Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sebastian Mularz, a prisoner at HMP Hull, on 17 August 2022

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 l 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.

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 Sebastian Mularz was found dead in his cell at HMP Hull on 17 August 2022. Mr Mularz had been in prison for only five days when he died. The post-mortem examination was unable to establish the cause of Mr Mularz's death, but the pathologist concluded that it was from natural causes, possibly due to a brain abnormality that led to a seizure. Mr Mularz was 38 years old. I offer my condolences to Mr Mularz's family and friends.

The clinical reviewer found that the health care Mr Mularz received at Hull was equivalent to that which he could have expected to receive in the community. However, she was concerned that staff did not correctly monitor Mr Mularz's high blood pressure.

Mr Mularz had been dead for at least two hours when he was found at 6.15am on 17 August. I am concerned that staff did not identify that Mr Mularz was dead when he was checked around 45 minutes before. The officer who checked on him spent four minutes looking into the cell and tapped on the door to try to get a response, but then thought he saw Mr Mularz breathing so moved on. We consider that, given his concerns, the officer should have continued to try to get a response from Mr Mularz, and either gone into the cell or called for assistance when Mr Mularz failed to respond.

There were some delays with the emergency response. Staff delayed going into Mr Mularz's cell when they realised he was unresponsive and then failed to pass relevant information to the control room, which led to a delay in despatching the ambulance. Although it made no difference to the outcome for Mr Mularz as he was dead when found, such delays could be critical in a future emergency.

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

Susannah Eagle
Deputy Prisons and Probation Ombudsman **October 2023**

Contents

Summary

Events

1. On 13 August 2022, Mr Sebastian Mularz was remanded in prison custody, charged with assault, and sent to HMP Hull. It was not his first time in prison.

2. A nurse completed Mr Mularz's reception health screen at Hull. Other than high blood pressure, there were no other concerns about Mr Mularz's physical or mental health.

3. On 14 and 15 August, healthcare staff again took Mr Mularz's blood pressure. On both occasions his blood pressure was high.

4. During the night of 15 August, Mr Mularz repeatedly rang his cell bell. Mr Mularz's cellmate told the investigator that Mr Mularz had been acting strangely, including that he had tried to get out of the cell because he said he wanted to catch a bus.

5. On the morning of 16 August, staff moved Mr Mularz to a single occupancy cell and referred him to the mental health team.

6. Later that morning, a healthcare assistant took Mr Mularz's blood pressure. When she found his blood pressure was still high, she passed the result onto a nurse for review.

7. That afternoon, a mental health nurse visited Mr Mularz but identified no concerns.

8. That evening, Mr Mularz's strange behaviour continued and after he did not comply with staff orders to leave the exercise yard, officers physically escorted him back to his cell. A nurse visited Mr Mularz to check on him and found him standing on his desk and talking to himself. She again referred him to the mental health team.

9. During the night, Mr Mularz rang his cell bell. The officer who attended said that Mr Mularz was sweating profusely and talking to the corner of the room but would not talk to him.

10. At 5.34am on 17 August, during a routine check, an officer spent four minutes looking into Mr Mularz's cell. The cell light was on, and Mr Mularz was lying on his bed. The officer told the investigator that he looked to check if there was a ligature around Mr Mularz's neck, tapped the cell door and tried to speak with him, but Mr Mularz did not respond. The officer then thought he could see Mr Mularz's chest moving and so concluded that Mr Mularz was asleep.

11. At around 6.15am, during the morning roll check, an officer found Mr Mularz lying on his bed in an unusual position. When the officer could not get a response from Mr Mularz, he called a medical emergency code. When staff entered the cell, they found that Mr Mularz was cold, stiff and his lips were blue. Nevertheless, they started CPR. When paramedics arrived, they confirmed that Mr Mularz had died.

12. The toxicology report found no evidence of illicit substances in Mr Mularz's blood. The post-mortem examination was unable to establish Mr Mularz's cause of death.

However, the pathologist was satisfied that Mr Mularz died from natural causes and said it was possible that an abnormality in Mr Mularz's brain had led to a seizure.

