Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rolandas Karbauskas, a prisoner at HMP Lowdham Grange, on 25 March 2023

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

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.

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.

Mr Rolandas Karbauskas was found hanged in his cell on 25 March 2023 at HMP Lowdham Grange. He had been there only five days. He was 49 years old. I offer my condolences to Mr Karbauskas's family and friends.

Mr Karbauskas' death was the third of three self-inflicted deaths at Lowdham Grange in March 2023. HM Inspectorate of Prisons and the Independent Monitoring Board expressed concerns about the safety of the prison around the time of Mr Karbauskas' death. In February 2023, the management of the prison transferred from Serco to Sodexo and resulted in a reduction of staff levels, higher levels of drugs, violence, self-harm, less time out of cells and a deterioration in staff-prisoner relationships. In May 2024, the management of Lowdham Grange transferred to HMPPS.

Mr Karbauskas was at HMP Lincoln for approximately a year before he arrived at Lowdham Grange. Problems had occurred at both prisons, and it is clear how isolated and unhappy Mr Karbauskas had become. He did not speak English and staff efforts to use interpreting services were inconsistent. Towards the end of his life, Mr Karbauskas willingly spoke about his problems and said he had not been able to tell anybody because of the language barrier.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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Summary

Events

1. On 19 March 2022, Mr Rolandas Karbauskas was remanded to HMP Lincoln charged with murder. On 11 November, he was sentenced to life imprisonment. Mr Karbauskas was from Lithuania and did not speak English.

2. Mr Karbauskas arrived at Lincoln with a Suicide and Self-Harm (SASH) warning form. Staff in reception at Lincoln did not document whether they had seen it. It said Mr Karbauskas was very depressed, exhibiting bizarre behaviour and had been subject to intermittent observations. Aside from the information on the SASH form, it was also Mr Karbauskas' first time in prison. Staff did not record whether they had considered starting suicide and self-harm monitoring procedures, known as ACCT.

3. A reception nurse referred Mr Karbauskas to the mental health team, but they had not made arrangements to see him. When the open referral came to light six months later at a multi-disciplinary (MDT) meeting, the mental health team closed the referral without anyone seeing him first or telling him that he had been discharged from the service.

4. Mr Karbauskas received very few keywork sessions at Lincoln. Those which took place involved other prisoners being used to interpret and on other occasions staff decided that his lack of engagement was down to him not wanting to speak to them. Officers failed to document whether they had used telephone interpreter services.

5. On 20 March 2023, Mr Karbauskas transferred to HMP Lowdham Grange. The reception nurse used another prisoner to interpret and referred Mr Karbauskas to the mental health team. An officer also carried out an interview and used a prisoner to interpret.

6. A mental health nurse tried to assess Mr Karbauskas. He could not understand Mr Karbauskas and had not arranged an interpreter for the appointment despite the notes confirming he did not speak English. The nurse used hand gestures to communicate and told a colleague he would need to rebook the appointment using a translation service. He did not do so, and Mr Karbauskas was never assessed.

7. At approximately 9.45am on 25 March, an officer failed to complete the welfare checks when unlocking the prisoner cells. At approximately 10.30am, a prisoner found Mr Karbauskas ligatured by a shoelace attached to the bunk above him. He raised the alarm. Prison and healthcare staff attended and carried out cardiopulmonary resuscitation (CPR).

8. Paramedics arrived and at 10.55am, confirmed that Mr Karbauskas had died.

Findings

9. There were omissions in the care Mr Karbauskas received during his brief period at Lowdham Grange, and during the year he spent at Lincoln.

10. At Lincoln, the mental health team failed to action the mental health referral and they discharged him from the mental health service without seeing him or telling him. Keywork sessions were few and never utilised appropriate interpreting services.

11. At Lowdham Grange, prisoners were used to interpret, and a mental health assessment was not carried out because the nurse had not arranged an interpreter and did not rebook the appointment.

