Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aleksandras Maslennikovas, a prisoner at HMP Wandsworth, on 17 July 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 020 7633 4100

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 Aleksandras Maslennikovas, a Lithuanian national who spoke little English, was found hanged in his cell on 17 July 2023 at HMP Wandsworth. He was 47 years old. I offer my condolences to Mr Maslennikovas' family and friends.

Mr Maslennikovas was the fourteenth self-inflicted death at Wandsworth in three years. Up to the end of November 2024, there had been five further self-inflicted deaths since Mr Maslennikovas' death. Six out of the nine most recent self-inflicted deaths were foreign national prisoners.

Both HM Inspectorate of Prisons and the Independent Monitoring Board concluded that the shortage of available staff seriously undermined the prison's ability to function effectively. Staff struggled to provide even a limited regime and incidents of self-harm, and the number of prisoners being monitored by suicide and self-harm prevention procedures (ACCT) had risen. In May 2024, HM Chief Inspector of Prisons issued an Urgent Notification to the Secretary of State for Justice in relation to the very poor outcomes for prisoners witnessed at the most recent inspection.

It is difficult to say how well Mr Maslennikovas' risk of suicide and self-harm was assessed because interpreting services were not used, and he did not speak English well. Five days before his death, staff started ACCT procedures after he made cuts to his arm and said he was under threat but closed them 16 hours later. Wandsworth has recognised this failure in their management of Mr Maslennikovas and have begun work to rectify the problem.

The clinical reviewer concluded that interpreting and record keeping issues meant it was not possible to determine whether the clinical care Mr Maslennikovas received at Wandsworth was equivalent to what he could have expected to receive in the community.

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 14 June 2022, Mr Aleksandras Maslennikovas was remanded to HMP Wandsworth. A European arrest warrant for armed robbery had been issued in Mr Maslennikovas' home country of Lithuania. Mr Maslennikovas spoke little English. This was his first time in prison.

2. Mr Maslennikovas had a history of anxiety and depression. Despite Mr Maslennikovas' language barrier, staff never used the formal interpreting services available at Wandsworth and they sometimes used other prisoners to interpret.

3. Mr Maslennikovas was drug dependant in the community. When he was unable to obtain heroin, he abused alcohol. When he arrived at Wandsworth, he was referred to the substance misuse team and started on opiate substitution therapy (OST, where the prisoner is maintained on a dose of methadone), with the dose increased as needed to manage his withdrawal symptoms. Mr Maslennikovas was also prescribed an antidepressant for generalised anxiety.

4. In September, Mr Maslennikovas requested a reduction in methadone as he wanted to be drug free. Substance misuse staff reduced his methadone weekly and in October, Mr Maslennikovas started a ten-day detoxification programme of buprenorphine. However, once he completed the programme, substance misuse staff did not review Mr Maslennikovas and he did not have any further engagement with substance misuse services.

5. Mr Maslennikovas had no contact with his family and did not receive any visits. His last telephone contact with his friend was in February 2023.

6. There are no key worker entries, or any evidence of meaningful conversations with wing staff, in Mr Maslennikovas' prison record.

7. In December, prison staff found fermenting liquid in Mr Maslennikovas' cell. There is no evidence that this information was shared with healthcare staff.

8. On 12 July 2023, Mr Maslennikovas made four substantial cuts to his left arm and staff started suicide and self-harm monitoring (known as ACCT). He said that he was under threat from Lithuanian prisoners on the wing. The following morning, during an ACCT review, Mr Maslennikovas said he was no longer under threat and had no concerns. Wing staff closed the ACCT. No healthcare staff were present at the review.

9. On 14 and 15 July, Mr Maslennikovas' behaviour deteriorated, and he purposely burnt pieces of paper and damaged the furniture in his cell. He was hostile towards staff and said he was under threat and wanted to move wing. Staff did not consider whether his risk of suicide or self-harm had increased but moved him to another wing.

10. At around 8.34am on 17 July, a prisoner went to Mr Maslennikovas' cell. The cell door observation panel was covered so the prisoner looked through the crack in the bottom of the cell door, saw Mr Maslennikovas with something around his neck and

alerted an officer. The officer blew their whistle for staff assistance. Another two officers responded, opened the cell, and radioed a medical emergency code. Control room staff called an ambulance at 8.38am. Staff used their anti-ligature knife to cut the ligature and started cardiopulmonary resuscitation (CPR). Healthcare staff arrived at 8.39am and assisted with resuscitation attempts until paramedics arrived at 8.49am. At 9.37am, a paramedic pronounced Mr Maslennikovas' life extinct.

Findings

11. Mr Maslennikovas had multiple risk factors for suicide and self-harm, including being a foreign national prisoner, awaiting extradition, a history of mental ill-health and self-harm, a history of substance misuse and no contact with his family. Management of Mr Maslennikovas' ACCT was poor. There was no multidisciplinary input during the only case review and despite a serious act of self-harm, there was no clear assessment of Mr Maslennikovas' risk. The ACCT was closed 16 hours after being opened and only four days before his death.

