Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lukasz Lukasik, a prisoner at HMP Hull, on 27 May 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

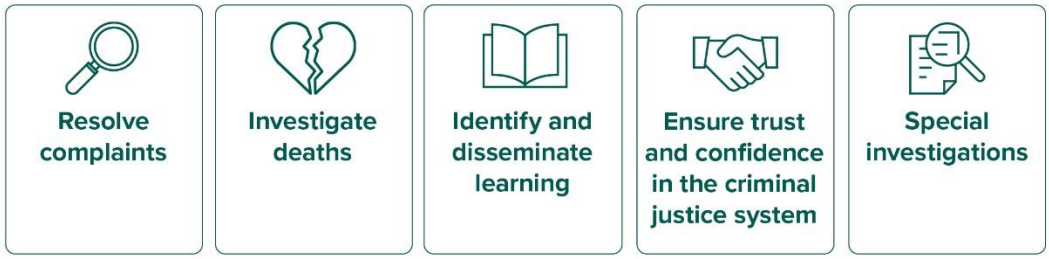
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 Lukasz Lukasik was found hanged in his cell on 21 May 2021 at HMP Hull. He was 36 years old. I offer my condolences to Mr Lukasik's family and friends.

On 14 May 2021, Mr Lukasik attended court by video link and changed his plea to guilty. Prison and healthcare staff were unaware of the change in his circumstances and our investigation found that Hull did not have a standard procedure for assessing whether there had been a change in risk for prisoners after attending video link court hearings.

Prison staff initially completed regular welfare checks and there was little to indicate to staff that he was at imminent risk of suicide.

There was a fourteen-minute delay between staff being unable to see Mr Lukasik in his cell and returning to check on him again. An emergency code was not called for a further seven minutes. Although this did not affect the outcome for Mr Lukasik as he had been dead for some time, it could make a critical difference in future medical emergencies.

The clinical reviewer concluded that the clinical and mental healthcare Mr Lukasik received at Hull was not equivalent to that which he could have expected to receive in the community.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2022**

Contents

Summary

Events

1. On 4 January 2021, Mr Lukasz Lukasik was remanded into prison custody charged with murder and sent to HMP Hull. Mr Lukasik was a Polish national who had lived in the United Kingdom for seventeen years. While he was in police custody, Mr Lukasik dislocated his left shoulder.

2. Mr Lukasik did not disclose any thoughts of suicide or self-harm at Hull and he was not managed under the Prison Service suicide and self-harm prevention procedures (known as ACCT). On 6 January, he was discharged from the prison's mental health service.

3. On 14 May, Mr Lukasik attended court by video link. During the hearing, he changed his plea to guilty. Prison and healthcare staff were unaware of Mr Lukasik's change of circumstances and his risk of suicide and self-harm was not assessed.

4. At around 4.52am, on 27 May, an operational support grade (OSG) conducting a roll check found Mr Lukasik hanging in his cell. The OSG radioed a medical emergency code. Prison staff started cardiopulmonary resuscitation (CPR). Healthcare responded but did not continue with CPR as it was clear Mr Lukasik was dead. Paramedics attended and at 5.32am confirmed that he had died.

Findings

5. Mr Lukasik had some risk factors for suicide and self-harm. However, he appeared to have settled well into prison and interacted well with other Polish prisoners. We are satisfied that in the days and weeks leading to his death, there was nothing to indicate that he was at increased risk of suicide and self-harm.

6. We are concerned that there is no evidence prison staff had any meaningful interaction with Mr Lukasik after he attended court by video link. There is nothing in his prison record about the hearing and staff were unaware that he had changed his plea.

7. We found that prison staff initially completed welfare checks but nobody saw Mr Lukasik for three weeks which covered the time that there was a change in his circumstances. This was a missed opportunity to provide additional support to him and to assess his risk of suicide and self-harm.

8. The OSG who completed the roll check did not return to Mr Lukasik's cell for 14 minutes despite the fact she could not locate him in his cell. The OSG did not call an emergency code for a further seven minutes after she found Mr Lukasik hanging and there was a further delay of seven minutes before the prison nurse arrived.

9. The clinical reviewer concluded that the clinical and mental healthcare Mr Lukasik received at Hull was not equivalent to that which he could have expected to receive in the community.