12. An officer failed to carry out a welfare check at unlock as he should have done.

Recommendations

- The Governor and Head of Healthcare at HMP Lincoln should:
    - review processes to ensure staff consider PERs and SASH forms and record that they have done;
    - conduct a regular audit to satisfy themselves the process is embedded; and
    - ensure staff know the red flags for suicide and self-harm and, where they are present, document their reasoning for not starting ACCT procedures.
- The Governor at HMP Lincoln and Director at HMP Lowdham Grange and their Heads of Healthcare should audit of the use of interpreting services to assure themselves that they are always used where appropriate, and if they are not ensure all staff are trained in their use.
- The Clinical Matron at HMP Lincoln should ensure that prisoners are not discharged from the mental health service without ever being seen face to face and that they are informed of the decision.
- The Director at HMP Lowdham Grange should ensure that staff understand they should complete a welfare check at unlock and consider randomised checks of CCTV footage to ensure they are being done.

The Investigation Process

13. HMPPS notified us of Mr Karbauskas's death on 25 March 2023.

14. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact her. A prisoner from Lowdham Grange contacted the IMB, who in turn contacted the investigator and she interviewed him. Another prisoner wrote a letter to tell us he had helped to translate for the reception nurse.

15. The investigator visited Lowdham Grange on 4 April 2023. She obtained copies of relevant extracts from Mr Karbauskas' prison and medical records.

16. The investigator interviewed six members of staff and a prisoner in Lowdham Grange in April and August 2023. She also interviewed three members of staff from HMP Lincoln by video conference in July 2023.

17. NHS England commissioned a clinical reviewer to review Mr Karbauskas' clinical care at the prison. She conducted joint interviews with the investigator.

18. We informed HM Coroner for Nottingham City of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office tried to contact Mr Karbauskas' family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

20. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Lowdham Grange

21. HMP Lowdham Grange is a Category B male adult prison located in Lowdham, Nottinghamshire. The prison was operated by Serco for 25 years but on 16 February 2023, Sodexo took over the running of the prison. This was the first time a prison had transferred from one private provider to another. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

22. In December 2023, HMPPS took over management of the prison on an interim basis, but in May 2024, the prisons minister announced that HMPPS would take over permanently.

HM Inspectorate of Prisons

23. The most recent full inspection of HMP Lowdham Grange was in May 2023. Inspectors reported that the prison was not safe, with high levels of drug use and violence. The transfer from Serco to Sodexo had led to uncertainty and anxiety among prisoners and staff, with significant numbers of key and specialist staff leaving.

24. The restricted regime put in place during the COVID-19 pandemic had continued for too long and although the new Director had quickly implemented a new regime, too many prisoners had too little time out of their cell. Access to work and education was poor and too little keywork was being delivered.

25. It found that although 11% of prisoners at Lowdham Grange were foreign nationals, a key recommendation from their last report to provide professional telephone interpreting and translated materials had not been achieved.

26. HMIP carried out an independent review of progress at the prison in January 2024. They found that levels of violence had increased by 55% and self-harm by 41% since the 2023 inspection. A high number of staff had resigned leaving the prison desperately short-staffed. Inspectors did not find sufficient progress had been made in a single one of the concerns raised in the full inspection.

Independent Monitoring Board

27. 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 January 2023, the IMB reported that the safety of the prison had deteriorated. There had been an increase in the number of prisoner-on-prisoner assaults, in self-harm and in weapons finds.

28. The Board considered that relationships between staff and prisoners had deteriorated and there had been a significant reduction in purposeful activity which had led to prisoners spending long periods locked in their cells. Healthcare services continued to be under great pressure and the IMB considered that physical and mental healthcare was at a lower standard to that in the community.

29. The Board issued an addendum to their annual report covering the period 1 February to 31 March 2023. The management and operation of the prison passed from Serco to Sodexo on 16 February 2023. The Board noted serious concerns relating to the operation of the prison and implications for safety over the next six to seven weeks. The number of prisoners on ACCT more than doubled, from 13 to 32, between the end of February and the end of March. A significant number of staff had left since the change in contract was announced in August 2022. IMB members had noticed low staffing levels on all wings.

Previous deaths at HMP Lowdham Grange

30. Mr Karbauskas was the eighth prisoner to die at Lowdham Grange since March 2020. Of the previous deaths, two were from natural causes, two were drug related, and three were self-inflicted. There are no similarities between the findings in this investigation and previous investigations. Mr Karbauskas' death was also the third of three self-inflicted deaths that occurred in March 2023. By the end of 2023, there had been two more self-inflicted deaths at the prison. As a result of these self-inflicted deaths, Lowdham Grange is receiving additional support and monitoring from regional and national safety teams.

