Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Pavlo Lapshyn, a prisoner at HMP Wakefield, on 23 September 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



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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 Pavlo Lapshyn, a 37 year old Ukrainian national, was found hanged in his cell on 23 September at HMP Wakefield. I offer my condolences to Mr Lapshyn's family and friends.

Mr Lapshyn was the third prisoner to take his own life at Wakefield in three years.

Mr Lapshyn had some risk factors for suicide and self-harm but there was no noticeable deterioration in his wellbeing in the time before his death. Staff had no reason to consider him at imminent risk of suicide and they could not have reasonably foreseen his death.

Mr Lapshyn was autistic and received good support from staff on the Mulberry Unit at Wakefield. However, the emergency response fell far below expected standards. Delays occurred due to a lack of confidence and leadership. While I cannot say that these delays affected the outcome for Mr Lapshyn, they present a clear risk for future incidents. A robust training and improvement package for Wakefield's emergency response will be essential.

I am disappointed in the lack of support offered to staff following the emergency response. Staff were in an emotionally charged situation, and the lack of post-incident care is likely to have impacted their wellbeing and capability.

Since Mr Lapshyn's death, there have been two homicides at Wakefield. Mr Lapshyn was also under threat, and there was little evidence of robust action to address the risks other than naturally occurred because he lived on a separate unit. Wakefield needs to demonstrate a robust approach to managing the risk of prisoner-on-prisoner violence.

I commend the staff on the Mulberry Unit for their work with and support for Mr Lapshyn. Despite the complex challenges he posed, they consistently engaged with him, built rapport, and encouraged his participation in productive activity. It is clear they had developed a strong and positive relationship with him.

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

Adrian Usher
Prisons and Probation Ombudsman **March 2026**

Contents

Summary 1

The Investigation Process.....2

Background Information.....4

Key Events.....6

Findings 14

Summary

Events

1. On 23 July 2013, Mr Pavlo Lapshyn was remanded to HMP Belmarsh charged with murder, engaging in conduct in preparation for terrorist acts, and causing an explosion with intent to endanger life. On 25 October, he was sentenced to life imprisonment with a minimum term of 40 years. Mr Lapshyn's offences targeted the Muslim community and were highly publicised in the media.

2. Mr Lapshyn was a Ukrainian national who arrived in the UK on 24 April 2013. He had a history of self-harm and suicide attempts in prison; the most recent incident was in 2017. He was monitored under suicide and self-harm procedures (known as ACCT) on six occasions between 2013 and 2016.

3. Mr Lapshyn served his sentence in multiple prisons. Staff were concerned about his risk to establishments due to his history of making improvised weapons and explosive devices. Mr Lapshyn was convicted of offences of arson (2017) and making an explosive substance (2020) that he committed in prison.

4. In 2014, Mr Lapshyn was diagnosed with autism and in October 2020, he was transferred to the Mulberry Unit – a specialist autism unit at HMP Wakefield.

5. On 18 March 2025, Channel 5 broadcast a documentary about Mr Lapshyn. Prison staff submitted intelligence reports that other prisoners had watched the programme and made threats towards Mr Lapshyn. In August and September, staff submitted further intelligence reports that prisoners on the adjoining B-wing were threatening Mr Lapshyn.

6. Between July and September, there were multiple regime lockdowns due to operational demand and staff redeployment. Mr Lapshyn expressed frustration with the lack of regime and restricted activities on several occasions.

7. At 1.59am on 23 September, an officer was completing routine checks. When she arrived at Mr Lapshyn's cell, he had covered his observation panel and she could not get a response from him. The Custodial Manager (CM), in charge of the prison overnight, arrived and opened the cell door. Mr Lapshyn was suspended with a ligature around his neck. The CM left the cell to get advice and when she returned, officers cut the ligature and started cardiopulmonary resuscitation (CPR).

8. At 2.25am, healthcare staff arrived. The nurse completed an assessment and concluded there were no signs of life. The officers stopped CPR. Paramedics arrived at 2.45am and confirmed life extinct at 2.50am.

9. The post-mortem report concluded that Mr Lapshyn died from hanging.

Findings

10. Mr Lapshyn had been at Wakefield for almost five years when he was found hanged in his cell. He had some risk factors for suicide and self-harm but he engaged with staff and activities and there was no noticeable deterioration in his mental health in the time before his death. We consider that there was no reason

for staff to consider he needed the support of ACCT procedures and that they could not have reasonably foreseen Mr Lapshyn's death.

11. Mulberry Unit staff tried to manage Mr Lapshyn's risk factors. They supported him as a foreign national prisoner and encouraged him to build and maintain relationships. Staff also supported Mr Lapshyn to engage in productive activity, despite the risk he posed to the establishment.

12. The emergency response on 23 September was delayed and ineffective, illustrating a lack of confidence and leadership.

13. Staff involved in the emergency response did not receive support.

14. Mr Lapshyn was under threat from other prisoners during his time at Wakefield. This was not managed appropriately - neither Mr Lapshyn nor the identified perpetrators were managed under violence reduction procedures.

15. The clinical review concluded that Mr Lapshyn's healthcare at Wakefield was of a good standard and equivalent to what he could have expected to receive in the community.

Recommendations

- The Governor should assure herself that Wakefield has robust processes in place to identify, assess and manage the risk of prisoner-on-prisoner violence.

