Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Swierczek, a prisoner at HMP Ranby, on 17 May 2024

A report by the Prisons and Probation Ombudsman

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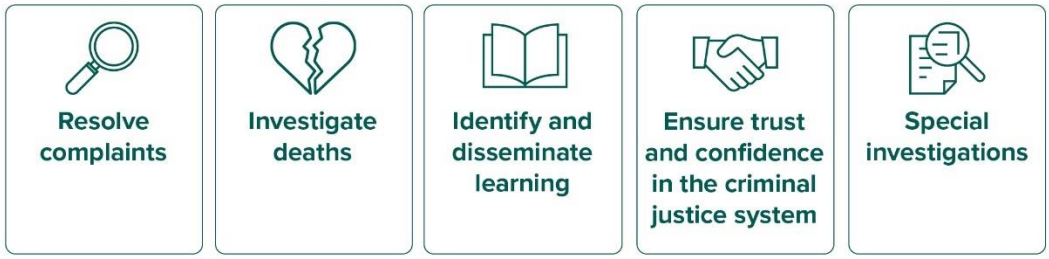
OUR VISION

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 Daniel Swierczek died from choking (on a foreign object that he had seemingly deliberately ingested) on 17 May 2024 at HMP Ranby. He was 39 years old. I offer my condolences to Mr Swierczek's family and friends.

Mr Swierczek had been at HMP Ranby since 2 April after transferring from HMP Nottingham to serve a relatively short sentence of 28 weeks. Shortly after his arrival, staff thought Mr Swierczek was paranoid and referred him to the mental health in-reach team. Following assessments, he was not considered to be displaying psychotic symptoms but was found to be struggling to adjust to prison. Mr Swierczek had no history of suicide attempts or self-harm and consistently denied such thoughts. Staff described him as future focused and looking forwards to his release on 22 May.

There was no evidence that Mr Swierczek's risk of suicide had substantially risen in the days before his death, or that staff could have foreseen his actions.

Another regulatory body conducted an investigation and found that there were deficiencies in the cell call bell system at Ranby. We do not know if Mr Swierczek tried to raise the alarm before he collapsed.

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 **January 2025**

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Summary

Events

1. On 21 March 2024, Mr Daniel Swierczek was sentenced to 28 weeks in prison for harassment without violence against his partner and driving under the influence. He was initially taken to HMP Nottingham.

2. At his reception screen, Mr Swierczek was identified as needing to complete an alcohol detoxification programme. He denied any thoughts or intent of suicide and self-harm and told staff that he had no history of either. During his health screen, he reported health issues including hypertension, anxiety and depression. Mr Swierczek was not considered suitable to share a cell due to his previous convictions.

3. On 2 April, Mr Swierczek transferred to HMP Ranby. He was due to be released from prison on 22 May. Mr Swierczek resided on house block 1, a standard residential wing and remained there during his time at the prison.

4. Almost two weeks after arriving at Ranby, staff referred Mr Swierczek to the mental health team, as he was displaying signs of paranoia. Mr Swierczek consistently denied thoughts of suicide and self-harm.

5. On 7 May, a psychiatrist and a nurse from the mental health in-reach team assessed Mr Swierczek and concluded that he was not displaying any signs of psychosis. Mr Swierczek accepted that he overthought things and was struggling to adjust to prison.

6. The day before his death, Mr Swierczek met with his mental health nurse, discussed his discharge plan, and attended a drug and alcohol relapse prevention support group, where he engaged well. No other concerns were raised.

7. On night of 16 May, Mr Swierczek made three telephone calls to his mother and brother, he did not say anything of note and did not raise any concerns.

8. At 7.29am on 17 June 2024, during a routine check, an officer found Mr Swierczek unresponsive on the floor of his cell. The officer radioed a medical emergency code.

9. Staff entered the cell and after checking for signs of life, began cardiopulmonary resuscitation (CPR). Nursing staff attended and assisted.

10. At 7.47am, paramedics arrived and took over resuscitation attempts and were joined by a critical care doctor at 8.21am. At 8.24am, it was confirmed that Mr Swierczek had died.

