Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marek Witulski, a prisoner at HMP Peterborough, on 9 July 2020

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.

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

Mr Marek Witulski died in hospital on 9 July 2020, after being found hanging in his cell at HMP Peterborough three days earlier. He was 50 years old. I offer my condolences to Mr Witulski's family and friends.

This is a disturbing case. Mr Witulski was a Polish national and was due to be deported to Poland at the beginning of April 2020. However, due to the COVID-19 pandemic, the Home Office was unable to book flights until June, and then the flights were repeatedly cancelled. As a result, Mr Witulski remained in prison.

The reasons for Mr Witulski's continued detention were outside the prison's control. However, we are very concerned that staff did not do more to keep him informed of the situation and to check on his welfare, especially as he spent long periods locked in his cell for long periods because of the COVID-19 restrictions. When Mr Witulski's family raised concerns in May about the effect Mr Witulski's continued detention was having on his mental health, staff failed to check on his welfare or make a referral to the mental health team.

We are also concerned that although Mr Witulski spoke very little English, staff rarely used interpretation services to communicate with him, and that some interactions with him were not documented in his prison record.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **March 2021**

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Summary

Events

1. On 23 January 2020, Mr Marek Witulski, a Polish national, was sentenced to eight months in prison for causing death by careless driving. He was sent to HMP Peterborough.

2. On 2 April, the Home Office served Mr Witulski with a deportation order. Mr Witulski waived his right of appeal and agreed to return to Poland. However, due to the COVID-19 pandemic, the Home Office was unable to arrange flights to Poland. Mr Witulski was due to be released from prison on 23 May (halfway through his sentence) but instead he continued to be detained at Peterborough under immigration powers pending his deportation to Poland.

3. On 22 May, Mr Witulski's son and the Polish Embassy contacted the prison with concerns about Mr Witulski's continued detention and the effect on his mental health. A safer custody manager told the Polish Embassy that prison staff would refer Mr Witulski to the mental health team. This did not happen.

4. Attempts were made to deport Mr Witulski to Poland on 1, 16, 20 and 25 June, but the flights were cancelled due to the COVID-19 pandemic. A further flight was booked for 5 July and Mr Witulski's family were expecting him to return home, but this flight was also cancelled.

5. At around 3.25pm on 6 July, Mr Witulski's cellmate returned from the exercise yard to find Mr Witulski unconscious in the cell. Mr Witulski had used a belt to strangle himself. Staff immediately called a medical emergency code and started cardiopulmonary resuscitation (CPR). Healthcare staff arrived shortly afterwards and took over resuscitation attempts until paramedics arrived at around 3.30pm. Paramedics took Mr Witulski to hospital, but he never regained consciousness and died on 9 July.

Findings

6. Mr Witulski was detained for around three months after he expected to be deported to Poland. During this time, he spent most of the day in his cell because of the COVID-19 restrictions, and his interactions with staff and other prisoners were further restricted because of his very poor English.

7. While we accept that the reasons for Mr Witulski's continued detention were outside the prison's control, we are very concerned that staff did not do more to communicate the reasons to him, to check on his welfare and to assess his risk to himself.

8. Staff failed to refer Mr Witulski for an assessment with the mental health team or to check on his welfare after his family and the Polish Embassy raised concerns about his wellbeing on 22 May.

9. There is no evidence that staff had any meaningful interaction with Mr Witulski after 3 March. Although we were told that the prison's foreign national co-ordinator spoke to him after his flight to Poland was cancelled on 20 June, there is no record of this in Mr Witulski's prison record (NOMIS).

10. We found that the prison's local operating procedure (LOP) on the use of translation services was unclear and there were times when prison and healthcare staff did not use appropriate methods to communicate with Mr Witulski. We consider that the LOP requires clarification.