10. Mr Lukasik arrived at the prison with a dislocated shoulder and healthcare staff did not appropriately assess his clinical management plan for several weeks. The mental health nurse who assessed Mr Lukasik did not consider the outcome of a mental health assessment that took place while he was in police custody.

Recommendations

- The Governor and Head of Healthcare should ensure that following a court appearance by video link:
    - the prisoner's NOMIS record is updated with details of the hearing and the outcome; and
    - staff should speak to the prisoner and consider whether the risk to themselves has changed.
- The Governor should ensure that during a restricted regime, key work is delivered in line with the Exceptional Delivery Model.
- The Head of Healthcare should ensure that mental health staff consider the results of previous mental health assessments when completing the initial mental health assessment.
- The Head of Healthcare should ensure that healthcare staff review the clinical management plans of newly arrived prisoners promptly.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
    - night staff enter cells as quickly as possible in a life-threatening situation; and
    - night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.
- The Governor should ensure that this report is shared with staff mentioned in the report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

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

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

13. NHS England and Improvement commissioned a review of Mr Lukasik's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by video link because of the restrictions in place during the COVID-19 pandemic.

14. We informed HM Coroner for Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. We wrote to Mr Lukasik's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Hull

17. HMP Hull is a local prison that holds up to 1,056 men. City Healthcare Partnership provides health services. J wing is for vulnerable prisoners (those who are separated from the main population, usually because of the type of offence they have committed) and holds up to 130 men.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Hull was in July 2021. Inspectors reported that leaders had focused strongly on identification of risk in the early days in custody. Reception staff had learned to enter into sufficiently detailed conversation with the arriving prisoner to pick up signs of distress or risk of self-harm.

19. Inspectors found that interactions between officers and prisoners were generally helpful and courteous, and it was evident that the relatively stable and experienced staff group had sound knowledge of prisoners in their care. However, inspectors also noted that on some wings, staff remained remote and disengaged.

Independent Monitoring Board

20. 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 28 February 2021, the IMB reported that prisoners at risk of self-harm were carefully monitored.

21. The positive support provided by key workers was not always available to defuse some of the situations in the prison and this had made it more difficult for some prisoners to cope.

Previous deaths at HMP Hull

22. Mr Lukasik was the fourteenth prisoner to die at Hull since May 2019. Of the previous deaths, six were self-inflicted, six were from natural causes and one was drugs related.

23. In a previous investigation into the death of a prisoner at HMP Hull in November 2019, we made recommendations about the response of prison staff during medical emergencies. The Prison Service accepted our recommendation and issued an action plan which said that Hull had reviewed the staff induction programme to include medical emergency codes so that all staff received instructions on how to respond to medical emergencies. In April 2020, the prison issued a staff notice to remind staff of their responsibilities during medical emergencies. It is disappointing that we are having to raise this issue again in this report.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

26. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011, Management of prisoners at risk of harm, to self and from others (Safer Custody).

Key Events

27. On 4 January 2021, Mr Lukasz Lukasik was remanded to HMP Hull charged with murder. He had been in prison before. Mr Lukasik was a Polish national who had lived in the United Kingdom for seventeen years.

28. A prison officer completed Mr Lukasik's first night induction. The officer noted that Mr Lukasik did not have any thoughts of suicide or self-harm. Prison staff completed a cell sharing risk assessment (CRSA), which recorded that Mr Lukasik was a high risk for sharing a cell. In line with COVID-19 restrictions, Mr Lukasik was placed in isolation for fourteen days and allocated a single cell on G wing. Mr Lukasik was not allocated a keyworker due to the COVID-19 restrictions.

29. A nurse completed Mr Lukasik's initial health screen. She noted that Mr Lukasik was a Polish speaker with good English. Mr Lukasik had a history of substance misuse from 2018. He was treated for a dislocated left shoulder while he was in police custody and asked the nurse for pain relief. Mr Lukasik did not have any other physical health problems and was not taking medication. The nurse noted that he was not at risk of suicide or self-harm. Mr Lukasik said he was aware that he was facing a long prison sentence and did not regret his offence. Prison GPs prescribed pain relief medication for his dislocated shoulder and he was advised to wear a sling.