11. The post-mortem report gave Mr Swierczek's cause of death as choking. During post-mortem examination, a ball of material was found in the back of Mr Swierczek's throat, obstructing his airway and it was the opinion of the pathologist that this obstruction had led to his death.

Findings

12. Mr Swierczek had some risk factors that increased his risk of suicide including, alcohol misuse, index offence against a family member, it was his first time in prison, and he had displayed paranoid behaviour. He was well supported by the mental health team, chaplaincy and wing staff. It is not clear whether Mr Swierczek intended to die when he swallowed objects and we do not think that staff had reason to believe that his risk of suicide had increased in the days before his death or that staff should have considered suicide and self-harm monitoring.

13. The clinical reviewer concluded that the care Mr Swierczek received at Ranby was of a reasonable standard but only partially equivalent to what he could have expected to receive in the community. She found that healthcare staff did not complete a mental health capacity assessment, and record keeping was not in line with guidelines.

The Investigation Process

14. HMPPS notified us of Mr Swierczek's death on 17 May 2024.

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

16. The investigator contacted HMP Ranby on 20 May 2024 and obtained copies of relevant extracts from Mr Swierczek's prison and medical records.

17. The investigation was transferred to the investigator's colleague. He interviewed 10 members of staff at Ranby on 21 and 22 August.

18. NHS England commissioned a clinical reviewer to review Mr Swierczek's clinical care at the prison.

19. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's office contacted Mr Swierczek's family to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Swierczek's family asked why Mr Swierczek remained in a single cell on the induction wing and was not moved to another wing, and whether this was due to his mental health. They also asked whether there was evidence that he was in debt. These questions have been addressed in our report.

21. Mr Swierczek's family were provided with a copy of our initial report. In response they asked a number of questions related to information contained either in the report or interview transcripts. A response to these questions has been provided to the family in separate correspondence.

22. An inquest into Mr Swierczek's death was opened on 11 November 2024 and concluded on 7 August 2025. A jury found that Mr Swierczek took his own life while the state of his mind was unstable.

Background Information

HMP Ranby

23. HMP Ranby is a medium security training and resettlement prison in Nottinghamshire. Nottinghamshire Healthcare NHS Foundation Trust provides primary and mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Ranby was in March and April 2022, followed by a review of progress inspection in January 2023. Inspectors found that newly arrived prisoners were treated well. Reception and induction staff established a good rapport with arriving prisoners and completed the necessary processes without undue delay.

25. A group induction had resumed following COVID-19 restrictions, with an officer giving a short briefing on the first morning after arrival and a peer worker holding a fuller session. Gym staff spoke briefly with new arrivals and a chaplain visited each prisoner on the day after arrival. However, the induction provision was not sufficiently engaging or comprehensive. The progress inspection report highlighted that the amount of time out of cell had improved for many prisoners since the previous inspection. Those in work were unlocked for around five or six hours on weekdays. However, unemployed prisoners were unlocked for only around two hours a day and for meal collection, and those on the induction wing for as little as one hour a day.

Independent Monitoring Board

26. 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 2024, the IMB reported that the reception process for newly arrived prisoners was carried out with professionalism and care. All the relevant checks and processes were in place to enable prisoners to be passed through the system quickly and efficiently.

Previous deaths at HMP Ranby

27. Mr Swierczek was the seventh prisoner to die at Ranby since February 2021. Of the previous deaths, two were self-inflicted, three were from natural causes and one was drug related. To the end of October 2024, there have been no deaths at Ranby since Mr Swierczek's death.

Key Events

28. On 21 March 2024, Mr Daniel Swierczek was sentenced to 28 weeks in prison for harassment without violence against his partner and driving under the influence. He was sent to HMP Nottingham. This was his first time in prison.

29. During his reception health screen, Mr Swierczek reported health issues including anxiety and depression, atrial fibrillation (abnormally fast heart rate), high blood pressure and alcohol dependence. Mr Swierczek was placed on an alcohol detoxification programme.

