Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Milanas Senkevicius, a prisoner at HMP Wandsworth, on 9 May 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

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

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Milanas Senkevicius was found hanged in his cell at HMP Wandsworth on 9 May 2015. He was 23 years old. I offer my condolences to Mr Senkevicius' family and friends.

There was little obvious to indicate that Mr Senkevicius was at risk of suicide and self-harm at the time of his death, and I understand that it would have been difficult for staff at Wandsworth to have predicted or prevented it. However, I am concerned that although Mr Senkevicius, who was Lithuanian, spoke and understood little English, there was too little use of interpreting services at Wandsworth. This meant that his physical and mental health were not fully assessed and neither was his risk of suicide and self-harm. This is particularly concerning in a prison designated as a specialist facility for foreign nationals. We also identify some weaknesses in previous suicide and self-harm procedures and deficiencies in emergency procedures, both of which we have identified before, and the prison will need to address.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2016**

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Summary

Events

1. Mr Milanas Senkevicius appears to have come to the UK in about March 2014 and lived with his partner in Norfolk. He was wanted for crimes in Lithuania and there was a European Arrest Warrant for him. He did not speak or understand much English.

2. On 31 December 2014, Mr Senkevicius was arrested for theft. A suspended prison sentence, imposed in May 2014, was activated. On 1 January 2015, he was sent to HMP Norwich. Mr Senkevicius said he had epilepsy and asthma and had previously self-harmed by swallowing sharp objects.

3. On 6 January, Mr Senkevicius attended an extradition hearing in London and was taken to HMP Wandsworth. Nurses carried out initial health assessments without using interpreting services and did not identify his epilepsy, asthma and previous self-harm, although this was noted in his medical record.

4. On 18 February, Mr Senkevicius cut his arms and officers began Prison Service suicide and self-harm monitoring procedures (known as ACCT). He said he was frustrated about not getting visits and letters but was not suicidal. On 24 February, a supervising officer ended ACCT monitoring at a case review with no other member of staff present. There was no follow up after the ACCT was closed. On 5 March, a nurse assessed Mr Senkevicius' mental health, without using an interpreter.

5. In the early evening before his death, Mr Senkevicius appears to have been involved in some altercation with other prisoners but we have not been able to establish what that was about. Although some prisoners alleged after his death, that he had been trying to seek help on the night before his death, there is no evidence to support this. The prisoners closest to him, said they saw no signs shortly before his death that he had any suicidal thoughts. Another Lithuanian prisoner who knew Mr Senkevicius well said that they had talked about suicide if they were extradited but was surprised at Mr Senkevicius' actions as no extradition decision had been made and he was claiming asylum.

6. Just after 5.30am on 9 May, a night patrol officer saw Mr Senkevicius awake and standing in his cell. Mr Senkevicius told him he was okay. At 9.22am, a prisoner going to the next cell saw that Mr Senkevicius had hanged himself. The officers were shocked by what they had found and ran to get the wing supervising officer. When the supervising officer went to the cell he cut the ligature from around Mr Senkevicius' neck and radioed an emergency medical code. Although it was apparent that Mr Senkevicius was dead, he began cardiopulmonary resuscitation, which nurses continued. Paramedics arrived, examined Mr Senkevicius and at 9.45am, recorded that he had died.

Findings

7. Mr Senkevicius' friend said that they had made a pact to kill themselves if extradition was agreed, but no one else knew about this and no extradition decision had been made. There was no obvious sign that Mr Senkevicius intended to take

his own life and we recognise that it would have been difficult for staff at Wandsworth to have predicted or prevented his death.

8. However, we are concerned that despite his very limited English, healthcare staff at Wandsworth did not use interpreting services for initial medical assessments and the mental health assessment required after he was assessed as at risk of suicide and self-harm. The mental health assessment did not take place until two weeks after Mr Senkevicius self-harmed and ten days after the ACCT was closed. This was too long. ACCT procedures were not in line with national instructions.

9. There was a delay making an emergency radio call as the staff who found Mr Senkevicius were in shock. Such a reaction is understandable, but is important that staff act promptly in all emergencies, although we recognise that it would not have affected the outcome in this case. As rigor mortis was present, it was unnecessary and inappropriate for staff to attempt cardiopulmonary resuscitation, a matter we have raised with the prison before.