HMP Lincoln

31. HMP Lincoln is a Category B prison, which predominantly serves the courts of Lincolnshire. It holds remanded and convicted adult/young adult male prisoners. Nottingham Healthcare NHS Foundation Trust provides health services and there is 24-hour nursing cover.

HM Inspectorate of Prisons

32. The most recent inspection of HMP Lincoln was in December 2019 to January 2020. Inspectors reported that Lincoln was a much safer prison since their last inspection in 2017, though there had been two self-inflicted deaths since then. Inspectors said that the prison's approach to prisoners in crisis was good, and they had implemented previous PPO recommendations. The inspectors found that prisoners and staff had a good relationship, which was a real strength.

Independent Monitoring Board

33. In its latest annual report, for the year to 31 January 2023, the IMB reported that the number of ACCT documents opened had decreased by 34% from the previous reporting year and self-harm incidents by 28%.

34. Most IMB applications related to a variety of healthcare management issues. There was a recognised shortage of staff.

Keywork

35. The keyworker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people

settle into life in prison. Details of how the scheme should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*.

36. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

37. On 19 March 2022, Mr Rolandas Karbauskas was remanded to HMP Lincoln charged with murder. On 11 November, was sentenced to life imprisonment for murder and received a minimum term of 18 years. Mr Karbauskas was Lithuanian and did not speak English. This was his first time in prison.

HMP Lincoln

38. Mr Karbauskas arrived with a Suicide and Self-Harm (SASH) warning form which had been completed that day by 'Person A'. No one at Lincoln was able to clarify who this person was or where they were based. It is possible she was a member of escort staff, or someone based at the court.

39. Person A had ticked certain boxes on the SASH form indicating Mr Karbauskas seemed very depressed and was exhibiting bizarre behaviour or signs of mental disorder. At some point before arriving at Lincoln, he was subject to intermittent observations, but it is unclear exactly when. Person A also noted that Mr Karbauskas was very evasive when it came to answering questions about self-harm, behaved strangely, did not make eye contact and had not been eating while withdrawing from alcohol. She noted that HMP Lincoln had been informed but did not record by what method this had happened.

40. On reception, an officer noted in Mr Karbauskas' prison record that Mr Karbauskas had been assessed as unsuitable to share a cell. The prison record contains no reference to the SASH form or whether any consideration was given to beginning suicide and self-harm prevention procedures (known as ACCT).

41. The Reception nurse noted that she used the telephone interpreting service 'Language Line' to help her carry out the reception screen. She made no reference to a PER (Person Escort Record, which accompanies the individual from police custody to court and to prison and records details about risk), the SASH form or if she considered starting suicide and self-harm prevention procedures (known as ACCT). She referred Mr Karbauskas to the alcohol intervention service and noted a doctor would assess him that evening. (Lincoln was unable to provide the investigator with a copy of Mr Karbauskas' PER.)

42. Another nurse also saw Mr Karbauskas in reception. It is unclear if he used an interpreting service. He noted that Mr Karbauskas seemed low, but said he had no current thoughts of suicide or self-harm. He recorded that Mr Karbauskas had taken an overdose the year before and spent time (unknown exactly when) in a Lithuanian psychiatric hospital. Mr Karbauskas said he was depressed and would like to be referred (presumably to mental health services).

43. The nurse noted Mr Karbauskas was not on an ACCT, but that it was his first time in prison. He made no mention of the SASH form but noted he had seen the PER. He referred Mr Karbauskas to the mental health team.

44. A GP at the prison saw Mr Karbauskas that day and used the telephone interpreting service. She noted his alcohol intake, that he denied any mental health issues but said he had tried to drown himself in a lake 18 months beforehand. She made no reference to whether she had considered starting ACCT procedures.

45. On 23 March, a mental health nurse made four phone calls to Mr Karbauskas (via the in-cell phone) to arrange his mental health assessment. She received no reply and did not rebook the appointment. SystmOne (the electronic medical record) has nothing in place to flag when referrals are left unresolved.

46. While Mr Karbauskas was at Lincoln, staff noted issues communicating with him because of the language barrier. It is not clear what staff, including keyworkers, did to try and properly address the communication problem. Staff did not document whether they had used the formal interpreting services and, although another prisoner was used on one occasion, that prisoner's language was Russian, not Lithuanian. Keyworkers, on occasion, noted that Mr Karbauskas did not want to engage (although it is not clear how they established that). Mr Karbauskas received 12 keywork sessions during his time at Lincoln.