30. Staff completed a reception interview. Mr Swierczek said that he had no previous history of suicide attempts and self-harm and denied any current thoughts. Mr Swierczek spoke about his alcohol misuse issues and said that he also struggled with depression, anxiety and attention deficit hyperactivity disorder (ADHD). When asked about self-harm and any potential triggers, Mr Swierczek said that he could not think of any or any dates that might affect thoughts of self-harm and he was advised to speak with staff if this changed.

31. A cell sharing risk assessment indicated that Mr Swierczek had previous offences that included false imprisonment and stalking and in line with policy, he was deemed high risk and not suitable to share a cell.

32. Mr Swierczek completed the alcohol detoxification programme at Nottingham. No concerns were raised by him or about him by staff.

HMP Ranby

33. On 2 April. Mr Swierczek transferred to HMP Ranby. He was due to be released on 22 May.

34. On arrival at Ranby, a registered mental health nurse (RMN) completed a transfer health screen with Mr Swierczek. He recorded that Mr Swierczek reported no issues with illicit drugs but had used alcohol to excess. He had completed an alcohol detoxification programme at Nottingham and had his last dose of detoxification medication on 29 March. Mr Swierczek also reported a history of atrial fibrillation, panic attacks, anxiety and depression and said he was not currently on any prescribed medication. The nurse recorded that Mr Swierczek was relaxed during the consultation and gave no cause for concern. Mr Swierczek denied any thoughts of suicide and self-harm. The nurse created care plans for Mr Swierczek's high blood pressure and atrial fibrillation.

35. An officer completed an induction interview with Mr Swierczek. Mr Swierczek said that that he had no concerns about being at Ranby and no thoughts of suicide or self-harm. Mr Swierczek was given access to the reception shop (where prisoners can buy vapes, toiletries and other items) and the officer told him how he could add telephone credit. He recorded that Mr Swierczek would be going to the induction wing on house block (HB) 1. When Mr Swierczek arrived onto HB1, he was given access to the telephone and called his family to let them know that he had transferred to Ranby.

36. On 7 April, Mr Swierczek submitted an application to speak with someone from the mental health team and to ask for diazepam (used to treat anxiety, muscle spasms and seizures).

37. On 10 April, a Prison Offender Manager (POM) was notified that due to his offences being committed in the presence of children, Mr Swierczek was considered to pose a risk to children, and she explained what this meant in terms of contact. She completed an application for child contact with Mr Swierczek.

38. On 15 April, an Anglican chaplain spoke with Mr Swierczek when he attended the chaplaincy department for pastoral support. Mr Swierczek was coherent and at the end of the session he was laughing and joking. She noted that Mr Swierczek was struggling with being in prison as it was his first time, and he was struggling to adapt to the culture. She reassured Mr Swierczek.

39. The chaplain noted that Mr Swierczek had told him that he had witnessed the body of a prisoner being removed from their cell on 5 April. (There had been a death at the prison on this date. However, prison staff told us that the location of Mr Swierczek's cell would have made it very difficult for him to have witnessed anything as he had described to the chaplain). Mr Swierczek told the chaplain that it had impacted him in a negative way and that he believed that he would leave Ranby the same way. Mr Swierczek said, 'that's just the way I think I am going to go.' She asked Mr Swierczek if he was having suicidal thoughts. Mr Swierczek smiled and said, 'No, If I leave Ranby, or if I die in Ranby, it won't be by my own hand.' She said that he did not think that starting suicide and self-harm prevention procedures (known as ACCT), was appropriate at that point because he had asked Mr Swierczek explicitly whether he was having suicidal thoughts and he had told him he was not. She said that Mr Swierczek was very matter of fact about it, and he had put it down to the culture shock. She said his aim was to offer Mr Swierczek more pastoral care as he felt that he would benefit from regular contact with him.