- The Governor should review the learning identified in relation to the emergency response and introduce a robust assurance process to satisfy herself that:

    - prison staff are trained and understand their responsibilities during medical emergencies, and

    - prison leaders promptly share learning from serious incidents with both specific staff involved and with the wider staff group.

- The Governor should ensure that local policies reflect both the Prison Safety Policy Framework and the Follow up to Deaths in Custody Policy Framework requirements that staff and prisoners receive adequate support after a serious incident.

The Investigation Process

16. HMPPS notified us of Mr Lapshyn's death on 23 September 2025.

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

18. The investigator visited Wakefield on 29 September 2025. She obtained copies of relevant extracts from Mr Lapshyn's prison and medical records.

19. NHS England commissioned an independent clinical reviewer to review Mr Lapshyn's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed twelve members of staff at Wakefield in November. They also interviewed one member of staff in January and the investigator interviewed another member of staff in February, both by video conference.

20. We informed HM Coroner for Wakefield of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. The Ombudsman's office contacted Mr Lapshyn's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. The next of kin asked how to obtain Mr Lapshyn's death certificate (which the prison family liaison officer subsequently helped them to obtain) and asked for a copy of our report.

22. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and the action plan is an additional annex to this report.

23. We also shared the initial report with Mr Lapshyn's next of kin. They did not make any comments.

Background Information

HMP Wakefield

24. Wakefield is a long-term, high-security prison for male prisoners typically in security categories A and B. Healthcare services are provided by Practice Plus Group.

HM Inspectorate of Prisons

25. The most recent inspection of Wakefield was between June and July 2025. Inspectors noted that a redeployment of officers to other prisons left Wakefield unable to consistently run its full regime. They noted this had a direct impact on prisoners' daily lives with many spending long periods locked in their cells, unable to access activities. Inspectors found communication to prisoners and staff about regime changes was not good enough. Both prisoners and staff told inspectors they were frustrated by the constantly changing regime.

26. Inspectors spoke to prisoners and many said they felt unsafe. Inspectors found no coherent strategy to reduce violence or bullying.

27. Inspectors found prisoners living on the Mulberry Unit (a small unit for those with autism) spoke positively about the environment and support they received. However, there was no additional input from the healthcare team.

28. Inspectors noted that a foreign national offender specialist worker was on site regularly, and Home Office immigration enforcement officials visited Wakefield approximately every six weeks. Inspectors spoke to foreign national prisoners and found many were not aware of their eligibility for additional telephone credit to contact their families.

Independent Monitoring Board

29. 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 2023 to 2024, the IMB reported they were concerned about a reduction in experienced prison officers and the amount of sick leave being taken by staff, in part, due to serious attacks on officers. They noted this has impacted the regime for prisoners as activities were regularly cancelled due to low staffing levels.

Previous deaths at HMP Wakefield

30. Mr Lapshyn was the 19th prisoner to die at Wakefield since September 2022. Of the previous deaths, 16 were due to natural causes and two were self-inflicted. Up to the end of February 2026, there have been two deaths at Wakefield since Mr Lapshyn's death, both of which were homicides.

31. Our investigation into the self-inflicted death of a foreign national prisoner in 2024, identified delays in prison staff entering the cell after they found the prisoner hanging. The investigation flagged concerns that the officer did not make a dynamic risk assessment in line with national policy when there was a risk to life. The

investigation identified that Wakefield's Local Security Strategy (LSS) did not detail the expectation that staff go into a cell to preserve life if it is safe to do so. Wakefield have since updated their LSS to say that staff may act immediately without authority if they complete a dynamic risk assessment and it is safe to do so.

Assessment, Care in Custody and Teamwork (ACCT)

32. 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. 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.

33. As part of the process, a care plan (a plan of care, support and intervention) is put in place. Prison staff should not close the ACCT plan until all the actions of the care plan have been completed. Prison staff should record all decisions made as part of the ACCT process and any relevant observations about the prisoner in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in The Prison Safety Policy Framework which replaced Prison Service Instruction (PSI) 64/2011, Safer Custody in January 2025.

Incentives Scheme

34. Each prison has an incentives scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

Key Events

35. On 23 July 2013, Mr Pavlo Lapshyn, a Ukrainian national, was remanded to HMP Belmarsh, charged with murder, engaging in conduct in preparation for terrorist acts, and causing an explosion with intent to endanger life. This was Mr Lapshyn's first time in prison in the UK, however, he told prison staff he had served a ten-day prison sentence in Ukraine. Mr Lapshyn's offences targeted the Muslim community and were highly publicised in the media.

36. On 25 October, Mr Lapshyn was sentenced to life imprisonment for murder with a minimum term of 40 years, alongside two concurrent 12-year sentences. During his sentence, Mr Lapshyn was transferred to various different high secure prisons including HMP Long Lartin, HMP Full Sutton, and HMP Whitemoor.

37. Mr Lapshyn had arrived in the UK from Ukraine in April 2013. Staff did not use an interpreter while Mr Lapshyn was in prison. In interviews and case notes, staff said that, although it was evident English was not Mr Lapshyn's first language, he could communicate well. Mr Lapshyn made no calls to family or friends in the last six months before his death; he last had a visit in 2017.

