

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marcin Dlugolecki a prisoner at HMP Nottingham on 1 February 2017

**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, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Marcin Dlugolecki was found hanging in his cell in the induction unit at HMP Nottingham on 19 January 2017. He was resuscitated, but he died in hospital on 1 February, having never regained consciousness. He was 33 years old. I offer my condolences to Mr Dlugolecki's family and friends.

Mr Dlugolecki had only been in the prison for a few hours when he was found hanging. Although he said he had no thoughts of self-harm or suicide, his behaviour in that night was highly unusual. We are concerned that his level of risk was not properly tested and that he did not have the opportunity to speak to his family that evening because the prison could not facilitate an international call. There were also deficiencies in the emergency response; in particular, that staff did not go into his cell when they found him hanging.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

October 2017

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Summary

Events

1. On 18 January 2017, Mr Marcin Dlugolecki was remanded to HMP Nottingham charged with arson. It was his first time in prison in the UK. Mr Dlugolecki said that he had paranoid schizophrenia, but was not prescribed medication. A nurse dressed wounds on his feet, but he did not ask for painkillers. Mr Dlugolecki said he had no past or present thoughts of self-harm or suicide. He could not speak to his family in Poland, because the prison could not arrange international telephone calls in reception.
2. Just before 1.00am, Mr Dlugolecki rang his cell bell and asked the night officer for painkillers. The night officer spoke to a nurse, but she said that healthcare staff do not issue painkillers at night.
3. Over the next three hours, Mr Dlugolecki rang his cell bell 13 more times to ask about non-urgent matters that could only be dealt with in the morning, for example wanting to speak to the Polish Embassy. At around 4.00am, the night officer informed the night manager about Mr Dlugolecki ringing his cell bell, as it was disturbing the wing. He said that he did not consider Mr Dlugolecki to be at risk of self-harm or suicide. The night manager told the night officer to mute the cell bell alarm, but to monitor Mr Dlugolecki.
4. At just after 4.30am, a nurse went to the wing and checked Mr Dlugolecki because he had asked for a painkiller earlier. She went to the cell with the night officer and they found him hanging. The nurse radioed a medical emergency at 4.36am, but the night officer did not unlock the cell, as he said he was not certain that Mr Dlugolecki was hanging. Officers and another nurse attended at 4.39am, went into the cell and attempted to resuscitate Mr Dlugolecki. Paramedics arrived at 4.52am, continued resuscitation and took him to hospital at 5.22am. He did not regain consciousness and died on 1 February 2017.

Findings

5. Mr Dlugolecki should have had the same opportunity to speak to his family as any other prisoner arriving in custody. We consider that reception staff assessed Mr Dlugolecki's risk appropriately. We consider that the night manager should have formally assessed Mr Dlugolecki before instructing the night officer to mute his cell bell.
6. We consider it was likely that the night officer and nurse could see that Mr Dlugolecki was hanging and should have gone into his cell without delay.
7. Although the clinical reviewer concluded that Mr Dlugolecki received generally appropriate healthcare at Nottingham, she asked the Head of Healthcare to ensure that painkillers are issued to prisoners as required.

Recommendations

- The Governor should ensure that prisoners can make international calls from the reception telephones.
- The Governor should ensure that cell bells are muted only in exceptional circumstances, and after a senior officer has assessed the prisoner themselves.
- The Governor should ensure that all prison staff are made aware of PSI 24/2011 and Nottingham's local Instruction and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Nottingham on 9 February 2017. He obtained copies of relevant extracts from Mr Dlugolecki's prison and medical records.
10. The investigator interviewed two prisoners and six members of staff at Nottingham between April and May 2017.
11. NHS England commissioned a clinical reviewer to review Mr Dlugolecki's clinical care at the prison. The clinical reviewer conducted three interviews jointly with the investigator.
12. We informed HM Coroner for Preston and West Lancashire District of the investigation who confirmed that Mr Dlugolecki's cause of death was hypoxic brain injury caused by hanging. We have sent the Coroner a copy of this report.
13. One of the Ombudsman's family liaison officers spoke to a family friend who was acting on behalf of Mr Dlugolecki's mother. The friend asked:
 - Did staff assess Mr Dlugolecki when he arrived at HMP Nottingham?
 - What did Mr Dlugolecki say when he rang his cell bell that night?
 - When was an ambulance called and how did staff respond to the emergency?
14. Mr Dlugolecki's family solicitors received a copy of the draft report but they have not provided any response to our findings.