40. Later that day, a worker from the drug and alcohol team spoke to Mr Swierczek after he had submitted an application asking for support. She recorded that during her assessment, Mr Swierczek appeared paranoid although he denied thoughts of suicide, self-harm, drug use or of being under threat. Mr Swierczek said that he did not wish to be around drug users. She agreed a care plan with Mr Swierczek, and he signed a compact. Due to his presentation, she referred Mr Swierczek to the in-reach mental health team (IMHT). (She saw Mr Swierczek again on 19 April and recorded that arrangements would be made for the local drug interventions programme (DIP) team to work with Mr Swierczek following his release.)

41. On 20 April, staff warned Mr Swierczek about potentially breaching his child contact restrictions during a telephone call, as he had called out to the children that were in the room.

42. Later that day, a RMN, along with an officer, visited Mr Swierczek in his cell to complete a mental health assessment and following his request for diazepam. Mr Swierczek shook the nurse's hand when she entered his cell and said, 'There is nothing at all wrong with my mental health.' Mr Swierczek then told her that he feared for his life at Ranby and believed that other prisoners and staff were going

to kill him. She recorded that she attempted to rationalise this with Mr Swierczek, but he presented as delusional throughout the assessment.

43. Mr Swierczek spoke about having cameras in his cell for other prisoners to watch him, and hearing voices through the pipes in his cell telling him they could see what he was doing. The RMN recorded that Mr Swierczek believed that other prisoners were aware of his every movement while he was in his cell, and he could hear officers talking and laughing outside his door about him going to the segregation unit where he would not be able to use a telephone. Mr Swierczek said that he believed everyone was out to hurt him because of things that had happened between him and his partner.

44. The RMN recorded that Mr Swierczek had no insight into his mental health, had a long history of alcohol abuse and had received treatment for detoxification and liver damage, had a history of depression and anxiety and had previously been prescribed diazepam in 2022. Mr Swierczek said that diazepam stopped the tremor in his hand, but on examination his hands were steady.

45. Mr Swierczek said that he had no thoughts of suicide and self-harm and that his children meant more than anything to him and he could not do that [harm himself] to them. Mr Swierczek declined to give consent to share any information about his care and treatment. The RMN considered that he might benefit from being added to the mental health caseload due to his lack of insight into his current presentation and being assessed by the psychiatrist prior to his release. Following her assessment, she spoke with wing staff about Mr Swierczek's belief that he was at risk from other prisoners.

46. An officer completed a Challenge, Support and Intervention Plan (CSIP) referral. CSIP can be used proactively (before a violent incident occurs) as well as reactively (in response to a violent incident), to help prevent and reduce the likelihood of future violence. As well as those who are deemed likely to become violent, CSIP is also used to support potential victims of violence.

47. The officer said that she had not witnessed Mr Swierczek being targeted by other prisoners or bullied. He was in a cell that was easily visible to staff, and he had a good rapport with the wing cleaners, and they were supportive of him. She said that Mr Swierczek did interact with others but also chose to stay in his cell. She said that she did not consider that ACCT procedures were necessary at that time as Mr Swierczek did not express thoughts of suicide or self-harm and he talked about his children and how he could not wait to see them and wanted to be part of their lives.

48. On 22 April, Mr Swierczek attended another pastoral session with the chaplain. He told the investigator that most of their conversations centred on his belief that he was being targeted, and he felt that what he was describing was indicative of a mental health issue rather than an issue with staff or prisoners. He said that Mr Swierczek reacted quite badly the first time he suggested this and accused him of implying 'he was nuts' and he had to reassure him that was not the case. He said that during their conversations there was nothing to suggest that Mr Swierczek was a risk to himself.

49. On 30 April, Mr Swierczek made two telephone calls to his partner and to his mother. The investigator listened to the calls. Mr Swierczek said that he was fearful for his safety and believed that he was at risk. He said that people were outside his door and that he was paranoid about staff and prisoners working together. He asked his mother and his partner to contact the prison.

50. On 1 May, a family member called to the prison's safer custody hotline and raised concerns about Mr Swierczek. A duty manager asked an officer to check Mr Swierczek. The officer recorded that Mr Swierczek seemed very paranoid and spoke about people speaking to him through the pipes and vents. He noted that the conversation seemed to go in different directions, and he felt that Mr Swierczek's mental health had deteriorated since he arrived at Ranby. He noted that a CSIP had been raised, but Mr Swierczek was waiting to see the mental health team. He did not consider that ACCT support was needed at that time.