38. Mr Lapshyn had been managed under suicide and self-harm monitoring (known as ACCT) six times between 2013 and 2016. Staff opened ACCTs due to self-harm by cutting, swallowing metal objects, and Mr Lapshyn writing that he would harm himself. There were other concerns about Mr Lapshyn's risk of suicide and self-harm during this time. In October 2016, Mr Lapshyn set fire to his cell and two days later told Clinical Psychologist Ms A that this was a suicide attempt. Mr Lapshyn was later convicted of arson. In February 2017, prison staff read a letter Mr Lapshyn was preparing to send that mentioned suicide. This was the last time Mr Lapshyn was assessed as at risk of suicide or self-harm. There were also concerns about his mental health and healthcare staff prescribed quetiapine (an antipsychotic) until November 2017.

39. On 21 August 2018, prison staff searched Mr Lapshyn's cell and found suspicious items. When questioned, Mr Lapshyn said he was trying to make fireworks because he was bored. On 6 August 2020, Mr Lapshyn was sentenced to two years in prison for making an explosive substance.

40. Mr Lapshyn was diagnosed with autism in 2014. In June 2019, he was accepted for the Mulberry Unit at HMP Wakefield and transferred there on 12 October 2020. The Mulberry Unit is a small wing for prisoners identified as having autism that impacts their ability to cope in custody. The unit benefits from a higher staff-to-prisoner ratio than the standard wings, allowing staff to spend more time with prisoners and develop supportive relationships. Staff are selected through an interview process.

41. Between 2020 and 2024, prison staff placed Mr Lapshyn on the basic level of the incentives scheme on three occasions for brewing illicit alcohol (known as hooch), possession of unauthorised items, and making improvised tools. During this time, there were concerns about the risk Mr Lapshyn posed to the establishment. On 16 February 2023, Mr Lapshyn was moved to Full Sutton for one week after making a suspected Improvised Explosive Device (IED) and in 2024, the bomb squad attended Wakefield due to Mr Lapshyn hiding 'dangerous items'.

42. In 2022, the mental health team and wing staff identified that Mr Lapshyn was struggling with Post-Traumatic Stress Disorder (PTSD) symptoms although he had no formal diagnosis. Mr Lapshyn also spoke to prison staff about his anxiety around the war in Ukraine. On 6 April, healthcare staff prescribed Mr Lapshyn sertraline (an antidepressant). In 2024, Mr Lapshyn had several medication reviews and was switched to different antidepressants as he did not feel they were effective. During this time, healthcare staff assessed he was experiencing some moderate depressive symptoms, and he reported flashbacks and feelings of emptiness. Healthcare staff did not assess that there were any indications of suicide risk.

2025

43. On 28 January 2025, mental health triage nurse, Ms B, went to see Mr Lapshyn. Mr Lapshyn said he was sleeping poorly, his mood was 'up and down' and he was feeling paranoid. He said he had flashbacks to a political incident he was involved with in Ukraine which made him feel anxious and depressed. Mr Lapshyn said he wanted to calm his restlessness and said the mindfulness and breathing exercises he did on the Mulberry Unit helped. Mr Lapshyn said he did not feel his prescribed antidepressant (duloxetine) was helping and asked for a review. Nurse B's notes reference restlessness, irritability, PTSD symptoms, and mood fluctuations. Mr Lapshyn denied any current ideas or plans for suicide or self-harm.

44. On 14 January, a staff member submitted an intelligence report (IR) stating that healthcare staff had asked prison staff to bring Mr Lapshyn for his medication during B-wing (a standard wing adjoining the Mulberry Unit) unlock. The report highlighted that, due to Mr Lapshyn's offence, he was at risk from other prisoners and it had been agreed for some time that he would only collect medication when B-wing prisoners were locked in their cells. There is no record of any outcome from this.

45. On 27 February, a staff member submitted an IR stating that other prisoners were making 'veiled threats' towards Mr Lapshyn. They overheard two prisoners say Mr Lapshyn 'could be their means to martyrdom'. The IR noted that staff were aware of the possible threat and that measures were in place – there is no record of what these measures were.

46. In February, Mr Lapshyn said he would like a job that was not on the Mulberry Unit. Over the following months, the multidisciplinary team responsible for managing prisoners charged with terrorist offences (known as Pathfinder) discussed this, agreeing it was important for Mr Lapshyn to be occupied, and in June, it was agreed that he could work in the braille workshop, but there is no evidence that this was arranged.

47. On 10 March, psychiatrist Dr A saw Mr Lapshyn. Mr Lapshyn said he would like a mood stabiliser as he had flashbacks from being 'bullied' in Ukraine. Mr Lapshyn said he felt anxious and restless, particularly at night. He rated his mood as a four out of ten and said he had occasional thoughts that life was not worth carrying on but no thoughts or plans of suicide or self-harm. During interview, Dr A said he did not share this remark with prison staff as he did not assess there were indications of increased risk. Dr A prescribed a low dose of flupentixol (an antipsychotic).

48. On 18 March, Channel 5 (TV channel) aired a documentary about Mr Lapshyn's offence. The next day, a member of staff submitted an IR noting that two prisoners

on B-wing said they saw the documentary and that Mr Lapshyn was 'in big trouble'. The IR noted that the documentary appeared to have caused 'a stir' amongst the Muslim prisoners on B-wing. It also noted that Mr Lapshyn had previously received threats from Muslim prisoners due to his offence and it was likely the documentary had exacerbated this. The IR stated that staff on the Mulberry Unit were aware of the threat and that arrangements were in place for Mr Lapshyn to collect medication when other prisoners were locked in their cells.