Findings

13. The clinical reviewer found that the clinical care Mr Mularz received at Hull was equivalent to that which he could have expected to receive in the community. However, she was concerned that on 14 August, when Mr Mularz's blood pressure reading was high, healthcare staff did not take a second blood pressure reading in accordance with National Institute for Health and Care Excellence (NICE) guidelines.

14. There was a delay in entering Mr Mularz's cell when he was found unresponsive. The officer who found Mr Mularz told the investigator that staff were not allowed to enter cells alone while the prison was in night state. This is incorrect, as staff can enter a cell alone at night when there is an immediate threat to life if it is safe to do so.

15. When staff called the medical emergency code, they did not pass relevant information about Mr Mularz's condition to the control room, which resulted in a delay in an ambulance being despatched. This made no difference to the outcome for Mr Mularz as he was dead when found but could be critical in a future medical emergency.

16. We are concerned that staff did not identify that Mr Mularz was dead during the roll check at 5.34am. We acknowledge that the officer spent some time checking on Mr Mularz (far longer than expected for a standard roll check) and that he moved on when he thought he saw Mr Mularz breathing. However, Mr Mularz was dead at that time. We consider that the officer should have continued to try to get a response from Mr Mularz, and either gone into the cell or called for assistance when Mr Mularz failed to respond.

17. We are concerned that there was no CCTV footage available of the exercise yard so we could not review the events that led to Mr Mularz being physically escorted back to his cell on 16 August. The prison said there was a technical issue with the CCTV system.

Recommendations

- The Head of Healthcare should ensure that all staff are competent and trained in blood pressure readings and management in accordance with NICE guidelines NG136 Hypertension in adults: diagnosis and management.

- The Governor should ensure that staff understand that where there is an immediate threat to life, they can enter a cell alone at night where it is safe to do so.

- The Governor should ensure that when staff call a medical emergency code, they provide relevant information about the prisoner's condition to control room staff so that they can inform the ambulance service.

- The Governor and Head of Healthcare should ensure that staff understand the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

- The Governor should ensure that when staff have concerns about a prisoner's wellbeing during a roll check, they obtain a response from them to check they are alive and well.

- The Governor should ensure that all CCTV systems are fully functional, regularly checked and in the event of an error, every effort is made to identify and retain any data that is at risk of being lost.

The Investigation Process

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

19. The investigator visited HMP Hull on 3 and 4 November 2022. He obtained copies of relevant extracts from Mularz's prison and medical records.

20. The investigator interviewed nine members of staff, and one prisoner on 3 and 4 November.

21. On 23 February 2023, over the telephone, the investigator asked further questions of one of the staff members he had interviewed. He interviewed two more members of staff on 27 February and 2 March 2023.

22. NHS England commissioned an independent clinical reviewer to review Mr Mularz's clinical care at the prison.

23. We informed HM Coroner for Hull and East Riding of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

24. The Ombudsman's family liaison officer contacted Mr Mularz's ex-partner to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

Background Information

HMP Hull

25. HMP Hull is a local prison that holds up to 1,056 men in ten wings. City Healthcare Community Partnership (CHCP) provides health services at the prison. GP surgeries are held four days a week, with an out-of-hours service at other times.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Hull was in March 2022. Inspectors reported that healthcare services were failing in some critical areas. Inspectors were not confident that partnership working was providing sufficient oversight and governance. They found that staff shortages remained a challenge and a high level of unfilled nurse and healthcare assistant shifts continued to affect the delivery of safe care to prisoners. Instances of unplanned uses of force by staff on prisoners had decreased since the last inspection.

Independent Monitoring Board

27. 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.

28. In its latest annual report for the year ending 28 February 2022, the IMB reported uses of force by staff had reduced. All use of force incidents were now scrutinised and follow up action taken, including positive feedback for good practice, coaching conversations where improvement in performance is required, and exceptional cases escalated for further scrutiny or investigation.

