak. He noted that Mr Woskowiak reported no concerns about mental or physical health and did not report any drug or alcohol misuse. The nurse recorded that Mr Woskowiak had no history of self-harm and had no thoughts of suicide or self-harm. He did not use an interpreter or the telephone interpreting service. The nurse told us that he could not remember Mr Woskowiak but that his English must have been sufficient to carry out the assessment without an interpreter. He did not make any onward referrals to the prison doctor or to the mental health team. Mr Woskowiak had no further contact with healthcare services in prison and was not prescribed any medication.
24. Mr Woskowiak moved to F Wing, the prison's induction unit. An officer was expected to carry out a first night interview and induction procedures, but recorded that he was unable to do this without an interpreter. He said that he sometimes uses the telephone interpreting service but does not always have time. He did not remember Mr Woskowiak.

25. The next day, 20 March, an officer interviewed Mr Woskowiak using a Polish-speaking prisoner as an interpreter. The interview includes standard questions to help staff determine whether the prisoner is at risk of suicide or self-harm. The officer identified no risk. He assessed Mr Woskowiak as suitable to share a cell. On the risk assessment he circled 'yes' in the section for the officer's observations, indicating that he had identified a risk factor, but did not expand on this. (We were not able to speak to the officer about his contact with Mr Woskowiak as he was on long-term sick leave.)
26. On 23 March, Mr Woskowiak moved to C Wing, where he shared a cell with a Polish-speaking prisoner. On 2 April, he had an education induction appointment scheduled. All prisoners are expected to have this assessment to assess their educational needs and to determine suitable courses. From here, education staff could refer Mr Woskowiak for the English for Speakers of Other Languages (ESOL) course. Mr Woskowiak did not attend his assessment, but no reason was recorded and no one followed this up. We do not know whether Mr Woskowiak was aware the assessment.
27. On 8 April, Mr Woskowiak's cellmate was released and Mr Woskowiak moved to B wing, where there were other Polish-speaking prisoners. He shared a cell with another prisoner. The prisoner told us that Mr Woskowiak did not speak any English and he helped him by translating documents and speaking to prison staff on his behalf. He said that Mr Woskowiak did not have any money and he therefore shared his tobacco with him. He said he thought Mr Woskowiak was struggling to cope with prison and he sometimes found him crying in the cell. He did not tell any prison officers about this and did not think they knew that Mr Woskowiak was finding things difficult.
28. On 13 April, Mr Woskowiak was convicted of actual bodily harm. He was remanded back to the prison until sentencing on 22 May.
29. Mr Woskowiak's education induction appointment was rescheduled for 20 April, but he did not attend again. We do not know whether Mr Woskowiak knew this assessment had been scheduled. Education staff recorded that this was an "unacceptable absence". The Deputy Education Manager told us that an unacceptable absence would be, for example, if the prisoner said they did not want to go to their appointment, rather than they could not attend for reasons such as a clashing medical appointment. There is no record of the specific reason why Mr Woskowiak did not attend. His appointment was not rescheduled and he was therefore never referred for the ESOL course. There is no record that anyone spoke to Mr Woskowiak about this or told him that he would not get paid if he did not attend education classes.
30. On 29 April, Mr Woskowiak telephoned his son. Prisoners' telephone calls are recorded and, unless there are security grounds to target calls, prison staff listen to a random sample. They did not listen to Mr Woskowiak's calls when he was alive. A Polish-speaking prison officer at HMP Grendon listened to Mr Woskowiak's calls after his death. Mr Woskowiak asked his son if his wife was seeing someone else and if she ever spoke about him. He asked his son for money and help. Mr Woskowiak's son said he could not help him because of "what you have done".

