

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rimantas Zalalis, a prisoner at HMP Thameside, on 22 March 2021

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



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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 Rimantas Zalalis died in hospital from alcohol poisoning on 22 March 2021. He had been found collapsed in his cell at HMP Thameside two days before. Mr Zalalis was 46 years old. I offer my condolences to his family and friends.

Mr Zalalis had been at Thameside for less than seven hours when he was found collapsed in his cell. Although the reception nurse recognised that Mr Zalalis was withdrawing from alcohol when he arrived and should be monitored, she started suicide and self-harm monitoring (known as ACCT), rather than clinical monitoring. ACCT monitoring was inappropriate in the circumstances and was inadequate.

The investigation found that staff delayed called a medical emergency code when they discovered Mr Zalalis on the floor of his cell. This resulted in a delay in an ambulance being called. We cannot say whether this affected the outcome for Mr Zalalis, but we know that in a medical emergency, a delay of a few minutes can be critical. Staff need to be reminded of the importance of following the correct procedures in a medical emergency.

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

Sue McAllister CB
Prisons and Probation Ombudsman

June 2022

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Summary

Events

1. Mr Rimantas Zalalis, a Lithuanian national, was remanded in prison custody on 20 March 2021, after he was found collapsed in a park and it was discovered that he was wanted on a warrant from 2016. He was sent to HMP Thameside.
2. Mr Zalalis had a history of alcohol abuse and when he arrived at Thameside, a nurse assessed that he was showing alcohol withdrawal symptoms. She considered that Mr Zalalis should be monitored but there were no beds available in the prison's inpatient unit. Instead, she started Prison Service suicide and self-harm monitoring (known as ACCT) and set observations at one an hour (carried out by prison staff).
3. At around 9.25pm, Mr Zalalis's cellmate pressed their cell bell and said that Mr Zalalis was having a fit. Two prison custody officers (PCOs) went to the cell and saw Mr Zalalis lying on the floor. They called for the night nurse and once he arrived, they opened the cell. The night nurse found that Mr Zalalis was unresponsive and not breathing so he started cardiopulmonary resuscitation (CPR) and told the PCOs to call a medical emergency code. Another nurse arrived with the emergency bag and staff continued CPR while waiting for the ambulance to arrive.
4. Paramedics arrived shortly afterwards, and they managed to resuscitate Mr Zalalis. At around 10.10pm, they took Mr Zalalis to hospital. However, he died in hospital two days later. The post-mortem report concluded that he died from alcohol poisoning.

Findings

5. Despite the reception nurse recognising that Mr Zalalis was withdrawing from alcohol when he arrived at Thameside, we found no evidence that he was breathalysed, in line with the prison's healthcare policy, in order to establish the level of alcohol in his body. The reception nurse and a prison GP decided that Mr Zalalis should be monitored for signs of alcohol withdrawal but neither put a clear monitoring plan in place and there was not a proper handover to the night nurse.
6. We consider that the use of ACCT monitoring was inappropriate for Mr Zalalis as he was not at risk of suicide or self-harm. He should have been monitored for signs of alcohol withdrawal, which is very different from monitoring a prisoner who is at risk of harming themselves. We were told that it was not unusual for ACCT procedures to be used to monitor prisoners withdrawing from drugs or alcohol. We are concerned that such prisoners are being inadequately monitored by prison staff rather than healthcare staff.
7. The PCOs who saw Mr Zalalis on the floor of his cell should have called a medical emergency code straightaway. This would have prompted control room staff to call an ambulance immediately. Instead, a code was not called until after the nurse had arrived which resulted in a delay of a few minutes. While we do not know what effect this delay may have had on the eventual outcome for Mr Zalalis, we know that in a medical emergency, a delay of a few minutes can be critical.

8. The prison appointed two family liaison officers (FLOs) after Mr Zalalis's death to contact his next of kin and provide support. However, neither was able to produce the FLO log, which they said had been lost. They were also unable to provide Mr Zalalis's next of kin details, which meant we were unable to contact them about our investigation.