Background Information

HMP Nottingham

15. HMP Nottingham is a local prison holding just over 1,000 men. Nottingham Healthcare NHS Foundation Trust provides healthcare services at the prison. The healthcare centre is staffed 24-hours a day with two nurses on duty at night.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Nottingham was in February 2016. Although the Inspectorate found some improvement since the previous inspection for those arriving new into the prison, they still found that prisoners often arrived late in the evening and spent too long waiting in reception. They found prisoner peer supporters provided valuable support for new arrivals, although latecomers did not always have access to this help. Inspectors found that new arrivals received a comprehensive health screening, including mental health, by a registered nurse who made appropriate referrals. Inspectors observed good communication between healthcare staff and prisoners.

Independent Monitoring Board

17. 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 March 2016, the IMB repeated their previous concern at the impact on prisoners of late arrival from the courts. The IMB noted that throughout the year, the average time taken to progress through reception exceeded four hours and at times, rose to six hours.

Previous deaths at HMP Nottingham

18. Mr Dlugolecki's was the third self-inflicted death at HMP Nottingham since December 2014 and there was a further self-inflicted death at Nottingham on 3 February 2017. This investigation has found frailties in Nottingham's emergency response, which are echoed in the investigation into the death of a prisoner on 3 February 2017.

Assessment, Care in Custody and Teamwork

19. 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 multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

20. On 16 January 2017, Mr Marcin Dlugolecki was arrested and charged with arson of a business premises. At 5.15pm, on 17 January, Mr Dlugolecki was assessed by a police doctor, who noted that Mr Dlugolecki had blisters to both heels. Mr Dlugolecki asked for a shower but he said he did not want painkillers or for his feet to be dressed. The doctor noted that Mr Dlugolecki was smiling during the assessment and there was no evidence of mental health problems.
21. On 18 January, Mr Dlugolecki was remanded into prison custody from court. Mr Dlugolecki arrived at HMP Nottingham at 6.50pm. Court staff had noted on Mr Dlugolecki's escort record form that he posed a risk of violence to custody staff but did not indicate that he was at risk of suicide or self-harm.
22. An officer told the investigator that Mr Dlugolecki spoke reasonable English. Mr Dlugolecki told the reception officer that he had been in prison in Poland but had not been in a British prison. Mr Dlugolecki named his mother in Poland as his next of kin, but did not give her address. The officer said that he did not think that Mr Dlugolecki was at risk of self-harm or suicide.
23. The investigator spoke to two of the prisoners who arrived in Nottingham that evening, but only one remembered Mr Dlugolecki. He said that he asked the reception officers for painkillers for a toothache and Mr Dlugolecki asked for painkillers for a head injury, but they were both told that they had to wait for the nurse. He said that the reception nurse refused to give him painkillers.
24. The prison's night manager went to help reception staff to get prisoners to their cells. He spoke to Mr Dlugolecki about Poland while he was waiting to see the reception nurse and remembered that he spoke reasonable English. The reception nurses wanted to treat the injuries to Mr Dlugolecki's feet, so assessed him last so that they had more time. The manager offered Mr Dlugolecki a free phone call and he asked to telephone a number in Poland. The manager said could not arrange that in reception, so Mr Dlugolecki asked to phone his solicitor's mobile number. Mr Dlugolecki phoned the number but the call went through to voicemail. The manager told the investigator that Mr Dlugolecki would have been able to put international numbers on his own PIN account the next day.
25. At about 10.00pm, a nurse saw Mr Dlugolecki for a first reception health screen. She told the investigator that although Mr Dlugolecki's English was a little broken, she did not need to use the translation service. She noted that Mr Dlugolecki said he had no history of self-harm or any thoughts of self-harm or suicide. Mr Dlugolecki said that he had been diagnosed with paranoid schizophrenia but was not receiving any medication. She referred Mr Dlugolecki for a mental health assessment and noted on Mr Dlugolecki's cell sharing risk assessment that he appeared agitated and believed that people would kill him. She then dressed Mr Dlugolecki's feet injuries. She told the investigator that Mr Dlugolecki's feet looked sore but when she asked him if he needed painkillers, he said that he did not.
26. The night manager escorted Mr Dlugolecki to the first night centre. He said that Mr Dlugolecki was wearing prison trainers and he seemed to walk without

difficulty. Mr Dlugolecki was allocated to a double cell on his own, as he was deemed unsuitable to share a cell due to his alleged offence of arson.