Recommendations

- The Governor and Head of Healthcare should ensure that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

    - A multi-disciplinary approach for all case reviews, with healthcare staff attending all first case reviews.
    - Setting specific and meaningful ACCT caremap objectives and ensuring that all caremap actions have been completed before an ACCT is closed.
    - Holding an ACCT post-closure review within seven days

- The Head of Healthcare should ensure that mental health referrals for prisoners assessed as at risk of suicide and self-harm are prioritised and carried out promptly.

- The Governor and Head of Healthcare should ensure that all staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.

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

12. On 12 May 2015, the investigator visited Wandsworth and obtained copies of relevant extracts from Mr Senkevicius' prison and medical records. She watched CCTV footage of H Wing for the period from 5.28pm on 8 May to 10.45am on 9 May 2015. She interviewed four members of staff and nine prisoners (including the two prisoners who had responded to the notices) at Wandsworth in May, June and August 2015. In June, the clinical reviewer and investigator interviewed one member of staff together and spoke to the Healthcare Manager. The investigator obtained information from other staff by email and telephone.

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

14. One of the Ombudsman's family liaison officers was unable to contact Mr Senkevicius' partner by telephone to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The prison did not have an up to date address for her so we have been unable to contact her. It appears that his parents were dead and there is no record of other relatives.

Background Information

HM Prison Wandsworth

15. HMP Wandsworth is a local prison in south west London that holds over 1,250 men and primarily serves the courts in south London. St George's University Hospitals NHS Foundation Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

16. The most recent inspection of Wandsworth was in February and March 2015. Inspectors reported that, for reasons largely out of the prison's control, it faced severe problems. The prison had been designated a foreign national prisoner hub and held over 700 foreign nationals (40% of the population) but provision for foreign nationals was inadequate. There was little use of professional telephone interpreting and prisoners who did not speak English largely relied on other prisoners to make themselves understood. Many were frustrated and anxious about their inability to get advice on their cases. The prison was unable to tell Inspectors how many of their prisoners were facing extradition. Staff were insufficiently aware about what to do if a prisoner said they feared returning to their country or of human trafficking indicators. An on-site team from the Criminal Casework Directorate of the Home Office saw all foreign nationals when they arrived but could not advise prisoners facing extradition.

17. A member of staff had been appointed as Head of Equality, Foreign Nationals and Repatriations six weeks before the inspection and was allocated one and a half days a week for the role, which inspectors considered was insufficient to meet need.

18. The quality of ACCT documents was variable and inspectors found that many of those they examined were poor. Reviews were often conducted late, with minimal attendance. Caremaps failed to identify issues and set actions to mitigate risk.

Independent Monitoring Board

19. 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 2015, the IMB reported that staff shortages had impacted on service delivery. New initiatives, such as foreign national prisoner workshops, had been delayed by lack of staff. Telephone access to interpreting services had improved with new sites on every wing. The number of permanent healthcare staff was at the lowest ever level and the IMB reported that this had delayed assessments.

Previous deaths at HMP Wandsworth

20. There were ten deaths at Wandsworth in 2014 and three up to November 2015. Six of these were self-inflicted. One of the self-inflicted deaths in 2014 was of a prisoner potentially facing extradition, but there were no other significant similarities with the circumstances of Mr Senkevicius' death. In two other cases in 2014 and 2015 we found that staff attempted resuscitation when it was inappropriate, as it was evident that the prisoner had died.

Assessment, Care in Custody and Teamwork - ACCT

21. 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.

22. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

23. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. Mr Milanas Senkevicius was born and grew up in Lithuania. He appears to have arrived in the UK in about March 2014. We do not know much about his life in England except that he lived with a partner in Norfolk. An Emergency Services patient care record from a minor car accident on 24 May 2014 (contained in his prison medical record) described him as having poor English.

25. On 27 May 2014, Mr Senkevicius was remanded to HMP Norwich charged with theft. At an initial health assessment, he told a nurse, who used an interpreter, that it was his first time in prison. He said he had epilepsy and asthma and had brought medication with him from Lithuania, but this had run out. The nurse noted a minor risk of self-harm because Mr Senkevicius' police record showed he had threatened to head butt a wall when he was arrested. The nurse recorded that Mr Senkevicius appeared fit and well, but referred him to the GP because of his epilepsy and asthma.

