Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patryk Gladysz, a prisoner at HMP Wandsworth, on 19 January 2024

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 Patryk Gladysz died in hospital on 19 January 2024, after being found hanging in his cell at HMP Wandsworth on 5 January. He was 27 years old. I offer my condolences to Mr Gladysz's family and friends.

Mr Gladysz was the fifteenth prisoner to take his own life at Wandsworth since January 2021, and the eighth who was a foreign national. Up to the end of June 2024, there has been one further self-inflicted death at Wandsworth, also of a foreign national. These facts are clearly concerning and, in an investigation report issued after Mr Gladysz died, I urged HMPPS to consider how they can support meaningful improvement in prisoner safety at the prison.

Whilst Mr Gladysz had some risk factors for suicide and self-harm, there was little to indicate in the lead up to his death that he was at increased risk. However, there is minimal evidence that prison staff had any meaningful interactions with Mr Gladysz during his nine months at Wandsworth. Even in a prison such as Wandsworth, that has struggled for some time to provide a consistent regime in the face of considerable staff shortages, this finding is stark. Without regular engagement with prisoners, staff are unlikely to be able to pick up on changes in mood and behaviour that may indicate risk.

Services for foreign national prisoners, particularly those who 'slip under the radar' as was apparently the case for Mr Gladysz, were insufficient. There was not sufficient awareness of impending removal from the country being a possible risk factor for suicide and self-harm and formal interpreting services were not used effectively.

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 **November 2024**

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Summary

Events

1. On 17 April 2023, Mr Patryk Gladysz, was remanded in prison awaiting extradition to Poland and sent to HMP Wandsworth. This was his first time in prison in the UK. Mr Gladysz had a history of attempted suicide in the community.

2. Mr Gladysz had a diagnosis of schizophrenia and had been under the care of community mental health services since December 2019. When he arrived in Wandsworth, healthcare staff referred Mr Gladysz to the mental health team. He received fortnightly depot injections (a slow-release form of antipsychotic medication) for his schizophrenia.

3. Mr Gladysz shared a cell and spent most of his time either in his cell or mixing with other Polish prisoners on the wing. He engaged with the regime but did not work or go to education.

4. At around 8.07am on 5 January 2024, an officer unlocked Mr Gladysz's cell to let his cellmate out for work. Mr Gladysz was in bed at this time. At around 9.08am, an officer unlocked Mr Gladysz's cell and found him hanging. She immediately shouted for staff assistance and radioed a medical emergency 'code blue', indicating a life-threatening situation.

5. Prison and healthcare staff began cardio-pulmonary resuscitation (CPR). Paramedics arrived at around 9.25am and took over Mr Gladysz's care. They took him to St George's Hospital, where he died at 12.30am on 19 January.

Findings

6. While Mr Gladysz had several risk factors for suicide and self-harm, there was little to indicate to staff that he was at increased risk in the lead up to his death.

7. However, there is minimal evidence that prison staff had meaningful contact with Mr Gladysz during his time at Wandsworth. He did not have a key worker and, except for entries about a cell move, there was nothing recorded in his prison record between June 2023 and January 2024.

8. At the same time, Mr Gladysz spoke limited English and prison and healthcare staff did not use formal interpreting services when interacting with him. It is likely that this language barrier contributed to a lack of meaningful engagement with Mr Gladysz. Generally, provision for foreign national prisoners was poor.

9. The clinical reviewer found that healthcare provision for Mr Gladysz was equivalent to that he could have expected in the community. However, the clinical reviewer found that his healthcare plan did not take sufficient account of the potentially positive impact of purposeful activity on his mental health and there was not sufficient focus on encouraging this.

Recommendations

- The Governor and Head of Healthcare should ensure that interpreting services are used properly across HMP Wandsworth, including by:
    - Ensuring staff use appropriate interpreting services when discussing complex matters with prisoners with limited English.
    - Implementing monitoring to identify where staff or prisoners are being used to interpret, to ensure there is a clear picture of translation needs.
- The Governor should ensure that the new local foreign national strategy is developed to include actions to identify risk and to provide support for foreign national prisoners who may not proactively engage with existing support provision.
- The Head of Healthcare should ensure that the value of daily activity for those with long term mental health needs is included in relevant care plans and highlighted in clinical supervision.