29. The IMB noted that healthcare needs had generally not been consistently and satisfactorily met due to contractual failures and staff absences. They noted that in December 2020, the Care Quality Commission (CQC) had carried out an inspection of healthcare services and served a section 31 notice to CHCP. (A section 31 notice sets out that the CQC has reasonable cause to believe that there is a risk of harm, unless action is taken.) CHCP had begun work on an action plan. The IMB also noted that the most frequent concern raised in applications to them was about healthcare.

Previous deaths at HMP Hull

30. Mr Mularz was the eleventh prisoner to die at Hull since August 2020. Of the previous deaths, seven were from natural causes and three were self-inflicted. There are no similarities between our findings in the investigation into Mr Mularz's death and our investigation findings for the previous deaths.

Key Events

31. On 13 August 2022, Mr Sebastian Mularz was remanded in prison, charged with assault, and sent to HMP Hull. It was not his first time in prison.

32. A nurse completed Mr Mularz's reception health screen at Hull. Mr Mularz had elevated blood pressure (145/99mmHg), but there were no other concerns about his physical or mental health.

33. On 14 August, a healthcare assistant took Mr Mularz's blood pressure again. His blood pressure was still elevated (139/99mmHg). She booked a follow up appointment for Mr Mularz for the next day.

34. On 15 August, a nurse took Mr Mularz's blood pressure again. Mr Mularz's blood pressure was still elevated (142/95mmhg). She passed Mr Mularz's blood pressure reading on to the lead nurse for review.

35. During the night Mr Mularz constantly rang his emergency cell bell, causing a disturbance on the wing. Mr Mularz's cellmate told the investigator that initially Mr Mularz had acted normally, but then, on the evening of 15 August, he began acting strangely. His cellmate said that Mr Mularz was trying to get into his bed, interfered with the cell door, tried to get out of the cell and said he wanted to catch a bus.

36. On the morning of 16 August, staff moved Mr Mularz to a single occupancy cell. Because of Mr Mularz's odd behaviour, a supervising officer (SO) referred him to the Mental Health In-reach Team (MHIT).

37. At around midday, a nurse from the MHIT visited Mr Mularz and spoke to him at his cell door. She noted that Mr Mularz's cell was clean and tidy, and he was well kempt. She said that although Mr Mularz was Polish, he could speak very good English. She noted that Mr Mularz was animated and spoke quickly, but this appeared to be normal behaviour for him. She concluded that she had no concerns about Mr Mularz's mood or presentation.

38. That evening, Mr Mularz was on the exercise yard. Shortly before 6.50pm, the officers supervising the yard asked Mr Mularz several times to go back to the wing. The officers thought Mr Mularz had been behaving strangely and he did not comply. When Mr Mularz continued not to comply, the officers used 'guiding holds' to physically remove Mr Mularz from the yard and escort him back to his cell. (Guiding holds are the lowest level use of force technique that can be applied by one or two officers. The officer places one hand holding the prisoner's wrist/forearm and the other hand takes hold just above the prisoner's elbow. This enables the officer(s) to escort a prisoner through or away from an area to prevent a situation from escalating.)

39. Soon after Mr Mularz was returned to his cell, staff noticed that Mr Mularz had ripped the cell's phone and socket off the wall, dismantled the television and had tried to destroy his privacy board.

40. At 7.34pm, a nurse attended Mr Mularz's cell to check on him after the use of force incident. She noted that she was unable to assess Mr Mularz fully as he was talking to himself and climbing on his desk. She said that she did not understand much of

what he was saying, but when asked Mr Mularz said he had no injuries. She referred Mr Mularz to the MHIT.

41. At 9.33pm, Mr Mularz pressed his cell bell. Officer A attended the cell and spoke with Mr Mularz for around two minutes. He told the investigator that Mr Mularz was sweating profusely, was talking to the corner of the cell, banging the window, and pushing the cell door. He said he tried speaking to Mr Mularz, but it was like he had "glazed over" and he would not answer. He told the investigator that throughout the night he could see Mr Mularz's light on and until around 2.00am, he could hear him moving about in his cell.