49. On 5 April, Mr Lapshyn had a keywork session with Officer A. Mr Lapshyn said he wanted to be deported to Ukraine and asked for the details of the Ukrainian Consulate. On 30 April, Officer A told Mr Lapshyn he had spoken to his Prison Offender Manager (POM) who had said he would likely not be deported and would probably stay in the UK until 2053. Officer A noted that Mr Lapshyn seemed to appreciate being updated but said he would continue to write to the embassy.

50. On 26 May, Mr Lapshyn told his keyworker that he wanted something to help him sleep. On 2 June, Mr Lapshyn saw psychiatrist Dr A and said the flupentixol did not seem to work, and he would like to try an alternative. Dr A said he would trial olanzapine to manage Mr Lapshyn's agitation. Dr A recorded that Mr Lapshyn's mood was 'not great' but he had no thoughts of suicide or self-harm.

51. On 11 June, a member of staff submitted an IR which alleged that Mr Lapshyn had stolen a watch that belonged to another prisoner. The IR assessed it was likely that Mr Lapshyn took the watch with a view to making something 'more sinister'. On 13 June, prison staff gave Mr Lapshyn a negative behaviour warning due to concerns around his behaviour – they noted he was increasingly testing boundaries. On 14 June, staff recorded that Mr Lapshyn had an altercation with another prisoner (there is no more information available). On the same day, Mr Lapshyn was downgraded to the basic level of the incentives scheme.

52. On 3 July, Officer A and Mr Lapshyn updated his This Is Me (TIM) document (a supportive tool used to help staff understand the needs of neurodiverse prisoners). The updated TIM detailed Mr Lapshyn's triggers, outlined signs that might indicate he needed help, and set out specific ways staff could best support him. Mr Lapshyn identified that being reprimanded and told what to do were triggers for him. (There is no evidence that Mr Lapshyn displayed any of the behaviours he had described before his death.) The document set a goal for Mr Lapshyn to continue his work on the unit and potentially get a job to help keep his mind active.

53. On 9 July, Officer A spoke to Mr Lapshyn about work opportunities in the prison. Mr Lapshyn said he would find access to tools 'too tempting'. When this was shared at a Pathfinder meeting on 29 July, attendees were concerned that Mr Lapshyn's risk in employment was too high for the prison to manage. On 18 August, Mr Lapshyn told Officer A he was interested in getting a job and he was discussed again at the Pathfinder meeting on 20 August. On this occasion, attendees felt Mr Lapshyn expressed genuine interest in having a job and noted his keyworker believed work could be a positive step. Pathfinder staff agreed that the Mulberry Unit CM, CM A, would speak to the reducing reoffending team and would complete any appropriate risk assessments. The next Pathfinder meeting was set for 30 September. There is no record CM A spoke to the reducing reoffending team prior to Mr Lapshyn's death. During interview, CM A said he felt he could not suggest where Mr Lapshyn could work due to the high risk he posed to the establishment. Instead, CM A said

he hoped to get some horticulture opportunities on the Mulberry Unit and wanted to trial Mr Lapshyn working with this.

54. Throughout July and August, there were multiple lockdowns on the Mulberry Unit. These were due to staff training, operational demand, staff shortages, and staff redeployment. During this time, Mr Lapshyn expressed frustration and said the lack of gym sessions was negatively impacting his mental health.

55. On 25 August, Officer B found Mr Lapshyn shaving the end of a toothbrush. When questioned, Mr Lapshyn said he was making a tool to clean the fishtank. This interaction was overheard by a prisoner on B-wing who later questioned Officer B about it. Officer B confiscated the tool Mr Lapshyn had made and placed him on disciplinary measures. A member of staff submitted this information in an IR and noted that it was possible Mr Lapshyn was constructing a weapon as he would likely be aware of the threat towards him. The IR also noted that the prisoner who had questioned Officer B could potentially be a significant threat to Mr Lapshyn.

56. On 26 August, a member of staff submitted an IR that Mr Lapshyn was under increased threat from the Muslim population due to the documentary that was previously shown. The IR noted that there may be a price on Mr Lapshyn's head and said that prisoners had been overheard saying that they would 'get him' at the first opportunity. The IR stated Mr Lapshyn was carefully managed on the Mulberry Unit and, due to the threat towards him, he was not allowed to associate with the general population.

57. On 30 August, a member of staff submitted an IR that when a Supervising Officer (SO) had opened the door to the unit, a prisoner from B-wing had seen Mr Lapshyn, marched to the door shouting Mr Lapshyn's name and had asked the SO to go on the unit. The SO had said no and closed the door. A few minutes later, another prisoner banged on the adjoining door and asked staff to open it. The IR noted that the threat to Mr Lapshyn appeared to have escalated and it was evident that several prisoners were trying to access the Mulberry Unit.

58. On 2 September, a member of staff submitted an IR that the prisoner who had previously come to the Mulberry Unit door shouting Mr Lapshyn's name was now watching the door to the Mulberry Unit. The IR noted B-wing staff had been made aware and advised to be vigilant when unlocking the adjoining door. It noted that discussions were taking place to implement a safe unlock for moving prisoners from the Mulberry Unit to other areas.