51. At 12.34pm on 2 May, Mr Swierczek's partner rang the safer custody hotline and raised concerns about him. A Custodial Manager (CM) from the safer custody team, contacted house block 1 and asked staff to complete a well-being check. An officer completed a check at 12.38pm. Another officer recorded that Mr Swierczek was lying on his bed watching television. He asked Mr Swierczek how he was feeling, and he replied that he was okay and gave a thumbs up. He told Mr Swierczek that if he needed anything he could speak with the staff.

52. That evening, Mr Swierczek complained of chest pains and was sent to hospital for checks. He returned to Ranby later that evening with a plan to attend hospital for an outpatient cardiology appointment.

53. On 6 May, a Supervising Officer (SO) completed a well-being check on Mr Swierczek, after Mr Swierczek's friend contacted the prison with concerns that Mr Swierczek was at risk from other prisoners and staff. The SO noted that Mr Swierczek had been receiving support on the wing from support peers (prisoners trained by mental health staff to offer support) and wing staff. He recorded that Mr Swierczek appeared relaxed during their conversation and was reassured that staff had no intention to harm him. He said that he had no reason to believe Mr Swierczek was a risk to himself during his contact with him.

54. On 7 May, a RMN visited Mr Swierczek on the house block to complete a mental health assessment. He recorded that Mr Swierczek had been triaged by the mental health team and some concerns about his mental health had been identified.

55. Mr Swierczek said that his mental health was 'up and down', but he denied any strange thoughts. He said that he did not hear voices but heard things very loudly through the vents. Mr Swierczek said that the noise could be standard noises in the prison, but he felt that they were aimed at him. Mr Swierczek said that this created a bit of paranoia. Mr Swierczek said that the previous evening, he believed that someone was playing a recording of his voice on the wing that had been recorded using staff's body worn camera. Mr Swierczek said that while he felt intimidated, no one bothered him when he was outside his cell, however he did not know what to expect, and someone walking past could be carrying something.

56. Mr Swierczek denied having hallucinations and said that he felt great although he had felt depressed while in prison. He said that he knew he was overthinking his safety and did not know if things were aimed at him and did not want to sound like a 'loony bin'. Mr Swierczek denied any current thoughts of suicide and self-harm.

57. In concluding the assessment, the RMN recorded that objectively, Mr Swierczek was alert and appeared to have attended to his personal hygiene, he made eye contact, had normal posture and he had been able to establish a rapport. He noted that there was no evidence of psychosis, and he felt that Mr Swierczek was reporting thought broadcasting and paranoia but did not appear to present as acutely unwell in terms of his mental health. He noted that Mr Swierczek showed insight into his mental health, had accepted support from him and agreed to see the psychiatrist. In light of his observations, he did not consider that ACCT procedures were necessary at that time. He planned to see Mr Swierczek again the following week.

58. On 11 May, wing staff asked a nurse to see Mr Swierczek as they were concerned about his mental health. A RMN attended the house block to see Mr Swierczek in his cell. Mr Swierczek told her that he was happy to talk, and he noticed what she thought was a smell of Spice (a psychoactive substance) and she asked Mr Swierczek to come out onto the landing, which he was happy to do. She recorded that Mr Swierczek presented as confused and could not explain what his mental health issues were. He told her that he had 'put himself in trouble' but was unable to explain this. Mr Swierczek denied having taken illicit drugs. There was no evidence of delayed speech, but his eyes were glazed. She took Mr Swierczek's baseline observations, all of which were within a normal range. Due to his suspected illicit drug use, staff opened an Under the Influence (UTI) log to monitor Mr Swierczek. The log was started at 11.20am and staff completed a total of six observations up to 2.30pm, in line with local policy. No further concerns were reported.