27. An operational support grade (OSG) told the investigator that Mr Dlugolecki arrived on the first night centre at around 11.00pm and he was in a good mood. Just before 1.00am, Mr Dlugolecki rang his cell bell. When the OSG responded to the call, Mr Dlugolecki said that he wanted painkillers for his feet. He said that he telephoned the healthcare unit and spoke to a nurse. He said that before he could explain why he was phoning, she said "before you even ask, the answer is no". After he explained to her why he was phoning, she told him that nurses do not usually issue medication at that time of night and so she would not issue Mr Dlugolecki with any painkillers. He told the investigator that when he told Mr Dlugolecki that he would have to wait until the morning, he accepted that answer. The nurse told the investigator and clinical reviewer that she could not recall having this conversation with the OSG, but agreed that nurses do not ordinarily dispense painkillers at night.
28. Mr Dlugolecki rang his cell bell 13 more times. The OSG said that most of the conversations were about matters such as whether he would have a cooked breakfast in the morning, whether he would see someone from the healthcare team in the morning, whether he could see the senior officer on duty and whether he could speak to the Polish Embassy. He told the investigator that he was concerned about disturbing other prisoners, but thought Mr Dlugolecki seemed fine.
29. A prisoner told the investigator that he was in the cell next to Mr Dlugolecki and during the night, he kept saying he was in pain. He told him to try to get some sleep, as it was obvious the nurses would not give either of them any painkillers that night. (His prison records confirm that he was in cell 3-16, the cell adjacent to Mr Dlugolecki's cell.)
30. The record shows that Mr Dlugolecki rang his cell bell at the following times: 12.57am, 1.26am, 1.39am, 2.14am, 2.33am, 2.47am, 3.33am, 3.49am, 3.56am, 4.02am, 4.05am, twice at 4.06am and 4.14am. On one occasion, Mr Dlugolecki rang his cell bell while the OSG was talking to him at his door and on two occasions Mr Dlugolecki rang his cell bell the moment the OSG walked away from the cell after he had spoken to him. At around 4.00am, the OSG telephoned the night manager. He explained that he was not worried that Mr Dlugolecki was at risk, but the cell bell was disturbing the wing. He told him that he could mute the cell bell alarm, but he should still check Mr Dlugolecki. The OSG told the investigator that he did not tell Mr Dlugolecki that he had muted his cell bell.
31. After Mr Dlugolecki rang his cell bell at 4.06am, the OSG responded at 4.12am and spoke to Mr Dlugolecki for almost two minutes. As he walked away from the cell at 4.14am, Mr Dlugolecki pressed the cell bell again, and for the final time. He did not respond immediately to that call.
32. Soon afterwards, a nurse came to the first night centre to check the prisoners receiving methadone for detoxification from heroin. She told the OSG that she would like to check Mr Dlugolecki as she knew that he had been asking for pain relief for his feet. They arrived at the cell at 4.36am.

33. The OSG told the investigator that when he looked into the cell he could not see the whole of Mr Dlugolecki's body. He could see Mr Dlugolecki's legs as if he were seated on the pipes at the back of the cell but he could not see Mr Dlugolecki's head and torso. He saw a ligature running down from the window frame and he believed that Mr Dlugolecki was probably hanging, but he was not entirely certain so he did not consider it appropriate to enter the cell at that point. Instead, the nurse radioed a code blue emergency (indicating that a prisoner is unconscious, not breathing or is having breathing difficulties), while he ran to switch on the landing lights and to telephone the night manager.
34. The nurse said at interview that when she looked into the cell she could clearly see Mr Dlugolecki hanging: she could see his face and his eyes were open and fixed. She thought that his feet were on the ground and his position was slightly slumped. She said that when she radioed the code blue emergency she confirmed that an ambulance was needed and she collected the emergency medical bag.
35. The first officer to respond arrived at the cell at 4.39am. She wrote in her statement that when she looked into the cell she saw Mr Dlugolecki hanging from a torn towel that he had tied to the window latch. She unlocked the cell door and went into the cell followed by another officer. She supported Mr Dlugolecki's body while the other officer cut the ligature. They placed Mr Dlugolecki on the floor and started cardio-pulmonary resuscitation (CPR). Nurse Hardy returned to the cell with emergency equipment and another nurse and the OSG also arrived. The staff took turns in giving chest compressions while also giving oxygen. A nurse checked Mr Dlugolecki with a defibrillator, which advised that no shock should be given, but CPR should continue.
36. Paramedics arrived at the cell at 4.52am and they took over the efforts to resuscitate Mr Dlugolecki. At 5.06am, a pulse was detected and, at 5.13am, the paramedics took Mr Dlugolecki to hospital, where he was placed on life support in the intensive care unit. He remained there for the next 12 days.

Contact with Mr Dlugolecki's family

37. Due to Mr Dlugolecki's poor prognosis, Nottingham started death in custody procedures. They contacted West Midlands Police to help trace Mr Dlugolecki's mother in Poland and also contacted the Polish Embassy. West Midlands Police contacted Nottingham on the evening of 20 January with Mr Dlugolecki's mother's telephone number and Nottingham contacted her at 9.20am on 21 January using a translation service. They informed her of the news and told her that they would pay for a flight and accommodation in the UK so she could visit her son. When she visited, hospital staff explained her son's very poor prognosis and that supported the clinical decision to remove the life support systems. Mr Dlugolecki died in the early hours of 1 February. Nottingham contributed to his funeral expenses in line with national instructions.