12. Staff did not make use of the formal interpreting services available and there were incorrect notes in Mr Maslennikovas' prison record indicating that he spoke English. Staff used other prisoners to interpret for Mr Maslennikovas which, given that he complained he was being threatened by other Lithuanian prisoners, did not serve his needs well and breached Wandsworth's foreign national strategy.

13. There are no key worker entries in Mr Maslennikovas' prison record, nor any record of any meaningful conversations between staff and Mr Maslennikovas. Staff missed opportunities to monitor Mr Maslennikovas' welfare and to support him with any concerns he might have had.

14. Mr Maslennikovas was appropriately referred to substance misuse services and engaged with treatment. But there were omissions in the review process once he had completed his detoxification programme.

15. The clinical reviewer concluded that it was not possible to judge whether the clinical care offered to Mr Maslennikovas at Wandsworth was equivalent to what he could have expected in the community because formal interpreting services were not used to assess his care needs. However, the clinical reviewer concluded Mr Maslennikovas' access to substance misuse services at Wandsworth was broadly equivalent to what he could have expected in the community.

Recommendations

- The Head of Healthcare and the Substance Misuse Lead should ensure that there is a system in place to provide follow up appointments to those undertaking an opiate detoxification programme and includes a failsafe to ensure staff are alerted to those who have not been reviewed at the end of the programme.

- The Governor and Head of Healthcare should identify the best way to share intelligence and manage risk around alcohol misuse in those with substance misuse problems.

The Investigation Process

16. HMPPS notified us of Mr Maslennikovas' death on 17 July 2023.

17. 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 responded.

18. The investigator obtained copies of relevant extracts from Mr Maslennikovas' prison and medical records and viewed CCTV footage. She also obtained the NHS England 72-hour review and Oxleas Foundation Trust desktop review.

19. The investigator interviewed five members of staff at Wandsworth on 28 September and 16 November 2023. The case was transferred to another investigator.

20. NHS England commissioned a clinical reviewer to review Mr Maslennikovas' clinical care at the prison. The investigator and clinical reviewer interviewed two healthcare staff on 27 September 2023. The new investigator and clinical reviewer interviewed two healthcare staff on 30 September and 1 October 2024.

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

22. The Ombudsman's office wrote to Mr Maslennikovas' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Maslennikovas' next of kin did not respond.

23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Wandsworth

24. HMP Wandsworth is a local category B and C prison in London. It holds men in eight residential wings. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison. There is an inpatient unit which accommodates up to six prisoners with physical health needs and up to 12 prisoners with mental health needs.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Wandsworth was in April and May 2024. HMIP issued an Urgent Notification on 8 May 2024 to which the Secretary of State had 28 days to respond. A debriefing paper had also been prepared and was publicly available.

26. Inspectors noted that despite a high-profile escape in September 2023, significant weaknesses remained in many aspects of security. They found that the rate of self-harm was high and rising but around 40% of cell bells were not answered within five minutes. Inspectors found that many prisoners were clearly in distress without an appropriate level of support. There were weaknesses in the ACCT case management process. Reviews did not always identify appropriate risks and care maps were often blank or contained limited information. In their survey, only 37% of prisoners who had been supported using ACCT said that they felt cared for. Many prisoners inspectors spoke to said that ACCT reviews were perfunctory and rarely helped them to deal with their problems. Rates of violence had increased, and in February 2024, 44% of prisoners tested positive in random drug tests.

27. HMIP noted that Wandsworth was badly overcrowded, with a transient population, over half of whom were remand prisoners. Living conditions were very poor, cells were cramped and ill-equipped and the prison was too dirty. The buildings and facilities needed investment to make them a decent standard. Only 41% of prisoners said that staff treated them with respect. Inspectors found that very limited time out of cell, absent staff and no key work reduced the opportunity for staff to develop meaningful relationships with prisoners.

28. There was little purposeful activity, with most prisoners unemployed and spending over 22 hours a day locked in the cells. Inspectors found that prisoners had no idea when or if they would be unlocked each day or whether they would get access to fresh air. There were consistent failures to enable access to healthcare services due to prison staff absences.

29. Despite a full complement of officers, sickness, restricted duties and training commitments meant that over a third could not be deployed to operational duties each day. This led to curtailed regimes, cross-deployment and burnt-out staff. Staff at all grades were inexperienced. HMIP noted that staff were not wilfully neglectful, they just did not understand their role, and lacked direction, training and consistent support from leaders.

30. Inspectors concluded that the poor outcomes they found at Wandsworth stemmed from poor leadership at every level of the prison, from HMPPS and the Ministry of Justice, leading to systemic and cultural failings which had led to a shocking decline.