Recommendations

- The Head of Healthcare should ensure that staff:
 - carry out a breathalyser test on prisoners who are withdrawing from alcohol when they arrive; and
 - put an appropriate monitoring plan in place for prisoners withdrawing from drugs or alcohol and ensure that all relevant staff are made aware of the observations and monitoring required.
- The Director and Head of Healthcare should ensure that prisoners are not inappropriately monitored under ACCT procedures as an alternative to proper clinical monitoring by healthcare staff.
- The Director should remind staff of their responsibilities in a medical emergency, including that they should radio the correct medical emergency code immediately.
- The Director should ensure that family liaison officers record all family contact in the FLO log, including next of kin contact details, and provide it to the PPO investigator when requested.

The Investigation Process

9. We issued notices to staff and prisoners at HMP Thameside informing them of the investigation and asking anyone with relevant information to contact us. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Zalalis's prison and medical records.
11. NHS England commissioned an independent clinical reviewer to review Mr Zalalis's clinical care at the prison.
12. The investigator and clinical reviewer interviewed three members of staff in September and October 2021.
13. We informed HM Coroner for Inner South London of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The prison was unable to provide contact details for Mr Zalalis's next of kin. Therefore, the Ombudsman's family liaison officer was unable to contact his next of kin to explain the investigation or to ask if they had any questions or concerns.
15. We shared our initial report with the Prison Service. They did not identify any factual inaccuracies. They did, however, request some changes to the clinical review which NHS England agreed to make.

Background Information

HMP Thameside

16. HMP Thameside is a local prison which holds up to 1,232 male prisoners who have either been convicted or are on remand. It is managed by Serco. Healthcare is provided by Oxleas NHS Trust. A dedicated healthcare unit has inpatient facilities for 20 prisoners.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Thameside was in May 2017. Inspectors found that, overall, HMP Thameside was a relatively good prison, and they identified an unusually high number of examples of good practice.
18. Inspectors reported that a high number of prisoners were received into the prison each day. Reception processes were quick and prisoners needing stabilisation from substance misuse were promptly taken to the drug stabilisation unit. The unit was supportive and well-managed with prisoner peer support workers assisting during the reception, first night and induction periods.
19. Inspectors reported that outcomes for those with drug and alcohol problems were good, but treatment services were not adequately integrated, partly due to poor attendance at drug strategy committee meetings and a consequent lack of strategic leadership across departments.

Independent Monitoring Board

20. 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 June 2020, the IMB noted an improvement in healthcare services since the previous year. However, the Board reported a high demand on healthcare services and noted that the inpatient unit was almost always full, mainly with mentally ill patients.

Previous deaths at HMP Thameside

21. Mr Zalalis was the fifth prisoner to die at Thameside since March 2019. Of the previous deaths, two were from natural causes, one was self-inflicted, and one was drug related. There are no similarities between our findings from our investigation into Mr Zalalis's death and our investigation findings from the previous deaths.

Key Events

22. In the early hours of 20 March 2021, Mr Rimantas Zalalis, a Lithuanian national, was taken to hospital after being found collapsed in a park. It was discovered that he was wanted on an arrest warrant from 2016, so later that day he was remanded in prison custody and sent to HMP Thameside.
23. Mr Zalalis arrived at Thameside around 2.45pm. His Person Escort Record (PER - a document that accompanies prisoners between police, courts and prisons which sets out the risks they pose) said that Mr Zalalis was an alcoholic and he had leukaemia. Nurse A conducted his reception health screen. She was concerned about Mr Zalalis as, although his vital signs were within normal range, she noticed that he seemed unsteady on his feet, had signs of tremor and appeared confused. She said that she tried to find out if he had any accompanying medical notes, but he did not. She used Google Translate to ask him about his alcohol use. She assessed that he was withdrawing from alcohol and referred him to the GP for alcohol detoxification treatment. She did not breathalyse Mr Zalalis to establish the levels of alcohol in his body.
24. Nurse A discussed her concerns about Mr Zalalis with a prison GP. The GP shared the nurse's concerns and he considered that Mr Zalalis would be best observed by healthcare staff in the prison's inpatient unit. He ordered blood tests to establish the extent of Mr Zalalis's leukaemia. He also prescribed chlordiazepoxide (to help reduce alcohol withdrawal symptoms and prevent fitting) and thiamine (essential vitamins) and asked the nurse to arrange a bed in the inpatient unit for Mr Zalalis. However, there were no inpatient beds available, so Mr Zalalis was allocated a cell on the substance misuse wing. The nurse decided to start suicide and self-harm monitoring (known as ACCT) for Mr Zalalis and spoke to staff on the substance misuse wing to check that they would monitor him every hour during the night.
25. At 7.10pm, Nurse A opened the ACCT. She noted in the ACCT observation record that Mr Zalalis was very unwell, disorientated, confused, incoherent, with severe hand tremor and at risk of a fall. She wrote that he was vulnerable and that he had been referred to the inpatient unit, but no bed was available.
26. A Prison Custody Officer (PCO) checked on Mr Zalalis at 8.06pm and wrote in the ACCT observation record that he was sitting waiting to be placed in a cell. The PCO said they had no concerns about him. Staff moved Mr Zalalis to a cell on the substance misuse wing shortly afterwards.
27. At around 8.30pm, shortly before Nurse A finished her shift, she handed over Mr Zalalis's care to the night nurse, Nurse B, in a telephone conversation. She told Nurse B that Mr Zalalis was a new prisoner withdrawing from alcohol. Nurse B said that they did not discuss any particular level of observation, but his priority was on making sure that Mr Zalalis had some medication available in case he needed it during the night. He therefore asked Nurse A to arrange a prescription with the doctor, which she did.
28. Nurse B said that he did not know that Mr Zalalis was subject to ACCT monitoring. He said that prisoners on the substance misuse wing are usually monitored by healthcare staff during the night, regardless of whether or not they are subject to

