Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Piotr Kulik, a prisoner at HMP Gartree, on 7 March 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

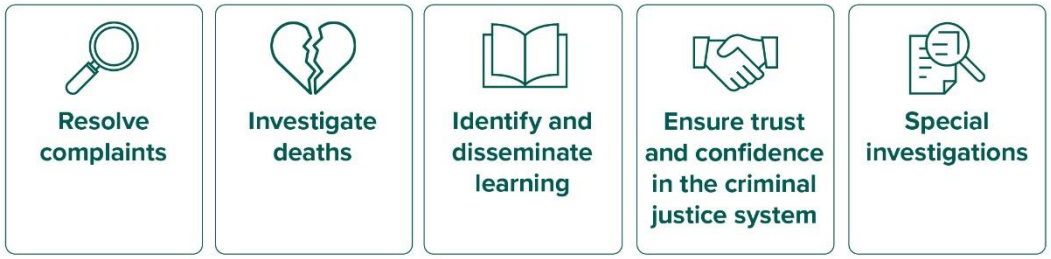
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Piotr Kulik died of metastatic cancer (cancer that has spread to other parts of the body) at HMP Gartree on 7 March 2023. He was 41 years old. We offer our condolences to Mr Kulik's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Kulik received at Gartree was equivalent to that which he could have expected to receive in the community.

5. The non-clinical care provided to Mr Kulik was of a good standard overall. Staff showed great compassionate and patience when trying to engage Mr Kulik, to ensure he was supported in difficult circumstances. We found an issue with the process for completing early release on compassionate grounds applications, which did not directly impact on Mr Kulik's death but delayed the progression of his application. This has since been rectified by the offender management unit.

The Investigation Process

6. We were notified of Mr Kulik's death on 7 March 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Kulik's clinical care at HMP Gartree.

8. The PPO investigator investigated the non-clinical issues relating to Mr Kulik's care.

9. The PPO family liaison officer wrote to Mr Kulik's next of kin, his aunt, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but asked for a copy of our report.

10. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.

11. We also shared the initial report with Mr Kulik's aunt. She did not identify any inaccuracies.

Previous deaths at HMP Gartree

12. Mr Kulik was the 17th prisoner to die at Gartree in three years. Of the previous deaths, 12 were from natural causes, three were self-inflicted, and one is awaiting classification. There are no similarities between our findings in the investigation into Mr Kulik's death and our investigation findings for the previous deaths.

Key Events

13. On 9 March 2012, Mr Piotr Kulik was given a life sentence for murder. He was transferred from HMP Lowdham Grange to HMP Gartree on 7 August 2018.

2022

14. Mr Kulik was a Polish national. He had no significant medical history prior to September 2022, when he reported abdominal pain, bloating, and blood in his stools to the prison doctor. After conducting blood tests, the doctor referred Mr Kulik the gastroenterology clinic at the local hospital.

15. On 29 October, Mr Kulik attended the gastroenterology clinic and was admitted for thorough investigation due to suspected cancer. He was diagnosed with blood clots in his lungs, liver lesions and ascites (excess fluid in the abdomen).

16. On 15 November, staff at the gastroenterology clinic informed Mr Kulik that he had advanced and untreatable cancer. They said that the cancer had started in the large bowel and had since spread to his liver. Staff drained the excess fluid in his abdomen and advised that he would need to return to hospital for regular drainage.

17. Following his terminal diagnosis, on 15 November prison healthcare staff placed Mr Kulik on the prison complex case list and arranged for his care to be discussed at weekly multi-disciplinary meetings. They created a palliative care plan which recorded Mr Kulik's daily weight and NEWS2 score (a tool used to identify acutely unwell patients). The Primary Care Matron confirmed that healthcare staff did not include a do not attempt cardiopulmonary resuscitation order (DNACPR) as they felt Mr Kulik had not fully accepted his terminal diagnosis and was not ready to discuss implications.

18. The prison appointed a family liaison officer, who met with Mr Kulik on 26 November to discuss his diagnosis. Mr Kulik confirmed that the next of kin details held on file were correct and a prison officer who spoke Polish helped the family liaison officer to communicate with Mr Kulik's family in Poland.

19. On 20 December, Mr Kulik was referred to LOROS (Leicestershire Organisation for the Relief of Suffering) hospice. He chose LOROS as his preferred place to die on 28 December, after a discussion with a prison nurse about his prognosis.

20. Mr Kulik was kept on normal location at Gartree. Healthcare staff asked him on several occasions if he wanted to move to a bigger cell which would have been able to fit in a larger hospital bed, but he said he wanted to remain on G wing with his peers.

21. On 30 December, staff found that Mr Kulik had become acutely unwell. He was admitted to hospital where he suffered a heart attack. The hospital team successfully resuscitated Mr Kulik, but he remained unconscious and hospital staff thought he would not survive the event. However, Mr Kulik recovered and discharged himself on 3 January 2023. He decided that he wanted to die in the prison instead of LOROS hospice.

2023

22. On 3 January 2023, the offender management unit (OMU) started an application for Mr Kulik's release on compassionate grounds. They completed the offender management section and submitted the form to the healthcare team for completion of their section. The form was sent to prison service email addresses instead of NHS email addresses, which healthcare staff use more frequently. Therefore, the form was not picked up and the application was not progressed.

23. On 5 January, medical records note that a DNACPR had been put in place for Mr Kulik.

24. On 6 January, prison healthcare staff referred Mr Kulik to substance misuse services (SMS) after smelling cannabis in his cell. A member of the SMS team discussed this with Mr Kulik, who denied smoking any cannabis, but accepted the team's advice against using it alongside prescribed opiate-based medication.

25. Over the course of January, medical records note that healthcare staff had concerns that Mr Kulik was being targeted by other prisoners on the wing. Several prison intelligence reports were submitted to this effect. On 12 January, a prison intelligence report suggested that Mr Kulik was swapping his medication for illicit psychoactive substances (PS, also known as 'Spice'). Two intelligence reports submitted on 15 and 29 January noted that Mr Kulik's canteen order was unusual and appeared to be related to debts he owed other prisoners on the wing. He had ordered a high number of vapes.

26. On 20 January, healthcare staff gave Mr Kulik three extra pillows to help him with the discomfort caused by his distended stomach. On 23 January, staff noted that the pillows were no longer in his cell. Medical records noted that when asked about the pillows, Mr Kulik appeared uncomfortable but would not confirm if he had sold them or if another prisoner had taken them.

27. Healthcare staff also spotted the prisoners that Mr Kulik was suspected to owe money to hanging around his cell on 23 and 24 January. They completed an intelligence report, noting their concerns. Another intelligence report noted that the same prisoners were in possession of Mr Kulik's pillows.

28. On 27 January, Mr Kulik was discussed at an MDT meeting, on the request of healthcare. The Deputy Governor, Head of Security, Head of Safety, Head of SMS, NHS Manager and a custodial manager on G wing all attended the meeting. Healthcare shared concerns that Mr Kulik was being targeted. The team decided that the custodial manager would speak to Mr Kulik after the meeting about their concerns. Mr Kulik said that he was not being bullied and that he had given his pillows away without pressure. He denied giving away his medication and said that he could do what he liked with his canteen. He admitted to smoking PS. The custodial manager offered Mr Kulik a move to a more appropriate cell, but Mr Kulik did not want to leave G wing.

29. The MDT decided on some other actions to support Mr Kulik. Wing staff conducted daily welfare checks on Mr Kulik, although it is unclear if this involved any staff interaction. The MDT decided to give Mr Kulik increased key work sessions and staff support. Mr Kulik received one key work session between the MDT meeting on

27 January and his death on 7 March. (Key work is part of the HMPPS Offender Management in Custody (OMiC) model launched in 2018 to improve prisoner and staff relationships and reduce the risk of self-harm and suicide through meaningful engagement.)

30. On 6 February, Mr Kulik was scheduled to attend LOROS hospice to have a permanent drain fitted so that he would no longer need to leave the prison for it. He refused to attend the appointment and continued to refuse the following week, despite being in extreme discomfort and having a very distended stomach.

31. On 13 February, Mr Kulik's NEWS2 score increased, and he agreed to attend LOROS hospice for drainage the next day. LOROS could not accommodate him and recommended that he was taken to hospital instead. Mr Kulik attended A&E at on 14 February but discharged himself before his ascites were drained because the unit was busy, and he was not prepared to wait.

32. Mr Kulik decided he would only go to LOROS hospice for drainage. However, on 18 and 19 February, he again refused to attend. He attended on 21 February and the drain was completed. LOROS hospice staff informed Mr Kulik that fitting a permanent drain would no longer be beneficial due to his deteriorating condition. Mr Kulik became upset and was angry with LOROS hospice staff. He requested to discharge himself and said he wished to die in prison. Mr Kulik returned to Gartree on 23 February. Healthcare staff reported that he was in constant pain and was very frail. They continued to encourage Mr Kulik to return to LOROS hospice, where he would be more comfortable, but he refused.

33. On 28 February, healthcare staff contacted wing staff to report that a pressure cushion and mattress topper had gone missing from Mr Kulik's cell and would not tell staff where they had gone. Prison officers found the missing items and returned them to healthcare. It is not known whether Mr Kulik sold them, gave the items away or whether they were taken from him.

34. On 2 March, Mr Kulik was asked to attend LOROS hospice to have his stomach drained and for a review of how his symptoms were being managed. He initially refused, however when prison staff probed further, Mr Kulik admitted that he was worried about leaving the prison due to the debts he owed. He said he was worried that his debts would be transferred to another prisoner, a friend of his, after his death. Prison officers offered to address the issues with Mr Kulik's debt for him. He seemed pleased with the offer and agreed to go to the hospice.

35. Mr Kulik died at approximately 2:30pm on 7 March 2023, at LOROS hospice.

Post mortem report

36. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Kulik's cause of death as metastatic cholangiocarcinoma (cancel that has spread into the bile ducts). Ulcerative colitis (a long-term condition where the colon and rectum become inflamed) was listed as a contributory factor.

37. The inquest, held on 21 August 2023, concluded that Mr Kulik died from natural causes.

Findings

Clinical care

38. The clinical reviewer found that the clinical care provided to Mr Kulik was equivalent to that which he could have expected to receive. She makes one recommendation for the NHS England Commissioner and Governor of Gartree to consider an alternative approach to treatment administration for terminally ill prisoners.

Non-clinical care

39. The non-clinical care provided to Mr Kulik was of a high standard overall. Staff were compassionate in their approach and consistently encouraged him to engage with support to ensure he received the best possible care.

Early release on compassionate grounds (ERCG)

40. On 3 January, a member of the offender management unit (OMU) sent a request to healthcare for their contribution to Mr Kulik's early release on compassionate grounds (ERCG) application form. The request was mistakenly sent to prison service email addresses instead of NHS accounts. Healthcare staff at Gartree do not routinely use their prison service email addresses and therefore the application was not picked up before Mr Kulik died. In response to this learning, the OMU have changed the process for ERCG applications to ensure NHS accounts are used. We therefore do not make a recommendation.

Other learning

41. We identified some incidental learning that did not impact directly on Mr Kulik's death but affected his dignity and comfort in the final stages of his life. We bring these matters the attention of the Governor, to improve future care.

Substance misuse

42. Mr Kulik admitted to smoking illicit psychoactive substances (PS – also known as 'Spice') during his conversation with a custodial manager on 27 January. The Governor will note that Mr Kulik was not referred to substance misuse services following this disclosure. It is possible that the custodial manager did not make the referral on compassionate grounds, given Mr Kulik's terminal illness, but he did not record the rationale for his decision. The Governor will want to assure himself that the decision was defensible.

Safeguarding

43. In the months leading up to Mr Kulik's death, staff had concerns that he was in debt and being targeted by other prisoners on his wing, due to his vulnerability. A multi-disciplinary meeting was held to discuss the risks on 27 January, with input from the safety and security team, wing staff, and healthcare. Although some of the actions from the meeting were completed, Mr Kulik was not given increased key work or

staff support. Neither Mr Kulik nor any of the alleged perpetrators were managed through Challenge, Support, and Intervention Plan (CSIP – HMPPS procedures used to support and manage prisoners who pose an increased risk of being violent, or a risk of being the victim of violence) and there is no evidence this was considered. There is also no evidence to suggest that a debt toolkit was considered to support Mr Kulik.

44. Mr Kulik refused to attend LOROS hospice for ascitic drains on at least eight occasions in February despite healthcare observations showing he was becoming acutely unwell. Documentation provided by the prison does not indicate that the concerns raised in the MDT meeting of 27 January were followed up with Mr Kulik during this time, including when his mattress topper and pressure cushion went missing on 28 February. On 2 March, prison staff agreed to resolve Mr Kulik's debt issues so that he could attend the hospice and be made comfortable before he died. The Head of Safety did not provide an explanation as to why prison staff had not attempted to help Mr Kulik resolve his debt sooner, for example through CSIP management or a debt toolkit.

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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T l 020 7633 4100