30. On 5 January, a social worker in the Mental Health Liaison and Diversion Services (a service to improve the health and justice outcomes for adults who come into contact with the criminal justice system where a range of complex needs are identified as factors in their offending behaviour) contacted healthcare staff to discuss how Mr Lukasik presented while he was in police custody. An assessment under the Mental Health Act 1983 concluded that Mr Lukasik displayed some evidence of mental illness and drug-induced psychosis, but he was not considered suitable for hospital detention. Mr Lukasik was calm and polite with no evidence of delusional thinking. There was no evidence that he was known to mental health services and that he required further assessment in prison.

31. The same day, a nurse completed a secondary health assessment. Mr Lukasik told the nurse that he had post-traumatic stress disorder (PTSD) caused by a history of physical abuse from his father. The nurse made a referral to the prison's mental health team.

32. The next day, a mental health nurse saw Mr Lukasik. She noted that he had fleeting thoughts of suicide but did not intend to harm himself. He said that he felt anxious when he first came to prison and he was assessed as having a moderate level of anxiety and depression. The mental health nurse told the investigator that Mr Lukasik's moderate anxiety and depression was mitigated by what he said about his plans to help himself. Mr Lukasik said he intended to get a job and gain IT qualifications. She had no concerns about Mr Lukasik's mental health and he was discharged from the mental health service.

33. Prison staff completed welfare checks on the wing. Mr Lukasik did not have any issues or concerns and told staff that he had made friends with other Polish

prisoners. Mr Lukasik said that he felt settled on the wing but he was still experiencing pain in his shoulder which prevented him from applying for a job.

34. On 8 March, Mr Lukasik had an x-ray of his left shoulder. The results showed a possible rotator cuff tear. An orthopaedic specialist at Hull Royal Infirmary advised an ultrasound scan and that a GP should complete an urgent review of the x-ray results. A prison GP reviewed the x-ray results on 13 April and noted that Mr Lukasik needed an ultrasound scan. This took place on 7 May.

14 May to 20 May

35. On 14 May, Mr Lukasik attended Leeds Crown Court by video link. The time of his court appearance is not recorded. During the hearing, Mr Lukasik changed his plea from not guilty to guilty. The Judge made a 'Judge's Remand Order' which remanded Mr Lukasik for sentencing rather than a trial. There is nothing about his court appearance or the outcome recorded on either Mr Lukasik's prison record or the wing observation book. Mr Gary Sword, the Head of Residence and Safety, told the investigator that the remand order was sent to HMP Leeds in error by the court which meant that Hull staff were unaware of the change in Mr Lukasik's circumstances.

36. An officer escorted Mr Lukasik during his court appearance. The officer told the investigator that he was not aware Mr Lukasik had changed his plea. After the court proceedings had ended, the officer returned Mr Lukasik to the wing. He told the investigator he was not aware that a change of circumstances should be recorded or that he should be seen by healthcare staff.

37. On 18 May, a prison GP told Mr Lukasik that the scan results showed a rotator cuff tear and he made a referral to an orthopaedic specialist.

38. At approximately 2.30pm on 20 May, a prison officer saw Mr Lukasik for a welfare check. Mr Lukasik was happy to engage in conversation and did not raise any issues or concerns. Mr Lukasik said that he kept in contact with a friend in the community. There was nothing to suggest that he was in crisis.

39. At approximately 7.30pm on 26 May, an OSG completed a roll check. The OSG told the investigator that she saw Mr Lukasik in his cell.

Events of 27 May

40. CCTV shows the OSG went to Mr Lukasik's cell at 4.52am. They told the investigator that they did not see Mr Lukasik in his cell. The OSG said they assumed that the cell was empty and went to the wing office to check if a prisoner was supposed to be in there.

41. The OSG returned to Mr Lukasik's cell at 5.06am. They used her torch to see into the cell and saw Mr Lukasik hanging from the toilet door.

42. CCTV shows that the OSG put their hand on their radio at 5.08am (we assume she was radioing for assistance) and remained outside of Mr Lukasik's cell. Shortly after, an officer arrived at Mr Lukasik's cell. Two officers entered Mr Lukasik's cell at 5.09am. One officer used their fish knife to remove the ligature. They started CPR, assisted by another officer. At 5.13am, the OSG radioed an emergency code

blue (indicating a prisoner is unconscious or having breathing difficulties). The control room immediately called an ambulance.