Recommendations

- The Director should ensure that, where a prisoner's family expresses concerns about a prisoner's wellbeing, staff should take immediate action to:
    - assess the prisoners needs and make appropriate referrals, as necessary; and
    - clearly document the concerns and the agreed actions in the prisoner's NOMIS record.
- The Director should ensure that staff:
    - promptly inform foreign national prisoners of any delay to their expected release/deportation date;
    - carry out a face-to-face welfare check, using the services of an interpreter if necessary, to assess the prisoner's risk in the event of any delay to their expected release/deportation date; and
    - clearly document the discussion, risk assessment, and actions taken in the prisoner's NOMIS record.
- The Director should ensure that all relevant interactions with prisoners, including those with the foreign national coordinator, are accurately recorded in the prisoner's NOMIS record.
- The Director and Head of Healthcare should ensure that staff use approved interpretation services to communicate with non-English speaking prisoners when discussing confidential or complex matters.
- The Director should ensure that the prison's local operating procedure on translation services is revised to make it clear when approved interpretation services must be used and when it is appropriate to use staff or prisoners as unofficial interpreters.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact her.

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

13. NHS England commissioned an independent clinical reviewer to review Mr Witulski's clinical care at the prison. The investigator interviewed six members of staff in November 2020. Due to coronavirus restrictions, the interviews were conducted by telephone.

14. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Witulski's family (in Polish) to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They raised no issues.

16. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out some factual inaccuracies which have been amended in this report.

17. We sent a copy of our initial report (in Polish) to Mr Witulski's family. They did not identify any factual inaccuracies. They raised some queries which we responded to in separate correspondence.

Background Information

HMP/YOI Peterborough

18. HMP/YOI Peterborough is operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. There is 24-hour healthcare provision. All healthcare is provided by Sodexo under the provisions of their contract with the Ministry of Justice.

HM Inspectorate of Prisons

19. The most recent inspection of HMP/YOI Peterborough men's prison was in July 2018. Inspectors reported that levels of self-harm were slightly higher than comparator prisons. They noted that risks were identified well during the reception interview and that staff managed suicide and self-harm procedures appropriately. However, many prisoners felt unsafe and unsupported. Inspectors noted that records of conversations with prisoners did not always evidence meaningful engagement by staff.

20. At the time of the inspection, 101 foreign national prisoners were held. Inspectors noted these prisoners received a reasonable level of support compared to other diverse groups. However, inspectors noted that professional telephone interpreting services were not used consistently across the prison and, in particular, these services were lacking during the reception and induction process.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to March 2019, the IMB reported that the prison had put considerable effort into training staff and managing suicide and self-harm. They noted many examples where staff had successfully engaged with troubled residents, but they felt some documentation was lacking in detail. The Board noted that the foreign national team offered support to overseas prisoners within three days of arrival.

Previous deaths at HMP/YOI Peterborough

22. Mr Witulski was the fifth prisoner to die at Peterborough since July 2018. Of the previous deaths, one was self-inflicted and three were from natural causes. There are no similarities between our findings in the investigation into Mr Witulski's death and our investigation findings for the previous deaths.

Early Removal Scheme

23. The Criminal Justice Act 2003 introduced the Early Removal Scheme (ERS) for foreign national prisoners. The mandatory scheme allows fixed-term foreign national prisoners, who are confirmed by the Home Office to be liable to removal

from the UK, to be removed from prison and the UK up to a maximum of 270 days before the halfway point of their sentence.

Key Events

24. On 23 January 2020, Mr Marek Witulski, a Polish national, was sentenced to eight months in prison for causing death by careless driving. He was sent to HMP Peterborough. It was his first time in prison.

25. The Person Escort Record (PER - a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose) noted that Mr Witulski had a previous history of self-harm 'over a year ago'. It also said that Mr Witulski spoke very little English. When Mr Witulski arrived at Peterborough, the reception officer noted that there were no current concerns about suicide or self-harm.

26. The reception nurse used a telephone interpretation service during the reception screening. She noted that Mr Witulski had type 2 diabetes and high blood pressure and he had brought in his own medication. She noted that he had no current mental health concerns. The next day, a GP prescribed medication for diabetes and high blood pressure.

27. On 30 January, Mr Witulski had an unallocated key worker session (meaning that a permanent key worker had not yet been allocated to him). There is no record that an interpreter was used. The key worker noted that Mr Witulski said he would probably be released after two months and just wanted to do his time peacefully.

28. On 11 February, Mr Witulski had a healthcare screening. Staff asked another prisoner to act as interpreter.

29. On 18 February, Mr Witulski met with his allocated key worker. The key worker noted that he was unable to hold a full discussion as Mr Witulski could not speak English. He said that next time he would bring along someone who could speak Polish.

