Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Patryk Skupinski, a prisoner at HMP Gartree, on 29 January 2025

## A report by the Prisons and Probation Ombudsman

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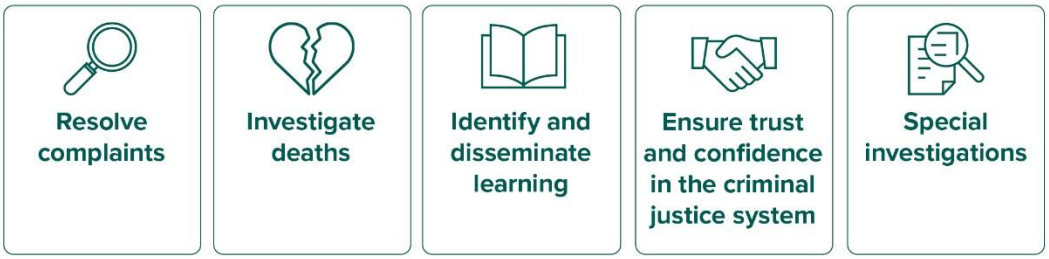
## OUR VISION

**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

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 Patryk Skupinski died from heart disease in combination with synthetic cannabinoid (psychoactive substances, PS) use on 29 January 2025, at HMP Gartree. He was 38 years old. I offer my condolences to Mr Skupinski's family and friends.

Mr Skupinski was given information about the risks of taking PS when he arrived at Gartree. He told staff he had no substance misuse issues and there is no record of any suspicions that he was using drugs in prison.

I make no recommendations.

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 24 January 2022, Mr Patryk Skupinksi was remanded in custody charged with murder. He was subsequently convicted and on 6 October 2023, was sentenced to life imprisonment.

2. Mr Skupinski told staff he did not use drugs and there is no record of any suspicions of him using drugs in prison.

3. In October 2024, Mr Skupinski was moved to HMP Gartree. He attended a substance misuse induction meeting at which he was told about the dangers of using psychoactive substances (PS). He maintained that he did not use drugs.

4. Shortly before 8.00am on 29 January 2025, an officer unlocked Mr Skupinski's cell for morning activities. The officer did not try to get a response from Mr Skupinski, despite a local instruction saying that officers should either obtain a verbal response or observe movement when unlocking prisoners.

5. Around 20 minutes later, another prisoner found Mr Skupinski lying on his bed unresponsive. The prisoner raised the alarm. Prison staff responded and found Mr Skupinski unresponsive, lying face down in a pool of vomit. They started CPR. When paramedics arrived, they saw signs of rigor mortis (stiffening of the body after death) and pronounced life extinct at 8.58am.

6. The post-mortem report concluded that Mr Skupinski died from heart disease in combination with synthetic cannabinoid (PS) use.

## Findings

7. Mr Skupinski had no known heart issues and there had been no suspicions of him using illicit drugs throughout his time in prison. He had been warned of the dangers of PS.

8. The clinical reviewer found that the care that Mr Skupinski received was of a good standard and equivalent to that which he could have expected to receive in the community.

9. Mr Skupinski would have been found dead earlier had the unlock policy been followed. The Deputy Governor told us that managers would issue the unlock policy to each member of staff, who would be required to sign to say they had read and understood it.

10. We make no recommendations.

# The Investigation Process

11. HMPPS notified us of Mr Skupinski's death on 29 January 2025.

12. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asked anyone with relevant information to contact her. One prisoner responded by letter. He said that the prison had lied about the time Mr Skupinski died. We are satisfied that the prison used the time that Mr Skupiniski was declared dead by paramedics.

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

14. NHS England commissioned an independent clinical reviewer to review Mr Skupinski's clinical care at the prison. The investigator and clinical reviewer jointly conducted interviews with six members of staff.

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

16. The Ombudsman's office contacted Mr Skupinski's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He asked what had led to his brother's death. This has been addressed in our report.

17. We shared our initial report with HMPPS. They found no factual inaccuracies.

18. We sent a copy of our initial report to Mr Skupinski's next of kin. They did not notify us of any factual inaccuracies.

# Background Information

## HMP Gartree

19. HMP Gartree, near Market Harborough in Leicestershire, holds male prisoners mainly sentenced to life imprisonment and other indeterminate sentences. Practice Plus Group provides healthcare. Nursing staff are available 24 hours a day.

## HM Inspectorate of Prisons

20. The most recent inspection of Gartree was in January 2023. Inspectors reported that Gartree was well led and generally provided good outcomes for prisoners. Inspectors noted that safety outcomes had improved and that respect and rehabilitation and release planning, were now reasonably good. Inspectors found that purposeful activity outcomes were not sufficiently good but were better than similar establishments.

21. Inspectors also found that the supply of illicit items, including drugs and mobile phones, had been identified as a significant threat to the prison. Prisoners said that that they could easily access illicit substances. Inspectors reported that leaders had taken some appropriate steps to disrupt the supply of drugs into the prison, including prompt analysis of security intelligence at a monthly tactical meeting. The prison's dedicated search team used a body scanner and search dogs efficiently in response to intelligence led search requests.

22. Inspectors concluded that too many illicit items, including drugs, were entering the prison. Although security measures had been improved, further action was needed to reduce supply.

## Independent Monitoring Board

23. 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 30 November 2024, the IMB reported that they remained concerned about the continued influx of drugs and illicit items and the inability of the Prison Service to restrict drone activity.

24. The Board reported that they were concerned that drugs and illicit items continued to infiltrate the prison by a variety of means. The Board were also concerned that their prevalence was closely linked to the levels of debt, violence and bullying that occurred at Gartree.

## Previous deaths at HMP Gartree

25. Mr Skupinski was the eleventh prisoner to die at Gartree since January 2022. Of the previous deaths, two were self-inflicted and eight were from natural causes. Up to the end of July 2025, there have been five further deaths, of which one was self-inflicted, one was drug related and three were from natural causes. There were no similarities between the findings in this investigation and the findings from our investigations into the previous deaths.

## Psychoactive substances (PS)

26. The term psychoactive substances (PS) is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

27. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

# Key Events

28. On 24 January 2022, Mr Patryk Skupinksi was remanded in custody charged with murder. He was sent to HMP Hewell. He was subsequently convicted and on 6 October 2023, was sentenced to life imprisonment.

29. When he arrived in prison, Mr Skupinski told staff he had no issues with drug or alcohol misuse. Over the next year, Mr Skupinski engaged well with the prison regime and worked on the wing as a cleaner. Mr Skupinski's prison record had many positive entries from staff commending his good behaviour.

30. On 31 October 2024, Mr Skupinski was moved to HMP Gartree. The reception nurse noted that Mr Skupinksi said he did not take drugs or drink alcohol.

31. On 14 November, Mr Skupinski attended an induction meeting on substance misuse, during which he was made aware of the effects of 'Spice' (a synthetic cannabinoid and type of psychoactive substance, PS) and that new stronger drugs, such as fentanyl and nitazenes (both synthetic opioids) were being used in Spice. Mr Skupinski maintained that he did not use drugs. He was given an induction pack at the end of the session.

32. Over the next two months staff recorded that Mr Skupinski was a mentor in the prison workshop and attended daily. Staff noted examples of positive attitude and behaviour.

## Events of 29 January

33. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 29 January. She also obtained information from East Midlands Ambulance Service. The following account has been taken from all sources.

34. At 5.07am, an operational support grade (OSG) carried out a routine roll check. CCTV shows him looking through the observation panel in Mr Skupinski's cell and using his torch to see into the cell. He was satisfied there were no issues.

35. At 7.13am, Officer A carried out another routine roll check. CCTV shows him looking through the observation panel of Mr Skupinski's cell and then continuing to the next cell.

36. At around 7.58am, Officer B unlocked prisoners for morning activities. CCTV footage shows that Officer B unlocked Mr Skupinski's cell door and opened it slightly. Officer B did not check on Mr Skupinski or try to get a response from him.

37. At around 8.20am, another prisoner went to Mr Skupinski's cell to see if he was ready to go to the workshop. He found Mr Skupinski lying face down and unresponsive on the bed. He pressed the emergency cell bell and the general alarm on the landing.

38. Officer A and Officer B responded to the alarm. When they went into Mr Skupinski's cell they saw him lying face down on the bed in a pool of vomit. They put Mr

Skupinski in the recovery position and checked for signs of life. Mr Skupinski was not breathing. Staff moved Mr Skupinski to the floor and started CPR.

39. Officer C, who also responded to the alarm, radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately). The OSG in the control room immediately called for an ambulance.

40. At around 8.45am, paramedics arrived. Paramedics assessed Mr Skupinski and noted that he was stiff and had rigor mortis (stiffening of the body that occurs roughly two to six hours after death). At 8.58am, they declared life extinct.

41. After Mr Skupinski's death, a tampered vape (often used to inhale illicit substances) was found in his cell.

## Contact with Mr Skupinski's family

42. Mr Skupinski's mother was listed as his next of kin, but she had been released from prison and deported back to Poland, so the prison did not have an address for her.

43. On 3 February, the prison appointed a family liaison officer (FLO). She contacted the Polish Consulate in Manchester to see if they could find any next of kin details for Mr Skupinski. The Consulate found details of Mr Skupinski's brother. They contacted him and broke the news of his brother's death.

44. The Consulate gave the prison FLO Mr Skupinski's brother's email address. She emailed him offering her condolences and asked for his mother's contact details. The FLO called Mr Skupinski's mother, to explain what had happened and offer support. She said she was happy for the prison to liaise with her son.

45. The Polish authorities arranged the repatriation of Mr Skupinski's body to Poland. The prison remains in contact with Mr Skupinski's family about the funeral costs and intends to contribute up to the standard limit once the final costs are known.

## Support for prisoners and staff

46. 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 provide confidential peer-support) to identify prisoners most affected by the death.

47. After Mr Skupinski's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Listeners were deployed and the staff care team also offered support.

48. The prison posted notices informing other prisoners of Mr Skupinski's death and offering support. The prison also deployed Listeners to the wing to offer support

Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Skupinski's death.

## Post-mortem report

49. The post-mortem report concluded that Mr Skupinski died from ischaemic heart disease in combination with synthetic cannabinoid (PS) use.

# Findings

## Clinical care

50. The clinical reviewer found that the care Mr Skupinski received was of a good standard and equivalent to that which he could have expected to receive in the community.

51. The clinical reviewer noted that Mr Skupinski had no significant medical history including any concerns about his heart.

52. The clinical reviewer was concerned that healthcare staff did not administer naloxone (medication that rapidly reverses an opioid overdose) until ten minutes after they had responded and that they only administered one dose (further doses of naloxone can be given every two to three minutes until an effect is noted or the ambulance arrives). However, this would have made no difference to Mr Skupinski who was dead when found.

53. The clinical reviewer also noted that healthcare staff did not stop CPR despite Mr Skupinski showing signs of rigor mortis.

54. She made three recommendations which the Head of Healthcare will wish to address.

## Delay in identifying that Mr Skupinski was dead

### Welfare check

55. Prison Service Instruction (PSI) 75/2011 Residential Services states that staff should assure themselves of the wellbeing of prisoners during or shortly after unlock.

56. Following a previous death at Gartree, the Acting Governor issued a Notice to Staff in March 2022, which said that staff must obtain a response from prisoners when unlocking them, either a verbal conversation or movement observed.

57. On 29 January, when Officer B unlocked Mr Skupinksi's cell, he did not check his welfare or obtain a response from him. (Mr Skupinski was found dead around 20 minutes later.) While it would have made no difference to the outcome for Mr Skupinski, a proper welfare check would have meant that he was found sooner and not by another prisoner.

58. When asked about this at interview, Officer B said that he was not aware that he should carry out a welfare check and that his role was just to unlock the cell doors. Other officers also told us at interview that they were unaware of a policy on welfare checks at unlock.

59. When the investigator told the Deputy Governor about this, he said that managers would issue the unlock policy to each member of staff and that staff would have to sign to say that they had read it and that they understood the policy. Given the prison is taking action to address the issue we do not make a recommendation, but

experience tells us that effecting genuine and long lasting behavioural change requires maintained focus.

### Roll check

60. Ambulance paramedics assessed that Mr Skupinski had rigor mortis when they arrived at 8.45am. As rigor mortis starts around two to six hours after death, Mr Skupinski was almost certainly dead when the roll check was completed at 7.13am that morning.

61. A roll check is primarily to check that all prisoners are present in their cell. We would also expect staff to identify during a roll check if it was obvious that a prisoner needed medical attention, for example, if they were hanging, lying on the floor, or in an odd position on their bed. In this case, Mr Skupinski was face down on his bed and we accept that it would not have been immediately apparent just by looking at him that he was dead. However, the policy around the checks required during roll checks at Gartree was unclear.

62. Gartree's Local Security Strategy (LSS - outlines procedures and processes for all aspects of security within a prison) in place at the time of Mr Skupinski's death, said that staff should obtain a positive response from the prisoner during a roll check and if they fail to do so, they should open the cell door. When Officer A completed the early morning roll check, he did not obtain a positive response from Mr Skupinski or open the cell door.

63. The investigator asked the Head of Security if he expected officers to wake prisoners up at every roll check, including very early in the morning. He said that it would not be decent to wake prisoners up at 5.00am and 7.00am to conduct a roll check. The investigator pointed out that according to the LSS, staff were expected to obtain a positive response at all roll checks, regardless of the time of the check.

64. Gartree has since changed its LSS. The LSS now states that staff must check the presence of the occupants in every cell. If they cannot see the prisoner, they will need to open the cell to check their presence.

## Drug Strategy

65. Gartree's current Drug Strategy dated 2025, sets out the actions that the prison has taken and plans to take to restrict the supply of drugs, reduce demand and build recovery. Each element of the drug strategy has a detailed plan of specific actions. Governance is via a monthly drug and alcohol strategy meeting, a meeting that is well attended by internal prison departments and external agencies.

66. The Deputy Governor told the investigator that like many prisons, Gartree had identified that drones were the main route for not only illicit substances but other illicit articles that threatened the safety and good order of the prison. The Deputy Governor said that Gartree had commissioned a company to make protector cages for the windows to stop drones being able to fly to the window to drop off illicit items.

67. This project was ongoing, and the prison was in the process of commissioning a company to install the protector cages. The Deputy Governor hoped that the work would be completed within the next six months.

68. While the prison was waiting for the cages to be fitted, they continued to try to disrupt drug routes by using effective searching procedures, reporting and using intelligence and using internal and external drug testing procedures to identify trends and risks. Gartree also worked closely with local police and the corruption protection unit.

69. Gartree's Drug Strategy details how Gartree will try to reduce the demand for drugs by putting incentives in place to try to encourage prisoners to make prosocial decisions and refrain from using drugs. This includes engaging with family, friends and peers to help develop support networks for prisoners that are struggling with substance misuse. Gartree also utilises support from stakeholders, healthcare staff and Inclusion (the prison's substance misuse team) who talk to prisoners about the risks of taking drugs in prison.

70. In addition, the Drug Strategy describes how Gartree will enable recovery and take a whole prison approach to support prisoners that want to desist from taking drugs. The prison has an Incentivised Substance Free Living unit (ISFL) unit that holds around 27 prisoners and encourages, rewards and supports prisoners in not taking drugs.

71. The prison continues to carry out Mandatory Drug Testing (MDT) and met their target of 174 random drug tests between July and December 2024. In addition, the prison completed over and above the target of 30 drug tests at weekends. In total 26 prisoners tested positive for drugs, 14 of those tested positive for PS.

72. We make no recommendation.

## Inquest

73. At the inquest, held from 9 to 13 March 2026, the jury concluded that Mr Skupinski died by misadventure alongside a heart condition.

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