59. Also on 2 September, Officer A spoke to Mr Lapshyn about the threat that surrounded him and Mr Lapshyn said he had received threats while in the shower. Officer A recorded that Mr Lapshyn understood that this threat would likely follow him through his sentence. Mr Lapshyn also told Officer A he was worried he was the longest serving prisoner on the Mulberry Unit. He said he did not want to be moved as this was the only place that had allowed him to engage in a routine and he enjoyed the activities.

60. The same day, Officer C found hooch in the shower and suspected Mr Lapshyn. Officer C noted that Mr Lapshyn had been a little more restless recently, so staff were trying to occupy him as much as possible.

61. On 3 September, Mr Lapshyn's POM, POM A, visited him. Mr Lapshyn said he felt he should be reduced from category A (the highest category requiring high secure conditions) to category B, as there were too many restrictions on him. POM A explained that, for this to happen, there would need to be evidence of good behaviour and completed risk reduction work.

62. Throughout September, staff submitted multiple IRs detailing the threats made towards Mr Lapshyn, one of these threats came from a prisoner also located on the Mulberry Unit. The IRs noted that Mulberry Unit staff were aware but gave little information about how the risk was being managed. Staff concluded that it was not safe for Mr Lapshyn to attend a creative writing course with other prisoners.

63. On 10 September, the Mulberry Unit was locked down for staff training. On 12 September, Mr Lapshyn asked Officer A why the wing kept getting locked down, especially over weekends. Officer A told him it was due to low staffing.

64. On 15 September, Officer D noted that he had observed a subtle yet noticeable change in Mr Lapshyn's behaviour and demeanour. He assessed that Mr Lapshyn was increasingly vigilant, spending extended periods closely monitoring the movements and whereabouts of staff members. Officer D questioned Mr Lapshyn who denied any inappropriate activity. Officer D believed this behaviour indicated boredom and noted it warranted closer observation and consideration of more activities to occupy Mr Lapshyn. During interview, Officer D said he was concerned that Mr Lapshyn may have been involved in illicit activity. He did not have any concerns about his mental health.

65. That day, staff found a large bottle of fermenting liquid on the Mulberry Unit. Officer E questioned Mr Lapshyn who handed over two more bottles. A member of staff submitted an IR which included a security analysis that it was a realistic possibility that Mr Lapshyn's recent suspicious behaviour was due to the threats he had been receiving.

66. Due to being found with fermenting liquid, staff downgraded Mr Lapshyn to the basic level of the incentives scheme. Staff scheduled a seven-day review for 23 September and set targets for positive behaviour, purposeful activity, and for Mr Lapshyn not to possess any unauthorised items. On 17 September, prison manager Mr A held a disciplinary hearing and Mr Lapshyn pleaded guilty. During interview, Mr A said that, initially, Mr Lapshyn disagreed with the punishment. However, based on his previous interactions with Mr Lapshyn, Mr A knew that explaining the decision-making process would help him understand and accept the outcome. He said he showed Mr Lapshyn the tariff book, outlined the range of available sanctions, and explained that he had applied the minimum penalty in light of the mitigation Mr Lapshyn provided. Mr A said that, after this, Mr Lapshyn appeared satisfied with the decision.

67. On 19 September, Officer F noted that Mr Lapshyn was in a bad mood for the majority of the day. Officer B thought this could have been linked to the disciplinary sanction which Mr Lapshyn said was harsh. The unit was locked up due to staff shortages during the afternoon. The next day, poor weather led to exercise in the open air being cancelled and Officer B recorded that Mr Lapshyn spent the majority of the day in his cell.

Events of 22 and 23 September

68. The following account has been taken from documentary evidence provided by Wakefield, Body Worn Video Camera (BWVC) and CCTV footage, medical records and transcripts of interviews with staff. The times on the CCTV and BWVC are not synchronised but are similar. The below timings are taken from the CCTV footage.

69. On 22 September, Officer C noted that Mr Lapshyn seemed to have settled after the weekend but was still not happy with the outcome of his recent disciplinary hearing and he had slightly resisted the basic regime. A new prisoner arrived on the unit and he and Mr Lapshyn went on the exercise yard together – interviews and case notes do not indicate there was any conflict. CCTV shows Mr Lapshyn interacting with staff and prisoners, cleaning the landing, watching the landing television, and participating in an art activity.

70. Staff locked Mr Lapshyn in his cell for the evening at around 6.30pm. In interview, staff and prisoners said they did not have any concerns about Mr Lapshyn.

71. On the night of 23 September, Officer G was completing routine category A checks (each category A prisoner must be checked five times a night). Officer G reached Mr Lapshyn's cell at 12.15am. During interview, Officer G said Mr Lapshyn had covered his observation panel but uncovered it when she knocked and called his name. Officer G said Mr Lapshyn smiled and gave her a thumbs up and she told him to keep his observation panel uncovered. In interview, Officer G said it was quite usual for Mr Lapshyn to cover his observation panel. She had no concerns about his welfare.

72. Officer G started the next round of category A checks and reached Mr Lapshyn's cell at 1.59am. Officer G said she completed these checks at unpredictable times, and 1.59am was earlier than staff had carried them out the previous week. Mr Lapshyn had again covered his observation panel. Officer G knocked and called Mr Lapshyn's name, but he did not respond. In interview, Officer G said she thought Mr Lapshyn might have been wearing his ear defenders and could not hear her. Officer G left Mr Lapshyn's cell at 2.00am, completed more category A checks, and returned with Officer H at 2.03am. Officer G said she completed the category A checks on the way to get another member of staff as she was concerned she could not get a response from Mr Lapshyn.