31. Mr Woskowiak then telephoned his brother in Poland. He said he had lost his job and was facing a prison sentence of around three years. Mr Woskowiak asked his brother to ask his wife to send him some money. Mr Woskowiak's brother said he would send a message to her.
32. On 30 April, Mr Woskowiak went to a gym induction session. There were no other entries in his prison record in the last week of his life to indicate that Mr Woskowiak had any formal contact with prison staff.
33. At around 8.30am on 6 May, an officer went to the cell that Mr Woskowiak shared with another prisoner. He told the prisoner that he was going to transfer to HMP Portland that morning. The officer said that the prisoner and Mr Woskowiak spoke while they packed his bags together. He thought that Mr Woskowiak appeared positive during the conversation. The prisoner told us that Mr Woskowiak was a bit scared when he told him he was leaving, as he did not know what would happen to him in future. Mr Woskowiak and the prisoner then said goodbye and the prisoner left. The officer asked Mr Woskowiak if he was okay, and he said Mr Woskowiak replied by putting his thumb up. At around 9.15am, the officer locked Mr Woskowiak into his cell. He told us that it was likely that another Polish-speaking prisoner would have been found to share with Mr Woskowiak but no arrangements had been made at the time and he did not tell Mr Woskowiak that they would find someone else.
34. Prisoners on B Wing were locked in their cells during the morning as most prison officers were attending a union meeting. At around 11.30am, Officer A unlocked the cells on Mr Woskowiak's landing for prisoners to collect their lunch. He did not check Mr Woskowiak's welfare when unlocking the cell, as local and national instructions require. He told us that this was because it often leads to confrontation with prisoners who see it as an invasion of their privacy. As he was going back towards the stairs, a prisoner shouted to him to look in Mr Woskowiak's cell. He saw Mr Woskowiak hanged from a ligature made of a blanket, which went up and over the toilet door in the cell.
35. Officer A was not carrying a radio, as his role that morning did not require it. He did not shout for staff assistance. He said he had asked the prisoner to press the general alarm button at the end of the landing. He told the investigator that he had heard the alarm sound as he went into the cell, but in his incident statement, written on the day of the emergency, he wrote that he had been in the cell by himself for around ten minutes before he heard the alarm. The prisoner was released two days after Mr Woskowiak died and did not respond when we wrote to him for further information.
36. Officer A said he went into the cell and checked Mr Woskowiak's pulse, but could not find one. He told us that Mr Woskowiak felt warm. He said that the ligature was tight to Mr Woskowiak's neck and the toilet door and there was not enough room to cut it. He then tried to open the door, but, at first, could not get it open, as there was a plastic knife wedged between the door and the frame. He said that he struggled to loosen the knife before he could pull it from the door. When he pulled the knife out, Mr Woskowiak's body fell forward onto the floor. He then loosened the ligature. He checked Mr Woskowiak for signs of life, could not find any, and began cardiopulmonary resuscitation.

37. In his incident statement, the officer said he had been in the cell for around ten minutes at this stage and he then heard the alarm bell. When we interviewed him, he said he was not sure about the timings and it could have been three to five minutes before support arrived.
38. The control room recorded that the general alarm was pressed at 11.34am. The control room officer said that the computer showed that the alarm pressed was the one by the treatment hatch on B Wing not on Mr Woskowiak's landing. The treatment hatch is off the spur on which Mr Woskowiak lived and would require someone to walk down two flights of stairs, along the length of the wing and then into the treatments area. It is not clear who pressed the alarm.
39. Officer B, who was working in the wing servery, responded to the alarm and went to the foyer area. He said there were a lot of prisoners and officers in the area and, at first, he did not know what had happened. He then saw some prisoners on the third floor landing pointing at a cell, and went up the stairs to the cell. The officer said that some of the officers in the foyer appeared to 'flap' and did not know what to do.
40. When Officer B arrived at the cell, he found Officer A administering cardiopulmonary resuscitation. Officer A asked him to radio a code blue medical emergency call (indicating a life threatening situation such as when a prisoner is unconscious or not breathing). His radio did not work, but a SO then arrived and made the call. The control room records that they received a code blue call at 11.35am. Control room staff then telephoned for an emergency ambulance.
41. A nurse arrived. She said that when she first arrived on the unit, officers told her that it was a false alarm, but then called her back and directed her to Mr Woskowiak's cell. She took over resuscitation when she reached the cell, helped by other nurses who arrived shortly afterwards. The nurses attached a defibrillator, which found no shockable heart rhythm so they continued with resuscitation. Paramedics arrived at the cell at around 12.00pm and took over emergency treatment. At around 12.40pm, they pronounced Mr Woskowiak had died.

