Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Waldemar Pniewski a prisoner at HMP Littlehey, on 27 January 2025

A report by the Prisons and Probation Ombudsman

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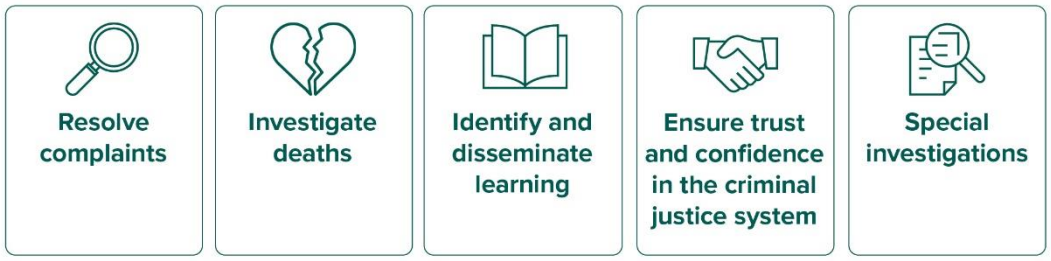
OUR VISION

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

1. 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.

2. 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.

3. On 13 May 2021, Mr Waldemar Pniewski was sentenced to 9 years in prison for sex offences. He died from metastatic squamous cell carcinoma of the lung (lung cancer which has spread to other parts of the body) on 27 January 2025, while a prisoner at HMP Littlehey. He was 56 years old. We offer our condolences to Mr Pniewski's family and friends.

4. The PPO family liaison officer wrote to Mr Pniewski's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

5. NHS England commissioned an independent clinical reviewer, to review Mr Pniewski's clinical care at HMP Littlehey. The clinical review is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Pniewski received at Littlehey was of a good standard and at least equivalent to that which he could have expected to receive in the community. She found that Mr Pniewski was accompanied by Polish speaking staff to hospital appointments, to translate. The clinical reviewer made one recommendation not related to Mr Pniewski's death that the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Pniewski's care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

10. At an inquest held on 30 September 2025, the Coroner concluded Mr Pniewski died of natural causes.

Adrian Usher **July 2025**
Prisons and Probation Ombudsman

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