59. On the morning of 13 May, Mr Swierczek attended an outpatient's cardiology appointment at the hospital. Mr Swierczek told hospital staff that he had swallowed a nicotine vape capsule. Hospital staff sent him for an X-ray and the results showed no evidence that he had swallowed anything. Hospital staff informed healthcare staff at Ranby of the result.

60. While at hospital, Mr Swierczek was reported as appearing paranoid. Mr Swierczek was discharged from hospital with a recommendation that he was reviewed by the mental health team. On his return to Ranby, staff referred Mr Swierczek to the mental health team. There is no evidence that his claims of having swallowed something were recorded anywhere other than his medical notes or passed on to prison staff and the safer custody team for further investigation.

61. On 14 May, a psychiatrist saw Mr Swierczek. He noted that Mr Swierczek adamantly denied any recent substance misuse. He noted that Mr Swierczek's presentation was very much in keeping with prolonged alcohol misuse/dependence. He concluded that there was no evidence of acute mental illness or depressive illness, and it was adjustment to prison and long-term alcohol use that were causing Mr Swierczek's issues.

62. The psychiatrist recorded that he did not have any concerns about Mr Swierczek harming himself or ending his life. He wrote that Mr Swierczek was future orientated and responsive to encouragement about the next steps. He felt that Mr Swierczek would benefit from follow up in the community, primarily from substance misuse services.

63. On 15 May, a RMN saw Mr Swierczek to review his mental state and risk. Mr Swierczek confirmed that he would like support from mental health services after his release and the nurse recorded that he would be referred to RECONNECT (a care after custody service that seeks to improve the continuity of health care of people leaving prison) to support Mr Swierczek with accessing a GP in the community, who would be able to refer him to secondary mental health services.

64. The RMN recorded that Mr Swierczek was excited about his release but nervous about returning to prison. Mr Swierczek denied using illicit substances but said that he might have done so without his knowledge as he had taken vapes from other prisoners. He advised him about the risks of doing so. Mr Swierczek spoke about his plans after his release and returning home.

65. In concluding the assessment, the RMN recorded that he did not feel that Mr Swierczek needed to be monitored on an ACCT as he did not present as acutely unwell, recognised his treatment needs which evidenced his insight, and there was also future planning, with Mr Swierczek having a plan for his employment. He recorded that Mr Swierczek would be seen again in a week and a discharge plan would be completed in preparation for his release.

66. On 16 May, Mr Swierczek was informed that following a review, all restrictions regarding contact with his children had been removed.

67. That day, Mr Swierczek attended a psychosocial group session about relapse prevention with a senior substance misuse nurse. She described Mr Swierczek as appearing low in mood, but he fully engaged with the session. She said that she recalled Mr Swierczek saying that he did not like prison and was embarrassed about being there. Mr Swierczek had said that he was both excited and nervous about his release. He had been engaging with his peers and fully completed the forms required. She said that she did not notice any signs of paranoia.

68. While Mr Swierczek was in his group session, a RMN spoke with him briefly. Mr Swierczek told him that he had learnt his lesson and would not be returning to prison, but he also said that he felt nervous and felt that he had been set up and he would not get out of prison. The nurse reassured Mr Swierczek that the only reason he would not be released on Wednesday 22 May, would be if he committed an offence against prison rules. Mr Swierczek denied any thoughts of suicide and self-harm, and said that although he felt safe, he planned to stay in his cell until he was released and that he overthought things. The nurse gave Mr Swierczek a copy of his Discharge Care Plan and informed him that he would see him again on Monday 20 May.

69. During the afternoon on 16 May, a nurse visited Mr Swierczek to complete his RECONNECT needs assessment. She recorded that Mr Swierczek fully engaged and was motivated to engage with the support offered by the service. She recorded that Mr Swierczek presented as slightly paranoid and noted that prior to

prison he had been consuming excessive amounts of alcohol on a daily basis, and he struggled to recall events leading up to his arrest. She also said that Mr Swierczek was somewhat vague about his mental health needs, and she got the impression that he was reluctant to talk about his symptoms. When she asked Mr Swierczek about his plans after his release, Mr Swierczek became emotional when speaking about his partner and children. He said that he had tried not to think about it as he had struggled to come to terms with being in prison.

70. CCTV shows at 5.48pm, Mr Swierczek returned to his cell and the door was locked for the evening. A routine roll check was carried out at 6.47pm and staff had no concerns about Mr Swierczek.

71. While at Ranby, Mr Swierczek made a total of 44 telephone calls. On the evening of 16 May, he made three calls between 10.31pm and 11.29pm to his mother and brother. He did not say anything of note but he ended all three calls telling his mother and brother that he loved them.

Events of 17 May

72. The following account is based on written evidence provided by Ranby, CCTV and Body Worn Video Camera (BWVC) footage and transcripts of interviews with staff.

73. CCTV shows at 3.23am on 17 May, Mr Swierczek's in-cell light was turned off. It was turned on again at 4.53am and then off again at 4.55am. The night officer had no reason to visit Mr Swierczek's cell during the night as he was not subject to ACCT monitoring.

74. Officer A was completing a morning routine roll check on HB 1 and arrived at Mr Swierczek's cell at 7.28am. When he looked into the cell through the observation panel, he could see Mr Swierczek lying on the floor, partially obscured by the toilet. He called to Mr Swierczek and knocked on the door, but he did not respond. He called to his colleague, Officer B, who was on the landing above to come down so he could enter the cell and at the same time a SO arrived onto the wing. All three staff entered the cell and called out to Mr Swierczek. Officer A checked for a pulse and on turning Mr Swierczek over, he saw that Mr Swierczek had no colour and there were no signs of life. While this was happening, Officer B radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties) at 7.29am. Control room staff called an ambulance immediately.

75. Staff commenced cardiopulmonary resuscitation (CPR) which continued until nursing staff arrived and took over at 7.34am. Paramedics arrived at 7.47am, followed by a critical care doctor at 8.21am. At 8.24am, the doctor confirmed that Mr Swierczek had died.

Events following Mr Swierczek's death

76. Following Mr Swierczek's death, the police spoke with two prisoners who were located either side of Mr Swierczek. One prisoner said that they had heard shouting, mumbling and banging coming from Mr Swierczek's cell the night before Mr Swierczek was found. The prisoner was not sure of the time, but said it was

after 7.00pm. The prisoner said that he could not hear exactly what Mr Swierczek was saying. The prisoner said that he had spoken with Mr Swierczek several times and had last seen him when they collected their evening meal. He said Mr Swierczek was looking forward to being released.

77. Another prisoner told the police that they had heard Mr Swierczek coughing violently during the night. The prisoner said that Mr Swierczek had coughed about four times; he thought it sounded serious, could not be certain of the time, but said it was before 10.00pm.

78. The investigator was unable to verify the accounts with these prisoners as they had been released from prison. However, we note that the paramedics who arrived at 7.47am continued resuscitation efforts until 8.24am, indicating that there were no clear signs that Mr Swierczek had been dead for some time.

Contact with Mr Swierczek's family.

79. Two members of staff were appointed as family liaison officers.

80. The two staff left HMP Ranby at 9.00am and arrived at Mr Swierczek's mother's address at 11.30am. The staff informed Mr Swierczek's mother of his death and remained at the property to meet other family members and offering support.

81. The prison contributed towards funeral expenses in line with national policy.

Support for prisoners and staff

82. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

83. After Mr Swierczek's death, all those staff involved were advised to attend the visit hall where they received a debrief from prison manager including the paramedics that had attended. Police also attended and statements were taken from those staff directly involved.

84. The staff care team provided support and the prison followed the postvention toolkit, with Samaritans attending the prison. Notices informing prisoners of Mr Swierczek's death were published with signposting to chaplaincy support for those that required it. Those prisoners subject to ACCT monitoring were reviewed in case the events had a negative impact on them.

Post-mortem report

85. The post-mortem report gave Mr Swierczek's cause of death as choking. During post-mortem examination, a ball of cleaning cloth-type material was found in the

back of Mr Swierczek's throat, obstructing his airway and it was the opinion of the pathologist that this obstruction had led to his death. In addition, further investigation found a rosary necklace and two razor blades in Mr Swierczek's stomach.

