Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Osvaldas Pagirys a prisoner at HMP Wandsworth on 14 November 2016

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Osvaldas Pagirys was found hanging in his cell in the segregation unit at HMP Wandsworth on 11 November 2016 and died in hospital three days later. He was 18 years old. I offer my condolences to Mr Pagirys' family and friends.

This is quite an appalling and tragic case. Mr Pagirys was a vulnerable young 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. This compounded and did not address his rising risk factors: he was found with ligatures around his neck on several occasions and on the day he was taken to the segregation unit tried to strangle himself with a piece of clothing. Yet neither the management of his risk of suicide and self-harm, nor action to address his deteriorating mental health, were adequate.

I am extremely concerned that staff continued to segregate Mr Pagirys without consideration of 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 from taking place.

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. Mr Pagirys' life might have been saved had staff responded promptly to his cell bell.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **September 2017**

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Summary

Events

1. Mr Osvaldas Pagirys, a Lithuanian national, arrived at HMP Wandsworth on 8 August 2016. He was being held at Wandsworth pending extradition to Lithuania after being arrested for stealing sweets.

2. Mr Pagirys was 18 years old. He was anxious about the prospect of being returned to Lithuania and struggled with prison life. He found it hard to communicate effectively in English and difficult to understand and cope with the disruption of cell moves, which happened on several occasions after he had attended court hearings. His distress became disruptive, which resulted in him being subject to the basic regime for the majority of his time in prison, and he began to self-harm. Between 8 August and 9 November, Mr Pagirys was found with a ligature around his neck on five occasions.

3. On 9 November, Mr Pagirys was taken to the segregation unit for a disciplinary hearing after he had broken his cell window. Staff started suicide and self-harm monitoring procedures (known as ACCT) after he tried to strangle himself with his T-shirt. Mr Pagirys was sentenced to 14 days cellular confinement. Shortly afterwards a nurse found him with a noose around his neck, saying he wanted to die. The same nurse then assessed him as fit to be segregated.

4. On 11 November, while still subject to ACCT monitoring and on hourly observations, Mr Pagirys rang his cell bell at 1.00pm. Staff did not respond to it until 1.37pm, and found Mr Pagirys hanging in his cell. Staff carried out cardiopulmonary resuscitation (CPR) until paramedics arrived and Mr Pagirys was transferred to hospital. He died in hospital three days later.

Findings

5. We do not feel that Mr Pagirys, a vulnerable 18 year old who struggled to communicate in English, was managed sympathetically. His increasing distress was managed initially by reducing his regime and then punitively.

6. We found no evidence that staff had considered whether there were exceptional circumstances that justified his segregation of this distressed 18 year old or that alternative options were considered. We found the nurse's assessment of Mr Pagirys' fitness for segregation woefully inadequate and his conclusion incomprehensible.

7. The delay in responding to Mr Pagirys' cell bell on the day he was discovered hanging was unacceptable. Cell bells should be answered promptly, certainly within five minutes. Had staff responded to Mr Pagirys' cell bell within that timeframe, his life might have been saved.

8. We found weaknesses in the management of ACCT procedures at Wandsworth. ACCT records were incomplete and some were unavailable. Staff failed to properly engage with Mr Pagirys to establish his risk factors, case reviews were held without an interpreter and were often not multi-disciplinary, and staff did not always adhere to the frequency of set observations.

9. There was a long delay in arranging a mental health assessment for Mr Pagirys and in diagnosing and treating Mr Pagirys' depression. The clinical reviewer concluded that the care Mr Pagirys received at Wandsworth was not equivalent to that which he could have expected to receive in the community.

Recommendations

- **The Governor should ensure that staff identify vulnerable prisoners at heightened risk of suicide and self-harm and ensure that if any disciplinary measures taken against them they are necessary, appropriate and proportionate.**
- **The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:**
  - **A trained ACCT assessor completes an assessment within 24 hours of the ACCT being opened and attends the first case review.**
  - **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attend all first case reviews.**
  - **Enhanced case management measures are considered for the more challenging, complex or vulnerable prisoners.**
  - **Staff adhere to the frequency of observations set out in the ACCT document.**
  - **Staff set specific and meaningful ACCT caremap actions that are aimed at reducing prisoners' risks to themselves and review them at each case review.**
- **The Governor should review the operation of the segregation unit and satisfy herself that it is able to deliver its basic function of holding prisoners there appropriately, safely and securely and in decent conditions.**
- **The Governor should ensure that prisoners at risk of suicide and self-harm are not held in the segregation unit unless all other options have been considered and discounted, and that the exceptional circumstances justifying segregation are fully documented.**
- **The Governor and Head of Healthcare should ensure that Nurse X has the necessary skills and experience to properly assess whether a prisoner is fit for segregation.**
- **The Head of Healthcare should ensure that urgent referrals for mental health assessments are conducted promptly and should review the process for undertaking assessments of prisoners who have a poor command of English, which should include a review of the use of an interpreting service.**

- **The Governor should ensure that all cell bells are answered within five minutes.**
- **The Governor and Head of Healthcare should ensure that, when a prisoner does not speak or understand English well, professional interpreting services are used, especially for those at risk of suicide or self-harm.**
- **The Governor should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary during the course of the investigation.**

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her. No one came forward.

