Prisons & Probation Ombudsman
Independent Investigations

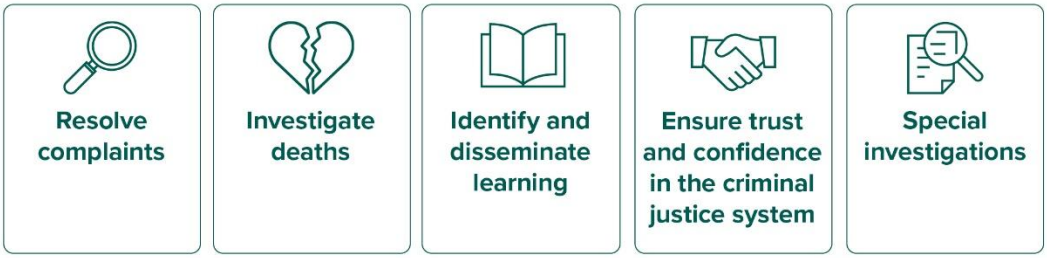
Independent investigation into the death of Mr Alexander Muzyczka, a prisoner at HMP Leeds, on 7 February 2025

A report by the Prisons and Probation Ombudsman

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 Alexander Muzyczka died after being found hanged in his cell on 7 February 2025 at HMP Leeds. He was 37 years old. I offer my condolences to Mr Muzyczka's family and friends.

Mr Muzyczka was the 17th prisoner to take their own life at Leeds since February 2022. This high number of self-inflicted deaths has been recognised as a significant concern and Leeds is receiving additional support and monitoring from regional and national safety teams.

Mr Muzyczka had been at Leeds for nine days when he took his own life. I conclude that there was no particular reason for staff to have considered him a risk to himself. Mr Muzyczka had some unusual beliefs which meant he often did not engage with staff. Staff were respectful of this. However, the clinical reviewer found that Mr Muzyczka's mental health should have been assessed with more urgency and a clear plan made for how to best care for him, given his limited engagement.

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 **October 2025**

Contents

Summary

Events

1. On 30 January 2025, Mr Alexander Muzyczka appeared in court and was remanded to HMP Leeds charged with sending a threatening communication. This was Mr Muzyczka's first time in prison.

2. Mr Muzyczka refused to engage in the reception process. He claimed to be a sovereign man and asserted that the prison had no legal authority to detain him. Staff moved him to a single cell on the induction unit.

3. During his initial healthcare screening, Mr Muzyczka refused to answer questions about his physical and mental health. The nurse urgently referred him to the mental health team.

4. Between 31 January and 5 February, Mr Muzyczka refused to engage with healthcare staff. Staff made further urgent referrals for a mental health assessment on 30 January, 31 January, and 3 February. He declined to participate in a mental health assessment on 3 February.

5. On 5 February, Mr Muzyczka attempted to open a locked door leading to another part of the prison. Staff challenged him and used guiding holds to return him to his cell. He remained calm during the interaction but reiterated his belief that the prison had no legal authority to detain him.

6. Later that day, staff noted a negative entry in Mr Muzyczka’s record for his misuse of his cell bell. He had repeatedly pressed the bell and demanded to be released.

7. On 6 February at 9.31pm, Mr Muzyczka called staff using his cell bell and stated he planned to settle down and get on with his time at Leeds. Staff had no concerns about him.

8. On 7 February at 5.26am, when checking prisoners, an officer found that Mr Muzyczka’s cell door observation panel was covered, and he did not respond when the officer called him. The officer carried on checking other prisoners but returned to Mr Muzyczka’s cell three minutes later. She then left again and came back with another officer to unlock the inundation point (for inserting a hose in the event of a cell fire). They saw Mr Muzyczka suspended by a ligature made from bed sheets tied to the window. Staff immediately radioed an emergency code and entered the cell at 5.31am. They cut the ligature and began CPR immediately. Healthcare staff arrived shortly after, and paramedics arrived at 5.42am. They pronounced life extinct at 5.55am.

Findings

9. We are satisfied that staff at Leeds appropriately assessed Mr Muzyczka’s risk of suicide and self-harm and it was reasonable that they did not assess that he was a risk to himself.

10. There was an unacceptable delay of five minutes in going into Mr Muzyczka's cell when his observation panel was found to be covered and he did not respond.

11. There was no sufficient policy in place at the time of Mr Muzyczka's death, setting out targets for assessing a prisoner urgently referred to mental health. The Local Operating Policy for Referral into Integrated Mental Health Services has been appropriately updated following Mr Muzyczka's death.

Recommendations

- The Head of Healthcare at HMP Leeds and Mental Health Lead should ensure that the referral process to the mental health team is clear and defines what is meant by an urgent referral.

- The Head of Healthcare should ensure that a detailed account of multi-agency meetings is made in a prisoner's medical record detailing a clear action plan.

The Investigation Process

12. HMPPS notified us of Mr Muzyczka's death on 7 February 2025.

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

14. The investigator visited Leeds on 20 February. She obtained copies of relevant extracts from Mr Muzyczka's prison and medical records.

15. The investigator interviewed eight members of staff at Leeds on 18 March. She interviewed one member of staff via Microsoft Teams on 16 April.

16. NHS England commissioned a clinical reviewer to review Mr Muzyczka's clinical care at the prison. The clinical reviewer attended eight joint interviews at Leeds.

17. We informed HM Coroner for West Yorkshire Eastern District of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Muzyczka's father to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Muzyczka's father asked us to consider whether the prison received any information from the police relating to Mr Muzyczka's mental health, and whether he subsequently received a mental health screening at Leeds.

19. We have answered his questions in this report.

20. Mr Muzyczka's family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). Practice Plus Group (PPG) pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Leeds

22. HMP Leeds is a local prison holding men who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health and substance misuse services.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Leeds was in June 2022, which was followed up by a review of progress inspection in July 2023. In the initial inspection, it was reported that prisoners arriving at Leeds were treated with respect, with risks identified and addressed at reception. However, the high number of prisoners arriving each day placed substantial pressures on staff, with arrivals being held in reception for up to five hours. It was also reported that Prison Service suicide and self-harm support measures, known as ACCT, were started appropriately when needed, case reviews took place on time and had regular input from mental health staff.

24. The progress inspection reported that despite their previous concerns about the high number of prisoners who had taken their own lives, there had been a failure by leaders to make progress in reducing the rate of suicide, although the prison was making progress in some areas.

Independent Monitoring Board

25. 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 December 2023, the IMB continued to express concern at the high number of deaths in Leeds. They also noted that the number of prisoners arriving at Leeds, and subsequent mental health referrals, put considerable pressure on the mental health team to ensure that diagnosis and treatment was both thorough and effective.

Previous deaths at HMP Leeds

26. Mr Muzyczka was the 26th prisoner to die at Leeds since February 2022. Of the previous deaths, eight were due to natural causes, 16 were self-inflicted, and one was drug related. Up to the end of June 2025, there had been two further deaths, one due to natural causes, and one awaiting classification. As a result of the number of deaths, Leeds was identified as requiring additional support and monitoring from regional and national safety teams.

27. In previous investigations, we found that Leeds needed to improve their assessment and management of prisoners at risk of suicide and self-harm. We have also found that improvement was needed to mental health referral, assessment and treatment.

Assessment, Care in Custody and Teamwork (ACCT)

28. 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.

29. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. 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 the *Prison Safety Policy Framework*.

The Sovereign Citizen Movement

30. The Sovereign Citizen Movement is a loose group of individuals from a variety of countries who believe that they can declare themselves independent from government authority by submitting specific documents. They claim they are not subject to governmental laws or statutes unless they explicitly consent to them. Their claims have been consistently rejected by courts in various countries.

Key Events

31. On 30 January 2025, Mr Alexander Muzyczka appeared at court and was remanded to prison, charged with sending a threatening communication in January 2019. At court, custody officers used a low level of restraint to escort him onto the prisoner transport van, as he refused to board it voluntarily.

32. Mr Muzyczka arrived at HMP Leeds with a Digital Personal Escort Record (D-PER), which noted the use of the restraint at court but contained no further information from the police. It was Mr Muzyczka's first time in prison. He refused to engage with the reception process and would not confirm any personal details. He did not take up the offer of a phone call. Mr Muzyczka maintained that he should not be in prison, identifying himself as a "sovereign citizen". When he refused to enter a holding room in reception, staff used guiding holds (a low level of restraint) to move him there. The Head of Reducing Reoffending was present and attempted to explain the legal basis for his detention.

33. The Head of Reducing Reoffending and other prison staff escorted Mr Muzyczka to the induction wing and placed him in a single cell. He immediately informed Ms Buckley that the cell was unsuitable due to a blocked toilet. Staff then moved him to a different cell on the same landing.

34. At 11.03pm, a nurse conducted Mr Muzyczka's initial health screening on the induction wing. Staff told her that they had moved him to the wing before screening because of his bizarre behaviour. (Usually this screening would take place in reception.) As the prison was in night state (when staffing levels are reduced), the nurse conducted the assessment through the locked cell door. The nurse spent about 45 minutes talking to Mr Muzyczka. She told the investigator that Mr Muzyczka communicated clearly but refused to provide specific medical information and spoke about bizarre topics. The nurse assessed him as high risk under the Cell Sharing Risk Assessment (CSRA, which assesses the risk a prisoner poses to a cell mate) due to his bizarre behaviour and submitted an urgent referral to the mental health team that night. She also raised his case at the multidisciplinary team meeting the following day to highlight her concerns and request he be seen urgently. The nurse told the investigator that she would have started suicide and self-harm monitoring procedures (known as ACCT) had Mr Muzyczka expressed any thoughts of self-harm or suicide.

35. Prison officers carried out welfare checks on Mr Muzyczka at 9.38pm and on 31 January at 1.34am, 4.15am, and 5.10am. They reported no concerns during these checks.

36. On 31 January, a GP at Leeds, went to see Mr Muzyczka on the wing due to the concerns documented by the nurse the previous day. Mr Muzyczka refused to engage, stating that he was being held illegally and tortured. He declined all offers of medical assistance. The GP submitted an urgent task to the mental health team requesting a review as he was unsure if Mr Muzyczka was displaying symptoms of psychosis.

37. The same day, healthcare staff completed a medication reconciliation. This confirmed that Mr Muzyczka was not being prescribed any medication in the community before he came to prison.

38. On 1 February, healthcare staff attempted to complete Mr Muzyczka's secondary screening but he refused to engage. Between 2 and 5 February, healthcare staff also attempted to carry out Mr Muzyczka's physical observations daily, but he refused to engage each time.

39. On 3 February, a nurse tried to assess Mr Muzyczka's mental health but he refused to engage. He said he was a sovereign man, and tried to close the cell door. Due to the limited contact, the nurse was unable to assess Mr Muzyczka's mental health. He raised Mr Muzyczka's case at the daily multi-disciplinary team meeting and requested a follow-up triage assessment to be scheduled for a later date when Mr Muzyczka might be more settled.

40. On 5 February, during the day, Mr Muzyczka attempted to open a locked door that led to another part of the prison. An officer challenged him, and he responded by stating he was a "sovereign man" and the "saviour of God", insisting that he needed to be released. The officer talked with Mr Muzyczka for approximately five minutes before instructing him to return to his cell. When he refused, staff used guiding holds to escort him back. The officer referred Mr Muzyczka for a Challenge, Support and Intervention Plan (CSIP – used for those who are a risk to others).

41. That evening, an officer noted a negative behaviour entry on Mr Muzyczka's record for misusing his emergency cell bell. The officer told the investigator that Mr Muzyczka repeatedly activated the cell bell, claiming he was being held against his will and needed to be released from Leeds.

42. On 6 February, the multidisciplinary complex case clinic (MPCCC), chaired by healthcare staff, discussed Mr Muzyczka. The team agreed to urgently rebook him for a mental health review. They also allocated him a care coordinator and formally referred him as a complex care case.

Events of 6 and 7 February

43. The investigator reviewed CCTV footage, body-worn video camera (BWVC) recordings, and staff radio communications from 6 and 7 February. She also obtained information from the Yorkshire Ambulance Service. The following account is based on all sources. (The CCTV clock was 34 minutes behind the actual time. The actual time is documented below.)

44. Mr Muzyczka was last seen on CCTV on 6 February at 4.35pm, collecting food from the servery and returning to his cell. Between 4.41pm and 4.59pm, officers responded to his cell bell twice. At 5.03pm, an officer completed a routine check of all prisoners, including Mr Muzyczka. Between 5.04pm and 7.02pm, officers responded to his cell bell four times. Mr Muzyczka was again repeating his belief that he was being unlawfully detained and wanted to leave the prison. At 8.42pm, an officer completed another routine check of all prisoners, including Mr Muzyczka.

45. At 9.31pm, an officer responded to Mr Muzyczka's cell bell. She told the investigator that he appeared confident, happy, and settled. He told her he wanted to move on

and serve his time at Leeds. An officer had spoken with Mr Muzyczka several times since his arrival and reported that his behaviour on 6 February was consistent with previous nights. She had no concerns that he was at risk of suicide or self-harm.

46. On 7 February, an officer was doing a routine check of all prisoners. At 5.26am, she got to Mr Muzyczka's cell and found the cell door observation panel was covered. She knocked but received no response. At 5.27am, she moved on to check other prisoners. At 5.29am, she returned to Mr Muzyczka's cell turned on the light and looked through the side of the door. At 5.30am, she briefly left, returned 24 seconds later, and unlocked the inundation point (used to insert a hose in case of cell fire) to get a better view. An officer arrived 15 seconds later (as an officer had told him the observation panel was covered) and also looked into the cell. Mr Muzyczka was hanging at the back of the cell by a ligature made from twisted bed sheets attached to the window. An officer a code blue (an emergency code used when a prisoner has stopped or is having difficulty breathing). Control room staff immediately requested an ambulance.

47. At 5.31am, officers went into the cell. An officer tried to cut the ligature with her anti-ligature knife but struggled due to the thickness of the sheets. Seconds later, an officer entered the cell and used an officer's anti-ligature knife to cut the ligature from the window. An officer then untied the ligature from Mr Muzyczka's neck. He immediately began CPR. A Healthcare Assistant (HCA) and a nurse arrived at 5.32am. They attached the defibrillator, inserted an airway and administered oxygen. Paramedics arrived at 5.42am, took over Mr Muzyczka's treatment and continued CPR. They pronounced Mr Muzyczka's life extinct at 5.55am.

48. After Mr Muzyczka's death, staff found a note in his cell, dated 4 February. The note expressed his intention to file criminal claims against prison staff and senior leaders over his detention at Leeds. It did not mention any intent to take his own life.

Contact with Mr Muzyczka's family

49. The prison appointed an officer as the family liaison officer (FLO). As Mr Muzyczka had not identified any next of kin when he arrived at Leeds, the FLO liaised with the police who provided the address for Mr Muzyczka's father. At 11.55am, The FLO and Head of Reducing Reoffending visited Mr Muzyczka's father at his home address and broke the news of his son's death and offered their condolences. Leeds contributed to Mr Muzyczka's funeral costs in line with national instructions.

50. The FLO maintained regular contact with Mr Muzyczka's father, offering him and other family members support.

Support for prisoners and staff

51. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner 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 provide confidential peer-support) to identify prisoners most affected by the death.

52. After Mr Muzyczka's death, a Custodial Manager (CM) debriefed 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 Muzyczka'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 Muzyczka's death. Listeners were made available across the establishment.

Post-mortem report

54. The pathologist gave Mr Muzyczka's cause of death as hanging.

Inquest

55. The Coroner's inquest held in 9th February 2026 determined the medical cause of death to be hanging.

56. The jury returned a narrative conclusion, stating that Mr Muzyczka hanged himself. The act was considered unforeseeable by both prison and healthcare staff. The jury was unable to conclude that he intended to end his life.

Findings

Assessment of risk of suicide and self-harm

57. The *Prison Safety Policy Framework* sets out the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and the procedures (known as ACCT) that staff must follow when they identify a prisoner at risk. Prison Service Instruction (PSI) 7/2015, *Early Days in Custody,* requires reception staff to examine the PER and any other available documentation to identify immediate needs and risks already recorded.

58. Mr Muzyczka's only known risk factor was that this was his first time in prison. There was no recorded history of suicidal thoughts or attempts or self-harm, the medication reconciliation confirmed he was not on any mental health medication, and he declined to share any personal history. Mr Muzyczka was polite and calm in his communication with staff but challenged the legal authority of the prison to detain him.

59. Mr Muzyczka said he was a sovereign citizen. At that time, staff were unaware of this belief system. Staff considered Mr Muzyczka's behaviour was 'bizarre' and appropriately referred him for a mental health assessment.

60. During Mr Muzyczka's healthcare screening on 30 January, a nurse spent approximately 45 minutes talking with Mr Muzyczka. She was satisfied that he was not exhibiting behaviours that indicated he was at risk of suicide or self-harm.

61. The Head of Reducing Reoffending, and officers all had contact with Mr Muzyczka. They all said that while some of his language was 'bizarre', he did not present as a risk of suicide and self-harm. A nurse also had contact with Mr Muzyczka. While he was unable to complete a mental health assessment, he also did not assess Mr Muzyczka as a risk to himself.

62. We are satisfied that staff at Leeds appropriately assessed Mr Muzyczka and it was reasonable that they did not consider him to be a risk of suicide or self-harm.

Clinical Care

63. Mr Muzyczka refused to cooperate with healthcare staff assessing his physical health. However, the clinical reviewer was satisfied that entries in this medical record described kind, respectful and compassionate interactions between healthcare staff and Mr Muzyczka.

Mental Healthcare

64. The clinical reviewer concluded that the mental healthcare Mr Muzyczka received was not satisfactory and only partially equivalent to that which he would have received in the community.

65. Mr Muzyczka was urgently referred to the mental health team three times. Despite this, he was only seen once by the mental health team, four days after arriving at

Leeds. The clinical reviewer concluded that the mental health team did not respond with appropriate urgency to assess Mr Muzyczka.

66. The Deputy Head of Healthcare said that there was no policy in place at the time of Mr Muzyczka's death specifying a target for a prisoner to be seen following an urgent referral. She told us that 'best practice' would be for someone to be seen within 48 hours following an urgent referral, however five days was the set target for all mental health referrals, whether urgent or routine.

67. The local mental health operational policy states that a duty worker is allocated each day who can be contacted in the case of urgent referrals to the mental health team. The clinical reviewer notes that the duty worker was either not contacted about the urgent referrals or did not assess Mr Muzyczka in line with the policy. It is also of concern that the Deputy Head of Healthcare, was seemingly unaware of this arrangement when interviewed. We make the following recommendation:

The Head of Healthcare at HMP Leeds and Mental Health Lead should ensure that the referral process to the mental health team is clear and defines what is meant by an urgent referral.

68. The clinical reviewer also found that the record of the MPCCC meeting lacked detail or any clear plan with the only action being another urgent referral to mental health. We make the following recommendation:

The Head of Healthcare should ensure that a detailed account of multi-agency meetings is made in a prisoner's medical record detailing a clear action plan.

Governor to note

Emergency Response

69. When an officer found Mr Muzyczka's observation panel blocked and obtained no response, she continued checking other prisoners. She returned to his cell three minutes later and then left again to get the key for the inundation point. She returned and unlocked this. There was a delay of five minutes from when the officer first got to the cell, to staff going in.

70. The officer told the investigator that prisoners often want privacy and she thought Mr Muzyczka could be asleep. She recognised that there should always be concern when an observation panel is blocked. She told the investigator that she opened the inundation point as, although it is used for cell fires, she could see through this into the cell. Delays in entering a cell due to blocked observation panels has not been an issue in previous or subsequent investigations following deaths at Leeds and we understand that a local policy setting out how staff should respond to blocked observation panels is in development. We therefore make no recommendation but bring this to the Governor's attention.

Good Practice

71. The FLO, a relatively new family liaison officer, recognised that Mr Muzyczka's belongings should be presented to Mr Muzyczka's family sensitively and decently

and so personally provided special bags to place his belongings in. The PPO investigator also witnessed the FLO challenging staff who had left Mr Muzyczka's belongings outside of the cell prior to clearing.

72. We are pleased to see a family liaison officer undertake the role with such care and respect for the deceased and their family.

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