The Investigation Process

10. The PPO were notified of Mr Gladysz's death on 19 January 2024.

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

12. The investigator visited Wandsworth on 23 January 2024. She obtained copies of Mr Gladysz's prison and medical records, CCTV and body worn video camera footage of the emergency response. She also obtained the HMPPS Early Learning Review and Ambulance Service records.

13. NHS England commissioned a clinical reviewer to review Mr Gladysz's clinical care at the prison. The investigator and clinical reviewer jointly interviewed five members of staff at Wandsworth in February 2024.

14. The investigator interviewed an additional eight members of prison staff and two prisoners between January and March 2024.

15. We informed HM Coroner for Inner West London area of the investigation, who provided the provisional cause of death. We have sent the Coroner a copy of this report.

16. The Ombudsman's office contacted Mr Gladysz's mother and father to explain the investigation and ask if they had any matters they wanted us to consider. Mr Gladysz's father did not respond.

17. Mr Gladysz's mother explained that Mr Gladysz told her that when he felt suicidal he would press his cell bell, but nobody answered it. She asked whether her son's schizophrenia was properly treated. Mr Gladysz's mother also asked whether he should have been more closely supervised, given that he had previously tried to take his life.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy, and this report has been amended accordingly.

19. We sent a copy of our initial report to Mr Gladysz's mother and their solicitor. The solicitor representing Mr Gladysz's mother pointed out one factual inaccuracy. The report has been amended accordingly.

Background Information

HMP Wandsworth

20. HMP Wandsworth is a local Category B prison in London. It is made up of eight residential wings. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison. There is an inpatient unit for up to six prisoners.

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

HM Inspectorate of Prisons

22. The most recent inspection of HMP Wandsworth was in April and May 2024. The full report of this inspection was not available at the time of writing. However, on 8 May 2024, HMIP issued an urgent notification. The Secretary of State has not yet responded to this. A debriefing paper had been prepared and was publicly available.

23. Inspectors found that the rate of self-harm was high and rising but around 40% of cell bells were not answered within five minutes. They found that the prison was badly overcrowded and had a transient population. They found that there was very limited time out of cell, absent staff and a failure to deliver any key work, reducing the opportunity or staff to develop meaningful relationships.

24. There was a substantial lack of work and education spaces and poor use of those available meant that there was very little purposeful activity. They noted that prisoners did not know when or if they would be unlocked each day meaning that life on residential units was unpredictable and confusing for staff and prisoners.

25. Inspectors noted that despite a full complement of officers, due to sickness, restricted duties and training commitments, over a third could not be deployed to operational duties.

26. Inspectors also noted that around half of the population were foreign nationals and services had not been designed with this in mind. Interpretation and translated materials were not routinely used when they needed to be, and prisoners did not have the opportunity to meet the rest of their national group for mutual support. Inspectors pointed out that Wandsworth had recently introduced a foreign nationals' strategy which had a realistic action plan to address some of the shortcomings.

27. Inspectors concluded that the poor outcomes they found at Wandsworth stemmed from poor leadership at every level of the prison, from HMPPS and the Ministry of Justice, leading to systemic and cultural failings which had led to a shocking decline. Following this inspection, the then Governor resigned.

Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2023 the IMB reported

several serious concerns. They noted concerns with staff shortages, commenting that staff turnover was high and the process to remove unsuitable staff was long and complex. They also noted that over 31% of staff had less than one year's experience.

29. The IMB annual report also noted that at the end of the reporting period there were 1,584 prisoners in HMP Wandsworth, 682 of which were foreign nationals.

Previous deaths at HMP Wandsworth

30. Mr Gladysz was the twentieth person to die at Wandsworth since January 2021. Out of these, his was one of fifteen self-inflicted deaths, four of which concerned Polish prisoners who were awaiting possible extradition to Poland (and a further four concerned other foreign national prisoners). In previous investigations we made recommendations about use of interpreting services for prisoners with limited English language skills, regular and meaningful conversations to identify increased risk, and key work provision.

31. Until the end of June 2024 there had been one more self-inflicted death at Wandsworth, also of a Polish prisoner. As a result of the number of self-inflicted deaths, Wandsworth is receiving support and monitoring from HMPPS headquarters.