Independent Monitoring Board

31. 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 May 2023, the IMB highlighted what it termed serious and fundamental concerns. These included staff shortages, the prison not being safe and inhumane conditions.

32. The Board noted that Foreign Nationals (FNs) accounted for around 45% of the prison population, they were drawn from over 80 different nationalities and their interests were of major concern for the equalities team. (The largest numbers were from Poland, Romania, Albania, Hungary and Lithuania.) The Board was pleased that all wings had FN representatives to support prisoners directly, raising issues on their behalf at the equalities monthly meetings. In reception, leaflets were available in several languages, and this extended to the kiosks. The Big Word simultaneous interpreting service was used occasionally. FNs were often given cells to share with nationals from the same country. The representative of the BEST charity (befriending and support team for foreign national prisoners), with very limited resources, provided an excellent service but, overall, the level of support for FNs remained patchy. Coping with the high number of nationalities, and a variety of prisoners with different first languages and ethnicities, remained a constant challenge.

Previous deaths at HMP Wandsworth

33. Mr Maslennikovas was the nineteenth prisoner to die at Wandsworth since July 2020. Of the previous deaths, 12 were self-inflicted, four were from natural causes, one was drug related and the cause of one death had not yet been established. Up to the end of November 2024, there have been five self-inflicted deaths since Mr Maslennikovas' death. As a result of these self-inflicted deaths and the Urgent Notification issued by HMIP, Wandsworth is receiving additional support and monitoring from HMPPS regional and national safety teams.

Assessment, Care in Custody and Teamwork

34. Assessment, Care in Custody and Teamwork (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.

35. 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 identifying support actions is put in place. The ACCT plan

should not be closed until all the support actions on the caremap have been completed.

Key work

36. The key worker 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.

37. 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

38. On 14 June 2022, Mr Aleksandras Maslennikovas was remanded to HMP Wandsworth. A European arrest warrant for armed robbery had been issued for Mr Maslennikovas in his home country, Lithuania. It was his first time in prison.

39. Mr Maslennikovas' Person Escort Record (a document that accompanies prisoners between police custody, court and prison) said that he had anxiety and depression and that he only spoke Lithuanian.

40. An officer conducted Mr Maslennikovas' first night interview. He noted that it was Mr Maslennikovas' first time in prison, and he said he did not have any self-harm or suicide concerns. He noted that Mr Maslennikovas' spoken language was Lithuanian, that he spoke little English but spoke some Russian and Polish. Mr Maslennikovas said that he had problems reading and writing in English. Despite Mr Maslennikovas' language barrier, there is no evidence that the officer offered or used telephone interpreting services.

41. A nurse completed Mr Maslennikovas' reception health screen. His urine sample was positive for cocaine and opiates. Mr Maslennikovas said that he used heroin and crack cocaine in the community. She referred Mr Maslennikovas to a GP and the substance misuse service. In contrast to the officer's assessment, she recorded Mr Maslennikovas' main spoken language as English and that an interpreter was not needed.

42. A GP at the prison saw Mr Maslennikovas and started him on opiate substitution therapy (OST, where the prisoner is maintained on a dose of methadone) and prescribed 15 millilitres (ml) methadone. The GP used an online interpreting tool (Google Translate) during the consultation.

43. Mr Maslennikovas was located on the first night induction unit.

44. Mr Maslennikovas did not have any contact with his family and did not receive any visits during his time at Wandsworth. The only telephone number on his prison phone account contact list was a friend. There is no record that he made a call to anyone on his first day in prison; his last recorded contact with his friend was in February 2023.

45. On 15 June 2022, Mr Maslennikovas attended a secondary health screen with a nurse and a pharmacist at the prison. It was noted an interpreter was not thought to be needed, although Mr Maslennikovas' English was poor. Mr Maslennikovas said that he was not registered with a GP and bought tramadol (an opiate pain relief) from Lithuania for knee and elbow pain.

46. On 16 June, Mr Maslennikovas had his third day induction. He met with BEST (befriending and support team for foreign national prisoners), Department for Work and Pensions, Home Office immigration staff and probation staff. There is no record that staff used interpreting services.

47. Mr Maslennikovas also met with a worker from Catch 22, a support service specifically for foreign national prisoners (FNPs) which can help them apply for asylum, among other services. She noted that Mr Maslennikovas did not speak any

English. Mr Maslennikovas confirmed that he was due to be extradited to Lithuania and had applied to the EU Settlement Scheme for settled status in the UK. Mr Maslennikovas said that he did not have any thoughts of suicide or self-harm. He said that he misused drugs and would like to be referred to Change, Grow, Live (CGL), a charity that provides drug and alcohol addiction support and advice. Mr Maslennikovas said that he was receiving methadone but was having trouble sleeping. She noted she would refer him to the healthcare team.

48. On 19 June, Mr Maslennikovas asked for an increase in his methadone dose as he was achy and having difficulty sleeping. The GP increased the methadone dose to 30ml.