11. NHS England commissioned a clinical reviewer to review Mr Pagirys' clinical care at the prison.

12. The investigator visited Wandsworth on 15 November 2016. She obtained copies of relevant extracts from Mr Pagirys' prison and medical records.

13. The investigator interviewed 16 members of staff and two prisoners at Wandsworth in December 2016 and January 2017.

14. We informed HM Coroner for Inner West London of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Pagirys's mother to explain the investigation and ask if she had any questions at this stage. She said that Mr Pagirys had problems with nerves, had not felt well the last time she visited him on 5 November and that he had not received any medication. Mr Pagirys' family were sent a copy of the initial report, but did not comment on it.

16. Aspects of this report have already been disclosed, in line with our established practices. HMPPS received a copy of this report and provided an action plan in response to our recommendations.

Background Information

HMP Wandsworth

17. HMP Wandsworth is a local prison in south west London that holds up to 1,658 male prisoners and primarily serves the courts of south London. St George's University Hospitals NHS Foundation Trust provides physical healthcare services at the prison. South London and Maudsley NHS Foundation Trust provides mental health care. In May 2016, Wandsworth was designated as one of six proposed reform prisons where Governors would be given more autonomy to develop innovative practices.

HM Inspectorate of Prisons

18. The most recent inspection of Wandsworth was in February/March 2015. Inspectors found that prisoners who did not speak English largely relied on other prisoners to make themselves understood and many were frustrated and anxious about their inability to get advice about immigration or extradition issues. There was little use of professional telephone interpreters.

19. Inspectors found that the quality of assessment, care in custody and teamwork (ACCT) documentation was mixed, but too many records were poor, with insufficiently detailed and often late case reviews, poor recording of triggers and poorly focused care maps.

20. The use of the segregation unit had increased. The unit's regime was impoverished, few prisoners had a television, there was no in-cell work or access to educational material and most cells were in a poor condition. Staff on the unit managed some very challenging prisoners, but this was not always reflected in their case notes. Inspectors recommended that the use of segregation should be monitored and only used when warranted.

21. Inspectors noted that prisoners' cell bells went unanswered for long periods of time.

22. The incentive and earned privileges scheme (IEP) was administered fairly, but prisoners did not find the scheme motivational and the regime was too punitive for many prisoners on the basic level.

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 31 May 2016, the IMB reported that the overall shortage of staff affected almost every aspect of prison life and the lack of officer continuity meant providing any pastoral care was extremely difficult.

Previous deaths at HMP Wandsworth

24. PPO investigation reports into the four previous apparently self-inflicted deaths at Wandsworth in 2015 were critical of the management of ACCT procedures and

the lack of supportive interaction through an effective personal officer scheme for prisoners who were quiet and compliant. We have also previously criticised the prison for not being able to produce important paperwork. In this case, the prison was unable to produce one of Mr Pagirys's ACCT documents.

Assessment, Care in Custody and Teamwork

25. 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.

26. 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 multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

27. 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 Prison Service Instruction (PSI) 64/2011.

Key Events

28. On 30 July 2016, Mr Osvaldas Pagirys, an 18-year old Lithuanian national, was arrested for shoplifting sweets and was found to be the subject of a European Arrest Warrant. Police recorded that he did not speak English. Mr Pagirys told the police that he wanted to die and had a history of self-harm. Police started constant supervision because they considered him at high risk of suicide and self-harm.

29. On 1 August, Mr Pagirys was refused bail and was remanded to HMP Pentonville. Court staff completed a suicide and self-harm warning form, noting that he had told police and court staff that he did not want to live and was very tearful. The nurse in reception noted that Mr Pagirys appeared tearful but he said he had no history of mental illness or thoughts of suicide or self-harm, or any substance misuse, although the Person Escort Record (PER) noted he used cannabis. Mr Pagirys asked for something to help him sleep, and she prescribed him sleeping tablets

30. On 8 August, Mr Pagirys was refused bail again and remanded to HMP Wandsworth. He told an officer that he had no thoughts of suicide or self-harm. During an initial health screen with a nurse, Mr Pagirys repeated that he had no thoughts of suicide or self-harm, said he was not currently taking any mental health medication nor taking intravenous drugs. She noted he had limited English.

31. On 9 August, the prison received a letter from the court's mental health team, written on 1 August. The court mental health nurse described Mr Pagirys as extremely tearful and distraught. The nurse noted that he had been subject to constant supervision in police custody, but he said he had no thoughts of suicide or self-harm. She noted that he had been prescribed medication for stress in Lithuania. She recommended that he see a doctor as soon as possible. She referred Mr Pagirys for an urgent mental health assessment.