ACCT monitoring. He said that he was busy with other duties after he came on shift, so he did not actually check on Mr Zalalis.

29. A PCO said that he had a handover at 8.30pm when he came on duty. He said he was aware that Mr Zalalis was subject to ACCT monitoring, but he did not know the reasons for this. He said that he did not look at the ACCT document before checking on Mr Zalalis at 9.10pm. He wrote in the ACCT observation record that he saw Mr Zalalis lying on his back with no visual signs of self-harm.
30. At around 9.25pm, Mr Zalalis's cellmate pressed their cell bell and told the PCO that Mr Zalalis was having a fit. The PCO and a colleague went to the cell and saw through the door hatch that Mr Zalalis was lying on the floor. The PCO radioed for healthcare staff to attend. When Nurse B arrived around two minutes later, they all entered the cell.
31. Nurse B immediately realised that Mr Zalalis required emergency medical attention, so he asked the officers to call an emergency code blue (indicating that a prisoner is unresponsive or not breathing and an ambulance needs to be called immediately).
32. Nurse B started cardiopulmonary resuscitation (CPR) immediately and his colleague arrived shortly afterwards with the emergency bag to assist him. Staff continued attempts to resuscitate Mr Zalalis until the paramedics arrived and took over. The paramedics successfully resuscitated Mr Zalalis and at around 10.10pm, took him to hospital. However, he died in hospital two days later, on 22 March.

Contact with Mr Zalalis's family

33. The prison told us that they appointed two family liaison officers (FLOs) to contact Mr Zalalis's next of kin and to offer support. However, the prison was unable to provide us with the FLO log, which they said could not be found. One FLO wrote an account from memory, which said he had contacted Mr Zalalis's uncle and had offered a financial contribution to the funeral (though he said that the family got help from a charity instead). However, as there is no FLO log, there is no contemporaneous record of contact with the family. The prison was also unable to provide the contact details for Mr Zalalis's uncle.

Support for prisoners and staff

34. After the emergency response, prison and healthcare staff said they attended a debrief and felt supported by managers. The prison posted notices informing staff and prisoners of Mr Zalalis's death and offering support.

Post-mortem report

35. The report of the post-mortem examination concluded that Mr Zalalis died from alcohol poisoning.

Findings

Clinical management

36. Nurse A recognised that Mr Zalalis was withdrawing from alcohol when he arrived at Thameside and that he should be monitored. However, she did not take or record his blood alcohol level. The prison's healthcare policy says, 'for patients identified as abusing alcohol, the breathalyser should also be used', but this was not done.
37. Nurse A referred Mr Zalalis to a prison GP, who prescribed detoxification medication and told the nurse that Mr Zalalis should be observed. However, he did not specify by who and how often. The nurse asked the night nurse, Nurse B, to 'keep an eye' on Mr Zalalis, but the risks were not properly shared with him or wing staff.
38. We make the following recommendation:

The Head of Healthcare should ensure that staff:

- **carry out a breathalyser test on prisoners who are withdrawing from alcohol when they arrive; and**
- **put an appropriate monitoring plan in place for prisoners withdrawing from drugs or alcohol and ensure that all relevant staff are made aware of the observations and monitoring required.**

