Prisons & Probation Ombudsman
Independent Investigations

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A distressed 18-year-old Lithuanian man who had been arrested for stealing sweets killed himself in the segregation unit of HMP Wandsworth in an “appalling” case, according to an investigation by the Prisons and Probation Ombudsman (PPO).

Osvaldas Pagirys, who struggled with English, was repeatedly assessed by staff at Wandsworth prison as not suffering from significant mental health problems after being interviewed without an interpreter. On the one occasion when he was interviewed with a professional interpreter, a GP concluded that he did need mental health treatment.

On the day of his death, Mr Pagirys rang a bell in his cell in the segregation unit at lunchtime but it was not answered for 37 minutes, at which time he was found hanging, unconscious. He never regained consciousness and died three days later. Wandsworth had previouly been criticised by prisons inspectors for long delays in answering bells. The PPO concluded: “Mr Pagirys’ life might well have been saved had staff responded sooner.”

Mr Pagirys had been found with a ligature around his neck on five previous occasions, including on the day he was declared fit for segregation – following what the PPO said was a ‘woefully inadequate assessment” by a nurse which failed to question the impact segregation would have on his mental health. The prison manager who authorised segregation based on the nurse’s assessment said she did not know Mr Pagirys had been seen in the unit with a noose around his neck.

A coroner today recorded a narrative verdict following an inquest into the death on 14 November 2016. Elizabeth Moody, the acting PPO, published the report, which was presented to the coroner, and said:

“The circumstances of Mr Pagirys’death were appalling and tragic.

“He was a vulnerable, 18-year-old, Lithuanian man who found it hard to cope with prison life and to communicate in English. Staff responded to his increasing levels of distress punitively and he was subject to an impoverished, basic regime during much of his time at Wandsworth.

“Staff did not satisfactorily acknowledge his vulnerability or address his rising risk factors. Neither the management of his suicide risk, nor action to address his deteriorating mental health, were adequate. It is emblematic of the poor care Mr Pagirys received at Wandsworth, that it took staff 37 minutes to respond to his cell bell prior to discovering him hanging in his cell.”

He had been arrested on 8 August 2016 in London for shoplifting sweets and was found to be the subject of an European Arrest Warrant in Lithuania. Extradition proceedings started and he was refused bail, going first to Pentonville and then Wandsworth, where he spent the last three months of his life.

Police had considered him a high risk of suicide and placed him under constant supervision. In Wandsworth, the PPO found, there was a pattern of unpredictable, emotional and distressed behaviour – with Mr Pagirys varying between saying he did not want to live and, on other occasions, that he did not want to harm himself. At one time, he was ‘jovial’; on other occasions, he cried. He cut himself with a broken piece of porcelain and also damaged his cell a number of times and was aggressive.

One nurse described him as “child-like”. He could not understand why he was moved so frequently – at least 32 times in Wandsworth - and sanctioned for challenging these moves. During a disciplinary hearing for possession of a knife, Mr Pagirys said that he tried to hang himself because he did not want to be extradited to Lithuania, as all his family were in Croydon.

The PPO report concluded that Wandsworth failed in the basic requirement to communicate effectively with Mr Pagirys. “The mental health team at Wandsworth assessed Mr Pagirys on a number of occasions but each time, they concluded that

he had no significant mental health problems. We are concerned that mental health staff did not use an official interpretation service for these assessments. Their use of Mr Pagirys' cellmate as an interpreter on one occasion was inappropriate."

A clinical reviewer – a medical professional consulted by the PPO – said that "a meaningful assessment of mental health cannot be undertaken if there is a language barrier, and the failure of mental health staff to use interpretation services called into question the validity of their assessments." The clinical reviewer also noted that the conclusion that Mr Pagirys had no significant mental health issues was at variance with a GP's diagnosis of depression, which the GP had reached having used an interpreter during her consultation.

The PPO identified a number of other key concerns:

- Mr Pagirys was subject to special procedures to support prisoners at risk of suicide. Before he was segregated staff should, therefore, have considered whether there there were any exceptional circumstances that justified segregation or whether alternative options were available. This did not happen.
- Suicide management procedures were not well managed and records were incomplete. Staff did not always adhere to the frequency of observations set for Mr Pagirys.
- The clinical care Mr Pagirys received at Wandsworth was not equivalent to that which he could have expected to receive in the community.

Elizabeth Moody said:

> "The PPO sees examples of good practice by prisons in the course of our investigations. But where we see poor practice – as in this case - we need to draw attention to it so that lessons can be learned for the future.
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> "I am extremely concerned at the overall standard of care delivered by HMP Wandsworth. Staff continued to sanction and segregate Mr Pagirys without consideration of his vulnerability and the policies designed to protect prisoners at risk of suicide and self- harm. I am also concerned that a nurse assessed such a young, evidently vulnerable and highly distressed man as fit for segregation,

when his risk of suicide and self-harm was high, and that no manager or member of staff seems to have taken effective steps to prevent a deeply troubling death."

- ENDS –

Notes to editors:

1. The Prisons and Probation Ombudsman is part of the regulatory framework for prisons, alongside HM Inspectorate of Prisons and Independent Monitoring Boards.

2. The PPO investigates the deaths of and complaints from prisoners, probation supervisees, and immigration detainees. The PPO's full Terms of Reference can be found on its website (www.ppo.gov.uk).

3. The PPO made nine recommendations to Wandsworth covering its management of suicide prevention procedures, the operation of its segregation unit, answering of cell bells and use of interpretation services for prisoners who had a poor understanding on English. In addition, the PPO recommended that urgent mental health referrals should be carried out promptly and there should be a review to assess whether the nurse who assessed Mr Pagirys as fit to be located in the segregation unit had the necessary skills and experience to make such judgements. The prison accepted all recommendations.

4. The PPO publishes the reports of its investigations on its website after the inquest has taken place.

5. HM Inspectorate of Prison's report on its most recent inspection of HMP Wandsworth can be found at https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-wandsworth/