Assessment, Care in Custody and Teamwork

32. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

33. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key work

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

35. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to

increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

36. On 17 April 2023, Mr Patryk Gladysz was remanded into custody awaiting extradition to Poland and sent to HMP Wandsworth. Mr Gladysz was held under a European Arrest Warrant, having been sentenced in his absence to one year in prison in Poland for aggravated theft causing bodily injury. This was his first time in prison in the UK.

37. When Mr Gladysz arrived at Wandsworth, he had a diagnosis of schizophrenia and was under the care of a community mental health team. Mr Gladysz had attempted suicide by hanging in the community in 2019.

38. Mr Gladysz's Person Escort Record (a document that accompanies prisoners between police custody, court and prison) set out that he spoke limited English and that he had schizophrenia.

39. During his initial health screening, Mr Gladysz told the nurse he had harmed himself in the past but that the last time was many years ago. He denied having any current thoughts of suicide or self-harm. The nurse noted that he was under the care of a community mental health team and sent a referral to the mental health in-reach team. Mr Gladysz's medical records note that he needed an interpreter.

40. Prison staff carried out a first night in custody interview. During this conversation, Mr Gladysz said that he had never self-harmed and denied any current thoughts of suicide or self-harm.

41. There is no evidence that an interpreter was used during Mr Gladysz's first night in custody interview and health assessment. During his time at Wandsworth, staff recorded that they had used an interpreter just once.

42. On 18 April, Mr Gladysz had his secondary health screening. Healthcare staff noted that he had schizophrenia and had a fortnightly antipsychotic depot injection. Mr Gladysz denied any current thoughts of self-harm or suicide. A nurse recorded that Mr Gladysz spoke English well and that an interpreter was not needed.

43. On 19 April, Mr Gladysz moved from the induction wing to C Wing, a residential wing. He declined to attend his third day induction. This included an education induction in which prisoners complete a maths and English assessment. Wandsworth's education provider informed us that they sent Mr Gladysz a standard maths and English assessment pack to his cell, but that he did not return this.

44. On 20 April, Mr Gladysz had an induction session with a staff member from Catch 22 (a foreign national support service at Wandsworth). The staff member recorded that Mr Gladysz spoke little English, had an extradition case, and wanted to return to Poland as soon as possible.

45. On 25 April and 3 May, Mr Gladysz requested distraction packs via the prison kiosk. Prison staff delivered these to Mr Gladysz on both occasions. It is unclear from prison records whether any conversation was conducted in relation to these requests.

46. On 25 April, mental health staff gave Mr Gladysz his first depot injection. This was accompanied by a conversation about his wellbeing.

47. Between 25 April and 28 December, mental health staff administered Mr Gladysz's depot injection every fortnight (with one exception on 23 November). Mr Gladysz was compliant with his medication. The majority of these occasions were accompanied by a routine review of Mr Gladysz's mental health.

48. On 26 April, Mr Gladysz applied to claim asylum, followed by an initial screening on 3 May. At the time of his death, his application was still pending. There is no evidence that any updates were given to Mr Gladysz relating to his application.

49. On 1 May, Mr Gladysz moved to B Wing, a standard residential wing.

50. On 22 May, Mr Gladysz met a member of Catch 22, who provided him with a list of solicitors for legal aid. Mr Gladysz did not engage further with Catch 22 for the remainder of his time in prison.

51. On 7 June, whilst receiving his depot injection, Mr Gladysz said that he was still awaiting the process of extradition to Poland. He reported to the member of the mental health team that he had no idea what was going on. There is no record that this information was shared with prison staff.

52. On 22 June, a nurse recorded that Mr Gladysz appeared downcast when speaking about his immigration status. He reported that regular family contact had kept his spirits up.

53. On 19 October, a mental health nurse recorded in her notes that Mr Gladysz was seen on the wing by healthcare staff but that there was a communication breakdown. She noted that she would arrange an interpreter for his assessments. At interview, she said that she could not recall this incident.

54. On 20 October, healthcare staff recorded that Mr Gladysz said that he felt anxious and afraid and was due to have his depot injection. The mental health nurse conducted a face-to-face consultation with Mr Gladysz to review his care plan and risk assessment. He denied any thoughts of self-harm. She recorded that she used an interpreter for this assessment. In interview, she said that she did not use an interpreter for any of her interactions with Mr Gladysz.