26. On 28 May, Mr Senkevicius told another nurse, who used a telephone interpreting service, that he had no history of mental illness and no thoughts of suicide or self-harm. He said he had a brain injury from some time previously, for which he was prescribed "Ropnol". (This was possibly Rohypnol, a benzodiazepine used as an anticonvulsant and sedative.) Mr Senkevicius became frustrated when the nurse asked for more details of this and told the interpreter that he wanted to stop the assessment. The nurse referred him to the mental health team because of his reported brain injury and the incomplete assessment and noted that Mr Senkevicius would need an interpreter at every appointment. Mr Senkevicius did not attend his appointment with the GP the next day. We do not know why, as no reasons were recorded.

27. On 3 June, Mr Senkevicius received a nine week suspended sentence and was released from Norwich before he had a mental health assessment. On 31 December, he was arrested for theft and on 1 January 2015, he was remanded to HMP Norwich again. His escort record from the court to the prison noted that he spoke little English, needed an interpreter, and that he had epilepsy and asthma.

28. At an initial health assessment using a telephone interpreting service Mr Senkevicius said that his last epileptic fit had been three months previously and he had not taken any medication for two months. He was not using inhalers for asthma. He said he had no thoughts of suicide or self-harm. The nurse recorded that he seemed fit and well.

29. On 2 January, at a second health assessment using a telephone interpreting service, a nurse noted that Mr Senkevicius had some trouble understanding the process for obtaining prescribed medication. A GP reviewed Mr Senkevicius, also using the telephone interpreting service, and noted that Mr Senkevicius said that he had been prescribed carbamazepine for epilepsy and wrote a prescription.

30. The next day, a nurse prescriber stopped Mr Senkevicius' carbamazepine prescription. She noted that the records showed that Mr Senkevicius was unsure of the name of the medication he was taking. He was apparently not registered with a GP in the UK, so there were no community medical records and she did not know how he had obtained it. He had reported that his last seizure was three

months previously, and that his seizures were not complicated by drug or alcohol use.

31. On the evening of 5 January, Mr Senkevicius told a prison GP that he had a sharp spasmodic pain in his stomach. He said that, two months earlier, he had self-harmed by swallowing sharp objects and had gone to hospital, but had refused an operation to remove them. The GP gave him paracetamol and ibuprofen and asked that he be taken to hospital urgently. As there were insufficient staff to take Mr Senkevicius to hospital that night, he was admitted to the prison's inpatient unit for monitoring. (It does not appear that Mr Senkevicius went to hospital for further treatment or mentioned any more stomach pain.)

32. Mr Senkevicius was wanted in connection with robbery, theft and criminal damage in Lithuania and there was a European Arrest Warrant for his return to stand trial. On 6 January, he appeared at Magistrates Court for an extradition hearing and was remanded to HMP Wandsworth. His escort record did not refer to his self-harm or any health issues.

33. At an initial health screen a nurse, who did not use an interpreter, noted that Mr Senkevicius said he was fit and well and had no history of self-harm. He did not record that Mr Senkevicius suffered from epilepsy or asthma or that he had previously swallowed sharp objects; it seems that he did not read Mr Senkevicius' medical record, which recorded these issues. The nurse told the investigator that he could not remember Mr Senkevicius well, but he had thought his English was good enough to answer the set questions.

34. An officer interviewed Mr Senkevicius as part of the prison's first night procedures. He noted that Mr Senkevicius said he had no thoughts of self-harm and was happy to share a cell. There is no record that he used an interpreter.

35. On 7 January, a nurse held a more detailed health assessment but did not use an interpreter. He recorded that Mr Senkevicius declined vaccinations and screening for tuberculosis and sexually transmitted diseases and refused to give his permission for the prison to obtain his community medical records. The nurse noted that Mr Senkevicius could tell the time and read and write, and had no health issues. (The nurse no longer works at Wandsworth and did not reply to emails from the investigator.) After induction, Mr Senkevicius moved to a shared cell on H Wing, part of Trinity Unit, where most foreign nationals in the prison are housed.

36. An officer told the investigator that he remembered Mr Senkevicius very well and that he did not speak much English. On his second day on H Wing, Mr Senkevicius complained to him that he could not talk to his cellmate because of the language barrier and asked to be moved. He said Mr Senkevicius had communicated this using a combination of sign language and with the help of another prisoner. The next day, he moved Mr Senkevicius to a cell with another Lithuanian.

37. The officer said Mr Senkevicius was always laughing and running about the wing. He became a wing cleaner and seemed happy with this job. He said that he knew nothing of Mr Senkevicius' personal circumstances or that anything might be bothering him and he did not appear vulnerable. He said Mr Senkevicius used to become frustrated because he could not speak English, but he thought this

became less of an issue over time, as Mr Senkevicius mixed well with other prisoners and had a group of friends from Lithuania.