Events of 17 August

42. On 17 August, Officer A conducted the morning roll check (a count of prisoners to check that they are all present in their cells). At 5.34am he attended Mr Mularz's cell and looked through the observation panel for around four minutes. He told the investigator that the cell light was still on, and Mr Mularz was lying on his bed. He said he checked to see if there was a ligature around Mr Mularz's neck, tapped the cell door and tried to speak with him, but Mr Mularz did not respond. He told the investigator that he thought he could see Mr Mularz's chest moving and so concluded that Mr Mularz was asleep.

43. At 6.10am, Officer B took over from night staff and started his roll check. At around 6.15am, he opened the observation panel of Mr Mularz's cell. He told the investigator that Mr Mularz was lying on his bed in a strange position, with his feet just slightly off the floor.

44. Officer B closed the cell's observation panel and then opened it again to see if Mr Mularz moved, but Mr Mularz stayed in the same position. He then kicked Mr Mularz's door, but he did not respond. At 6.17am, he radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

45. At 6.18am, an operational support grade (OSG) in the control room called the Ambulance Service. Once connected to the Ambulance Service, she transferred the call to the wing. However, all the staff on the wing were attending to Mr Mularz so they were not available to take the call. The control room then called the ambulance service again at 6.22am.

46. Officer B waited outside Mr Mularz's cell until another officer arrived. At 6.25am, both officers entered Mr Mularz's cell. They lifted Mr Mularz off the bed and found that Mr Mularz was stiff, cold to the touch, and his lips were blue. Officer B told the investigator that from Mr Mularz's appearance, he thought Mr Mularz was already dead.

47. Officer B started cardiopulmonary resuscitation (CPR). At 6.26am, a nurse arrived. She told the investigator that Mr Mularz's pupils were fixed and dilated, he was grey in colour, very cold to touch and that his body was stiff. She said she tried to insert an airway to administer oxygen, but it was not possible as Mr Mularz's jaw was too stiff. She decided to put an oxygen mask over Mr Mularz's face, to make sure that he was getting some oxygen through his nose.

48. The nurse told the investigator that as officers had already started CPR, she made the decision to continue. She and the officers then took turns administering CPR.

49. At 6.46am, paramedics arrived at Mr Mularz's cell. After performing an electrocardiogram (ECG), the paramedics pronounced Mr Mularz dead at 6.49am. A second ambulance crew arrived at 6.50am. All ambulance staff left the cell at 6.52am.

Contact with Mr Mularz's family

50. On 17 August, the prison appointed family liaison officers. They visited Mr Mularz's ex-partner's address, but she was at work. They arranged to meet her at her workplace and broke the news of Mr Mularz's death. They maintained contact and liaised with the Coroner and funeral director.

51. The prison contributed to the costs of Mr Mularz's funeral in line with national policy.

Support for prisoners and staff

52. On 17 August, after Mr Mularz's death, senior staff 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.

53. The prison posted notices informing other prisoners of Mr Mularz's death and offered support.

Post-mortem report

54. The pathologist found no external signs of trauma, and the toxicology report showed that Mr Mularz was not under the influence of drugs or alcohol when he died. The pathologist found an abnormal vascular growth on Mr Mularz's brain (an asymptomatic capillary telangiectasia), and said that in very rare cases, this type of growth can a cause a fatal seizure. However, due to the lack of supportive evidence, the pathologist concluded that the cause of death was unascertained.

Findings

Clinical care

55. It is unclear what exactly caused Mr Mularz's death, but the pathologist concluded that it was from natural causes, possibly due to a growth on the brain that might have caused a seizure.

56. The clinical reviewer was satisfied that the physical and mental health care Mr Mularz received at Hull was equivalent to that which he could have expected to receive in the community. However, she made one recommendation about the monitoring of Mr Mularz's blood pressure.

57. On 13 August 2022, at the reception health screen, Mr Mularz's blood pressure reading was high at 145/99mmHg. NICE guidelines ('NG136 Hypertension in adults: diagnosis and management') cover identifying and treating primary hypertension (high blood pressure). The guidelines state that an acceptable blood pressure should not exceed 140/90mmHg.