55. On 27 October, the mental health nurse saw Mr Gladysz to review his care plan. Mr Gladysz felt he was managing well on his prescribed medication and said that his mental wellbeing was good.

56. On 23 November, Mr Gladysz did not receive his scheduled depot injection. Staff we spoke to were unable to explain why he did not receive the injection.

57. On 14 December, Mr Gladysz had his regular depot injection. A mental health nurse recorded that Mr Gladysz appeared reasonably calm but reported ongoing auditory hallucinations (hearing voices). Mr Gladysz denied any thoughts of suicide or self-harm.

58. On 28 December, Mr Gladysz had his regular depot injection. No concerns were raised. This was the last depot injection that Mr Gladysz received.

59. The investigator spoke to two Polish prisoners who said that Mr Gladysz frequently told them about his schizophrenia and about hearing voices. They said he would say things like, “I can speak to the devil” or “I am the devil”. The prisoners said that they had not seen Mr Gladysz speak to staff about this.

60. Mr Gladysz’s cell mate told us that once, after receiving his injection, Mr Gladysz said that he wanted to go to hospital because he heard noises. He rang his cell bell and an officer, who spoke Polish, took Mr Gladysz away to speak to him. The cell mate believed this happened several months before Mr Gladysz died. This event is not recorded in Mr Gladysz’s prison records. We have not been able to interview the officer in relation to this incident due to long-term absence from work.

61. Mr Gladysz’s mother said that he had told her that when he felt suicidal he would press his cell bell, but nobody came in response. We have reviewed cell bell records for the two weeks before Mr Gladysz’s death. The cell bell was pressed relatively infrequently and was answered promptly each time.

Events of 3 - 5 January 2024

62. On 3 January, Mr Gladysz called his mother and spoke to her for almost nine minutes. His mother shared with the prison’s family liaison officers that Mr Gladysz seemed fine and made no reference to intentions to harm himself. Mr Gladysz had told her he was getting along well with his cellmate who spoke Polish.

63. On 4 January, prison staff completed routine checks of Mr Gladysz’s cell at around 5.42pm and 9.02pm. They did not identify any issues of concern.

64. Mr Gladysz’s cell mate told the investigator that on the evening of 4 January, he and Mr Gladysz watched television together for about an hour. He said that there was nothing unusual about Mr Gladysz’s behaviour and that he did not share any intentions to harm himself. A prisoner from a nearby cell, who was friends with Mr Gladysz, told the investigator that he did not observe any changes in Mr Gladysz’s behaviour in the lead up to his death.

65. On 5 January, a member of prison staff signed for a roll check (a routine count of prisoners) at 5.18am. However, from the CCTV there is no evidence that this routine check took place. The Head of Safety has informed us that Wandsworth is conducting a local investigation into this.

66. At around 8.07am, an officer unlocked Mr Gladysz’s cell to let out his cellmate for work. The officer left the Prison Service shortly after Mr Gladysz’s death and did not respond to our request to interview him as part of this investigation. He told the police in a statement that he saw Mr Gladysz lying on the bottom bunk but did not see his face as he was facing the wall.

67. The officer recorded that he heard the cell mate speaking in another language and that upon leaving his cell the cell mate faced back towards Mr Gladysz and said, “I’m going out”. The cell mate told us that he did not speak to Mr Gladysz at all that morning.

68. A Supervising Officer (SO) told the investigator that, between 8.00am and 9.00am, a wing officer informed him of a conversation they had had with another prisoner.

The officer said that the prisoner had told them that another prisoner had not been receiving his injections, was concerned about his mental health and was hearing voices. He said that he told this officer to follow up to find out which prisoner they were referring to.

69. We spoke to the officer who the SO believed had spoken to him that morning. She told the investigator that she did not say anything to the SO at this time. She explained that she spoke to a prisoner after Mr Gladysz had been found hanging, who told her that Mr Gladysz used to share that he was schizophrenic and heard voices. At this point she shared this information with the SO.