86. While it is clear that Mr Swierczek would have knowingly swallowed the items found during post-mortem, there is no evidence indicating his motivation or intention for doing so.

Other investigations conducted following Mr Swierczek's death.

87. While attending the prison, Nottinghamshire police noted that the cell call system for Mr Swierczek's cell bell was not working and was in a poor state of repair. This was reported to the Coroner who commissioned a separate investigation and report into the cell call system at Ranby.

88. Chartered electrical engineers working on behalf of Nottinghamshire police completed a review of the electrical and cell call systems at Ranby. In their investigation report they noted that on 16 May, the prison works department had responded to an earlier report of a cell call bell not working. CCTV shows works staff at Mr Swierczek's cell at 1.39pm and a light can be seen to illuminate on the outside of the cell. However, this call did not register on the call log which indicated that Mr Swierczek's cell bell was faulty. The report concluded that electrical anomalies were identified across the residential units, including Mr Swierczek's cell, and that these failures left prisoners and staff vulnerable to the potential of electrocution, and to fire detection and alarm systems not working.

89. The Governor of Ranby told the investigator that the prison had previously raised concerns about the cell call system on HB 1 and had submitted a bid for funding to have the system repaired, although a full replacement system would be a substantial cost. She said that since the issues raised by the independent report, cell call bells are checked daily across the prison, not just HB 1, and if a cell call bell is found not to be working and cannot be resolved by the works department, the prisoner is relocated to another cell.

90. Because of these identified issues with the call bell system on HB 1 at the time of Mr Swierczek's death, we cannot say whether Mr Swierczek pressed his cell bell on the night of 16 May or morning of 17 May.

Findings

Assessment of risk

91. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Swierczek had some risk factors for suicide and self-harm including a history of alcohol misuse, first time in prison, offence against a family member and latterly indications of paranoia around his safety.

92. Mr Swierczek was appropriately supported by wing staff, a CSIP was submitted, and reassurance was provided to Mr Swierczek from chaplaincy staff, mental health staff, drug and alcohol support workers and prisoner mentors. Despite his paranoia, which Mr Swierczek described as him 'overthinking' things, he spoke positively about the future and denied any suicidal ideation when challenged. His family raised several concerns about him via the safer custody hotline, and on each occasion a well-being check was completed and documented.

93. In the days before his death, the mental health in-reach team and other agencies spoke to Mr Swierczek in preparation for his release on 22 May. As with previous contacts, Mr Swierczek was recorded as being future focused with plans for gaining employment and addressing his physical and mental health needs, albeit he said that he was nervous about release and returning to custody.

94. After Mr Swierczek's death, a friend of his told a prison chaplain that Mr Swierczek was viewed as a 'soft touch' on the wing and other prisoners regularly borrowed items from him. Staff noted that Mr Swierczek seemingly struggled with the prison environment but there was no particular evidence that he was being bullied. There was also no evidence that would suggest Mr Swierczek was in debt to others or had been targeted for such reasons.

95. Mr Swierczek was never considered at raised risk of suicide or self-harm, or subject to ACCT monitoring in prison, and the reasons provided for reaching the conclusions and decisions not to monitor him are well documented. Mr Swierczek had once before claimed to have swallowed items, but X-rays indicated that he had not done so. We consider that, on the evidence available, there were no clear indications that Mr Swierczek posed a risk to himself or should have been monitored under ACCT procedures. Although clearly Mr Swierczek's cause of death was self-inflicted, the reasons for his actions remain unknown, and we cannot be sure that he intended to die. We do not think that staff could have predicted his actions.

Clinical care

96. The clinical reviewer concluded that the clinical care extended to Mr Swierczek at Ranby was of a reasonable standard and partially equivalent to what he could have expected to receive in the community.

97. The clinical reviewer has made recommendations about issues not related to Mr Swierczek's death which the Head of Healthcare will wish to address.

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