49. On 20 June, a GP from the substance misuse services saw Mr Maslennikovas. Mr Maslennikovas said that he was experiencing cramps, irritability, sweating and generalised anxiety. He said that, in the community, when he did not have access to heroin, he would use alcohol. The GP increased Mr Maslennikovas' methadone to 40ml and prescribed 15 milligrams (mg) of mirtazapine (antidepressant), to be increased to 30mg after seven days.

50. That day, Mr Maslennikovas moved to a standard residential wing.

51. There are no keyworker entries, or any evidence of meaningful conversations with wing staff, in Mr Maslennikovas' prison record.

52. On 22 June, the GP from the substance misuse services increased Mr Maslennikovas' methadone to 45ml. On 15 July, Mr Maslennikovas attended his 28-day review with a pharmacist at the prison. She noted that Mr Maslennikovas was stable on 45ml of methadone.

53. On 28 July, a prison GP saw Mr Maslennikovas to discuss his trouble with sleeping. Mr Maslennikovas had brought another prisoner to the consultation to interpret for him. The GP prescribed 7.5mg of zopiclone (to aid sleep) for three nights and advised Mr Maslennikovas to speak to the substance misuse services about increasing his methadone.

54. On 1 August, Mr Maslennikovas requested to increase his methadone dose. The GP from the substance misuse services increased the dose to 50ml.

55. Also on that day, a worker completed Mr Maslennikovas' initial assessment for education. He noted that Mr Maslennikovas should complete English for Speakers of Other Languages (ESOL) classes, English and Maths level entry two.

56. On 2 August, Mr Maslennikovas moved to D wing, the drug recovery unit. He shared a cell with a Latvian prisoner.

57. On 26 August, a worker from CGL saw Mr Maslennikovas. Mr Maslennikovas' cellmate interpreted for him. Mr Maslennikovas thanked her but said that he did not want any more assistance. She advised Mr Maslennikovas how to reconnect with the team at any point.

58. On 5 September, Mr Maslennikovas requested a reduction in methadone. The GP from the substance misuse services agreed, and Mr Maslennikovas' methadone was reduced by 5ml per week. The weekly reductions were actioned without any

further discussions with Mr Maslennikovas, including whether he was coping with the reduction in methadone.

59. On 6 October, a nurse saw Mr Maslennikovas. Mr Maslennikovas said that he wanted to be drug free and the nurse started him on a 10-day detoxification programme and prescribed buprenorphine, an opiate based medication which is taken in tablet form under the tongue. At the end of the detoxification programme, Mr Maslennikovas should have been reviewed, but this did not happen. Mr Maslennikovas did not have any further engagement with the substance misuse service. He continued to be prescribed 30mg of mirtazapine which he kept in his cell and there is no evidence that healthcare staff reviewed him.

60. On 30 December, an illicit brewed alcohol detection (IBAD) dog found two litres of fermenting liquid in Mr Maslennikovas' cell. Staff placed Mr Maslennikovas on report and gave him a suspended punishment (where the punishment, such as loss of privileges or loss of earnings, is not initiated immediately, it lies on file and if the prisoner is put on report again within the timeframe set, the punishment is initiated). There is no evidence healthcare staff, or the substance misuse service, were informed about the fermenting liquid find.

61. On 10 May 2023, an officer gave Mr Maslennikovas a behaviour warning after he was seen passing items from his cell window to another prisoner in the exercise yard.

62. On 27 June, Mr Maslennikovas attended court for an extradition hearing. The court concluded that Mr Maslennikovas was to be extradited to Lithuania. It is not known if Mr Maslennikovas was given a time frame for extradition.

63. On 3 July, Mr Maslennikovas sent an application to Catch 22 asking to speak to an immigration worker. On 5 July, a worker from Catch 22 emailed Home Office immigration staff and asked them to see Mr Maslennikovas. The immigration team told us that they had no record of this email. There is no evidence that anyone from the immigration team went to see Mr Maslennikovas.

Events of 12 – 16 July

64. On 12 July, Mr Maslennikovas made four substantial cuts to his left arm, which required 10 stitches by healthcare staff (it is not documented what Mr Maslennikovas used to cut himself). He said he had done this because he was under threat from other Lithuanian prisoners on the wing. At around 6.00pm, an officer started ACCT procedures. She set observations at one per hour. Staff noted in the ACCT document that Mr Maslennikovas refused to engage in the care plan, but they recorded that Mr Maslennikovas said he was under threat. Staff noted that the protective factor (things that improved the situation) for this was 'good support', but they did not record who would or could provide this support. Staff explained what support was available to Mr Maslennikovas and ensured he had credit on his phone to be able to contact friends and family. A Custodial Manager (CM) told Mr Maslennikovas to self-isolate if a wing move could not be facilitated. There is no evidence that interpreting services were used to communicate with Mr Maslennikovas.

65. At around 10.00am on 13 July, an officer completed the initial ACCT assessment and then she and a Supervising Officer (SO) (since promoted to custodial manager) held an ACCT review. There is no evidence that they used interpreting services. No healthcare or mental health staff were present (and no evidence healthcare staff were invited). .There is no evidence that healthcare staff reviewed Mr Maslennikovas aside from dressing his wounds. Mr Maslennikovas said that any issues he had had with Lithuanians on the wing were resolved and he had no further concerns. He said he had last self-harmed 17 years ago and did not know why he had done it the previous day. He said he had support from family and his children. (Mr Maslennikovas had no contact with family or friends and there is no evidence that the SO or the officer took steps to confirm whether Mr Maslennikovas had contact with his family.) Mr Maslennikovas said he had no other thoughts of suicide or self-harm. The SO noted that Mr Maslennikovas was clean and well kempt, engaged well and was open and honest. Due to Mr Maslennikovas' presentation and claim that the issue of being under threat was resolved and he would not self-harm again, the SO closed the ACCT.

66. Due to Mr Maslennikovas' act of self-harm, his mirtazapine prescription was changed to not in-possession meaning he would need to attend the medications hatch on the wing each day to receive his medication. However, due to staff shortages that day, prison staff were not able to escort Mr Maslennikovas to medications hatch to receive his medication, so he had no medication that day. He did not attend for his medication on 14 July either, but we do not know why.

67. At around 8.00pm on 14 July, Mr Maslennikovas deliberately burnt pieces of paper in his cell and set off the fire alarm. He told an officer that he did it because he wanted to move off the wing as he was under threat. The officer told Mr Maslennikovas that she would mention his concerns to the night staff. There is no evidence that staff investigated Mr Maslennikovas' concerns or considered that he was in the post-closure review phase of his ACCT and that this might indicate an increase in his risk.

68. During the early hours of 15 July, Mr Maslennikovas damaged the furniture in his cell and cut himself in the process. A nurse attended Mr Maslennikovas' cell and noted that he was hostile and would not allow him to assess the wound. Wing staff did not think it was safe for the nurse to go into the cell. The nurse noted in Mr Maslennikovas' medical record that he *'remains on ACCT'* rather than he was in the post-closure review phase of the ACCT. The incident is not detailed in Mr Maslennikovas' prison record therefore it is not possible to say whether the duty prison manager was aware, or whether wing staff made any consideration to Mr Maslennikovas being in the post-closure review period.

69. At around 6.15pm that day, Mr Maslennikovas and his cellmate smashed a pipe in their cell, causing flooding, and staff noted that they seemed to be encouraging each other's behaviour. Mr Maslennikovas' behaviour was hostile, and he was demanding a move to the care and separation unit (CSU, where prisoners can be segregated away from other prisoners for their own safety, or for the safety of others). Healthcare staff were unable to assess Mr Maslennikovas for injuries due to his behaviour and made no follow-up appointment to assess him. There is no evidence that wing staff explored the reasons why Mr Maslennikovas wanted to move off the wing, or the change in his behaviour, and there is no evidence that staff used interpreting services to help understand his concerns.

70. Later that evening, Mr Maslennikovas was moved to a shared cell on B wing, a standard residential wing. An officer held an interim ACCT review with Mr Maslennikovas due to his move to B wing. There is no evidence that any other prison staff or healthcare staff attended the review. Mr Maslennikovas told the officer that he did not feel suicidal or have thoughts to self-harm but said he had been very stressed on D wing. She noted that Mr Maslennikovas could not understand a lot of English and decided that the ACCT post-closure review should remain as 20 July, when the post-closure period was due to end. There is no evidence that she used interpreting services during the review despite noting Mr Maslennikovas' difficulty with understanding English.

71. Between 10 and 18 July, the observation book for B wing showed it was a volatile environment. Prisoners reported to staff that they did not feel safe and wanted to be moved. Cell searches found improvised weapons, fermenting liquid, mobile phones and illicit substances, and there were instances of violence between prisoners.

72. On 16 July, Mr Maslennikovas did not collect his mirtazapine prescription from the medications hatch and there is no evidence that healthcare staff followed this up.

Events of 17 July

73. The following account has been taken using written evidence provided by Wandsworth, CCTV footage and transcripts of interviews with staff and prisoners.

74. At 7.08am on 17 July, two officers, along with another prisoner, went to Mr Maslennikovas' cell to help his cellmate move his property as he had to attend court.

75. At around 8.34am, a prisoner went to Mr Maslennikovas' cell to speak to his cellmate (who had left for court). The prisoner saw that the observation panel of the cell door was covered with a towel. The prisoner knocked on the door, but there was no response, so he bent down and looked under the cell door. He saw Mr Maslennikovas with something tied around his neck. The prisoner banged on the door again, but got no response so called over Officer A. The prisoner told the officer that Mr Maslennikovas was hanging. She appeared to have a brief discussion with the prisoner before she looked through the panel and then called to an unknown staff member on the landing below for assistance, but they did not respond so, at 8.37am, she radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). The control room called an ambulance immediately.