47. On 30 September, a healthcare administrator recorded in Mr Karbauskas' medical record that on 29 September, healthcare staff held a multi-disciplinary team meeting to discuss allocations. A nurse, a therapist, a neurodiversity practitioner and a senior forensic psychologist attended the meeting. They noted that Mr Karbauskas had an open mental health referral from March 2022. The open referral came to light after an administrative data cleanse.

48. The healthcare administrator recorded that the MDT attendees had noted that the pharmacist saw Mr Karbauskas every day for medication (for back pain) and that the physiotherapist, and a GP had also seen him. The mental health referral did not contain information about the reasons for the referral and wing staff, other clinicians and Mr Karbauskas had not raised any issues since. The MDT attendees agreed there was no rationale to see him and decided to close the referral and discharge him from the mental health caseload without any further investigation.

49. On 11 November, Mr Karbauskas received a life sentence with a minimum of 18 years imprisonment. He was not assessed by healthcare staff on his return from court as he should have been.

HMP Lowdham Grange

50. On 20 March 2023, Mr Karbauskas transferred to HMP Lowdham Grange.

51. A nurse completed Mr Karbauskas's reception screen and asked another prisoner to interpret. Mr Karbauskas told her that he had been depressed for a while but had not been able to tell anybody because of the language barrier. He wanted to work with the mental health team and have some medication to help him with what he described as 'daily struggles'. He said he had always had an issue with his mental health, but he denied any thoughts of suicide or self-harm. The nurse referred him to the mental health team.

52. Later that day, a Prison Custody Officer (PCO) took Mr Karbauskas to E wing and carried out what he described as an induction keyworker session. He asked another prisoner from C wing who spoke Lithuanian to interpret. Mr Karbauskas said that he was happy to be at Lowdham Grange and felt safe there. He said he had no history of self-harm or suicide attempts (although he had told staff at Lincoln that he did). He said he was looking forward to making a fresh start and he hoped to make positive and progressive steps towards his sentence plan. He expressed an interest

in employment and education. The PCO told him that he could use the Kiosk or in-cell technology to apply for positions. Mr Karbauskas assured him that that everything else was fine and the PCO said if anything else arose he should not hesitate to approach a member of staff.

53. A prisoner mentor (a prisoner who fulfils a support role for other prisoners) introduced himself to Mr Karbauskas. He spoke a few words of Lithuanian and asked if he could help with anything. Mr Karbauskas appeared timid but showed Mr Davis his artwork. The next day, the mentor gave him some colouring pencils as Mr Karbauskas' had almost worn out. (On another day, he helped Mr Karbauskas order his canteen and add his brother's telephone number to the system.)

54. Also on 21 March, an officer made an entry on NOMIS (electronic prisoner record) for the chaplain. She wrote:

'The Quaker Chaplain. Mr Karbauskas can speak no English at all. I spent a great deal of time trying to get an interpreter but there were no staff to collect a Lithuanian prisoner. An officer told me that there are a number of Lithuanian prisoners on Houseblock 4, and he felt it would be wise if he could be moved to Houseblock 4 as soon as possible. I saw him, and he is Christian. He has put his name down as RC.'

55. On 22 March, a foreign national representative at Lowdham Grange saw Mr Karbauskas on Houseblock 2 to assist with his induction. Other staff were present and, as they had a one-off issue getting through to the interpreting service, a seconded officer fluent in Lithuanian was used to interpret. She asked Mr Karbauskas if he needed a foreign national phone code to be set up to call his family abroad, but he said that he was only in contact with his brother (who lived in Lincoln) and his solicitor as he was appealing against his conviction. She checked with the public protection team for any restrictions and offered him a phone call to his brother, but his brother declined the call.

56. During the induction, Mr Karbauskas was also asked if he had any substance misuse issues and he said not since he came into custody, however he disclosed that he suffered from depression and anxiety, but that his medication had not been sorted out at Lincoln. Another attendee at the meeting referred him to the mental health team.

57. Mr Karbauskas said that he liked to work, so he was offered ESOL (English for Speakers of Other Languages) classes. He also said that he had not eaten much, and he was assisted with logging his menu and any phone numbers he needed.