43. At 5.20am, a nurse arrived at Mr Lukasik's cell. The nurse did not continue CPR as it was evident Mr Lukasik was already dead. The nurse said that Mr Lukasik's tongue was swollen and purple and rigor mortis was evident, all signs that Mr Lukasik had been dead for some time. The paramedics arrived at 5.20am and at 5.32am, and confirmed that Mr Lukasik had died.

Contact with Mr Lukasik's family

44. The prison appointed a Family Liaison Officer (FLO) and identified Mr Lukasik's friend as his next of kin. As Mr Lukasik's friend was no longer living at the address recorded on Mr Lukasik's prison record, the prison asked for assistance from the police. The police visited Mr Lukasik's friend at approximately 12pm on 27 May and broke the news of his death.

45. The same day, the police visited Mr Lukasik's mother at her home and broke the news of his death. The family liaison officer contacted Mr Lukasik's mother and offered support.

46. The prison contributed towards the cost of Mr Lukasik's funeral in line with Prison Service guidance.

Support for prisoners and staff

47. After Mr Lukasik's death, a 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 Lukasik'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 Lukasik's death.

Post-mortem report

49. A postmortem concluded the cause of death as hanging.

Inquest

50. An inquest on 4 December 2023 concluded Mr Lukasik's death as suicide.

Findings

Assessment of risk

51. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at HMP Hull should have recognised Mr Lukasik as at risk and started ACCT procedures.

52. Mr Lukasik had some risk factors for suicide and self-harm. He was charged with the murder of his father and faced a life sentence if found guilty. Mr Lukasik also changed his plea to guilty thirteen days before his death.

53. No one who met Mr Lukasik in the weeks before his death considered that he was at increased risk, and staff described his death as unexpected. The prison officer who completed a welfare check the week before Mr Lukasik's death described him as happy to engage in conversation and noted that his only concern was related to his shoulder injury. Both prison and healthcare staff were unaware that Mr Lukasik had changed his plea and without this knowledge, we are satisfied that it was reasonable for staff to have concluded that Mr Lukasik did not pose a risk of suicide or self-harm, which warranted ACCT monitoring, in the weeks leading to his death.

Court appearance

54. PSI 07/2015, Early days in custody, says that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video link. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, says that prisons must have procedures in place so that prisoners who have attended court by video link who request help, or who are identified as needing help, from healthcare staff, are told how to access it and are able to receive it in an appropriate timeframe.

55. There was no evidence that Mr Lukasik was assessed by healthcare staff following his video link appearance on 14 May 2021 and they were unaware of this significant change in his circumstances. There appeared to be no standard procedure at Hull for prison staff to assess whether a prisoner's status or demeanour had changed or whether they might need to see healthcare staff after a video link court appearance. There was nothing noted in Mr Lukasik's prison or clinical record about the hearing on 14 May or the outcome.

56. In March 2021 the Director General of HMPPS wrote to all Governors and Directors requiring them to review local processes to ensure that, in line with the expectations of PSI 07/2015 and PSO 3050, similar health screening arrangements and the same processes for assessing risk of self-harm or suicide are followed after video link appearances as on reception following a physical appearance in court.

57. In September 2021, four months after Mr Lukasik's death, Hull introduced a procedure to ensure that any change in a prisoner's circumstances is either

recorded in the change of circumstances log in reception or, for prisoners attending court by video link, the video court log. When prisoners are returned to the wing, any change in circumstances should be documented in the observation book and recorded in the prisoner's record. Night staff should carry out two additional welfare checks on prisoners with a change of circumstances which should be recorded in the prisoner's record. Reception staff should provide a copy of both logs to the night orderly officer to ensure the welfare checks are documented.

58. The procedure also states that a prison officer will be present during a video link court appearance. Any prisoner with a change of circumstances should be taken back through the reception process to ensure they are seen by healthcare staff and any change in risk is identified. We consider the staff missed the opportunity to assess Mr Lukasik's risk of suicide and self-harm.