76. Officer B responded and went to Mr Maslennikovas' cell. Officer A opened the cell door and went into the cell, while Officer B waited outside. Mr Maslennikovas had used his dressing gown cord to hang himself from the top bunk bed. Officer C arrived at the cell approximately 20 seconds later and called a code blue again. Officer D had also arrived at the cell and immediately entered with Officer A and Officer C. Officer C stepped back out of the cell as she could not hear staff coming to assist and blew her whistle (she said the whistle was loud as she was concerned staff might have turned their radio down). Officer C went back into the cell and supported Mr Maslennikovas' weight and Officer A used her anti-ligature knife to cut the ligature. They placed Mr Maslennikovas on the floor and Officer D started CPR.

77. Healthcare staff arrived at 8.39am and assisted with CPR and applied the defibrillator, until paramedics arrived at the cell at 8.49am and took over CPR. At 9.37am, a paramedic pronounced Mr Maslennikovas' life extinct.

Contact with Mr Maslennikovas' family

78. The prison appointed a family liaison officer (FLO). Mr Maslennikovas' had not given any contact details for his next of kin when he arrived at Wandsworth, so the FLO contacted the Lithuanian Embassy and the local police for assistance to identify Mr Maslennikovas' family and friends.

79. On 19 July, the Lithuanian Embassy contacted Mr Maslennikovas' son to inform him of Mr Maslennikovas' death. Also, that day, the FLO took a call from a friend of Mr Maslennikovas following contact from the police, who provided the contact details of Mr Maslennikovas' daughter, who was in the UK. Officer B, who spoke Lithuanian, spoke to Mr Maslennikovas' daughter later that day and, with the support of the FLO, informed Mr Maslennikovas' daughter her of her father's death. The FLO provided support to Mr Maslennikovas' daughter and offered advice as to the next steps.

80. The prison contributed towards Mr Maslennikovas' funeral costs in line with national policy.

Support for prisoners and staff

81. After Mr Maslennikovas' death, the Head of Operations 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.

82. The prison posted notices informing other prisoners of Mr Maslennikovas' 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 Maslennikovas' death.

Post-mortem report

83. The post-mortem report gave Mr Maslennikovas' cause of death as ligature compression of the neck and buprenorphine toxicity.

84. The post-mortem report noted that the concentration of buprenorphine present at the time of Mr Maslennikovas' death was significantly higher than that associated with the target therapeutic range and was much higher than those concentrations associated with recorded overdose episodes and in illicit drug users abusing buprenorphine. It is not possible to determine how Mr Maslennikovas obtained the buprenorphine because he had not been prescribed it at Wandsworth since October 2022.

Findings

Assessment of risk

85. Prison Service Instruction (PSI) 64/2011, on safer custody, which was in place at the time of Mr Maslennikovas' death and since replaced by the Prison Safety Framework, requires staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under suicide and self-harm procedures (known as ACCT). Mr Maslennikovas had multiple risk factors for suicide and self-harm. It was his first time in prison, he had a history of self-harm, a history of substance misuse, had no contact with his family and he was a foreign national prisoner who was due to be extradited.

ACCT management

86. Mr Maslennikovas did not have a recent history of self-harm with the last reported self-harm attempt 17 years earlier. However, on 12 July, Mr Maslennikovas made substantial cuts to his left arm and staff appropriately opened an ACCT. There is no evidence that staff used formal interpreting services at all during the ACCT process (and we discuss this in more detail shortly) but Mr Maslennikovas said he had harmed himself because he was under threat from other Lithuanian prisoners on the wing.

87. The following morning, just 16 hours after staff began ACCT procedures, due to Mr Maslennikovas' presentation (well kempt and engaged well) and him saying he would not self-harm again and he was no longer under threat, staff considered that he was no longer at raised risk of suicide and self-harm and closed the ACCT. Mr Maslennikovas said he no longer felt under threat but it is not clear that staff had taken any steps to understand the nature of the threat or how he had managed to resolve it so quickly (and essentially overnight while locked in his cell). There is no evidence that the staff involved in closing the ACCT took into account any of Mr Maslennikovas' known risk factors.

88. Healthcare staff were not present at the ACCT review, and they had not apparently assessed his mental health since his self-harm. The Head of Healthcare at Wandsworth said that during the daily morning meeting, the mental health team is given a list of prisoners who are on an ACCT and due for a case review. They then decide which healthcare staff are best suited to attend each review that day and inform wing staff. She said sometimes healthcare staff cannot attend the review, but they will email the ACCT case manager with relevant information. She said that sometimes, wing staff do not invite healthcare staff to the case reviews, and this seems to be the case for Mr Maslennikovas.