Support for prisoners and staff

38. Nottingham held a staff debrief for those 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.

39. The prison posted notices informing other prisoners of Mr Dlugolecki's significant act of self-harm. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected.

Cause of death

40. Mr Dlugolecki's death certificate recorded his cause of death as hypoxic brain injury caused by hanging. The coroner advised us that there was no post-mortem examination, as Mr Dlugolecki died in hospital, where he had been treated for the last 12 days of his life.

Findings

Assessment and management of risk

41. When Mr Dlugolecki arrived at Nottingham he was seen by a reception officer and a reception nurse, who recorded information about Mr Dlugolecki's mental health history. The night manager also spoke to him about where he was from in Poland. None of the staff in reception considered that Mr Dlugolecki might be at risk. Nor had the West Midlands Police considered Mr Dlugolecki to be at risk during the two days he was in custody with them before he was taken to Nottingham. After Mr Dlugolecki was moved to the first night centre, the OSG had extensive interaction with him when responding to his cell bell calls, but did not consider that he was at risk of suicide.
42. Prison Service suicide and self-harm prevention procedures rely on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. We consider that the assessments that staff made that Mr Dlugolecki was not at risk were not unreasonable at the time their assessments were made. The clinical assessments made by the reception nurse were also reasonable, although there are some matters in the clinical review for the Head of Healthcare to consider.

Access to telephone

43. Prison Service Instruction (PSI) 07/2015 about early days in custody requires that newly arrived prisoners must be given access to a telephone in reception, or in the first night location, to contact their legal adviser or their family. Although Mr Dlugolecki was allowed to telephone his legal adviser, he initially asked to telephone Poland but he was told he could not do so as the reception telephones do not permit international calls from the prison PIN.
44. If it is the case that the reception telephones in Nottingham do not permit international calls, this means that non-UK citizens in particular are liable to be prevented from contacting their families when they first arrive in the prison. This is at variance with the requirements of PSI 07/2015. We make the following recommendation:

The Governor should ensure that there is a system in place to allow international calls from the reception telephones.

Muting of cell bell

45. Just before 1.00am, Mr Dlugolecki made the first of 14 cell bell calls over a period of three and a quarter hours. Most of the calls were about matters that could be dealt with in the morning. The OSG was concerned that the cell bell was disturbing other prisoners so he spoke to the night manager about the disturbance and said that there were no signs from Mr Dlugolecki's demeanour to suggest he might be at risk of self-harm or suicide.
46. The night manager told the investigator that the OSG was very experienced and cautious of risk. He said that he took account of his explanation that Mr Dlugolecki was not presenting a risk of self-harm or suicide and he considered it

was appropriate to advise him to mute the cell bell but to continue making periodic checks on Mr Dlugolecki.

47. Despite the OSG's assessment that he had no cause for concern that Mr Dlugolecki might harm himself, it is clear that Mr Dlugolecki was behaving in an erratic manner: for instance believing it would be plausible to contact the Polish Embassy during the early hours of the morning. We consider that before agreeing to mute the cell bell, he should have assessed Mr Dlugolecki for himself and to have stressed to him the correct purpose of the cell bell.

The Governor should ensure that cell bells are muted only in exceptional circumstances, and after a senior officer has assessed the prisoner themselves.

Emergency Response

48. At night, officers have a cell key in a sealed pouch for use in an emergency. Prison Service Instruction (PSI) 24/2011, which covers management and security at nights, states that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night manager and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.
49. Nottingham's local instruction says that at night staff should consider entering a cell on their own if they suspect that a prisoner's life is in immediate danger, but must balance the preservation of life against the security of the prison.
50. In her interview, the nurse said that when she looked into Mr Dlugolecki's cell she could see his face and it was clear he was hanging. However, the OSG said that he could not see Mr Dlugolecki's head or upper torso so he was uncertain of the situation. The investigator and clinical reviewer both looked into through the observation panel into the cell and concluded that they would have had the same view.
51. We consider on balance that it should have been clear to the OSG that Mr Dlugolecki was hanging and he should have entered the cell at that stage rather than waiting for other officers arrive in response to the code blue alarm. The delay in this case might have been critical. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of PSI 24/2011 and Nottingham's local Instruction and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

Healthcare provision

52. The clinical reviewer concluded that Mr Dlugolecki's care at Nottingham was broadly equivalent to that which he might have expected to receive in the

community. She noted that the nurse conducted an appropriate mental health risk assessment and made an appropriate referral for Mr Dlugolecki to be assessed the following day by the mental health team.

53. The clinical reviewer noted that Mr Dlugolecki's injuries were such that she would have expected them to be painful and is concerned that he was not issued painkillers when he asked for them around 1.00am. The clinical reviewer has made a recommendation about provision of painkillers, as well as other recommendations, which can be found in her report

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