30. On 20 February, the Home Office served Mr Witulski with a notice of intention to deport him from the UK to Poland. Mr Witulski signed a disclaimer stating he did not wish to make any representations against his proposed deportation.

31. Mr Witulski's key worker met with Mr Witulski again on 23 February and 3 March. The key worker told the investigator that he used a Polish-speaking prisoner as an interpreter on both occasions. However, the notes of the key worker sessions indicate that the key worker had difficulties communicating with Mr Witulski and there is no mention of a Polish-speaking prisoner being present.

32. Mr Witulski's key worker recorded on 23 February that Mr Witulski expressed concern that no one had checked his blood sugar for his diabetes for "a long time", and on 3 March that he said his diabetes was getting bad as he was running out of medication. The key worker recorded that he took Mr Witulski to speak to the nurses and have his medication re-ordered, but there is no record of this in Mr Witulski's medical records.

33. Mr Witulski's key worker told the investigator that Mr Witulski was focused on returning to Poland and he did not want to engage with any work or activity in prison. He said he had no concerns about Mr Witulski. There were no key worker

sessions after 3 March. The key worker told the investigator that he was off work so was unable to hold further key worker sessions.

34. Mr Witulski was eligible for the Early Removal Scheme (ERS), meaning that he could be deported to Poland after serving only one quarter of his prison sentence. The prison's foreign national co-ordinator told the investigator that Mr Witulski was therefore eligible for deportation around the end of March. On 31 March, the Home Office issued a deportation order to be served on Mr Witulski.

35. On 2 April, the foreign national co-ordinator met with Mr Witulski and served the deportation order. He did not use an interpreter for the meeting, but he told the investigator he thought that Mr Witulski understood him. Mr Witulski waived his right of appeal and signed the paperwork to say he agreed to return to Poland.

36. However, due to the COVID-19 pandemic resulting in a national lockdown and border closures in several countries, Home Office staff were unable to arrange a flight to Poland for Mr Witulski. Records show significant communication between the foreign national co-ordinator and the Home Office attempting to arrange a flight for Mr Witulski. However, there is no record that prison staff told Mr Witulski about these difficulties.

37. On 22 May, Mr Witulski's son wrote to the prison asking why his father continued to be detained and expressing concerns about his mental health, saying Mr Witulski could "no longer withstand mentally". He said that Mr Witulski had expected to be released after eight weeks yet had remained in prison for more than four months. On the same day, the Polish Embassy sent an email to the safer custody team at the prison expressing similar concerns about Mr Witulski's mental health on behalf of his family.

38. On 26 May, a safer custody manager replied to the Polish Embassy by email. He wrote that wing staff said that Mr Witulski had no issues and that he had been expecting to be released on 22 May but was told he would be remaining in prison under immigration detention. He also wrote, "I have asked staff to raise a referral for Mr Witulski to see our mental health team".

39. The safer custody manager told the investigator that he had contacted wing staff to ask them to carry out a welfare check on Mr Witulski and, if necessary, to make a referral to the mental health team. We found no record of this. He said he believed it was the responsibility of the wing staff to carry out the welfare check and any follow up action. He could not say why the mental health referral was not made or why the information was not documented in Mr Witulski's prison record (NOMIS).

40. A Senior Prison Custody Officer (SPCO) said that he became aware some time after 26 May that the safer custody team had contacted the wing about Mr Witulski. He told the investigator that he was not directly involved in following up any action about Mr Witulski's welfare, but he thought other members of staff on the wing might have been. He said he did not know which members of staff were involved or what action had been taken. He said that he thought any follow up action should have been the responsibility of the safer custody team. There is nothing in Mr Witulski's prison record to show that any member of the wing staff had checked on his welfare.

41. Records show that attempts were made by the Home Office to fly Mr Witulski back to Poland on 1, 16, 20 and 25 June, but the flights were cancelled by the airline. The foreign national co-ordinator told the investigator that he went to speak to Mr Witulski after the flight was cancelled on 20 June. He said he was accompanied by a Polish-speaking member of staff as he wanted to explain to Mr Witulski why he had not yet returned to Poland. He said he thought that Mr Witulski understood the problem with the flights. He said that Mr Witulski took the news well and he had no concerns about him after they spoke. He did not make a note of this conversation in Mr Witulski's prison record.