58. On 23 March, a manager asked a mental health nurse to see Mr Karbauskas. When he got to the wing, a PCO told him that Mr Karbauskas was a foreign national with very limited English and that he required interpreting services.

59. At interview, the nurse said he asked Mr Karbauskas how he was, and he replied, 'No English'. He asked him if he was okay, and Mr Karbauskas said he was. He then tapped the side of his own head and said to Mr Karbauskas, 'Are you mental?', to which Mr Karbauskas said, 'I am not.' The nurse made an arm cutting gesture with his hand, and Mr Karbauskas said, 'No, no, no.'

60. The nurse said Mr Karbauskas' cell was clean and so was Mr Karbauskas. He asked an officer on the wing how they were managing to communicate with him, and the officer said they were using another Lithuanian-speaking staff member.

61. The nurse said he told the Mental Health Matron an interpreter was needed for the assessment. He noted in Mr Karbauskas' medical record that he had seen Mr Karbauskas on the wing and that his English was limited. He also noted that an interpreter would be required, but that Mr Karbauskas reported no concerns and that he had not identified any risks. The nurse noted he planned to rebook the appointment using the telephone interpreting service, but there is no evidence that he did this.

62. On 24 March, the prisoner mentor saw Mr Karbauskas again. Mr Karbauskas indicated he had not taken any dinner because he had indigestion. The mentor gave him some coffee, biscuits and fruit.

Events of 25 March

63. At 6.45am, we are told staff carried out the routine check on the wing. This check was not captured on the CCTV footage given to the investigator which started later when the unlock began. The prison was unable to retrospectively provide the footage proving the check was done as there was a technical issue when the management of the prison transferred from one company to another.

64. At 9.47am, a PCO started the wing unlock. She unlocked the cell doors but did not look in on the prisoners or make any contact with them, contrary to policy.

65. At 10.14am, a member of works staff checked the inundation port on Mr Karbauskas' cell door, but the observation flap was shut so he would not have seen into the cell.

66. At 10.29am, the prisoner mentor went to Mr Karbauskas's cell and found him lying on the bottom bunk. A towel was hung over the end of the bed slightly obstructing his view, but he could see a ligature (a shoelace) around Mr Karbauskas' neck attached to the bunk above.

67. The prisoner mentor touched Mr Karbauskas and he was cold. He called for staff and pressed the cell bell.

68. At 10.30am, two PCOs got to the cell and at 10.31am one of them called a code blue (indicating a prisoner is unconscious or having breathing difficulties). They started CPR while Mr Karbauskas was still on the bed and did not remove the ligature around his neck.

69. At 10.33am, a nurse and other staff arrived. The nurse advised they move Mr Karbauskas outside of the cell and, at that point, noticed rigor mortis was present. They removed the ligature from around his neck and a PCO continued with CPR.

70. At 10.34am, staff in the control room called an ambulance and at 10.53am, paramedics arrived. Paramedics tried to insert an airway but could not as Mr Karbauskas's tongue and swollen and his jaw had locked. They stopped CPR attempts and confirmed his death at 10.55am.

Contact with Mr Karbauskas' family

71. On 25 March, the prison appointed a Family Liaison Officer. She visited Mr Karbauskas' brother, but he was not home and could not get back quickly. She broke the news of Mr Karbauskas' death to his brother's wife.

72. Mr Karbauskas' body was repatriated to Lithuania to be buried and the prison contributed to the costs in line with national policy.

Support for prisoners and staff

73. After Mr Karbauskas' death, a manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

75. The post-mortem report concluded Mr Karbauskas died as a result of hanging. There were no significant toxicological findings.

Findings

76. Across the two prisons, Lincoln and Lowdham Grange, a number of opportunities to help Mr Karbauskas were missed. Poor reception processes, infrequent key working, inappropriate clinical decisions, and a missed welfare check all contributed. The ability of staff at both prisons to effectively recognise Mr Karbauskas' risk was impacted significantly by one thing – the failure to consistently use appropriate interpreting services. Subsequently, Mr Karbauskas was isolated and suffering mentally, but this was never adequately addressed.

Assessment of risk on arrival at HMP Lincoln

77. Mr Karbauskas arrived at Lincoln with a number of risk factors. He was charged with murder and was in prison for the first time, and he had a history of mental ill-health, including suicide attempts. According to the SASH form, he had been monitored via intermittent observations, seemed very depressed and was exhibiting bizarre behaviour. A note on the form said staff at Lincoln had been informed before his arrival but there is nothing in the record to indicate this or that anyone considered the information in the SASH form.