89. On 14 and 15 July, Mr Maslennikovas displayed further unusual behaviour, burning paper and smashing up his cell, and he said that he wanted a move off the wing. On 15 July, he and his cellmate again smashed their cell and Mr Maslennikovas asked to move to the CSU. Most of the staff who spoke to him about his behaviour were seemingly unaware that his ACCT was in the post-closure phase and certainly there is no evidence that they considered whether the ACCT should be reopened.

90. Later, on 15 July, Mr Maslennikovas was moved to B wing (which was volatile at the time). While we have not seen any particular evidence to suggest that he was in crisis in the hours before his death, nor have we seen any particular evidence that staff had taken steps to properly assess his risk at any time before that. We do not consider that staff took steps to support Mr Maslennikovas or prevent his death in any meaningful way.

Actions taken at Wandsworth since Mr Maslennikovas' death

91. Mr Maslennikovas was the fourteenth prisoner at Wandsworth to take his life since January 2020. Up to the end of November 2024, five more prisoners had taken their life.

92. Wandsworth has been identified as requiring additional support due to the high number of self-inflicted deaths that have occurred in a short period of time, the UN from HMIP and a high profile escape in 2023 and HMPPS arranged for a task force to help the prison. The action plan from the subsequent meetings has included work on early days processes, quality assurance and case management training for ACCTs and guidance for safety admin teams.

93. Wandsworth has put a number of other actions in place to help staff identify and support prisoners who might be at risk of suicide and self-harm. This includes introducing a single case management model for ACCT procedures, rebolstering the Listeners programme (prisoners trained by the Samaritans to provide confidential support), introducing a programme to train prisoners in mental health, and promotion of Big Word interpreting services. In addition, we were told that, as of February 2024, the Safer Custody team was fully staffed. This has resulted in the team having around 500 contacts with prisoners a month.

94. In May 2024, we issued a recommendation to the then Governor that she provide the Ombudsman with a clear plan of how she was addressing issues identified with assessing and managing prisoners' risk of suicide and self-harm. The prison responded and said that a new, highly experienced Governor had been appointed along with an additional temporary Deputy Governor for 12 months to strengthen and inject experience into the Senior Leadership Team, and to provide a clear vision for improving delivery and outcomes. The prison set out a number of other planned measures to support improvement across a number of areas.

95. Given the well-evidenced difficulties Wandsworth faced at the time of Mr Maslennikovas' death and the targeted support the prison is now receiving, we make no recommendation.

Interpreting services

96. Staff at Wandsworth have access to Big Word telephone interpreting service, which is available 24-hours a day. Staff can telephone and request an interpreter in the language needed. There are specific telephones (with two receivers) that can be used to access the Big Word service to facilitate a three-way conversation.

97. We conclude that there is sufficient evidence in Mr Maslennikovas' file to conclude that he spoke very limited English and struggled to read and write in English. A prison GP was the only person to record having used interpreting services for Mr

Maslennikovas during his time at Wandsworth. There is no evidence that prison staff considered using an interpreter at all. At times, Mr Maslennikovas asked his cell mate to interpret for him, which is not always appropriate and poses risks, such as confidentiality issues and potential for bullying and coercion.

98. It is difficult to see how staff could have had any meaningful conversations with Mr Maslennikovas and captured adequate in-depth information about his health, level of risk and concerns without the use of official interpreting services.

99. The clinical reviewer concluded that, while there are huge difficulties managing the logistics of effective translation in an appropriate time frame for prisoners, Mr Maslennikovas should have been seen in a clinical environment with an independent form of translation of sufficient quality to ensure that he understood his treatment options, particularly in relation to his substance misuse.

100. This is not the first time that we have raised concerns about staff's failure to use interpreting services for foreign national prisoners at Wandsworth.

101. Wandsworth have taken steps to promote interpreting services. Since February 2024, they have produced pocket cards for staff and have put posters around the prison. They have also ensured that new prison staff receive information about interpreting services at the point of their induction.

102. The new local foreign national strategy makes clear the instances when using prisoners to interpret is not appropriate, such as when discussing offence details, or personal and medical matters. It notes that Big Word is not being used frequently enough and emphasises the importance of increasing its use.

103. In July 2024, we made a recommendation to about using a standardised approach to interpreting services to better meet the needs of foreign national prisoners. The prison responded that where a prisoner's first language is not English, this is recorded on arrival and a visual marker is placed in the medical records that prompts the clinician to consider using interpreting services. Specially adapted telephones are in all clinic rooms, and allow three-way telephone conversation, and the Equalities Manager has commenced regular audits of telephone availability to ensure that suitable phones are available for Big Word to be used.

104. Usage of the Big Word is monitored in the monthly Foreign National meeting, which has been introduced in line with the new Foreign National Strategy to ensure the prison is appropriately responding to the needs and risks of the large Foreign National population, including language needs. Areas with low usage are reminded of the importance of evidencing when interpreting services have been used.