38. On 26 January, an officer introduced himself as Mr Senkevicius' personal officer. He wrote in his prison record that Mr Senkevicius had a poor grasp of English and became frustrated when he could not communicate with staff. He noted that Mr Senkevicius had thrown his meal on the floor and shouted when officers had told him he could not use the wing telephone at meal times.

39. A H Wing officer at the time described Mr Senkevicius as cheeky, mischievous and cheerful. She said that his English was not very good and he needed another prisoner to translate. However, she said Mr Senkevicius could understand adequately what was said to him and could make himself understood. She did not know anything about his personal circumstances. She said he enjoyed being a cleaner but was not very good at it. When he was not needed as a cleaner and had to stay in his cell, he used to say he wanted to go to the segregation unit. She thought his extreme responses were the result of his poor understanding of English.

40. On 4 February, an officer submitted a security information report after a prisoner told him that Mr Senkevicius and three other prisoners had discussed how to retrieve illicit parcels from the roof of the works department, which had been thrown over the prison wall.

41. On 12 February, an officer gave Mr Senkevicius a formal warning for smoking on the landing and another officer reported that he smelled strongly of alcohol. During the evening meal, he pushed an officer and was charged with a disciplinary offence.

42. Mr Senkevicius was taken to the segregation unit and his medical record shows that a nurse completed a segregation health screen but does not record whether she used an interpreting service. On 16 February, a nurse assessed Mr Senkevicius as fit to attend a disciplinary hearing. The prison could not find any of Mr Senkevicius' segregation records, including the medical assessments and the outcome of the disciplinary hearing. We assume that Mr Senkevicius went back to H Wing on 16 February.

43. At 7.30pm on 18 February, Mr Senkevicius told officers he had inserted a pin into a cut in his left arm. He refused to let a nurse examine him. Officers began ACCT suicide and self-harm prevention procedures. Mr Senkevicius was referred for a mental health assessment, which is done automatically when staff open an ACCT at Wandsworth.

44. The next day, 19 February, an officer assessed Mr Senkevicius as part of ACCT procedures. She noted that Mr Senkevicius was happy to use another prisoner to interpret. Mr Senkevicius showed her some cuts on his left arm and said he had made them out of frustration, but not in an attempt to kill himself. He said he had been trying to book a visit with his pregnant partner for over two weeks and was frustrated and angry that no one had confirmed the visit. He also said he was having problems receiving his post. Mr Senkevicius said this was the first time he had ever harmed himself. He said he felt better, except his arm hurt.

45. Immediately after the assessment, a SO, the H Wing manager held the first ACCT case review, which the officer attended. There was no member of healthcare staff

present, which is a requirement of national Prison Service instructions. There is no record of whether they used the telephone service or another prisoner to interpret. The officers assessed Mr Senkevicius' risk of suicide and self-harm as low and set the level of observations at three during the day and hourly at night. There were two caremap actions, for Mr Senkevicius to submit applications to the visits department about his partner's visit, and to reception about his property. (The SO did not record any more information about Mr Senkevicius' property concerns.) On 20 February, the officer emailed the visits department about Mr Senkevicius' visit. According to prison records, Mr Senkevicius' partner and a friend visited him together on 28 March and 22 April.

46. On 24 February, a SO held an ACCT case review with Mr Senkevicius. Another Lithuanian prisoner interpreted. There was no other member of staff present. The SO reported that Mr Senkevicius had resolved the issue of his partner's visit but did not record how and there was no mention of his property or the problems he had had with his post. The SO wrote that Mr Senkevicius was much happier and agreed that the ACCT could be closed. There is no record of a post-closure review on 3 March, as should have happened.

47. On 4 March, a nurse saw Mr Senkevicius in the Trinity Unit clinic. Mr Senkevicius asked another Lithuanian prisoner to translate for him. He said he had warts on his hands and a rash on his neck and abdomen. A GP prescribed treatment the next day.

48. On 5 March, a mental health nurse saw Mr Senkevicius for a mental health assessment, as a result of the referral when the ACCT was opened. She did not know that ACCT monitoring had stopped on 24 February. She told the investigator that she did not remember Mr Senkevicius but she would have used the telephone interpreting service if there had been any problems communicating. She said that Mr Senkevicius' English was adequate for the assessment. She noted that he had self-harmed because he had not wanted to be transferred to Wormwood Scrubs but this had been resolved as he was now back in Wandsworth. (There is no record that a transfer to Wormwood Scrubs had ever been considered.) Mr Senkevicius had agreed that there was not much that the mental health team could do and she recorded that he had no history of mental illness and did not appear mentally ill.