73. Officer G and Officer H both tried to get a response from Mr Lapshyn and a better view of his cell but were unsuccessful. In interview, Officer G said she completed a dynamic risk assessment and, due to Mr Lapshyn's history as a bomb and weapon maker, did not assess it was safe to enter his cell.

74. Officer G radioed for SO A (we do not know at what time) who attended alongside Officer I. SO A was also unsuccessful in getting a response from Mr Lapshyn and rang the night manager, CM B. In his statement, Officer I said he was able to remove the inundation port (an opening in the cell door that can be used to fit a hose for extinguishing in-cell fires) and saw Mr Lapshyn suspended from the window, he believed he was deceased but took no action.

75. At 2.18am, CM B arrived and quickly opened the cell door. Mr Lapshyn was hanging from a ligature attached to the window. CM B told officers Mr Lapshyn had 'been there a long time'. She asked them to ring an ambulance but said there were

no signs of life. No member of prison staff entered Mr Lapshyn's cell or checked him for vital signs. At 2.20am, CM B left the cell to 'get advice' (we do not know who from). The officers present did not enter the cell until CM B returned at 2.22am and instructed them to cut the ligature.

76. Accounts differ about which member of staff radioed a code blue (indicating a prisoner is unconscious or having difficulty breathing), but statements, interviews, and the control room radio log indicate that a member of staff called it at around 2.21am.

77. Officers cut and removed the ligature and lowered Mr Lapshyn to the bed, Officer H began CPR. At 2.25am, Nurse A arrived. CM B told Nurse A that Mr Lapshyn had been suspended for a long time and that she thought there was no chance that he could be resuscitated. In interview, Nurse A said this did not affect her decision-making, she completed a physical assessment and concluded there were no signs of life.

78. At 2.45am, paramedics arrived at Mr Lapshyn's cell and completed their assessment. They confirmed life extinct at 2.50am. There was no evidence of rigor mortis (stiffening of the body that normally occurs several hours after death) noted in contemporaneous records.

79. Mr Lapshyn left a note which indicated that he had deliberately ended his life. He asked Officer A to look after the aquarium.

Contact with Mr Lapshyn's family

80. On 23 September, Officer J was appointed as the family liaison officer. Mr Lapshyn's friend was listed as his next of kin. Officer J was unable to contact him and attempted to contact the Ukrainian embassy for support on multiple occasions.

81. On 12 November, the Coroner's office told Officer J that international funeral services had contacted a family friend of Mr Lapshyn's who was acting on behalf of his mother. Officer J contacted the family friend the same day but there were difficulties with communication. Officer J called them with an interpreter the next day. He also spoke to Mr Lapshyn's mother. They were already aware of Mr Lapshyn's death.

82. Officer J discussed funeral arrangements with the next of kin who requested that Mr Lapshyn was buried in the UK. Officer J arranged Mr Lapshyn's funeral and shared the details with the next of kin.

83. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

84. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to identify prisoners most affected by the death).

85. After Mr Lapshyn's death, Wakefield did not complete a hot debrief for the prison or healthcare staff involved in the emergency. In interview, staff reported that some managers checked on their wellbeing afterwards. However, the care team were not on shift when night staff left the prison that morning. The care team appear to have spoken with some members of staff involved in the emergency response when they returned to work the following night.

86. The prison posted notices informing other prisoners of Mr Lapshyn's death and offering support. There is no evidence that staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Lapshyn's death.

Post-mortem report

87. The post-mortem gave Mr Lapshyn's cause of death as hanging.

Findings

Assessment of Mr Lapshyn's risk

88. The Prison Safety Policy Framework lists risk factors and potential triggers for suicide and self-harm and sets out how prisoners identified as at risk should be managed. Mr Lapshyn had some of these risk factors: he was convicted of a violent crime, was life sentenced, had a neurodiverse condition, struggled with boredom, was a foreign national, and had previously self-harmed. Between 2013 and 2016, Mr Lapshyn had been on ACCT on six occasions due to self-harm. There is no evidence of any self-harm or suicide attempts during Mr Lapshyn's time at Wakefield.

89. Shortly before his death, Mr Lapshyn was appropriately placed on basic regime for brewing hooch. Case notes state Mr Lapshyn was not happy with his disciplinary sanction, and that he struggled with being on basic regime due to boredom. During interviews, staff said that Mr Lapshyn had been on basic regime several times in the past and, while it frustrated him, it had never indicated an increased risk of suicide or seemed to significantly impact his mental health. Prison and healthcare records support this.

90. Although Mr Lapshyn was on basic regime, Mulberry Unit staff recognised the negative impact it could have on him and made efforts to keep him occupied. During interview, staff said that they still invited Mr Lapshyn to join activities on the wing. On the day before his death, CCTV shows Mr Lapshyn engaging with staff and other prisoners in an art activity.

91. In hindsight, it appears that Mr Lapshyn experienced different frustrations which, combined, may have contributed to his decision to take his life – he was under threat, he could not return to Ukraine for many years, changes in the prison regime disrupted his routine, and he was on basic regime. However, officers on the unit had developed a good rapport with Mr Lapshyn and he gave no indications that he was contemplating suicide. Contemporaneous case notes and later interviews demonstrate that staff had no concerns about Mr Lapshyn's wellbeing.