32. On 11 August, a mental health nurse assessed Mr Pagirys, using his cellmate as an interpreter. Mr Pagirys said that he was stressed because he had no one to speak to in Lithuanian and was paranoid. He told the nurse that he was eating and sleeping well and had no thoughts of suicide or self-harm. The nurse told Mr Pagirys that he should contact the mental health team if he thought he needed support.

33. According to Mr Pagirys' prison records he was subject to suicide and self-harm monitoring procedures from 16 to 17 August. The prison has been unable to find the ACCT document. A summary of the ACCT case review held on 17 August that was recorded by a Supervising Officer (SO), said that Mr Pagirys had no thoughts of self-harm but had issues with his phone account, visits and prison kit. Mr Pagirys' phone account was activated the next day and he spoke to his mother.

34. On 21 August, an officer wrote in Mr Pagirys' prison records that he was vulnerable on the wing because of his mental health issues. She said that he would often become emotional and start crying and shouting, but when staff spoke to him, he was unable to articulate what was wrong. It was difficult to get

him back to his cell and once there, he would make a lot of noise. An officer recorded that officers left Mr Pagirys locked in his cell when other prisoners were on the wing, to keep him safe.

35. On 24 August, the court remanded Mr Pagirys back to Wandsworth until 21 September, when a video link hearing about his extradition was due to take place. The same day, Mr Pagirys broke the observation panel on his cell door. A SO placed Mr Pagirys on a basic regime, which meant he lost some access to time out of his cell and his television. He was moved to the wing's constant supervision cell because of the damage to his cell. There is no record that he was considered at high risk of suicide or self-harm, which would normally be the reason for using this cell. The following day, 25 August, an officer moved Mr Pagirys to a cell on another wing and noted that he was still showing destructive behaviour. The officer left a television in his cell to calm him down.

36. On 9 September, a SO recorded that Mr Pagirys attended a disciplinary hearing and would remain subject to the basic regime until 17 September because of damage to his cell.

37. Mr Pagirys was refused bail by video link on 21 September and the next hearing was scheduled for 18 October. When he returned from the video link hearing, Mr Pagirys was given a different cell. Another prisoner said this frustrated Mr Pagirys, who did not understand why he had to move, especially as he had spent some time cleaning and tidying his previous cell.

38. At around 11.00am on 22 September, an officer started ACCT monitoring because Mr Pagirys had refused to hand over a blade to staff and had cut himself and punched himself in the face. He recorded that Mr Pagirys appeared distressed about his cell move and that he clearly had mental health issues, which made him vulnerable. He was placed on hourly observations. A SO agreed that Mr Pagirys could exceptionally share with an older Lithuanian prisoner as a support measure and he was moved. (Prisoners under 21 should not share a cell with prisoners over 21.)

39. At around 11.30am, staff attended Mr Pagirys' cell after being alerted by a prisoner. Staff found Mr Pagirys with a ligature around his neck that he had secured to his window. His cell was flooded as a result of him having smashed it up. Staff cut the ligature and attempted to calm him down, but Mr Pagirys continued to punch himself in the face and cry because he wanted to move out of his cell. At 12.45pm, staff again found Mr Pagirys with a ligature around his neck that he had secured to his window. When the ligature snapped, Mr Pagirys repeatedly cut his arm with a broken piece of porcelain. The ACCT record noted that Mr Pagirys seemed confused and seemed to be struggling with life in an adult prison. When a nurse dressed his wounds later that day, he noted that Mr Pagirys appeared anxious and tearful and that he had said he was not coping with prison. He made an urgent referral to the primary care mental health team. He noted that Mr Pagirys spoke poor English.

40. A SO carried out the ACCT assessment interview with Mr Pagirys at 4:55pm on 23 September. She held the first case review at the same time, with only Mr Pagirys in attendance. She conducted both using an online translation tool, which Mr Pagirys found frustrating. Mr Pagirys was upset about being on the

basic regime. He also said he was struggling without drugs and alcohol, although he had not mentioned this before. She did not explore this with him. (There was no information or intelligence to suggest Mr Pagirys was dependent on either.) He told her that he self-harmed when upset or angry by cutting his arm but had never attempted suicide. She continued hourly observations.

41. On 27 September, a SO chaired an ACCT case review with a member of chaplaincy staff in attendance who acted as an interpreter. He noted that the case review was an interim measure, pending a full multidisciplinary meeting planned for 29 September. Mr Pagirys said that not having a television made him anxious and said that he thought about harming himself. Observations remained at least once an hour.

42. On 28 September, an occupational therapist tried to assess Mr Pagirys' mental health, but found it difficult due to his poor English. He told her that he had no thoughts of suicide or self-harm. She recorded that she would try to undertake a full assessment in the coming days.