ACCT monitoring

39. Staff started ACCT monitoring for Mr Zalalis because there was no inpatient bed available, and they thought he needed to be monitored because he was withdrawing from alcohol. Mr Zalalis was not at risk of suicide or self-harm, so we consider this was an inappropriate use of ACCT procedures.
40. We heard from staff during the investigation that it was not unusual for prisoners to be monitored under ACCT procedures because they were withdrawing from drugs or alcohol. While we recognise that this level of monitoring is better than nothing, we consider that there is potential for ACCT monitoring to be inappropriately used in place of clinical monitoring. Prison staff are not qualified to carry out clinical monitoring of prisoners withdrawing from drugs or alcohol and they should not be expected to do so.
41. The PCO said he did not know the reason why Mr Zalalis was being monitored under ACCT procedures and he believed he was observing him due to his risk of suicide or self-harm. We consider that the use of ACCT procedures in this way could potentially lead to prisoners receiving an inappropriate level of monitoring if staff do not know what they are looking for.
42. We make the following recommendation:

The Director and Head of Healthcare should ensure that prisoners are not inappropriately monitored under ACCT procedures as an alternative to proper clinical monitoring by healthcare staff.

Emergency response

43. The prison's policy on opening cell doors during night state says that a minimum of two members of staff should be present before opening a cell. The PCO said that when he and his colleague saw Mr Zalalis on the floor, they did a risk assessment and considered it was unsafe for them to enter the cell as they did not know either Mr Zalalis or his cellmate. He said they decided to call for the night nurse and wait for them to arrive before opening the cell.
44. We accept that it was a reasonable decision not to enter the cell straightaway and wait for another member of staff to arrive. However, we consider that staff should have called a medical emergency code as soon as they saw Mr Zalalis on the floor of the cell. Mr Zalalis's cellmate had already told them that Mr Zalalis was having a fit and once they saw him on the floor, they should have called a code blue (which is used to indicate that a prisoner is unconscious, having breathing difficulties or fitting). The code blue would not only have alerted the nurse and advised them of the correct equipment to bring but would also have triggered the calling of an ambulance immediately.
45. We do not know if the delay affected the outcome for Mr Zalalis, but we do know that in a medical emergency, a delay of a few minutes can be critical. We therefore make the following recommendation:

The Director should ensure that staff are reminded of their responsibilities during a medical emergency, including that they radio the correct medical emergency code immediately.

Family Liaison

46. Prison Service Instruction (PSI) 64/2011 on Safer Custody says, "A log book recording contact with the next of kin must be opened when the FLO is first deployed to the family. Every contact with the family and their representatives should be recorded wherever possible." It goes on to say that this record should be kept even if the FLO has been unsuccessful in making contact with the next of kin and that this information may be required by the PPO investigator.
47. We are concerned that the FLO log was not available to the investigator as we were told it had been lost. While the FLO provided an account of his contact with the family from memory, there is no contemporaneous record. The prison was also unable to provide us with Mr Zalalis's next of kin details, which meant that we were unable to contact them to tell them about the PPO investigation. We make the following recommendation:

The Director should ensure that family liaison officers record all family contact in the FLO log, including next of kin contact details, and provide it to the PPO investigator when requested.

Inquest

48. The inquest, held from 7 to 16 May 2024, concluded that Mr Zalalis's death was alcohol related. The jury found that there were failings in the management of the risk of alcohol withdrawal by the healthcare staff at Thameside which may have affected the outcome. The factors that they considered may have contributed to the death included:
- The delay to assess and administer the appropriate alcohol withdrawal treatment.
 - The lack of secondary medical assessment after the administration of chlordiazepoxide and being sent to his cell.
 - The lack of appropriate handover arrangements between medical staff (day and night shift) and engagement with prison officers regarding risks and observation requirements.
 - The inability of the night nurse to make an observation round earlier.
 - More broadly there appeared to be issues with outdated policies and procedures and a general lack of training/understanding of the roles and responsibilities of day/night shift medical staff and the roles and responsibilities of prison officers.
49. The jury also found that there was an inappropriate delay in prison staff calling a code blue and in entering the cell. However, it was not possible for them to say whether it made a substantial difference to Mr Zalalis's chance of survival.

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