92. We are satisfied that staff had no particular reason to consider Mr Lapshyn at increased or imminent risk of suicide in the time before his death. We conclude that staff could not have reasonably foreseen his death.

Threats from other prisoners

93. Due to Mr Lapshyn's high-profile offence, he was regularly under threat while in prison. This threat appears to have escalated after Channel 5 broadcast a documentary about Mr Lapshyn's offences on 18 March. The threat level appears to have escalated again at the end of August.

94. Wakefield put some measures in place to reduce the risk to Mr Lapshyn. Staff from the unit took Mr Lapshyn to collect his medication when prisoners on B-wing were in their cells. Officers also spoke to Mr Lapshyn about the threat he faced. During interview, staff said that a note placed on the Mulberry Unit door and a notice sent to all staff alerted wider staff of the risk. We requested a copy of the notice from Wakefield and were told by Mr A that no such notice existed.

95. During staff interviews, there was a mixed understanding about the use of Challenge Support and Intervention Plans (CSIP – a case management approach to managing prisoners who pose a risk of violence which can also support victims of violence and bullying). During interview, Mr A confirmed that prison staff should use CSIP for both perpetrators and victims of violence. Prison staff did not refer any of the prisoners who made threats towards Mr Lapshyn to CSIP. Mr A acknowledged that Mr Lapshyn may have met the threshold for a CSIP referral as a victim, however, he also said staff may have felt Mr Lapshyn's location on the Mulberry Unit effectively managed the risk due to a higher staff presence and reduced contact with potential perpetrators in the general population.

96. Mr A acknowledged that, at the time of Mr Lapshyn's death, CSIP was not well-embedded at Wakefield. He explained that work is underway to improve this, including revisions to Wakefield's safety strategy. Since Mr Lapshyn's death, Mr A told us that Wakefield have introduced several changes: every violent incident – including verbal threats – now results in a CSIP referral, and a new process has been established within Safety Intervention Meetings (SIM - multi-agency meetings used to discuss prisoners who are at risk of harm) to address the impact of media coverage on the safety of prisoners. The media team now provides the safety team with advance notice of any upcoming documentaries or programmes about prisoners at Wakefield, staff then discuss this at the SIM and assess and manage related risks. We have requested a copy of the new safety strategy to evidence these claims, but it is still in progress.

97. Mulberry Unit staff had multiple conversations with Mr Lapshyn about the threats he was facing. In interview, staff said they did not feel it negatively impacted his well-being. There are no prison or healthcare records that indicate that Mr Lapshyn told staff he was feeling scared or worried. Likewise, there is no evidence of any noticeable deterioration in mental health and Mr Lapshyn made no reference to being under threat in the note he left. While being under threat may not have contributed to Mr Lapshyn's death, there have been two homicides at Wakefield since the death of Mr Lapshyn, which indicates that managing prisoner-on-prisoner violence is an overarching concern. We make the following recommendation:

The Governor should assure herself that Wakefield has robust processes in place to identify, assess and manage the risk of prisoner-on-prisoner violence.

Purposeful Activity

98. Prison staff recognised that Mr Lapshyn struggled with boredom and that it would negatively impact his wellbeing. During his time at Wakefield, staff attempted to manage Mr Lapshyn's boredom by considering him for education or employment, however, there were barriers due to the complexity of Mr Lapshyn's risk.

99. In the period before Mr Lapshyn's death, from July to September, there were regime changes and wing lockdowns that meant Mr Lapshyn had to spend more time in his cell. These lockdowns were due to staff shortages, redeployment, and training. There were several occasions when Mr Lapshyn expressed frustration about the amount of time he was in his cell, and said this impacted on his mental health. We assess that, despite these difficulties, staff acted appropriately and tried to engage Mr Lapshyn in other purposeful activity. We make no recommendations.

100. We are aware that Wakefield's ability to run a full regime was impacted by the two homicides that followed Mr Lapshyn's death. Since February 2026, Wakefield have been working to progress towards reopening a full regime.

Emergency Response

101. The emergency response in the early hours of 23 September fell far below what might reasonably be expected of staff. Our investigation identified a range of troubling issues. Wakefield's Local Security Strategy says that when prisoners cover their observation panel during night state and staff cannot obtain a response, they must immediately inform the CM. This did not happen on the night of 23 September. Instead, when she could not see or obtain a response from Mr Lapshyn at 1.59am, Officer G continued to complete category A checks. When a colleague joined her, still neither radioed the CM, instead radioing the SO. During interview, some officers did not appear to know that they could enter a cell without a CM if there was a risk to life and they had completed a dynamic risk assessment. Our concerns are reinforced by similar findings from a 2024 investigation, in which an officer did not consider entering a cell where there was a risk to life. The recurrence of this issue indicates it remains an ongoing problem at Wakefield.

102. When the SO and other officers arrived, one of them looked through the inundation point and saw Mr Lapshyn hanging. No one entered the cell or radioed a code blue. If staff had radioed a code blue this would have immediately alerted healthcare staff and led to the prompt calling of an ambulance.