### **Contact with Mr Woskowiak's family**

42. An operational manager contacted the police for a risk assessment before visiting the person Mr Woskowiak had given as his next of kin. The police told him that the name did not match the address. The police gave the prison Mr Woskowiak's wife's address. At 6.00pm, the manager and a colleague visited Mr Woskowiak's wife with a police officer and police interpreter and informed her of Mr Woskowiak's death.
43. After the initial visit, no one from the prison contacted Mr Woskowiak's wife for the next two weeks. The operational manager said that this was because he did not have a telephone number for her. On 20 May, Mr Woskowiak's wife (through a friend who interpreted for her) told our family liaison officer that she did not know what the prison would contribute to funeral and repatriation costs. An operational manager then contacted Mr Woskowiak's wife and took over responsibility for family liaison. In line with Prison Service instructions, the prison

contributed to the costs of the funeral and the repatriation of Mr Woskowiak's body to Poland.

### **Support for prisoners and staff**

44. After Mr Woskowiak's death, the Governor 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.
45. The prison posted notices informing other prisoners of Mr Woskowiak's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Woskowiak's death.

### **Post-mortem report**

46. A post-mortem examination identified the cause of death as hanging.

# Findings

## Communication with prisoners who speak little or no English

47. Prison Service Instruction (PSI) 64/2011, which gives instructions to staff about safer custody, states:

“All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process.”

48. The Prison Service's policy on foreign national prisoners states:

“Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline.”

49. It was evident that Mr Woskowiak spoke and understood very little English. It was noted on his Person Escort Record that he needed a Polish interpreter, and his Polish cellmate told us that he did not speak a word of English. As with all prisons, Bullingdon has a contract with a professional telephone interpreting service, yet when Mr Woskowiak arrived at the prison in March, reception staff did not use the service and there is no record they used anyone else to interpret for them. It seems highly unlikely that Mr Woskowiak would have been able to understand their questions sufficiently well for reception staff to make reliable assessments of his health, state of mind or risk of suicide and self-harm.

50. We checked with the prison's finance department and established that in March, April and May the telephone interpreting service was used just three times. We consider it unlikely that all of the foreign national prisoners who passed through Bullingdon in that time spoke and understood English well enough for the interpreting service to be used so infrequently. There were 132 foreign national prisoners in Bullingdon in July, and most months the population is over 100. Although there is no record of their proficiency in English, the fact that there is an active English as a second language course suggests that a number of foreign national prisoners are not proficient in English when they arrive. We are concerned that we have investigated the self-inflicted deaths of a number of foreign national prisoners recently, where we have found that the failure to communicate effectively with them through appropriate interpretation services has been a factor in their deaths. We make the following recommendation, which we have made in other investigation reports:

**The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.**

51. As part of his induction, Mr Woskowiak should have seen a member of the education department for an assessment. However, he missed the initial assessment and a rebooked assessment two weeks later. The reasons for his non-attendance were not recorded. However, prison staff knew that Mr Woskowiak spoke little or no English and relied on other prisoners to interpret for him. This isolated him from the general population and cannot have helped his mental health. We consider that he should have received help to improve his English through a direct referral to English classes, which might have helped him to adapt to prison life, interact with other prisoners and staff better and give him some useful occupation to distract him. We make the following recommendation:

**The Governor should ensure that foreign national prisoners who do not speak or understand English well are referred promptly for English classes.**

52. Bullingdon's foreign national prisoner policy requires the prison to hold forums for foreign national prisoners in order for them to raise issues specific to the group and to reduce isolation. The foreign national coordinator should run these forums, but when Mr Woskowiak was at the prison, no one held the post and no forums were held.
53. Bullingdon's equalities strategy requires information for foreign national prisoners to be displayed on foreign national notice boards on every residential unit. These should be maintained and updated and should contain relevant translated material. We did not see any such information on B Wing. We make the following recommendation:

**The Governor should appoint a foreign national coordinator and ensure that foreign national prisoner forums are held regularly and translated material is available on every residential unit, in line with the local policy.**

### Managing the risk of suicide and self-harm

54. A SO and a nurse did not use an interpreter to speak to Mr Woskowiak when he arrived. This did not help effective assessment of Mr Woskowiak's risk of suicide and self-harm. However, they did not need to speak to Mr Woskowiak to establish that he had a number of risk factors for suicide and self-harm. He had been charged with a violent offence against a close family member, this was his first time in prison and he was a foreign national.
55. In a PPO thematic report on the risk factors which increase the risk of suicide and self-harm, published in April 2014, we identified these and other risk factors that staff need to take into account when assessing the risk of suicide and self-harm. They are also set out in Prison Service instructions to staff. There is no record that any member of staff took account of these factors when assessing Mr Woskowiak's risk. We make the following recommendation:

**The Governor should ensure that reception staff consider and record all the known risk factors of a newly arrived prisoner when determining risk of suicide and self-harm.**

## Personal officers

56. An officer was Mr Woskowiak's assigned personal officer, but said he had not been told which prisoners were his responsibility. Officers on B Wing are assigned a group of cells for personal officer duties, the details of which are on the roll board in the staff office. It should therefore not be necessary for managers to allocate individual prisoners to officers.
57. There were no personal officer entries in Mr Woskowiak's case notes and no entries from other officers about his welfare throughout Mr Woskowiak's time at the prison. We acknowledge the difficulties of running a successful personal officer scheme in a large local prison such as Bullingdon with a high turnover of prisoners. However, none of the officers we spoke to during the course of the investigation really knew Mr Woskowiak. Mr Woskowiak's cellmate told us that he had been struggling to cope with prison, but there is no indication that any officer spoke to Mr Woskowiak to check how he was, although this was his first time in prison. Instead, the staff relied on his cellmate to let them know if he had any concerns. We do not consider that Mr Woskowiak received appropriate support from staff at Bullingdon. We make the following recommendation:

**The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.**

## Emergency response

58. The timing of events when Officer A discovered Mr Woskowiak is not clear. His accounts in his incident statement and when interviewed were different. In his statement, he said he was in the cell for around ten minutes before he heard the alarm, which he had asked a prisoner to press, and before colleagues arrived to assist him. When we interviewed him, he said he had heard the alarm as he was going into Mr Woskowiak's cell and it was around three to five minutes before other staff arrived. The prisoner who Officer A had asked to press the alarm, was released two days later, and we do not know his account of events. The control room officer said that their computer indicated that the alarm pressed was by the B wing treatment hatch. The distance of this alarm from Mr Woskowiak's cell indicates that it was not pressed immediately when Mr Woskowiak was found and it is not clear who did press it.
59. Officer A did not call for help or otherwise alert other staff, such as by using his whistle and was not carrying a radio. We recognise that his first and commendable instinct was to try to save Mr Woskowiak, by freeing him from the ligature, but it is also important to request immediate emergency help. We understand that it can be difficult to recall the exact sequence of events in an emergency, but it appears that there was some delay in raising the alarm. An emergency medical code was not broadcast until 11.35am. While this was too long, it does not appear that he could have been in the cell for ten minutes before help arrived. (In such a stressful situation it understandable that it might have appeared as long as that to him.) We cannot know whether earlier intervention by healthcare staff or the emergency services might have saved Mr Woskowiak.

60. A nurse noted that when she first arrived on B Wing, officers had told her it was a false alarm. Officer B also described a degree of confusion and said that officers on the wing did not know what was happening and some did not know what to do. We make the following recommendation:

**The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including immediately and efficiently communicating the nature of the emergency so that healthcare staff attend quickly with relevant emergency equipment and that the control room calls an ambulance without delay.**

### Family liaison

61. Two operational managers, who are trained family liaison officers, broke the news of Mr Woskowiak's death to his wife, with the help of a police interpreter, on the day of his death. The Governor did not formally assign the role of family liaison officer to one operational manager until six days later, but even then, he did not contact Mr Woskowiak's wife again. He said this was because he did not have a telephone number for her. Two weeks passed before anyone from the prison made any further contact with Mr Woskowiak's wife, prompted by our family liaison officer.

62. PSI 64/2011 states:

“The role of the FLO ... will start from the point that the news of the death is broken to the family. They will then maintain contact with the family, and provide information and practical support where appropriate ... At the first meeting the family must be informed of the death, written contact details given and arrangements made for a subsequent meeting.”

63. We appreciate that language difficulties made contacting Mr Woskowiak's wife more problematic, but this should have been addressed at the first meeting. Mr Woskowiak's wife should have been given contact details at the prison and the prison staff should have arranged how and when they would contact her. It was very poor practice that no one contacted Mr Woskowiak's wife for two weeks after the initial meeting. Understandably, this caused her additional anxiety and distress. We make the following recommendation:

**The Governor should ensure, in line with national instructions, that a family liaison officer is assigned immediately after the death of a prisoner to provide information and ongoing practical support.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations