ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. HMPPS** **2. Minister of State for Prisons** **3. Ministry of Justice/HMP Wandsworth** **4. Secretary of State for Health and Social Care** **5. Oxleas NHS Foundation Trust**
1	**CORONER** I am Priya Malhotra, assistant coroner, for the coroner area of Inner West London.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 21 February 2024 an inquest opened into the death of Patryk Gladysz, aged 27 years. The investigation concluded at the end of the inquest on 15 July 2025. The conclusion of the jury was that the deceased hung himself with a ligature. His intentions in doing so remain unknown. It is likely that the following factors are likely to have possibly contributed, in a more than minimal way to Patryk's death: 1. There was no in-depth psychological assessment of Patryk. 2. There were low staffing levels in the prison and the in-reach healthcare teams. 3. There was a lack of clear inter-departmental communication. 4. There was a lack of knowledge of Patryk's history and personal circumstances and inconsistent familiarity of related policies and procedures.
4	**CIRCUMSTANCES OF THE DEATH** Patryk had a diagnosis of schizophrenia in 2019. He was under the care of his community mental health team, with regular contact with his care co-ordinator and received a fortnightly anti-psychotic depot injection. On 17 April 2023 Patryk arrived at HMP Wandsworth awaiting extradition to Poland. It was noted he required an interpreter and had limited English in his Prison Escort Record and NOMIS, although this was subsequently inconsistently recorded. He claimed asylum on 26 April 2023 preventing his extradition. Patryk was under the care of the in-reach mental health team (Oxleas) within HMP Wandsworth. He received a fortnightly depot injection, which was missed on 23 November 2023. He next received his injection on 14 December 2023 – 5 weeks later. On 14 December 2023 he first reported hearing voices. Until the time of his death, Patryk had not been seen by a psychiatrist. An assessment and risk assessment of Patryk took place on 20 and 27 October 2023 – evidence before the jury was that it should have been completed within 5 days of Patryk being case loaded to the mental health in-reach team; this was in April 2023 – the assessment was approximately 6 months late. An official interpreter was not used for the assessments, which lasted 15-20 minutes. The jury heard mental health in-reach team staff were understaffed at the time, which impacted their ability to undertake meaningful mental health assessments and that staff who administered his depot injection did not know he previously attempted to ligature in the community. He was not allocated a key worker and HMP Wandsworth adopted a qualified key worker scheme. There was no entry on Patryk's NOMIS

	confirming there was any meaningful interaction with him between 22 May 2023 and 5 January 2024. Patryk had two interactions with Catch22, the last interaction was on 22 May 2023. There was inconsistency in staff knowledge of whether health care staff had access to the NOMIS. Senior Prison officers demonstrated a lack of awareness of policy documents concerning the heightened risk of foreign national prisoners. On 5 January 2024 at 09:08 Patryk was found in his cell with a ligature around his neck. A return of spontaneous circulation was achieved, and he was taken to St George's Hospital at 10:46. A CT scan showed complete loss of grey white matter differentiation and Patryk's death was confirmed on 19 January 2025 at St George's Hospital.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows – (1) Staffing within the Mental Health In-reach team impacting the timely undertaking of meaningful and quality mental health assessments. (2) Staffing within HMP Wandsworth resulting in a dilution to the requirements for the key worker scheme. (3) Knowledge of prison staff of the heightened risk of foreign nationals in custody, despite a higher proportion of foreign nationals being detained at HMP Wandsworth. (4) Communication between prison and healthcare staff regarding: (a) knowledge sharing of those presenting with a serious and enduring mental health illness, such as schizophrenia; (b) inconsistent understanding of healthcare access to the NOMIS by both prison and healthcare staff; and (c) de-activation of NOMIS accounts for healthcare staff due to lack of use – 21 healthcare accounts were de-activated notwithstanding an increase in available terminals. (5) Prison officer checks of roll calls/ACCT observations - recent audit by HMP Wandsworth suggests on-going challenges. (6) First Aid refresher training is not up to date for all healthcare staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 15 September. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to Patryk's next of kin. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	*Priya Malhotra* 18 July 2025