70. At around 9.00am, Officer A began unlocking cells for prisoners to come out for exercise. At around 9.08am, she opened the observation panel to Mr Gladysz's cell and saw that it was dark inside. She told us that she thought that the window had been covered with a towel. She said that she could not see Mr Gladysz on the bunk or in the room anywhere.

71. Officer A opened the door and saw Mr Gladysz suspended with a ligature (made from bedsheets) from the metal frame of the top bunk bed. She said that she then shouted for staff assistance and radioed a medical emergency code blue (used to indicate when someone is unresponsive or not breathing). The control room operator telephoned for an ambulance.

72. Officer A started to cut the ligature and a few seconds later was joined by more staff. Two officers supported Mr Gladysz's body whilst Officer A cut the ligature.

73. The SO directed staff to start CPR and an officer started this immediately. A few seconds later, a nurse entered the cell. The nurse shouted for the emergency bag to be collected and for further assistance. She was joined around a minute later by additional healthcare staff. The nurse instructed officers to help move Mr Gladysz onto the landing of the wing and then took over CPR.

74. While conducting the emergency response, prison and healthcare staff noted that they saw lacerations on Mr Gladysz's upper left thigh, which they thought looked to be a few days old. Mr Gladysz had not reported these cuts and staff told us that they had not seen them before.

75. At around 9.25am, a London Ambulance Service rapid response team arrived on the landing and continued CPR for around an hour. At 9.38am, they managed to restore Mr Gladysz's circulation, although he remained unconscious throughout.

76. At 10.30am, paramedics took Mr Gladysz to St George's Hospital, where he was placed on life support. He died at 12.30am on 19 January.

Contact with Mr Gladysz's family

77. The prison appointed two family liaison officers. At 11.30am on 5 January, they visited Mr Gladysz's great uncle's address and explained the events and that Mr Gladysz was in a critical condition. (Although Mr Gladysz's mother was listed as his next of kin, she lives a long distance from the prison and the family liaison officers chose to visit his great uncle to explain what had happened, as he lives in London.) Mr Gladysz's great uncle informed Mr Gladysz's mother by phone and she attended

the hospital that evening. Mr Gladysz's father, who lives in Poland, also visited Mr Gladysz in hospital over the coming days. Mr Gladysz's mother and great uncle were with him when he died.

78. The prison contributed toward the cost of Mr Gladysz's funeral in line with national policy.

Support for prisoners and staff

79. After Mr Gladysz's death, the Head of Residence chaired a debrief for all 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.

80. The prison posted notices informing other prisoners of Mr Gladysz's death and offered support. Staff visited those who were close to Mr Gladysz to check on their wellbeing. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Gladysz's death.

Post-mortem report

81. The post-mortem report and toxicology reports were not available when we issued our report. The pathologist gave a provisional cause of death as hypoxic brain injury and cardiorespiratory arrest caused by hanging.

Findings

Identifying risk of suicide and self-harm

82. Prison Service Instruction (PSI) 64/2011, on safer custody, requires staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under suicide and self-harm procedures (known as ACCT).

83. When Mr Gladysz arrived at HMP Wandsworth in April 2023, he had a number of risk factors for suicide and self-harm: he was a foreign national prisoner awaiting extradition, spoke limited English, had schizophrenia, had a history of attempted suicide and was in prison in the UK for the first time.

84. Mr Gladysz did not leave a note and we do not know if there was a particular trigger that caused him to take his life. In the lead up to his death there was no evidence to suggest to staff that Mr Gladysz was at increased risk of suicide or self-harm. While Mr Gladysz had risk factors for suicide and self-harm, we are satisfied that it was not unreasonable for staff, on the basis of the very limited knowledge they had of him (which we address later), to conclude that he did not need to be monitored under ACCT procedures at the time.

Self-inflicted deaths at HMP Wandsworth

85. Mr Gladysz was the 15th prisoner at Wandsworth to take his life since January 2021. Up to the end of June 2024, one more prisoner, another Polish man who lived on the same wing as Mr Gladysz, has taken his life.

86. Wandsworth has been identified as requiring additional support due to the large number of self-inflicted deaths that have occurred in a short period of time and HMPPS has arranged for a task force to help the prison. The action plan from the subsequent meetings has included work on early days processes, quality assurance and case management training for ACCTs and guidance for safety admin teams.