43. Two custodial managers chaired Mr Pagirys' ACCT case review on 29 September. No one from the healthcare team attended and there was no interpreter present. He said he had self-harmed to get away from his cellmate and now felt safer because he had found some other Lithuanian prisoners on the wing. They agreed to close the ACCT document.

44. On 30 September, Mr Pagirys flooded his cell and assaulted a SO, who restrained him and took him to a constant supervision cell in the segregation unit. A nurse assessed him and noted that he was naked and presented as "very agitated, tearful, crying and shouting". When he was given his clothes, he had tried to use them as a ligature to hang himself. Despite his poor English, Mr Pagirys told the nurse that he had taken two clonazepam tablets (a benzodiazepine used to treat seizures) and the nurse noticed that he smelled of alcohol. Nurses checked him throughout the evening but could not physically examine him until the next morning because he was too agitated.

45. The same day, the duty Governor chaired an ACCT case review and reopened Mr Pagirys' ACCT. Two nurses and the SO from the segregation unit were at the review and agreed that he was at high risk of suicide and self-harm and should remain subject to constant supervision. One nurse noted that Mr Pagirys said he had taken clonazepam tablets and that his mental health had not been assessed as planned on 28 September, due to language difficulties. The nurse agreed to arrange an urgent mental health assessment and asked that a translator be used during the mental health assessment, as Mr Pagirys' English was poor.

46. At an ACCT case review the next day, 1 October, the duty Governor agreed with the two nurses present that Mr Pagirys' risk had reduced. Mr Pagirys had started the day seemingly very distressed, trying to flush his clothes down the toilet and flooding his cell, but had a good visit from his family and said he no longer wanted to hurt or kill himself. Observations were lowered to three times during the day and at least once every hour during the night. Mr Pagirys was moved from the segregation unit to B Wing. There is no evidence that the outstanding mental health assessment was discussed.

47. On 3 October, Mr Pagirys told a nurse that he could not cope with prison and needed help. He asked to see a doctor so he could be prescribed sleeping tablets. The nurse referred him for an urgent mental health assessment and booked him an appointment with the GP. The same day, a SO chaired an ACCT case review, with only Mr Pagirys present. Mr Pagirys said he was not sure whether he wanted to hurt himself or not and asked to stay on the wing, but the SO explained that he had to move to another wing but had not noted the reasons for the move. (Mr Pagirys was moved to A Wing later that day.) The SO considered that Mr Pagirys's risk remained the same and maintained the same level of observations.

48. A prison GP assessed Mr Pagirys on 6 October using a telephone interpretation service. He would not tell the GP whether he intended to self-harm again and she described him as tearful with poor eye contact. She prescribed antidepressants and sleeping tablets, and referred him for a mental health assessment. She tried to assess Mr Pagirys the next day but he was not in his cell, so she planned to try again the following week.

49. At an ACCT case review chaired by a SO on 10 October, attended by a chaplain, a mental health nurse and a substance misuse worker, Mr Pagirys said he felt better and had no thoughts of suicide or self-harm. He raised concerns about being on the basic regime and staff reminded him that he had to improve his behaviour to regain his privileges. The review agreed to maintain his observations at three per day and at least once every hour during the night.

50. On 17 October, a nurse from the mental health team assessed Mr Pagirys. She recorded that Mr Pagirys' English was limited, but he was able to converse and she did not use translation services. She described him as jovial and smiling. He appeared stable in mood and mental state and she concluded that he did not need primary care mental health support. She noted that his main issue was not having a television (because he was on basic regime). The same day, a SO added to Mr Pagirys' caremap that he was not happy that he was still subject to the basic regime, and he agreed to review his privilege level.

51. On 18 October, a SO reviewed Mr Pagirys' privilege level and determined that he should remain subject to the basic regime for seven more days. The same day, Mr Pagirys appeared in court and was remanded back to HMP Wandsworth until 21 October. When he got back from court, he tried to hang himself because he was upset that he did not go back to the same cell on B Wing. The night manager and a SO convened a case review and agreed that his behaviour was unpredictable and he needed to be subject to constant supervision, so Mr Pagirys remained on B Wing and staff arranged this. A nurse from the mental health in-reach team assessed Mr Pagirys and concluded that he did not need mental health support. She described Mr Pagirys as "childlike" and said that he was only concerned about being on the basic regime and not having a television.

52. A nurse from the mental health team assessed Mr Pagirys again the next day, 19 October, and agreed that he did not need to be subject to constant supervision or mental health support. Mr Pagirys said that he was upset about being on the basic regime and not having a television. She said that Mr Pagirys spoke

English during the assessment and she did not consider he seemed depressed. Officers agreed to check Mr Pagirys at least three times an hour.

53. On 20 October, a prisoner told staff that Mr Pagirys had a knife in his cell. A SO searched Mr Pagirys' cell and found it. He charged Mr Pagirys with the possession of an unauthorised object.

