

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marcin Szymanski a resident at Ozanam House Approved Premises on 3 September 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

My 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 Marcin Szymanski died of a hypoxic brain injury on 3 September 2015, after apparently trying to drown himself three days earlier, while he was a resident at Ozanam House Approved Premises, Newcastle upon Tyne. He was 28 years old. I offer my condolences to Mr Szymanski's family and friends.

Mr Szymanski had been released from prison on 13 August 2015, and had lived at Ozanam House Approved Premises since 21 August. Staff at Ozanam House had no concern that Mr Szymanski was at current risk of self-harm or suicide during his time there. He had started work, he appeared to have accepted that his relationship with his partner was over and he seemed to be planning for the future. I am satisfied that staff at Ozanam House could not have predicted Mr Szymanski's actions or prevented his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

April 2016

Contents

Summary	2
The Investigation Process	4
Background Information	5
Key Events	6
Findings.....	10

Summary

Events

1. On 13 August 2015, Mr Marcin Szymanski was released from HMP Durham after serving an 11-month sentence for breaching a non-molestation order. Before he went to prison, he had threatened to kill his ex-partner, his child, and himself.
2. Before his release, Mr Szymanski's offender manager (probation officer) had asked the police to check Mr Szymanski's planned release address, which he said was a friend's. Subsequent checks, on the day Mr Szymanski was released, established that the address was unsuitable. However, this was after Mr Szymanski had left the probation office. His offender manager therefore arranged for him to live at Ozanam House Approved Premises, Newcastle, from 21 August.
3. A worker at Ozanam House noted that Mr Szymanski was assessed as a high risk of harm to himself and others because of his previous threats to kill his partner, his son, and himself. As a result, they checked him more frequently than usual when he was in the approved premises, but there was little to indicate that Mr Szymanski was currently suicidal. Staff considered he seemed happy and settled; he got a job and was apparently planning for his future.
4. On 30 August, Mr Szymanski did not return to Ozanam House by his curfew time of 11.00pm. Probation staff began procedures to recall him to prison as this was a breach of his licence conditions and they informed the police. The police discovered that Mr Szymanski was in hospital in a critical condition, after he had walked into a lake in a local park, in an apparent suicide attempt. Mr Szymanski never recovered and died in hospital on 3 September.

Findings

5. Although probation staff had assessed Mr Szymanski as a high risk of harm because of threats he had allegedly made before his prison sentence, they did not consider he was at risk of suicide at the time he was living at Ozanam House. The staff saw nothing to indicate that he planned to kill himself and believed he had settled and was planning for the future. We do not consider that staff at Ozanam House could have foreseen or prevented Mr Szymanski's death.

The Investigation Process

6. The investigator issued notices to staff and residents at Ozanam House informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
7. The investigator visited Ozanam House on 1 October 2015, and collected Mr Szymanski's records. She interviewed a member of staff and obtained further information from Northumberland social services
8. We informed HM Coroner for Newcastle upon Tyne of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
9. One of the Ombudsman's family liaison officers contacted Mr Szymanski's next of kin, his brother and his sister-in-law, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They wanted to know more about the circumstances of Mr Szymanski's death and whether drugs were involved. They wondered whether Mr Szymanski was in debt and whether he had been bullied.
10. Mr Szymanski's brother and sister in law received a copy of the initial report. They pointed out some factual inaccuracies. This report has been amended accordingly.

Background Information

Ozanam House Approved Premises

11. Approved Premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.
12. Ozanam House is an Approved Premises near the centre of Newcastle upon Tyne. It helps to resettle prolific lower risk offenders as well as those who have committed more serious offences. Ozanam House has a manager, offender supervisors and support staff.
13. Each resident is allocated a key worker who acts as their primary point of contact and assists with practical issues. Regular key work sessions give residents the opportunity to discuss any difficulties and issues such as benefits, health, and future accommodation are routinely discussed. Residents at Ozanam House are all asked to register with a local GP. Approved Premises do not provide healthcare and a resident's medical treatment is a confidential matter between the resident and their doctor, as with anyone else living in the community.
14. Residents are required to abide by the rules and regulations of Ozanam House, including an overnight curfew. During the day, they are permitted to go out unaccompanied and there is no requirement to tell staff where they are going. Breakfast, an evening meal and supper is provided for all residents.
15. All new residents have an induction to Ozanam House when they arrive, which covers local house rules and their expected behaviour. Alcohol and illicit drug use is forbidden at Ozanam House.

Previous deaths at Ozanam House

16. Mr Szymanski's death was the seventh at Ozanam House since 2007. There were no significant similarities with the circumstances of the other deaths.