87. Wandsworth has put a number of other actions in place to help staff identify and support prisoners who might be at risk of suicide and self-harm. This includes introducing a single case management model for ACCT procedures, rebolstering the Listeners programme (prisoners trained by the Samaritans to provide confidential support), introducing a programme to train prisoners in mental health and promotion of Big Word interpreting services. In addition, we were told that, as of February 2024, the Safer Custody team was fully staffed. This has resulted in the team having around 500 contacts with prisoners a month.

88. In May 2024, we issued a recommendation to the then Governor, that she provide the Ombudsman with a clear plan of how she is addressing issues identified with assessing and managing prisoners' risk of suicide and self-harm. The prison's response to this recommendation is currently outstanding and we do not therefore repeat it or make a further recommendation.

Key work and meaningful interaction

89. Other than fortnightly contact with the mental health staff, there is no evidence of any meaningful engagement between prison staff and Mr Gladysz during his time at Wandsworth. Except for entries about a cell move in August, there are no entries at all in his prison record between June 2023 and January 2024. The staff we interviewed did not demonstrate that they had had anything other than very basic conversations with him.

90. When conducting the emergency response, staff noticed cuts to Mr Gladysz's upper thigh which appeared to have been made in the days before he hanged himself. These may indicate earlier self-harm. Prisoners that we spoke to said that Mr Gladysz frequently told them that he heard voices. They told us that Mr Gladysz was happy to talk about this if asked. The wing staff we spoke to were not aware of his mental health diagnosis or the fact that he regularly spoke about hearing voices and did not believe that Mr Gladysz was at risk of suicide or self-harm. While we cannot say whether Mr Gladysz would have disclosed such things to staff, concerted efforts to engage with him may have made this more likely.

91. The Head of Reducing Reoffending told us that because of staffing levels, and to provide the best regime and access to purposeful activity, key work had been suspended since the COVID-19 pandemic. As a result, Mr Gladysz did not have a key worker during his time at Wandsworth. Key work might have provided Mr Gladysz with an opportunity to develop a meaningful relationship with a named member of staff and to share his concerns. Wandsworth have informed us that re-introducing key work forms part of their 2024/25 business plan. However, while staffing levels are reduced, only priority prisoners will receive key work. This priority cohort will include those foreign national prisoners who are referred by Catch 22. Once staff levels allow, all prisoners will receive key work.

92. Several staff members told us that they felt that Mr Gladysz had "fallen under the radar", not coming to the attention of staff given that he was not monitored under ACCT procedures and that he appeared to engage with the regime. A staff member told the investigator that he generally did not see positive staff-prisoner interactions and that staff needed time and confidence to do this. The Governor will want to ensure that staff understand the importance of having regular, meaningful conversations with prisoners to identify changes in appearance, behaviour or mood that may indicate increased risk (both in terms of risk to self and to others).

93. The lack of entries in Mr Gladysz's prison records has made it difficult to understand what, if any, engagement staff had with Mr Gladysz. It appears to have been very limited. Wing staff told us that they only tended to record interactions which were significant, or which would be helpful for other departments to know. We understand from the Head of Safety that there is ongoing work to coach staff in recognising that significance is not an objective measure and that it is important to ensure that they show and document the work they are doing with prisoners.

94. Wandsworth has also informed us that since Mr Gladysz's death there is a process in place to ensure that all prisoners have a quality conversation with a member of staff, and a case note entry, at least once a month. This is being monitored by monthly checks and staff are required to follow up on any prisoner without case

notes. We understand that, as part of this process, custodial managers are required to dip test case notes to quality assess these.

95. A staff member told us these conversations were often just asking a prisoner if they were all right and then, if they did not want to talk, telling them about the regime for the day. He said there were a lot of forced conversations which were not necessarily beneficial.

96. While any conversation with a prisoner is usually better than none, welfare conversations should be focused on the wellbeing of the prisoner, with the use of interpreting services where necessary. Staff should ensure that they probe further, engage in a full conversation and speak about wider matters, rather than accepting that a prisoner is fine and has nothing they wish to discuss. We acknowledge that this is a skill to be honed, like any other, and that an inexperienced staff team will likely find it harder and require more guidance and support to deliver. The Governor will wish to consider further how these interactions are embedded and quality assured.

