Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lukasz Strag, a prisoner at HMP Birmingham, on 26 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. In March 2024, Mr Lucasz Strag was sentenced to 19 years imprisonment for conspiracy to supply class A drugs. He died of urosepsis (infection that starts in the urinary tract and spreads to the bloodstream) on 26 January, in a hospice, while a prisoner at HMP Birmingham. Metastatic gastric cancer (cancer of the stomach that spreads to other parts of the body) contributed to but did not cause his death. He was 44 years old. We offer our condolences to Mr Strag's family and friends.

4. The Ombudsman's office wrote to Mr Strag's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned, an independent clinical reviewer, to review Mr Strag's clinical care at Birmingham. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Strag received at Birmingham was of a good standard and equivalent to that which he could have expected to receive in the community. She found that prison healthcare staff were caring and advocated for Mr Strag. The clinical reviewer made recommendations not related to Mr Strag's cause of death that the Head of Healthcare will wish to consider.

7. The PPO investigator investigated the non-clinical issues relating to Mr Strag's care. We did not find any non-clinical issues that warranted a recommendation but bring the Governor and Head of Healthcare's attention to the below.

Governor and Head of Healthcare to note

Pain relief

8. On 19 January at around 9.30pm, Mr Strag told staff he was in pain. However, healthcare staff were unable to give him pain relief medication for three hours as his cell was locked. According to Birmingham's local security strategy, at least three officers must be present to open a cell door during night state (when there are reduced numbers of staff in the prison). A nurse recorded that she contacted Custodial Manager (CM) and told him Mr Strag was in pain. The CM said he had other priorities at the time (there was a fire on another wing) and was unable to attend. Three hours later, after the nurse had asked prison staff several times to open the door, she radioed an emergency code. The CM attended promptly and the nurse gave pain medication to Mr Strag. We bring this to the attention of the Governor and the Head of Healthcare to consider the need for a process that allows

healthcare staff to access prisoners under palliative care promptly during the night state.

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

Inquest

10. The inquest hearing was held on 4 September 20225. The Coroner concluded that Mr Strag died of natural causes.

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

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