54. On 21 October, Mr Pagirys appeared in court, where his extradition to Lithuania was ordered. His custody warrant confirmed that he was to remain in prison until he was extradited to Lithuania. After Mr Pagirys had returned to Wandsworth, staff were called to his cell on B Wing, by a prisoner and found Mr Pagirys in a distressed state with a noose around his neck. Later that day, a psychiatrist made a note in Mr Pagirys' medical record that he had put a noose around his neck because he was subject to the basic regime and that he agreed he did it in an attempt to get what he wanted. He identified no mental health issues and discharged Mr Pagirys.

55. The Head of Safety held a disciplinary hearing on 22 October regarding Mr Pagirys' possession of a knife. Mr Pagirys could not explain why he had the weapon and said he did not intend to use it to self-harm. He 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 disciplinary hearing found him guilty and he received 14 days cellular confinement, suspended until 21 January 2017. The Head went on to chair an ACCT review with segregation officers, a mental health nurse and another Lithuanian prisoner to interpret. Following the advice of the mental health nurse, the review agreed to increase Mr Pagirys' observation level to at least one check every half an hour.

56. On 25 October, Mr Pagirys moved to D Wing and broke a pipe in his cell. Staff restrained him to prevent him from cutting himself. A nurse reviewed his mental health and recorded that he told her he wanted a television and that he was worried about his extradition. The nurse concluded that Mr Pagirys did not need mental health intervention and noted that he would continue to be the subject of ACCT monitoring and support.

57. The next day, a SO chaired an ACCT case review with Mr Pagirys and a nurse. He recorded that Mr Pagirys was very unhappy and unstable because he continued to be subject to a basic regime. He said that he told Mr Pagirys to improve his behaviour to regain his privileges. The review agreed that his level of risk had not changed and his observation remained at one check every half an hour. He agreed to move to the segregation unit while his cell was repaired but returned to a cell on D Wing later that day.

58. A nurse reviewed Mr Pagirys' mental health on 27 October, and wrote (apparently in error) that he continued to be subject to constant supervision. Mr Pagirys told her that he felt much better and no longer had thoughts of suicide or self-harm. The same day, a SO chaired an ACCT case review, only attended by Mr Pagirys. He also told the SO that he no longer had thoughts of suicide or self-harm and was just upset because he had no television. The SO agreed with Mr Pagirys that his risk had reduced and he only needed to be checked at least once an hour by staff.

59. On 1 November, Mr Pagirys became angry when he said that officers refused to give him an asthma pump, which he had been prescribed. (There is no evidence that he had been prescribed an asthma pump in his prison medical record.) He broke his cell window and a SO punished him with 14 days cellular confinement at a disciplinary hearing, although he suspended the cellular confinement and did not activate the extant suspended cellular confinement punishment.

60. At an ACCT case review on 2 November, Mr Pagirys told a SO through an interpreter that he had problems on the wing, but he did not have any thoughts of suicide or self-harm at that time. The SO noted that Mr Pagirys had not hurt himself for three weeks and agreed with those at the review, a chaplain and a substance misuse worker, that he no longer needed to be subject to ACCT monitoring so closed the ACCT.

61. On 8 November, an officer recorded that Mr Pagirys cut his arm when an officer asked him to return to his cell. Mr Pagirys barged past the officer and racially abused him. He then smashed his cell window and was charged with damaging prison property.

Segregation from 9 – 11 November 2016

62. On 9 November, Mr Pagirys was taken to the segregation unit for his disciplinary hearing. An officer recorded in his prison record that he stripped naked, was crying and tried to strangle himself with a T-shirt. He started ACCT monitoring and asked officers to check Mr Pagirys at least five times an hour until he could be properly assessed.

63. The Head of Security at Wandsworth held the disciplinary hearing in the segregation unit. She told the investigator that she reviewed the details of the offence and knew that Mr Pagirys had committed a number of offences over the previous few months. She used a Lithuanian interpreter to explain the charges. Mr Pagirys explained that he had broken the window because he was frustrated about not getting an asthma pump. She activated the suspended 14 days cellular confinement, which meant that Mr Pagirys would be held in the segregation unit for 14 days.

64. After the disciplinary hearing, Nurse X undertook a segregation health screen to determine if Mr Pagirys was fit to be segregated. In answer to the question asking whether the prisoner was awaiting a transfer to an NHS secure mental health setting, he indicated both “yes” and “no” (Mr Pagirys was not awaiting a transfer). He also marked both “yes” and “no” to the question asking whether the prisoner had self-harmed while in custody and whether they were subject to ACCT monitoring. Mr Pagirys was subject to ACCT monitoring and so Nurse X should have gone on to answer the question, “Do you think the prisoner’s mental health will deteriorate significantly if segregated?”, but he failed to do so. Nurse X concluded that no healthcare intervention was required and that Mr Pagirys was fit to be segregated, but he made no assessment of the impact that segregation might have on Mr Pagirys’ mental health as he should have done. In his corresponding entry in Mr Pagirys’ medical record, Nurse X recorded that when he saw Mr Pagirys in the segregation unit, Mr Pagirys had a noose around his neck, was crying and said that he wanted to die. Nurse X recorded that Mr Pagirys had no injuries and was “well in himself”. He referred Mr Pagirys for a

mental health review and wrote that he had concluded he was fit to be segregated. In his statement, Nurse X said that, "there weren't any apparent clinical reasons to unfit him to remain for a period of segregation".