59. An increasing number of prisoners are being sentenced by video link, especially since the COVID-19 pandemic. As they do not leave the prison, they are not subject to the standard screening procedures that they would have had when returning to the prison and passing through reception. We acknowledge the significant difficulties Hull faced due to the COVID-19 pandemic, and that Hull have already reviewed and revised processes for identifying those men who may be at increased risk. However, these new protocols need to be implemented and understood by all those involved in the process, in particular by prison staff who escort prisoners to video link court hearings. We recommend:

- The Governor and Head of Healthcare should ensure that following a court appearance by video link:
- the prisoner's NOMIS record is updated with details of the hearing and the outcome; and
- staff should speak to the prisoner and consider whether the risk to themselves has changed.

Key work scheme

60. Key work was formally suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. On 12 May, the Prison Service issued an Exceptional Delivery Model (EDM) for key work which set out the priority prisoner groups for who it was recommended that key work should continue. The priority groups included prisoners at risk of suicide or self-harm and prisoners who had been advised to shield because they had been assessed as clinically extremely vulnerable to COVID-19.

61. We acknowledge the significant pressures faced at Hull around the time of Mr Lukasik's death because of reduced staff numbers and the impact of the COVID-19 restrictions. We are satisfied that staff initially completed regular welfare checks with Mr Lukasik and made reasonably detailed records of their conversations. Mr Lukasik made friends with other Polish prisoners and he appeared settled on the wing. However, staff did not complete a welfare check for three weeks in May 2021 and no check took place around the time when Mr Lukasik changed his plea to guilty. At this point, Mr Lukasik was at an increased risk of suicide and self-harm. Although we recognise that welfare checks may have happened without being

recorded, we would have expected any meaningful contacts to have been recorded if they took place. We recommend:

- The Governor should ensure that during a restricted regime, key work is delivered in line with the Exceptional Delivery Model.

Emergency response

62. At night, officers have a key in a sealed pouch for use in an emergency. PSI24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

63. The OSG saw Mr Lukasik in his cell at 7.30pm on 26 May. When they returned to his cell at 4.52am the next morning, they could not see Mr Lukasik and returned to the wing office to check if the cell occupancy details were correct.

64. CCTV shows there was a delay of fourteen minutes before the OSG returned to Mr Lukasik's cell and found him hanging. We do not criticise the OSG for not entering Mr Lukasik's cell immediately and alone when they were unable to get a response from him. However, we consider that they should have acted with more urgency to summon assistance by using their radio when they could not see him in his cell, rather than returning to the wing office. In these circumstances, we consider that staff should assume the worst and act with urgency. The OSG did not call an emergency code for a further seven minutes after they found Mr Lukasik hanging and there was a further delay of seven minutes before the prison nurse arrived, a total delay of 28 minutes. We cannot say that the delay affected the outcome for Mr Lukasik. We note that the prison nurse did not start CPR because it was clear that Mr Lukasik had been dead for some time. However, early intervention is crucial in improving the outcome in cases of hanging. We make the following recommendation:

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
    - night staff enter cells as quickly as possible in a life-threatening situation; and
    - night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.

Learning lessons

65. We consider that it is important for staff who were involved in Mr Lukasik's care to see the findings of, and learn lessons from, our investigation. We make the following recommendation:

66. The Governor should ensure that this report is shared with staff and that a senior manager discusses the Ombudsman's findings with them.

Mental and clinical healthcare

67. The clinical reviewer concluded that Mr Lukasik's mental and clinical healthcare was not equivalent to that which he could have expected to receive in the community.

68. They found that Mr Lukasik was appropriately assessed by the mental health team. The mental health nurse noted that Mr Lukasik did not disclose a history of mental health problems and she assessed his risk of suicide and self-harm. However, they did not review the assessment completed by the Mental Health Liaison and Diversion Services (in police custody) which concluded that Mr Lukasik had displayed some evidence of mental illness and drug-induced psychosis which required further assessment in prison. We recommend:

    - The Head of Healthcare should ensure that mental health staff consider the results of previous mental health assessments when completing the initial mental health assessment.

69. The clinical reviewer was concerned that Mr Lukasik did not receive an initial clinical follow-up for his dislocated shoulder when he arrived at Hull. Mr Lukasik's shoulder was not x-rayed until several weeks after he arrived at Hull when he continued to complain that he was in pain. A GP did not review the x-ray results for a further five weeks. We recommend:

    - The Head of Healthcare should ensure that healthcare staff review the clinical management plans of newly arrived prisoners promptly.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100