Foreign national provision

97. Mr Gladysz was a Polish national who spoke limited English. Upon arrival at Wandsworth, he was due to be extradited to Poland. His asylum claim created a barrier to extradition, and he was still waiting for an update on this at the time of his death.

98. Six out of nine of the most recent self-inflicted deaths at Wandsworth have been of foreign national prisoners. Whilst we acknowledge that approximately half of Wandsworth's population is made up of foreign national prisoners this is above average and therefore concerning.

99. Impending removal from the UK can be a trigger for suicide and self-harm for foreign national prisoners. PSI 52/2011, *Immigration, Repatriation and Removal Services*, says:

> "*Foreign national prisoners can often experience isolation in prison due to language and cultural difficulties and lack of family visits and support. Prison staff should be aware of the heightened risk of self-harm in these cases and particular care should be taken when serving documentation relating to deportation which could cause distress."*

100. Catch 22 currently provides the specific support provision for foreign nationals at Wandsworth. With only two and a half staff members and high numbers of foreign nationals, except for an initial one to one induction, engagement is dependent on individuals proactively reaching out to them, attending groups they run or engaging with the foreign national representatives employed on each wing. Foreign national prisoners who do not actively engage with Catch 22 do not therefore receive any additional support.

101. In April 2023, Mr Gladysz had his induction with Catch 22, explaining that he was due to be extradited and wanted to go home as soon as possible. Around a week later he claimed asylum. In May and June, Mr Gladysz spoke about his uncertain immigration status with healthcare staff, and on one occasion appearing downcast

about it. While the mental health manager told the investigator that it was good practice to share this type of information with prison staff there was no evidence that this was done. Apart from these conversations, there is no indication that anyone else spoke to Mr Gladysz about his status or recognised concern about potential extradition as a possible risk factor.

102. The clinical reviewer also found that healthcare staff did not always discuss with Mr Gladysz the potential impact of his impending extradition. She concluded that this should have been reviewed to determine how he felt about it and its potential impact on his mental health and suicide risk.

103. We spoke to the two members of the senior leadership team who had additional responsibility as foreign national leads at the time of Mr Gladysz's death. Both told us that, due to other priorities, they had not been able to focus time on this role.

104. Mr Gladysz's death prompted the HMPPS Regional Safety Team to review the foreign national prisoner process at Wandsworth. They found that there was a lack of understanding among officers around foreign national offender risks. A national working group has been established to ensure gaps and good practice can be identified and to agree a consistent national approach. The Regional Safety Team have set out further considerations, such as the development of a foreign national awareness package for establishments that can be delivered during induction, and on-going training. They also aim to ensure that there are information sharing pathways between Home Office and HMPPS, particularly for high-risk cases with known suicide and self-harm risks linked to deportation or extradition.

105. Wandsworth have taken some actions locally to address their support for foreign national prisoners since Mr Gladysz's death. In March 2024, the Head of Safety launched a local foreign national strategy. While this is a good step in setting out the challenges of this cohort and the support available, there would also be value in including detail on communication channels and there is little consideration of how to target those who do not proactively engage.

106. In addition, Wandsworth have set up a new multi-disciplinary monthly meeting to look at foreign national support, are conducting monthly monitoring to ensure focus groups for all protected characteristics, including foreign nationals, are taking place and told us that they will ensure that information sharing between immigration and the safety team highlights any high-risk cases. They are also exploring developing a cohort of Polish Listeners to work with Polish prisoners.

Use of interpreting services

107. While there was no universal agreement about Mr Gladysz's level of English, we conclude that the weight of evidence indicates that he could not communicate well in English.

108. Whilst Mr Gladysz may have been able to understand basic words around the regime it is unlikely he would have been able to discuss more complex matters, including his mental health and risk to self.

109. Despite Mr Gladysz's level of English there is no evidence that prison staff used formal translation services when engaging with him. In interview, staff told us that

when there were issues with communication, they tended to use prisoners or staff who spoke the prisoner's language. While wing staff we spoke to knew how to use the formal interpreting service (Big Word) they rarely did this due to time and resource constraints. Some told us that prisoners often preferred using an officer rather than Big Word. Staff explained that generally translation services would only be used for formal documented meetings.