Key Events

17. Mr Marcin Szymanski was Polish and had lived in the United Kingdom for approximately 4 years. On 16 January 2015, a court imposed a non-molestation order after he assaulted his then partner. On 30 January, he appeared in court for breaching the order and was released on bail for a pre-sentence report. He did not attend a probation service appointment to prepare the report and, on 16 February, he was arrested and remanded to HMP Durham. A social worker reported that Mr Szymanski had threatened to kill his ex-partner and their child and then kill himself.
18. On 10 March, a probation officer who saw Mr Szymanski at Durham for the pre-sentence report assessed Mr Szymanski as a high risk of harm to his ex-partner and all children. She recorded that Mr Szymanski had been using amphetamines and cannabis before his arrest. On 29 July, he was convicted and sentenced to 11 months imprisonment. He was due to be released on 13 August, because of the time he had spent on remand.
19. Mr Szymanski's offender manager (probation officer) asked the police to check the address which Mr Szymanski had given as his proposed release address. An officer spoke to a man at the address, who said he was his friend and that Mr Szymanski could stay for one or two weeks if his partner agreed.
20. On 13 August, Mr Szymanski was released from prison and saw his probation officer at Blyth Probation Office. The probation officer explained his licence conditions, including that he should not contact his ex-partner and child or enter Berwick-upon-Tweed, where they lived. He had to live at an address agreed by his offender manager. Mr Szymanski did not speak or understand English well and the probation had not been able to arrange an interpreter because he had been given little notice that he would be supervising Mr Szymanski. The probation officer arranged an interpreter for the next meeting.
21. Mr Szymanski told the probation officer that he had arranged to stay with friends in North Shields for about a week but needed to check that this was still okay with them.
22. Mr Szymanski told the probation officer that he accepted that his relationship with his partner was over and that he understood his licence conditions. The probation officer asked Mr Szymanski to confirm his address as soon as possible, and they arranged to meet again on 21 August.
23. Later that day, after their meeting, the probation officer contacted Social Services in relation to Mr Szymanski's ex-partner and child. He gave the address where Mr Szymanski intended to stay. The social worker knew the address and the family and child who lived there. The social worker told him that it was not a suitable address for Mr Szymanski because of the risks he posed to children. The next day, the probation officer established through social services that Mr Szymanski had not stayed at the address he had given in any case. This meant that Mr Szymanski was in breach of his licence conditions and the probation officer prepared a report about this. He was unable to speak to Mr Szymanski, as he did not have a telephone number for him.

24. The probation officer was next due to meet Mr Szymanski on 21 August and he arranged for him to live at Ozanam House from that date. On 21 August, Mr Szymanski telephoned the probation officer and said that he could not attend his appointment as he had a job interview. Mr Szymanski maintained that he had stayed with his friends, as arranged. The probation officer, using an interpreter, told Mr Szymanski that he had arranged for him to stay at Ozanam House, because the address he had given was unsuitable. Mr Szymanski said that he would go to Ozanam House that afternoon.
25. At 2.30pm that afternoon, Mr Szymanski had an induction meeting at Ozanam House with a residential support worker, who used an interpreter. Mr Szymanski told her that he had had thoughts about suicide while he was in prison but had no current thoughts of harming himself. He said that he accepted that his relationship with his ex-partner was over and he would not go to Berwick-upon-Tweed, as the judge had warned him that he would go back to prison if he did.
26. The resident support worker assessed Mr Szymanski as a high risk of harm to himself, his ex-partner, his son and other children or partners (and, as a result, he was subsequently checked more frequently than usual when he was in the approved premises). She said that the induction process took longer than usual, as she was using an interpreter. She therefore planned to have a separate session to talk about drug and alcohol awareness. She explained his licence conditions again and Mr Szymanski signed to say that he understood the conditions of his licence and the rules at Ozanam House.
27. Mr Szymanski had received sertraline for depression when he was in prison until 29 July, but does not appear to have been prescribed it at the time of his release on 13 August. He had a prescription from before he went to prison. He said he wanted medication again but had not been to a chemist because he did not have any money to pay for it. A member of staff tried to use the previous prescription for Mr Szymanski but, as it was out of date, the pharmacist would not issue the medication. The residential support worker explained that he needed to register with a local GP as soon as possible and that Ozanam House staff would pay for and collect his prescription, which he could pay back later. It does not appear that Mr Szymanski ever received any medication while he was at Ozanam House.
28. On 25 August, the probation officer met Mr Szymanski, at Ozanam House, with an interpreter. They went through his licence conditions and the probation officer explained why he could not live at the address he had originally given. Mr Szymanski maintained that he had stayed at this address between 13 and 20 August.
29. Later on 25 August, a probation service officer, had a meeting with Mr Szymanski's at Ozanam House. The probation service officer did not use an interpreter and noted that Mr Szymanski found it difficult to understand some of the issues they discussed. They agreed that Mr Szymanski's brother would pick up his property from his ex-partner's house. They also arranged a GP appointment for him. However, Mr Szymanski's brother later told us that he did not know anything about these arrangements and had not attended.
30. On 25 August, Mr Szymanski was offered a trial for a job at a local crab factory, which would require him to leave the premises at 5.40am, earlier than his normal

curfew hours of 11.00pm to 7.00am allowed. The probation officer agreed this in principle, but asked Mr Szymanski to obtain some proof of employment. They agreed that Mr Szymanski should apply for Jobseekers Allowance in case the trial did not work out. Mr Szymanski did not leave Ozanam House that evening.