65. The Head of Security authorised Mr Pagirys's segregation after seeing Nurse X's completed health screen. She told the investigator she was unaware that Mr Pagirys had put a noose around his neck and that this information would have changed her view. That afternoon, a SO chaired an ACCT case review, even though Mr Pagirys had not had an ACCT assessment. Mr Pagirys was the only person in attendance. The SO spoke to the mental health in-reach team, who said that Mr Pagirys had no mental health issues. Mr Pagirys said that he was unhappy that he was segregated, but that he understood why he had been. He told the officer that he just wanted to sleep. The SO told the investigator that he did not know that Mr Pagirys had tied a ligature around his neck that day. He said that Mr Pagirys seemed much calmer than he had that morning, so he assessed his level of risk as low and reduced his observations to at least one every half an hour.

66. At about 11.00am on 10 November, the SO of Segregation chaired an ACCT case review with an officer. Neither the SO nor the officer could remember the case review when they were interviewed for this investigation. The SO recorded that Mr Pagirys had no thoughts of suicide or self-harm. They agreed that the frequency of his observations should be reduced to at least once an hour.

67. On 11 November, Mr Pagirys rang his cell bell at 1.00pm, during the lunchtime period. The cell bell alarm sounded in the segregation unit and CCTV shows that the light outside his cell illuminated to indicate that he had rung his cell bell. An officer had taken over the lunchtime patrol just before 1.00pm that day. She said that she did not hear the alarm and she described it as being very quiet. CCTV shows her, an SO and a prisoner cleaner carrying out their duties on the segregation unit. The light outside Mr Pagirys' cell remained lit until 1.37pm, when the officer said she first noticed the light and went to Mr Pagirys' cell. She opened the observation panel, could not immediately see him, but then saw him hanging from a ligature made from a bedsheet, attached to an air vent. She immediately called for staff assistance.

68. A manager on the unit and the SO ran immediately to Mr Pagirys' cell. They opened the door, cut the ligature and lowered Mr Pagirys to the floor. The manager checked for vital signs but found none, so began administering chest compressions. The SO radioed an emergency code blue call and an ambulance was requested immediately. Healthcare staff arrived and assisted the manager with cardiopulmonary resuscitation (CPR) until the paramedics arrived at 2.00pm. They stabilised Mr Pagirys and he was taken to hospital. Mr Pagirys did not regain consciousness and was pronounced dead at 7.41pm on 14 November.

Contact with Mr Pagirys' family

69. The prison family liaison officer telephoned Mr Pagirys' mother at 6.10pm to let her know that her son had been taken to hospital. He arrived at the hospital at 7.30pm, with a manager, and telephoned Mr Pagirys' family again to ask if they needed assistance getting to the hospital. They arrived at the hospital at 8.50pm

70. Wandsworth offered help with the funeral arrangements and contributed to the costs, in line with national instructions.

Support for prisoners and staff

71. After Mr Pagirys' death, a manager debriefed the staff involved in the emergency response. She offered her support and that of the staff care team.

72. The prison posted notices informing other prisoners of Mr Pagirys' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Pagirys' death.

Post-mortem report

73. Mr Pagirys' post-mortem report concluded that he died from a brain injury and heart attack through hanging. The toxicology report showed that Mr Pagirys had not taken any medication (including his prescribed medication) or any illicit drugs.

Findings

Managing Mr Pagirys' risk of suicide and self-harm

Identification of triggers and risk factors

74. PSI 64/2011 provides guidance to staff on assessing a prisoner's risk of self-harm and suicide and how to manage that risk. The PSI divides risk factors into several different categories, including young prisoners (Mr Pagirys was 18 years old), previous self-harm, irrational behaviour and lack of support. It also identifies triggers that might lead a prisoner to consider suicide or self-harm. These include court appearances, segregation and foreign nationals who are close to deportation.

75. Our Learning Lessons Bulletin, Risk factors in self-inflicted deaths in prison, published in April 2014, lists some incidents that frequently occur before a prisoner takes his or her own life. These include an ACCT being opened or reviewed, moving cells, self-harm, anti-social behaviour, observations being reduced and moving to segregation. Mr Pagirys was subject to all of these.