110. With one exception, there is no evidence that healthcare staff used interpreting services. (The nurse who recorded that she had used an interpreting service could not remember doing so at interview, so it is unclear whether this happened.) The clinical reviewer found that this led to a lack of depth in the assessments of Mr Gladysz's mental health and suicide risk and impacted on the ability of clinical staff to provide good quality healthcare.

111. Fellow prisoners we spoke to described Mr Gladysz as exhibiting frequent symptoms of schizophrenia, which other staff did not apparently notice. While Mr Gladysz's language needs may not have been the only reason he spoke more to his peers, it is likely that this contributed.

112. Wandsworth have taken steps to promote interpreting services. Since February 2024, they have produced pocket cards for staff and have put posters around the prison. They have also ensured that new prison staff receive information about interpreting services at the point of their induction.

113. Interpreting service usage data is monitored and areas with low usage are challenged. However, the Head of Safer Custody explained that this did not represent an accurate picture given that prison staff frequently used other prisoners and staff to translate.

114. The new local foreign national strategy makes clear the instances where using prisoners to interpret is not appropriate. It notes that Big Word is not being used frequently enough and emphasises the importance of increasing its use but lacks detail about how this will be achieved.

115. We consider that the current system relies too heavily on individual staff making ad hoc assessments of prisoners' English comprehension and that a standardised approach would serve prisoners' needs better. We have made a previous recommendation to the Director General of Operations for HMPPS to review the way in which English language ability is assessed, especially for foreign national prisoners. They have told us that as part of the procurement for new Prison Education Service contracts, they are seeking to procure a new English as a Second Language (ESOL) screening tool that will accurately identify any gaps in a prisoner's ability to read, write, speak, and understand English and indicate the level of support that the prisoner requires. The results will be recorded on HMPPS IT systems and be accessible to all staff who work with prisoners across all departments.

116. We make the following recommendations to Wandsworth:

The Governor and Head of Healthcare should ensure that interpreting services are used properly across HMP Wandsworth, including by:

- **Ensuring staff use appropriate interpreting services when discussing complex matters with prisoners with limited English.**

- **Implementing monitoring to identify where staff or prisoners are being used to interpret, to ensure there is a clear picture of translation needs.**

The Governor should ensure that the new local foreign national strategy is developed to include actions to identify risk and to provide support for foreign national prisoners who may not proactively engage with existing support provision.

Mental healthcare

117. The clinical reviewer concluded that the clinical care Mr Gladysz received at Wandsworth was equivalent to that which he could have expected to receive in the community.

118. Mr Gladysz was promptly placed on the caseload of the mental health in-reach team and allocated a care coordinator. With one exception, Mr Gladysz was seen fortnightly by a member of the mental health in-reach team. The clinical reviewer noted that, on the whole, staff allocation was very consistent, and Mr Gladysz was seen by a small number of clinicians who were familiar to him.

119. Mr Gladysz was not engaged in any purposeful activity during his time at Wandsworth. The clinical reviewer has noted that meaningful activity is important in both the promotion of good mental health and the prevention of suicide. The clinical reviewer found that Mr Gladysz's care plan did not sufficiently take account of the potentially positive impact of daily activity on his health and wellbeing and not enough focus was given to encouraging this.

120. We therefore make the following recommendation:

The Head of Healthcare should ensure that the value of daily activity for those with long term mental health needs is included in relevant care plans and highlighted in clinical supervision.

Roll checks

121. On the morning that Mr Gladysz hanged himself, the night patrol officer signed for a roll check that CCTV evidence shows they did not complete. This is unlikely to have made a difference to the outcome for Mr Gladysz, as he did not hang himself until after his cell mate left the cell, around three hours later. Wandsworth is conducting a local investigation into this incident and the Governor will wish to satisfy himself that these important checks are completed properly.

Good practice

122. We wish to highlight the work of the family liaison officers in this case. During the period in which Mr Gladysz was in hospital, the family liaison officers kept in constant communication with his family including, on occasion, staying at the hospital until late in the evening to support them.

Inquest

123. The inquest into Mr Gladysz's death concluded on 15 July 2025, and found that Mr Gladysz hanged himself with a ligature with his intentions unknown.

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