58. Mr Mularz attended a follow up appointment on 14 August. His blood pressure was again recorded as high. The clinical reviewer noted that Mr Mularz's blood pressure should have been taken a second time, but this was not done. This was not in line with NICE guidance. We recommend:

    The Head of Healthcare ensures that all staff are competent and trained in blood pressure readings and management in accordance with NICE guidelines NG136 Hypertension in adults: diagnosis and management.

Emergency response

Delay in entering cell

59. PSI 24/2011, Management and Security of Nights, says that under normal circumstances authority to unlock a cell at night must be given by the night orderly officer and no cell will be opened unless two or three (subject to local risk assessment procedures) members of staff are present, one of whom should be the night orderly officer. However, it says that 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, 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 should do a dynamic risk assessment to decide whether it is safe to enter a cell alone.

60. After calling the code blue, Officer B waited around eight minutes before entering Mr Mularz's cell. (Due to the differences in timings of witness accounts and digital evidence it is accepted that this time may be slightly shorter.) he told the investigator that he thought Mr Mularz might have been pretending, and that entering the cell may have placed him at risk. However, he also said that he did not immediately go into the cell as according to the prison's local safety procedures for

nights, he had to wait until there were at least two members of staff present before opening a cell. This is incorrect and not in line with prison policy.

61. We accept that the delay in entering the cell did not affect the outcome for Mr Mularz as he was dead when found. However, any delay in entering cells could make a significant difference in future emergencies. We recommend:

The Governor should ensure that staff understand that where there is an immediate threat to life, they can enter a cell alone at night where it is safe to do so.

Failure to pass relevant information to the control room

62. PSI 03/2013, Medical Emergency Response Codes, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate, and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately. The PSI says that the person using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use in the triage process.

63. When the OSG in the control room called for an ambulance immediately in response to the code blue, she had no information about Mr Mularz's condition. She put the call through to the wing office, but no one was available to take the call as staff were attending to Mr Mularz. She said she would call the Ambulance Service back in a few minutes, when someone was available to take the call. An ambulance was not sent to the prison at this time.

64. At 6.22am, the OSG called the Ambulance Service again, and successfully put them through to the wing office. An officer answered and explained the situation to the Ambulance Service. An ambulance was then dispatched to the prison. This was four minutes after the initial call was made in response to the code blue. We are concerned that information was not passed to the control room earlier, which resulted in a delay to the ambulance being dispatched. We accept that it made no difference in this case as Mr Mularz was dead when found, but any delay could be critical in a future medical emergency.

65. We recommend:

The Governor should ensure that when staff call a medical emergency code, they provide relevant information about the prisoner's condition to control room staff so that they can inform the Ambulance Service.

Inappropriate resuscitation

66. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. The guidelines state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be

futile". The guidelines say that the presence of rigor mortis indicates that resuscitation would be futile.

67. When staff discovered that Mr Mularz was unresponsive, he was stiff, cold to the touch and his lips were blue. He had clearly been dead for several hours (rigor mortis – stiffening of the body after death – sets in two to six hours after death). However, officers started CPR and a nurse let this continue when she arrived.

68. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Staff should not have attempted CPR on Mr Mularz and the nurse should have told staff to stop when she arrived. We recommend:

The Governor and Head of Healthcare should ensure that staff understand the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Roll check

69. When Mr Mularz was found unresponsive at around 6.15am on 17 August, he had rigor mortis which indicated that he had been dead for at least two hours. Therefore, Mr Mularz was dead when Officer A checked on him at 5.34am.

70. We have considered whether Officer A should have identified that Mr Mularz was unresponsive at the time of his roll check. He clearly had concerns about Mr Mularz, as he spent four minutes looking into his cell. He tapped the door and tried to speak with Mr Mularz but got no response. He then thought he could see Mr Mularz's chest moving so concluded that he was asleep. However, this could not have been the case as Mr Mularz was dead at the time.

71. While staff are not normally expected to obtain a response from a prisoner during a roll check (which is a count of prisoners rather than a welfare check), we consider that in this case, given Officer A's obvious concerns about Mr Mularz, he should have continued to try to get a response from Mr Mularz and either gone into the cell or called for assistance when Mr Mularz failed to respond.