105. Additional posts for foreign national peer mentors have been agreed, and Catch 22 will continue to provide support and mentoring to the reps. There has been a concerted drive to recruit foreign national Listeners to ensure there is appropriate support for the large foreign national cohort, and there are revisions being made to the Listeners rota to include displaying the languages Listeners speak to provide non-English speakers with a Listener they can communicate with. In light of Wandsworth's effort to increase the use of formal interpreting services, we make no additional recommendations.

Clinical care

Substance misuse care

106. Mr Maslennikovas was dependant on drugs in the community and said that he misused alcohol when he was unable to access heroin. When he arrived at Wandsworth, he was appropriately referred to substance misuse services and was prescribed methadone as part of opiate substitution therapy, which was adequately increased to manage his withdrawal symptoms. However, when Mr Maslennikovas asked to reduce his methadone, the dose was decreased weekly, but substance misuse staff did not review Mr Maslennikovas to see if he was coping or having any symptoms of withdrawal.

107. Mr Maslennikovas also completed a 10-day buprenorphine detoxification programme in October 2022. The clinician who gave Mr Maslennikovas his last dose of buprenorphine should have added him to a list for review, but this did not happen, and Mr Maslennikovas had no further engagement with substance misuse services.

108. The toxicology report shows Mr Maslennikovas had a significant amount of buprenorphine in his system. It is not possible to determine how Mr Maslennikovas obtained the buprenorphine. But, given he had not been prescribed the drug since October 2022, we suspect that he obtained it illicitly from another prisoner who was prescribed it.

109. At the time of Mr Maslennikovas' death, buprenorphine was issued in tablet form, which unlike methadone (a liquid), could be concealed in the mouth and then potentially traded within the prison. A non-medical prescriber at Wandsworth said that Wandsworth is changing from prescribing buprenorphine in tablet form to injection to reduce the risk of illicit trading.

110. The clinical reviewer said that the healthcare system at present does not appear to have a failsafe in the form of a simple audit to check which patients have been reviewed at the end of the detoxification programme and a clear record made of advice given. This may be particularly challenging in a remand prison but is an essential part of good clinical practice. We recommend:

    The Head of Healthcare and the Substance Misuse Lead should ensure that there is a system in place to provide follow up appointments for prisoners undertaking an opiate detoxification programme and includes a failsafe to ensure staff are alerted to those who have not been reviewed at the end of the programme.

111. Mr Maslennikovas told a substance misuse worker in June 2022 that he would abuse alcohol when he could not access heroin. This was documented in his healthcare record but there is no evidence that it was shared with prison staff. When a large quantity of fermenting liquid was found in Mr Maslennikovas' cell in December 2022, this information was not shared with healthcare staff or the substance misuse team and so no action was taken to support his substance misuse needs.

112. The clinical reviewer noted that possession of alcohol is a potential health risk in prisoners who have substance misuse problems. There appears to be no system, in a prison with significant numbers of prisoners who have substance misuse problems, to alert healthcare to those who may be misusing alcohol or for healthcare staff to alert prison staff of any concerns about prisoners whose use of alcohol may indicate a more significant level of abuse. We recommend:

    The Governor and Head of Healthcare should identify the best way to share intelligence and manage risk around alcohol misuse in those with substance misuse problems.

113. The clinical reviewer concluded that, overall, Mr Maslennikovas' access to substance misuse services at Wandsworth was equivalent to what he could have expected in the community, but the follow-up care fell below what he could have expected. She also noted that issues with record keeping (not all substance misuse engagement was entered into his healthcare record), and interpreting services made it impossible to determine if the overall clinical care Mr Maslennikovas received at Wandsworth was equivalent to what he could have expected in the community. The clinical reviewer makes other recommendations not related to Mr Maslennikovas' death that the Head of Healthcare will wish to address.

Key worker scheme

114. There is no evidence in Mr Maslennikovas' prison record that wing staff had any meaningful interactions with him. Because of staffing levels, and to provide the best regime and access to purposeful activity, key work at Wandsworth had been suspended since the COVID-19 pandemic. As a result, Mr Maslennikovas did not have a key worker during his time at Wandsworth. While we cannot say that Mr Maslennikovas would have engaged with staff, particularly if they did not use interpreting services, staff missed opportunities to have welfare conversations with Mr Maslennikovas and to support him with any concerns he might have had.

115. Since Mr Maslennikovas' death, Wandsworth have implemented a process to ensure that all prisoners have a quality conversation with a member of staff, and a case note entry, at least once a month. This is being monitored by monthly checks and staff are required to follow up on any prisoner without case notes. We understand that, as part of this process, custodial managers are required to dip test case notes to quality assess these. As a result of these changes, we do not make a recommendation.

Inquest

116. The inquest into Mr Maslennikovas' death concluded on 27 May 2026 and a jury returned a verdict of suicide.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 020 7633 4100