78. The Head of Healthcare at Lincoln said healthcare staff would normally receive suicide and self-harm related information on new arrivals and then redirect the information to the mental health team. The clinical matron was also asked how such information was dealt with and she said any communication of this nature was usually emailed by the court liaison and diversion team to the prison who then redirected it to mental health. Whoever picked up such information should tell the mental health crisis nurse and the reception nurse. This did not happen in Mr Karbauskas' case.

79. The records suggest that not all reception staff saw the SASH form, and only some appeared to have seen the PER (which could not be provided to the PPO). There is no evidence that anyone in reception at Lincoln considered starting ACCT procedures, although a nurse noted that he was not on an ACCT. (The nurse also referred him to the mental health team.)

80. We consider that there was sufficient information about Mr Karbauskas' risk of suicide and self-harm to indicate ACCT monitoring was required for a period of time, to allow him to settle and staff to assess his wellbeing.

81. The clinical reviewer concluded that the care Mr Karbauskas received at Lincoln was not equivalent to what he could have expected to receive in the community.

82. We recommend:

The Governor and Head of Healthcare at HMP Lincoln should:

- **review processes to ensure staff consider PERs and SASH forms and record that they have done;**
- **conduct a regular audit to satisfy themselves the process is embedded; and**

- **ensure staff know the red flags for suicide and self-harm and, where they are present, document their reasoning for not starting ACCT procedures.**

Use of interpreting services at HMP Lincoln and HMP Lowdham Grange

83. Prison Service Instruction (PSI) 07/2015, Early days in custody, says that Governors must ensure that all information is made available in an accessible format and in a range of languages reflecting the make-up of the local prison population, so that all prisoners understand the range of services that are available to them.

84. Mr Karbauskas was Lithuanian and did not speak English. (As of June 2023, Lithuanians made up four percent of the total prison population in England and Wales, but owing to their locations, Lincoln and Lowdham Grange are likely to have a significantly higher population of Lithuanians.) The records show instances of staff noting this and using telephone interpreting services or other staff to interpret. There are also instances where staff failed to use any appropriate means to communicate with him, and instead they used other prisoners and hand gestures. When Mr Karbauskas was invited to communicate through proper channels, he was eager and able to tell staff he was suffering mentally.

85. Both Lincoln and Lowdham Grange are equipped with telephone interpreting services and staff told us they were mostly easy and effective to use. Despite this, in Mr Karbauskas' case, use of the telephone service was inconsistent. Lincoln and Lowdham Grange should work with staff to find out why and take steps to address this. We make the following recommendation:

    The Governor at HMP Lincoln and Director at HMP Lowdham Grange and their Heads of Healthcare should audit of the use of interpreting services to assure themselves that they are always used where appropriate, and if they are not ensure all staff are trained in their use.

86. We were also made aware that the Kiosk at Lowdham Grange displayed information in English when Lithuanian was selected. The Director will wish to address this immediately.

Key work at Lincoln

87. Mr Karbauskas only had 12 keywork sessions at HMP Lincoln. The investigator asked Lincoln's keywork lead about this low input. He said that each prisoner should receive 45 minutes once a week, but that at the time Mr Karbauskas was there, they were only hitting 18.4% of the keywork target. At the time of the interview, the rate had improved, but only to 26.3%.

88. Although some of the gaps can be accounted for when Mr Karbauskas had his trial, input was still significantly below the target. Lincoln has since introduced a personal officer scheme alongside the keyworker scheme. All officers are now encouraged to employ a 'first fix' approach whereby they attempt to solve prisoners' issues rather than always refer them to a keyworker (which arguably should be the role of every prison officer as standard, so it remains to be seen whether badging it as a personal officer scheme makes a difference to staff behaviour).

89. The quality of the keywork sessions that did take place was problematic. Officers did not attempt to use interpreting services and instead either too quickly concluded that Mr Karbauskas did not want to engage or tried to use other prisoners to interpret. It is not appropriate to use other prisoners to interpret when the conversation may be of a sensitive nature.