31. On 26 August, Mr Szymanski went to the work trial. When he got back, he said that he had been offered a job, to start on 28 August. He said that he would be paid in cash.
32. On 28 August, the probation officer spoke to a housing officer about arranging an appointment in person for Mr Szymanski. There were no personal appointments available for the next two weeks, but the housing officer said that they would arrange an interpreter to help if Mr Szymanski telephoned them on 1 September.
33. On 28 August, Mr Szymanski went to work, but finished early that day. That evening, he went out to a shop with a friend around 10.00pm and returned at 10.35pm. When he got back, he said he was fine.
34. At 12.53pm on 30 August, Mr Szymanski signed out of Ozanam House and said he was going for a walk. At 11.00pm, he had not come back, which meant he was in breach of his licence conditions and liable to be recalled to prison. The night officer informed the police and began initial procedures for possible recall. Shortly afterwards, the police left a telephone message saying that Mr Szymanski was in hospital. The night officer contacted the hospital, and was told that it was unlikely that Mr Szymanski would leave hospital in the next 24 hours.
35. The next day, 31 August, the probation service officer telephoned the hospital but could not get further information about Mr Szymanski, without verification of his identity. He contacted the police and an officer told him that witnesses had seen Mr Szymanski leave his belongings in a pile and then walk into the lake in Leazes Park, Newcastle. Paramedics had rescued him and taken him to hospital, but he was in a critical condition. Hospital staff had contacted Mr Szymanski's mother in Poland, who planned to fly to England in the next few days. The police informed Mr Szymanski's ex-partner.
36. On 1 September, the probation service officer learnt from the hospital that Mr Szymanski was in a coma and was still in a critical condition. A doctor planned to carry out a brain scan when possible, and was unsure of his prognosis.
37. Mr Szymanski never recovered and died at the hospital on the evening of 3 September.

Contact with Mr Szymanski's family

38. Mr Szymanski's close family, including his brother, who he had named as his next of kin, were in Poland at the time of his death. Hospital staff and the police notified them of his death.
39. The manager at Ozanam House, spoke to Mr Szymanski's ex-partner to offer his condolences and asked if she wanted to visit Ozanam House. Mr Szymanski's mother came to England and she and his ex-partner made the funeral arrangements, which the Probation Service agreed to contribute to, in line with national instructions.

40. On 14 September, Mr Szymanski's mother and his ex-partner visited Ozanam House and spent some time in Mr Szymanski's room and collected his belongings. The manager at Ozanam House, using an interpreter, told them about Mr Szymanski's time at Ozanam House. At his mother's request, manager arranged for Mr Szymanski to be cremated quickly so she could take his ashes back to Poland.

Support for prisoners and staff

41. After Mr Szymanski died, the manager at Ozanam House held a house meeting with other residents to inform them about the death and offer support. Probation managers and he also held a meeting with Ozanam House staff and offered them support.

Post-mortem report

42. A post-mortem examination found that Mr Szymanski died of hypoxic brain injury due to drowning. A toxicology report, dated 16 October 2015, found that the only drug in Mr Szymanski's body was lignocaine, which was administered by paramedics as part of emergency treatment.

Findings

Assessment of risk of suicide and self-harm

43. Based on information from his pre-sentence report, staff at Ozanam House originally considered that Mr Szymanski was at high risk of harm to himself and others as, before he went to prison, he had allegedly threatened that he would kill his partner, his son, and then himself. They checked him more frequently than usual when he was in the approved premises but no one saw any signs that he intended to harm himself.
44. While Mr Szymanski was at Ozanam House, staff did not identify any signs that he was depressed, anxious, or suicidal. There is no evidence that he was in debt, being bullied or had taken any drugs. He appeared to be looking to the future, had got a job, and was looking for settled accommodation. He seemed to have accepted that his relationship with his ex-partner was over and that he was not allowed to see his child. Staff arranged an appointment for Mr Szymanski to see a doctor, although we do not know whether he attended the appointment, as community healthcare records are confidential and outside the scope of this investigation.
45. We are satisfied that staff at Ozanam House considered his risk appropriately but could not have foreseen or prevented his actions.

**Prisons &
Probation**

Ombudsman
Independent Investigations