103. When the CM did open the cell door, staff did not immediately enter and cut the ligature or assess Mr Lapshyn for signs of life. It seems that this was largely because CM B assumed Mr Lapshyn was deceased – in the absence of any checks for breathing or a pulse. Such was her certainty that she told healthcare staff who arrived shortly after the code blue call that he had been suspended for a long time. In fact, he had been checked and responded at 12.15am, less than two hours earlier.

104. We found that staff lacked confidence in conducting CPR (Officer H said he had never previously administered CPR and had not received training since he joined the service over two years earlier) and that not all staff carried a radio.

105. In December 2025, HMPPS shared a safety learning bulletin which informed staff that they can only decide to not immediately begin CPR if someone clinically trained has confirmed the person is deceased or if there are clear signs incompatible with life. We have shared this bulletin with Head of Safety, Mr A, and asked it to be disseminated to staff.

106. Prison leaders do not appear to have shared learning from Mr Lapshyn's death. During interview, CM B said senior leadership had not spoken to her about her actions during the emergency response. Mr A took over the Head of Safety position in December 2025 and said leadership had not informed him of any concerns around the emergency response. Given the extent of the failings in the emergency response, we find that both surprising and troubling. We make the following recommendations:

The Governor should review the learning identified in relation to the emergency response and introduce a robust assurance process to satisfy herself that:

- **all prison staff are trained and understand their responsibilities during medical emergencies, and**
- **prison leaders promptly share learning from serious incidents with both specific staff involved and with the wider staff group.**

Postvention

107. The Prison Safety Policy Framework requires Governors to ensure that staff receive appropriate post-incident support following a death in custody. Wakefield did not carry out a hot debrief with staff involved in the emergency response, nor did they complete a later debrief. Mr A said the later debrief did not take place because operational focus shifted to a subsequent homicide at the prison; however, that incident occurred more than two weeks after Mr Lapshyn's death. We are concerned that staff involved in Mr Lapshyn's death received no support after being involved in an emotionally challenging incident.

108. The Follow up to Deaths in Custody Policy Framework states that prisons must ensure that they have procedures in place to support prisoners who have been affected by a death in custody. When we visited Wakefield, prisoners on the Mulberry Unit praised the staff on the unit and said they had received good support. However, we are concerned that we have not received evidence that staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Lapshyn's death.

109. We previously identified Wakefield's failure to conduct a hot debrief during our investigation into a self-inflicted death in 2023 and highlighted this in our report. As we have identified the same issue, we make the following recommendation:

The Governor should ensure that local policies reflect both the Prison Safety Policy Framework and the Follow up to Deaths in Custody Policy Framework requirements that staff and prisoners receive adequate support after a serious incident.

Clinical Findings

110. The clinical reviewer concluded that the care Mr Lapshyn received at Wakefield was of a good standard and equivalent to what he could have expected to receive in the community. They noted that Mr Lapshyn received excellent support from the Mulberry Unit in relation to autism.

111. The clinical reviewer assessed that, upon reviewing records, speaking to staff, and considering Mr Lapshyn's clinical presentation, his death was not foreseeable and therefore not preventable.

Governor to Note

Foreign National Prisoners

112. Wakefield are creating a new foreign national strategy that they plan to implement in 2026. The new strategy acknowledges that foreign national prisoners at Wakefield are likely to be serving long sentences and are commonly very isolated from distant families and cultures. It also acknowledges that depression and general mental health needs can be greater in foreign national prisoners and that they are at increased risk of self-harm and suicide.

113. Mr Lapshyn was a foreign national prisoner and staff supported him as such. Staff gave him books in his language, Home Office immigration staff visited him, and staff supported him when he expressed anxiety about the war in Ukraine. While on the Mulberry Unit, staff tried to reduce Mr Lapshyn's isolation – they arranged for Mr Lapshyn to speak with other prisoners who spoke the same language, tried to arrange an inter-prison phone call with a friend who had left the unit, and engaged with him every day. Case notes show that, when Mr Lapshyn did not fully understand an issue, he felt able to approach staff for an explanation. There are also records that Mulberry Unit staff tried to learn some of Mr Lapshyn's language.

114. Mr Lapshyn had not made any telephone calls to family or friends in the last six months before his death, and it is unclear why. HMIP found that many foreign national prisoners were unaware they were eligible for additional telephone credit to contact their families. Records show that Mr Lapshyn did have telephone credit available. However, the Governor will wish to ensure that information about additional telephone credit is clearly communicated as part of the new foreign national strategy.

Good Practice

Neurodiversity support

115. While at Wakefield, Mr Lapshyn received excellent support from the Mulberry Unit. During interview, all staff were passionate about their work, and it was clear they had built a good relationship with Mr Lapshyn. To support his neurodiversity, the Mulberry Unit offered Mr Lapshyn sensory aids, a timetable of activities, and regular staff support and records show Mr Lapshyn's custodial behaviour greatly improved. Despite the restrictions of the long-term high security estate, Mulberry Unit staff and management worked hard to keep Mr Lapshyn occupied and build his social connections. Mr Lapshyn said himself on multiple occasions he was glad to be on the unit.

116. Since Mr Lapshyn's death, the Head of Healthcare, Mr B, has informed us that the mental health team have increased their provision on the Mulberry Unit. A speech and language therapist, social prescriber, and a learning disability nurse work with prisoners on the unit two days per week.

Inquest

At the inquest, held on 3 November 2026, the jury concluded that Mr Lapshyn died by suicide.

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