42. Around 30 June, a Polish-speaking English tutor spoke to Mr Witulski while she was delivering work to other prisoners on the wing. She told the investigator that Mr Witulski said he was annoyed that his flights had been cancelled. She told him that it was probably due to the pandemic. She said Mr Witulski was angry and frustrated but that she had no concerns about him.

43. Records show that on 3 July (incorrectly dated 3 June), the foreign national co-ordinator replied to an email apparently received from Mr Witulski's son on 17 June. He apologised for the uncertainty and confusion. He said that Mr Witulski remained detained as the airline had cancelled a number of flights. He said that that flights had now resumed, and Mr Witulski was booked on a flight to Poland on 5 July, arriving in Warsaw at 9.45pm. Mr Witulski's family were therefore expecting him home. However, the flight was again cancelled by the airline, but we found no evidence that this message was communicated to Mr Witulski or his family. The foreign national co-ordinator told the investigator that he did not speak to Mr Witulski after 20 June.

44. At around 3.25pm on 6 July, Mr Witulski's cellmate returned from the exercise yard to find him unconscious in the cell. Mr Witulski had placed an upturned chair on the top bunk bed and attached a belt to the chair. He then placed the belt around his neck and knelt down, resulting in self-strangulation. Staff immediately removed the ligature from his neck and radioed a code blue (an emergency code which tells the control room that a prisoner is unresponsive or not breathing and that an ambulance needs to be called immediately). Healthcare staff arrived shortly afterwards and took over resuscitation attempts until paramedics arrived at around 3.30pm. Paramedics took Mr Witulski to hospital, but he did not regain consciousness and died there on 9 July.

Contact with Mr Witulski's family

45. At 5.50pm on 6 July, the prison appointed a family liaison officer. She contacted Mr Witulski's wife by phone to tell her that her husband had been taken to the hospital. A Polish-speaking prison officer was also present to act as an interpreter. Mr Witulski's family were with him at the hospital when he died on 9 July.

46. The Prison Service arranged the repatriation of Mr Witulski's body to Poland and contributed towards the cost of his funeral in line with national policy.

Support for prisoners and staff

47. After Mr Witulski's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

48. The prison posted notices informing other prisoners of Mr Witulski's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Witulski's death.

Post-mortem report

49. The post-mortem report concluded that the cause of death was asphyxia due to hanging. The toxicology report showed no presence of illicit drugs or alcohol in Mr Witulski's body.

Findings

Assessment of Mr Witulski's risk of suicide and self-harm

50. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, gives guidance to staff on how to identify, manage and support prisoners who are at risk of harm to themselves or others. It sets out the procedures (known as ACCT) that must be followed whenever staff assess that a prisoner is at risk of suicide or self-harm.

51. At the time of sentencing, Mr Witulski expected that he would be deported to Poland within two months under the Early Removal Scheme. He told staff this when he arrived at Peterborough and said he just wanted to do his time peacefully. Despite signing the necessary deportation paperwork at the end of March, he continued to be detained under immigration powers beyond his conditional release date of 23 May.

52. We have seen evidence that the Home Office repeatedly tried to book Mr Witulski on a flight to Poland and that their failure to do so was due to restrictions caused by the COVID-19 pandemic. We also accept that this was outside the prison's control.

53. However, we consider that Mr Witulski's continued detention is likely to have been a source of distress and frustration for him. Although the foreign national co-ordinator said Mr Witulski was always polite and appeared accepting of the situation, the English tutor (who spoke Polish) said he was angry and frustrated, and his son said the situation was affecting his mental wellbeing.

54. We are, therefore, very concerned that there is no evidence that anyone explained the reasons for the delay to Mr Witulski or considered what effect the situation might be having on his mental health. Indeed, there is no record that any member of staff had any meaningful interactions with Mr Witulski at all in the four months after his last key worker session on 3 March. Given Mr Witulski's circumstances – detained well beyond the date on which he expected to be released, locked up for in his cell for most of the day because of the COVID-19 restrictions, and isolated by his inability to speak English – we consider this was unacceptable.