76. Mr Pagirys was frustrated that he frequently moved cells (at least 32 times while at Wandsworth) and his frustration often resulted in aggressive and disruptive behaviour. Staff responded by taking punitive action, initially by keeping Mr Pagirys in his cell, then putting him on the basic regime and subsequently taking disciplinary action and sentencing him to cellular confinement. Staff failed to recognise that Mr Pagirys was a vulnerable 18-year old, whose vulnerability was increased by his inability to express himself fully in English. Rather than repeatedly punishing him, they should have recognised that Mr Pagirys was distressed and taken steps to understand and address his issues. The actions taken by staff exacerbated Mr Pagirys' distress and were an inappropriate way to deal with a highly vulnerable young person.

77. Mr Pagirys' use of ligatures appears to have been triggered by specific events, namely his cell moves and his court appearances in connection with his extradition. While staff did note in prison records that Mr Pagirys became upset at cell moves and that he was worried about returning to Lithuania, we found very little evidence that staff had tried to engage with Mr Pagirys in respect of these concerns. Had it been explained to Mr Pagirys that he might not return to the same cell after his court appearances and had someone explained the extradition process, including timescales and rights of appeal to him, it is possible that his behaviour might have been more manageable.

78. We make the following recommendation:

The Governor should ensure that staff identify vulnerable prisoners at heightened risk of suicide and self-harm and ensure that if any disciplinary measures taken against them they are necessary, appropriate and proportionate.

ACCT management

79. PSI 64/2011 sets out the process that should be followed when an ACCT is opened. This includes that a trained ACCT assessor must undertake an assessment interview within 24 hours and that case reviews should be multidisciplinary where possible, with a mandatory requirement that healthcare staff must attend the first case review. When Mr Pagirys' ACCT was opened on 9 November, no assessment interview took place and only Mr Pagirys attended the first case review, chaired by a SO. Similarly, in respect of the ACCT opened on 22 September, only a SO and Mr Pagirys attended the first case review. We also identified a number of case reviews that were attended only by prison officers, with no indication that they had sought multidisciplinary input.

80. PSI 64/2011 also sets out how the prisoner's caremap should be completed as part of the ACCT process. Each action on the caremap must be tailored to meet the individual needs of the prisoner and be aimed at reducing the risk to themselves. While staff did identify some appropriate caremap actions for Mr Pagirys, such as explaining the basic regime and what Mr Pagirys needed to do to return to a standard regime, other caremap actions, such as explaining the need for cell moves and the extradition process, were omitted.

81. On the day of Mr Pagirys' death, he was subject to hourly observations. The ACCT record shows that he was checked at 12:20pm, but was not checked again until 75 minutes later, when he was found hanging in his cell. Staff failed in their duty to carry out the required level of observations as set out in the ACCT.

82. Only two ACCT case reviews were conducted with an interpreter present. A further case review noted an online translation tool had been used, but in the remainder there was no indication that any consideration had been given to providing interpretation or translation services. We are concerned that the fact Mr Pagirys was not able to express himself fully in his ACCT case reviews meant that staff could not properly understand his issues and assess his risk.

83. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:

- **A trained ACCT assessor completes an assessment within 24 hours of the ACCT being opened and attends the first case review.**
- **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attend all first case reviews.**
- **Enhanced case management measures are considered for the more challenging, complex or vulnerable prisoners.**
- **Staff adhere to the frequency of observations set out in the ACCT document.**
- **Staff set specific and meaningful ACCT caremap actions that are aimed at reducing prisoners' risks to themselves and review them at each case review.**

Decision to segregate Mr Pagirys on 9 November

84. Before being taken to the segregation unit on 9 November, Mr Pagirys had attempted to self-harm using ligatures on five occasions during his three months at Wandsworth. One of those occasions was when he was segregated on 30 September, when he used his clothes as a ligature. When taken to the segregation unit on 9 November, Mr Pagirys again tried to use an item of his clothing as a ligature. He was monitored under ACCT procedures as a result.

85. Prison Service Instruction (PSI) 64/2011, which covers safer custody, states that prisoners assessed as at risk of suicide and self-harm should be held in segregation units only in exceptional circumstances and that the reasons must be clearly documented in the ACCT record and include other options that were considered but discounted. We found no evidence that staff had considered whether there were exceptional circumstances in Mr Pagirys' case that justified his segregation. The ACCT document made no mention of how Mr Pagirys' case constituted exceptional circumstances and there was no record of any alternative options considered.

86. Healthcare must assess whether a prisoner is fit to be segregated. We found the assessment carried out by Nurse X was woefully inadequate, and significant aspects relating to Mr Pagirys' state of mind at the time of segregation were seemingly ignored. Given that Mr Pagirys had self-harmed while in Wandsworth and was on an ACCT document at the time of the assessment, Nurse X should have assessed whether his mental health would deteriorate significantly if segregated. There is no indication that Nurse X did so. Although Nurse X recorded in Mr Pagirys' medical records that he had seen him in the segregation unit with a noose around his neck, crying and saying he wanted to die, Nurse X assessed him as fit to be segregated saying that he was "well in self". The clinical reviewer commented that he found it difficult to understand how Nurse X had arrived at the decision that Mr Pagirys was fit to be segregated.