72. We acknowledge that Officer A looked into the cell for a prolonged period of time (far longer than expected for a standard roll check) and that he was being conscientious in trying to assess whether Mr Mularz was breathing. We also accept that it can be difficult to see whether someone is breathing from the other side of a cell door. Nevertheless, having tapped on the cell door and not got a response from Mr Mularz, we consider that he should have continued to try to get a response from him to satisfy himself that Mr Mularz was alive. We recommend:

The Governor should ensure that when staff have concerns about a prisoner's wellbeing during a roll check, they obtain a response from them to check they are alive and well.

Use of force

73. On the evening of 16 August 2022, Mr Mularz did not comply with requests to leave the exercise yard and officers used guiding holds to return him to his cell. A short

time later, Mr Mularz damaged items in his cell and was acting strangely. Less than 12 hours after being returned to his cell, he was found dead. Given that Mr Mularz was subject to use of force so close to his death, we have considered whether it was applied appropriately.

74. Prison Service Order (PSO) 1600, Use of Force, says that an initiation of force on a prisoner by staff must be reasonable and necessary (justified); force cannot be deemed necessary if a prisoner solely refuses a 'lawful order', it is important to consider what harm staff are trying to prevent. Once force has been initiated, no more force than necessary should be used, and the force must be proportionate to the circumstances (the force used must not be excessive).

75. PSO 1600 also says that use of force should always be a last resort. Wherever possible staff should try to resolve a situation using de-escalation and communication skills. A prisoner who has force used on them may find the experience traumatic as it may feel like they are being assaulted. It is therefore vital that staff are policy compliant when they use force.

76. Officer C initiated the use of force on Mr Mularz. He told the investigator that force was justified as the exercise yard is a "flash point", which could be easily taken over by prisoners, and that at that time there were fewer staff available to support if something happened. Both he and a colleague told the investigator that Mr Mularz's behaviour suggested that he was unpredictable, and Officer C added that he was concerned Mr Mularz might assault him. Both officers told the investigator that they felt the safest way to get Mr Mularz off the exercise yard was to do so by force.

77. Officer D did not turn on his body worn video camera (BWVC) until moments before force was initiated. The footage shows that Mr Mularz was sitting on a bench and was showing no signs of aggression. However, we accept that this was a complex situation, Mr Mularz was a large person, was acting strangely, he did not comply with requests to leave the exercise yard carried the risk of other prisoners getting involved, and there was a lack of available staff to support. It therefore was not unreasonable for Officer C to be concerned that the situation could develop into one that could threaten his and Officer D's safety, as well as the 'good order of the establishment' (prisoners taking control of the exercise yard).

78. However, these threats were potential and not imminent. In such cases, other options must be explored to de-escalate the situation before force is used.

79. Officer C told the investigator that there was a period of two to three minutes between asking prisoners to come off the yard and using force on Mr Mularz; and due to the potential threats, the situation presented, not many other options of dealing with the situation were explored. Officer D said there were five minutes between asking prisoners to come off the yard and using force.

80. We are concerned about the discrepancy in the amount of time officers said it took between asking prisoners to come off the yard and initiating force. At the lower end of two minutes, we would be concerned that this would not be long enough to explore and implement other options other than force.

81. CCTV footage of the exercise yard was not available due to Hull experiencing technical issues. Had CCTV footage been available, we would better understand

the situation and the actions of the officers and could have come to a firm conclusion on whether force was justified.

82. CCTV provides important evidence to support investigations and is vital for the safety and security of a prison environment. The issue surrounding Hull's CCTV system is of concern. We recommend:

The Governor should ensure that all CCTV systems are fully functional, regularly checked and in the event of an error, every effort is made to identify and retain any data that is at risk of being lost.

83. Although we cannot say whether force was justified or not, from the BWVC footage, we are satisfied that once force had been initiated, the force used by officers was not excessive.

Inquest

84. The inquest, held on 3 July 2025, concluded that Mr Mularz died from natural causes.

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 l 020 7633 4100