49. On 24 March, an officer introduced herself as Mr Senkevicius' new personal officer. She told the investigator that Mr Senkevicius did not speak much English and usually asked another prisoner to interpret when he needed to speak to staff. She said that Mr Senkevicius had been a landing cleaner for a while, but had to be pressed to do any work. He had a few friends and spoke to her only to ask things, such as when he had a visit. She said he did not appear vulnerable and always seemed upbeat.

50. On 13 April, an officer gave Mr Senkevicius an IEP warning for continuously banging his door because he wanted to be unlocked and sacked him from his job as wing cleaner because he did not do the job properly. Two hours later, Mr Senkevicius climbed on to the safety netting between the landings, holding a razor blade. He said he was protesting about losing his job. After 45 minutes, he gave

up. Staff demoted Mr Senkevicius to the basic level of the incentives and earned privileges scheme, until 28 April.

51. A good friend of Mr Senkevicius at Wandsworth, who had the cell above him, said Mr Senkevicius could not speak English very well and shouted and became angry when he could not make himself understood. He said officers penalised him unfairly when he was frustrated because of this. He said that when the officer sacked him from his cleaning job, Mr Senkevicius had threatened to cut or hang himself in protest. He had told him not to hurt himself but to do something else to protest, which was why Mr Senkevicius had climbed on the netting.

52. The friend said that, on several occasions when Mr Senkevicius was angry and frustrated, he had said that he would kill himself, but he had not believed he was serious. He said Mr Senkevicius was sometimes unhappy because he thought his partner was going to leave him, but most of the time, he was happy. They often spoke about meeting up back in Lithuania and working together.

53. On 23 April, an officer gave Mr Senkevicius an IEP warning for not attending work. (There is no record what his job was at the time.) On 27 April, Mr Senkevicius' cellmate went to Wormwood Scrubs after a court appearance. Mr Senkevicius was left alone in the cell from that date.

54. On 8 May, Mr Senkevicius' medical record indicates he submitted a medical application. The prison was unable to find the application and the contents are not recorded.

55. According to CCTV footage, at 5.28pm on 8 May, an officer unlocked Mr Senkevicius' cell on the third landing for dinner. Mr Senkevicius went to the fourth landing and phoned his partner between 5.29pm and 5.32pm. Meanwhile, on the third landing, a prisoner passed something to two prisoners, who then pulled him into a cell. Mr Senkevicius ran down from the fourth landing and became involved in an argument with the two prisoners before officers intervened. All four prisoners then walked along the landing. One of the two prisoners gestured to Mr Senkevicius to close his mouth. Mr Senkevicius and the other three prisoners went into a different cell. At 5.36pm, Mr Senkevicius and the prisoner who passed something to the others left the cell, went down to the first landing and collected their meals. At 5.40pm, Mr Senkevicius took his food up to his friend's cell on the fourth landing. At 5.41pm, he went back to his cell on the third landing and a female officer locked him in.

Night of 8 May and morning of 9 May 2015

56. Prisoner A, on the landing above and opposite Mr Senkevicius, said he could see Mr Senkevicius' cell door through the gap around his door. He said that, on the night of 8/9 May, he heard a cell bell ringing all night. He said he did not see Mr Senkevicius' cell bell light come on (which would indicate he had pressed the bell) but he had heard him asking for a Listener and being told one was not available. He was not sure what time during the night this was, but said he heard a voice saying in broken English: "Miss, Miss I don't feel right". He said a female officer told the prisoner to stop ringing the cell bell because other prisoners could not sleep. He said the night officer was female. (According to prison staffing logs, the

night officer was male that night). He said that he went to sleep when Film 4 finished, at about 3.20am.

57. Prisoner B had a cell two down from Prisoner A. Sometime between 7.00 – 8.00pm, he said he heard someone with a foreign accent on the landing below, asking for a Listener, which he thought was Mr Senkevicius. He said he heard a female officer say, "I haven't got time for this now, I am going home". After the female officer left, the person who had asked for a Listener carried on banging and pressing their cell bell. We have not been able to check this as the CCTV disk for the period between 6.55pm and 8.10pm is blank. CCTV footage shows the night patrol officer stop outside Mr Senkevicius' cell at 9.05pm, during the evening roll check.