55. We are particularly concerned that there is no record that anyone checked on Mr Witulski's wellbeing even after his family and the Polish Embassy contacted the prison directly in May to express concern. Although a safer custody manager told the Polish Embassy that Mr Witulski would be referred to the mental health team, this did not happen. Neither the safer custody team nor wing staff took responsibility for this failure. The safer custody manager said he expected the wing staff to take responsibility, and the SPCO said he saw this as the responsibility of the safer custody team. Neither recorded this at the time nor took any steps to ensure that someone was taking action. Mr Witulski appears to have fallen through the cracks as a result.

56. The foreign national co-ordinator told us that that he spoke to Mr Witulski about the delays on 20 June, but he made no record of this. We are very concerned that no one checked on Mr Witulski after his flight was cancelled on 5 July, despite knowing that his family were expecting him home.

57. We recommend:

The Director should ensure that staff:

- **promptly inform foreign national prisoners of any delay to their expected release/deportation date;**
- **carry out a face-to-face welfare check, using the services of an interpreter if necessary, to assess the prisoner's risk in the event of any delay to their expected release/deportation date; and**
- **document the discussion, risk assessment, and actions taken in the prisoner's NOMIS record.**

The Director should ensure that, where a prisoner's family express concerns about a prisoner's wellbeing, staff should take immediate action to:

- **assess the prisoners needs and make appropriate referrals, as necessary; and**
- **document the concerns and the agreed actions in the prisoner's NOMIS record.**

Record keeping

58. We found that some interactions staff said they had with Mr Witulski were not recorded in his prison record. In addition, those entries that were made did not always accurately reflect the interactions. For example, Mr Witulski's key worker said that he had two key worker sessions with Mr Witulski with a Polish-speaking prisoner as an interpreter, but he did not record this at the time (and instead recorded that it was difficult to have a discussion with Mr Witulski because of his poor English).

59. None of the interactions between Mr Witulski and the foreign national co-ordinator, or any other staff from the foreign national team, were recorded in his prison record. We recommend:

The Director should ensure that all relevant interactions with prisoners, including those with the foreign national coordinator, are accurately recorded in the prisoner's NOMIS record.

Interpretation services

60. The prison's local operating procedure (LOP) on translation services says that staff should use an approved telephone interpretation service to communicate effectively with non-English speaking prisoners. The LOP goes on to say, "*Where possible we will use both staff and other residents who have language skills to help us communicate with residents who do not speak English."*

61. However, the LOP makes it clear that for reasons of privacy and accuracy staff and other prisoners should not be used as interpreters for ACCT reviews, medical interviews or adjudications. An operational manager at the prison told the

investigator that staff are expected to use the interpretation service for key worker sessions, but this is not entirely clear from the LOP.

62. We found that healthcare staff used the approved interpretation service to complete Mr Witulski's healthcare reception screening. Otherwise, we found that a combination of staff and prisoners were used to translate conversations between Mr Witulski and members of staff, including for key worker sessions. This is unacceptable and we were particularly concerned to find that a healthcare assessment on 11 February was carried out with a Polish-speaking prisoner as an interpreter.

63. While we understand that there may be occasions when it might be appropriate to use staff or prisoners to interpret, we consider that guidance on the use of the official interpretation service requires clarity. We make the following recommendations:

The Director and Head of Healthcare should ensure that staff use approved interpretation services to communicate with non-English speaking prisoners when discussing confidential or complex matters.

The Director should review the prison's local operating procedure to ensure that staff are clear when approved interpretation services must be used and when it is appropriate to use staff or prisoners as unofficial interpreters.

Inquest

64. At the inquest, held from 29 September to 10 October 2025, the jury concluded that Mr Witulski died by suicide by hanging due to the failure of the combined authorities.

65. They found that, "Due to lack of communication between the Home Office and prison, and incorrect risk assessments, he was not offered the correct support. There was also insufficient relevant information given to the custody officers….After the COVID lockdown started and his official release date passed, neither he nor his family were informed of the possibility of applying for immigration bail by either the Home Office or prison….If all the information had been acted on, such as an ACCT being opened, a mental health referral being made and Mr Witulski and his family being kept adequately informed, the probability is he would have been released on bail and would not have self-harmed."

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