90. The investigator asked the keywork lead for his opinion of the keywork entries, and he said his impression was also that Mr Karbauskas did not want to engage. The investigator pointed out that, in fact, he had engaged well when a proper interpreting service was used or other officers who spoke Mr Karbauskas' language.

91. The keywork lead confirmed that there were no barriers to staff using the telephone interpreting service and that appropriate rooms and telephones are readily available.

Mental and clinical healthcare at Lincoln

92. After a nurse made a mental health referral, an agency nurse made four attempts to call Mr Karbauskas using the in-cell phone, but he did not answer, and the assessment was not rebooked. The clinical matron said that the nurse should have visited Mr Karbauskas in his cell to find out why he was not picking up his phone and complete the assessment face to face.

93. The referral remained open for six months until the matter was identified and discussed at an MDT, but no one assessed Mr Karbauskas in person. At the meeting, a collective decision was made to close the referral and discharge him from the service because there was no evidence he had since come into contact with the service or that anyone had raised any concerns about him. Staff failed to tell Mr Karbauskas he had been discharged from the service.

94. The clinical matron told us that they now have an administrator who conducts audits to identify open referrals that have not been dealt with. We are satisfied that, completed regularly, that system should detect any anomalies, however, no one should be discharged from the service without being seen or told. We make the following recommendation:

    The Clinical Matron at HMP Lincoln should ensure that prisoners are not discharged from the mental health service without ever being seen face to face and that they are informed of the decision.

95. In November 2022, Mr Karbauskas received a life sentence and was not assessed when he returned from the court. The Head of Healthcare said that officers had often taken newly sentenced prisoners straight to the wing rather than ensuring they were seen by healthcare staff as directed by national policy. He had been in contact with the prison's Safety Lead to ensure officers were made aware that such prisoners must be brought through Reception where they would be offered an assessment. We are content with this arrangement and do not make a recommendation.

Mental and clinical healthcare at HMP Lowdham Grange

96. The clinical reviewer did not find the care Mr Karbauskas received in his five days at Lowdham Grange equivalent to what he could have expected to receive in the community.

97. When Mr Karbauskas first arrived at Lowdham Grange, a nurse inappropriately asked another prisoner to translate for her. Mr Karbauskas said he had been depressed for a while, but the language barrier had stopped him telling anybody. However, he denied thoughts of suicide and self-harm, so the nurse referred him to the mental health team and did not consider opening an ACCT.

98. The investigator spoke to the physical health matron and the area healthcare lead. Both agreed that using other prisoners to interpret healthcare interactions was not appropriate. They were less sure if the reception area had the right facilities to use a telephone interpreter and did not think that staff inductions covered it. We have since established that there is a suitable room and telephone in reception.

99. On 23 March, an agency mental health went to see Mr Karbauskas following a nurse's referral. The agency mental health nurse could not understand Mr Karbauskas and communicated largely by hand signals. He noted in Mr Karbauskas' medical record that an interpreter would be required for an assessment but did not book one. The record was very clear that Mr Karbauskas could not speak English, so he should have known that an interpreter was needed. Wing staff have also confirmed that there was a room and phone that the nurse could have used.

100. As we have already made a recommendation to the Head of Healthcare at Lowdham Grange about the proper use of interpreting services, we make no further recommendation here.

Welfare checks at HMP Lowdham Grange

101. PSI 75/2011 says: 'The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.'

102. On 25 March, an officer did not carry out a welfare check when she unlocked each cell door before moving onto the next. She was a psychology student on a year's placement at Lowdham Grange but had left by the time the PPO carried out interviews.

103. In the officer's absence, the investigator spoke to the wing Custodial Operations Manager. She said that although she would personally open a prisoner's door after it had been unlocked, she did not believe it was mandatory. As noted above, this is not in line with prison policy and suggests that correct procedures are not widely understood at Lowdham Grange. We make the following recommendation:

The Director at HMP Lowdham Grange should ensure that staff understand they should complete a welfare check at unlock and consider randomised checks of CCTV footage to ensure they are being done.

Director to note

104. When staff responded to the prisoner mentor's call for help, they quickly began CPR. However, the two first officers on scene did not remove the ligature from Mr Karbauskas' neck rendering any first aid redundant. The Director will wish to consider whether there is any learning from the emergency response in this case.

Inquest

An inquest into Mr Karbauskas' death concluded on 7 February 2025 that his death was suicide due to self-inflicted ligature asphyxiation.

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