58. The cell call bell records for H Wing from midnight on 7 May until 9.26am on 9 May shows Mr Senkevicius did not press his cell bell. There is no evidence that any other prisoner on H Wing pressed his cell bell continuously that evening.

59. Mr Senkevicius' friend, whose cell was immediately above, said that he did not hear Mr Senkevicius pressing his cell bell or asking for a Listener. He said that, at about 11.00pm, he spoke to Mr Senkevicius' partner on an illicit mobile phone. He told her that Mr Senkevicius had a big heart but lost his temper easily. She said, "You know what he's like, when he doesn't like something he starts threatening". He said he had passed the phone down to Mr Senkevicius using a strip of material between their cell windows. At about 11.30pm, Mr Senkevicius banged on his ceiling and told him that everything had been okay on the phone and he had told his partner he would speak to her again first thing in the morning. Mr Senkevicius sounded calm and told him that he would tell him more in the morning over coffee and a cigarette.

60. Prisoner C, who had a cell adjacent to Mr Senkevicius, said that at about 11.00pm on 8 May, he heard Mr Senkevicius talking to his friend upstairs out of the window. He said Mr Senkevicius sounded fine. He said he usually goes to sleep about 2.00 or 3.00am and remembered it was a quiet night with no noise.

61. A prisoner who was in the cell on the other side of Mr Senkevicius, said Mr Senkevicius was always talking to his friend upstairs and continually banged on his ceiling to get his attention. He said that Mr Senkevicius had talked to his friend out of the window that night, as he did every night, and it sounded like one of their usual conversations. He said there was no other noise that night from Mr Senkevicius' cell or generally on the landing.

62. The prisoner who was in a cell opposite Mr Senkevicius, said that at about midnight or 1.00am, Mr Senkevicius heard him crying and asked him if he was okay. He said he had told Mr Senkevicius he could not take it anymore and Mr Senkevicius said, "Me too, me too". There was no noise after that and he said he fell asleep. He was being monitored under ACCT procedures at the time, and CCTV shows that the night patrol officer checked him once an hour through the night.

63. At 5.33am on Saturday 9 May, CCTV shows that the night patrol officer checked that all prisoners were present in their cells. He told the investigator he saw Mr Senkevicius standing still in his cell, which was unusual at that time. He said he asked Mr Senkevicius twice if he was okay. Mr Senkevicius nodded twice but did

not speak and he continued his check. He was at Mr Senkevicius' door for a minute before he moved on to check the other cells.

64. That morning, only prisoners who needed to collect medication had their cells unlocked. At 9.22am, CCTV shows Prisoner D went to see Prisoner C. Prisoner C asked him to ask Mr Senkevicius for a couple of cigarette papers. Prisoner D looked through the observation panel in Mr Senkevicius' door and saw Mr Senkevicius hanging from a sheet tied to the window bars. He told Officer A, who was standing near by. Prisoner D said that, at first, the officer did not seem to realise what he was saying and he repeated what he had said. CCTV shows that the officer went into Mr Senkevicius' cell within 30 seconds of the prisoner alerting her.

65. Officer A said that when she saw Mr Senkevicius she went into a state of shock. She said she could see that he was dead but shouted his name to get a response. Then she shouted for Officer B, who went straight to the cell. This was at 9.23am. He said he saw Mr Senkevicius hanging and panicked. He had a radio and a whistle, but said his mind froze and his only thought was to tell the SO. He and Officer A ran downstairs to tell the SO. CCTV shows this was 26 seconds after Officer B went into the cell, and that they came back with the SO at 9.25am.

66. At 9.26am, the SO cut the sheet from which Mr Senkevicius was hanging and radioed a code 1 emergency. This indicates a prisoner is unconscious, not breathing or is having breathing difficulties, alerts other staff to attend and the control room to call an ambulance. The London Ambulance Service records show the ambulance was called at 9.26am. The SO started cardiopulmonary resuscitation. Officer B said Mr Senkevicius' tongue was black and sticking out, he was very stiff and he looked like he had been dead for some time. He said that when the SO cut the ligature, there was no give in Mr Senkevicius' limbs and his body stayed in the same position.