87. In a Learning Lessons Bulletin we issued in June 2015, we examined learning from investigations into the self-inflicted deaths of prisoners who were segregated at the time of their deaths. We noted that segregation reduces some protective factors against suicide and should be used only in exceptional circumstances for those at risk of taking their own life. We found that too often, prisoners identified as at risk of suicide and self-harm were held in segregation units without sufficient evidence that staff had considered other options or identified exceptional circumstances to justify their segregation. This was clearly the case with Mr Pagirys.

88. Mr Pagirys' case highlights how difficult it is to manage and care properly for vulnerable prisoners who display challenging behaviour in prison. The enhanced case management process is designed to manage the most challenging prisoners. Enhanced case reviews involve more specialists and a higher level of operational management than a typical ACCT case review. We found no evidence that Mr Pagirys was considered for enhanced case management. This should have been considered.

89. Prisoners who are the most difficult can also be the most vulnerable and we recognise that their behaviour can be very damaging to others. Prison staff then

have difficult decisions to make about where to hold such prisoners, when all other options have been exhausted. This makes it more important to fully demonstrate that all of the options have been considered and that procedures to safeguard prisoners have been properly followed before segregation is used. We make the following recommendation:

The Governor should review the operation of the segregation unit and satisfy herself that it is able to deliver its basic function of holding prisoners there appropriately, safely and securely and in decent conditions.

The Governor should ensure that prisoners at risk of suicide and self-harm are not held in the segregation unit unless all other options have been considered and discounted, and that the exceptional circumstances justifying segregation are fully documented.

The Governor and Head of Healthcare should ensure that Nurse X has the necessary skills and experience to properly assess whether a prisoner is fit for segregation.

Mental health

90. 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. The clinical reviewer commented 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 their conclusion that Mr Pagirys had no significant mental health issues was at variance with the GP's diagnosis of depression, which the GP had reached having used an interpreter during her consultation.

91. Mr Pagirys was referred for an urgent mental health assessment on 22 September after he had cut himself and told a nurse that he was not coping with prison. He was not seen until six days later, on 28 September, but was not assessed because of language difficulties. No further attempt was made to assess him until 6 October, but Mr Pagirys was not in his cell so the assessment did not go ahead. It was not until 17 October, 25 days after the urgent referral was made, that Mr Pagirys was assessed by a mental health nurse. This delay was unacceptable.

92. The clinical reviewer found that there had been a delay in diagnosing and treating Mr Pagirys' depression, and during the period of delay Mr Pagirys had started to self-harm. He concluded that the care Mr Pagirys received at Wandsworth was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that urgent referrals for mental health assessments are conducted promptly and should review the process for undertaking assessments of prisoners who have a poor

command of English, which should include a review of the use of an interpreting service.

Response to cell bell

93. Mr Pagirys pressed his cell bell at 1.00pm. HMIP has an expectation that cell bells should be answered within five minutes and this is the standard we expect.

94. The officer on duty in the segregation unit over the lunchtime period said that she did not hear the cell bell and she did not notice the flashing light outside Mr Pagirys' cell until 1.37pm. We acknowledge that the cell bell alarm was quiet, but we find it unacceptable that she did not respond to the cell bell until 37 minutes had passed. The segregation unit is a small unit and knowing that the cell bell alarm was quiet, she should have carried out visual checks for cell bells. Mr Pagirys hanged himself during the 37 minutes it took to answer his last cell bell. Had staff answered the bell promptly, they might have been able to save his life. HMIP have previously criticised the prison for their slow response to cell bells. We make the following recommendation:

The Governor should ensure that all cell bells are answered within five minutes.

Translation services

95. PSI64/2011 states that all staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process.

96. There were many occasions during ACCT reviews, health assessments and wing interactions, where staff should have used translation services to communicate effectively with Mr Pagirys. Had they done so, they might have gained a better understanding of why Mr Pagirys felt so frustrated and, on occasions, acted aggressively. Equally, Mr Pagirys might have understood why staff took the action they did. Even when staff were asked specifically to use a translator (for example the nurse's note of 30 September requesting a mental health assessment and that a translator was needed) they did not do so. Some staff reported logistical difficulties using these services at Wandsworth. It is concerning that something as basic as being able to communicate with a prisoner was neglected. We make the following recommendation:

The Governor and Head of Healthcare should ensure that, when a prisoner does not speak or understand English well, professional interpreting services for prisoners are used, especially for those at risk of suicide or self-harm.

Missing documentation

97. It is concerning that, as in a previous death at Wandsworth, important ACCT documents are missing. As a result, we are unable to confirm that Mr Pagirys was managed under ACCT procedures in August 2016. This is particularly concerning given that other records show he was subject to constant supervision during this time.

98. In spite of repeated requests by the investigator for information about Mr Pagirys' extradition, the prison was unable to provide any relevant information.

The Governor should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary during the course of the investigation.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141