67. The emergency response nurse was in the healthcare unit when he heard the code 1 radio message. He collected the trauma bag and oxygen and went to Trinity Unit with a colleague. The nurses arrived at 9.29am and the SO was administering chest compressions. The nurse said Mr Senkevicius was not breathing and his pupils were fixed and dilated. He took over cardiopulmonary resuscitation and continued until the first paramedic arrived at 9.39am. (An ambulance crew arrived at the cell at 9.43am.)

68. The nurse said Mr Senkevicius was blue and very stiff. He attached a defibrillator but this found no shockable heart rhythm. At 9.45am, paramedics recorded that Mr Senkevicius was dead.

Evidence from Mr Senkevicius' friend

69. Mr Senkevicius' friend had shared a cell with him on H Wing until 27 April, when he had moved to Wormwood Scrubs. He returned to Wandsworth on 12 May. He said he had known Mr Senkevicius since they were children. He described Mr Senkevicius as always very happy and jolly and he would not have guessed that he would kill himself when he did. He said that they had both been very afraid of being extradited back to Lithuania because they thought they would be killed by the traffickers that they had used to get into the UK. He said that they had agreed that,

if they lost their cases against extradition, they would end their lives rather than go back. Whoever heard first would not wait to kill himself, in case he was sent back before he could do it. He said that they had not told anyone else about their plan, even their friends.

70. He said Mr Senkevicius had had a video link hearing with his solicitor at which his solicitor had told him he had no hope of staying in the UK. He did not know the date this happened but said it was sometime in April. He said he was surprised that Mr Senkevicius had killed himself because he was claiming asylum and, although his solicitor had not been positive about his chances, he had not heard the court's final decision.

Contact with Mr Senkevicius' family

71. An officer and one of the prison's chaplains acted as family liaison officers. Shortly after Mr Senkevicius was pronounced dead, the officer contacted the three prisons nearest to Mr Senkevicius' partner's home, which was some distance from Wandsworth, but they were unable to send anyone to break the news to her. At 5.35pm, the officer and chaplain arrived at the address listed in his record, but found she had moved. They telephoned her and broke the news later that evening. The prison offered to contribute to the cost of Mr Senkevicius' funeral, in line with national policy.

Support for prisoners and staff

72. The duty governor debriefed the staff involved in the emergency response and informed them of her support and that of the prison's care team.

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

74. Two prisoners said some officers and one of the chaplains came to their cells individually to see if they were okay. Another prisoner said he had been given a slip of paper saying Mr Senkevicius had died later that day, but no one had spoken to him face to face.

Post-mortem report

75. The post-mortem examination concluded that Mr Senkevicius died from compression of the neck due to hanging. The toxicology tests detected no drugs.

Findings

Communication with prisoners who speak little or no English

76. Prison Service Instruction (PSI) 64/2011, which gives instructions to staff about safer custody, states:

> "All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process."

77. The Prison Service's policy on foreign national prisoners states:

> "Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline."

78. It was evident that Mr Senkevicius spoke and understood little English. It was noted in documents that accompanied him from Norwich that he needed a Lithuanian interpreter. As with all prisons, Wandsworth has a contract with a professional telephone interpreting service, yet there is no record of any staff, either officers or healthcare staff, using this service. The nurse who assessed Mr Senkevicius' mental health did not use an interpreter. It seems highly unlikely that Mr Senkevicius would have been able to understand these interactions sufficiently well for staff to make reliable assessments of his health, state of mind or risk of suicide and self-harm.

79. There is some evidence that Mr Senkevicius preferred using other prisoners to translate for him and found the telephone service frustrating. During the ACCT process, officers twice asked another prisoner to translate, but did not apparently consider arranging for an interpreter to come into the prison. Only one healthcare assessment (by a nurse on 4 March) was aided by another prisoner translating.

80. Although we do not know that this was the case with Mr Senkevicius, we have investigated the self-inflicted deaths of a number of foreign national prisoners recently, where we have found that the failure to communicate effectively with them through appropriate interpretation services has been a factor in their deaths. It is particularly concerning that this is an issue at Wandsworth, which is a designated foreign national prisoner 'hub', with a high proportion of foreign national prisoners. Our concerns reflect those raised during the most recent inspection by HM Inspector of Prisons. We make the following recommendation:

The Governor and Head of Healthcare should ensure that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

Assessment of risk of suicide and self-harm

81. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody) lists a number of risk factors and

potential triggers for suicide and self-harm. Mr Senkevicius had some factors that increased his risk including previous self-harm, first time in prison, relationship problems (although staff were not aware of this) and being a foreign national prisoner, facing possible extradition.

82. Mr Senkevicius gave inconsistent accounts to prison staff in response to questions about his history of self-harm. He told the staff at Norwich that he had swallowed sharp objects and his police record noted he had threatened to head butt a wall. At his initial health assessments at Wandsworth, he apparently said he had not previously self-harmed, and no one reviewed his medical record, which referred to this. On 18 February, he cut his arm and said that this was the first time he had ever self-harmed. The ACCT was closed on 24 February, when a member of staff concluded that the causes of Mr Senkevicius' frustration and upset had been resolved. While it appears that this might have been a reasonable decision, based on the information at the time, we have some concerns about the operation of the ACCT procedures, which are dealt with below.

83. Mr Senkevicius' friend told the investigator that he and Mr Senkevicius had agreed that they would kill themselves if they could not prevent their extradition to Lithuania. They did not tell anyone else of this plan and he told the investigator that he was shocked by Mr Senkevicius' death. He was convinced that he had not intended to kill himself. In February, Mr Senkevicius said he had harmed himself because he was frustrated about difficulties in organising a visit with his partner and in receiving his post. He did not otherwise give staff or other prisoners who knew him any cause to think he would harm himself and his behaviour remained consistent throughout his time at Wandsworth. We have not been able to establish what the altercation with other prisoners on the evening before he died was about neither Mr Senkevicius nor the officer who intervened, raised any specific concerns about the incident.

84. Two prisoners on the landing above told the investigator that Mr Senkevicius pressed his cell bell repeatedly and asked to speak to a Listener that evening. Their accounts are not supported by the cell bell records or by the accounts of the prisoners in adjacent cells. We do not consider their evidence is supported by the facts. Mr Senkevicius' friend spoke to him at 11.30pm on 8 May and thought he sounded his normal self.

85. Without further knowledge of Mr Senkevicius, such as his ongoing extradition issues, it is unlikely that anyone would have immediately identified that he was at risk of suicide and self-harm. None of the wing staff considered that he was at risk of suicide and self-harm. We do not consider that the weight of risk factors was sufficient to outweigh staff and other prisoners' perceptions of Mr Senkevicius' mood and demeanour. We consider it would have been difficult for staff at Wandsworth to have predicted or prevented his actions.

ACCT procedures

86. The distance in time would suggest that Mr Senkevicius' death was not connected with the operation of ACCT procedures after he self-harmed in February 2015. However, we have sufficient concerns about their management to seek improvement. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible and that a member of healthcare staff should attend at least the

first ACCT case review. Neither happened. A prisoner interpreter was used to assess Mr Senkevicius, which is not best practice and there is no record of any interpreter at either of the case reviews. (See issues section on communication.)

87. Two caremap actions were set – both apparently for Mr Senkevicius himself to resolve by making applications, despite his poor English. At the second ACCT case review an SO acting alone, closed the ACCT, without a clear record that the issues that had been identified in the caremap had been addressed and completed. It was inappropriate and poor practice for the SO to hold an ACCT review and end ACCT procedures acting on his own. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff. It is a mandatory requirement that a post-closure review is held within seven days of an ACCT being closed, to check the prisoner's progress and whether there are any new or ongoing issues that need to be addressed. There is no record that this was done. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

- **A multi-disciplinary approach for all case reviews, with healthcare staff attending all first case reviews.**
- **Setting specific and meaningful ACCT caremap objectives and ensuring that all caremap actions have been completed before an ACCT is closed.**
- **Holding an ACCT post-closure review within seven days.**

Assessing and treating Mr Senkevicius' mental and physical health needs

88. At Norwich, Mr Senkevicius said that he had epilepsy and asthma, requiring medication. It is not certain that he had either because there were no community records, but neither condition was noted when he arrived at Wandsworth. He does not appear to have suffered any ill-health in Wandsworth. Nevertheless, these are both potentially life threatening conditions and his previous claim to have epilepsy and asthma should have been identified and properly examined. Two days before he transferred to Wandsworth, one of the Norwich GPs noted that Mr Senkevicius had swallowed sharp objects two months earlier and needed to be referred to hospital for further examination. This was not picked up when he arrived at Wandsworth.

89. All prisoners assessed as at risk of suicide and self-harm at Wandsworth are referred for a mental health assessment. This is a sound practice. However, a nurse did not assess Mr Senkevicius until 5 March, over two weeks after he had self-harmed and ten days after the ACCT was closed (and without any assistance with interpretation). We consider that this is too long to assess a prisoner at risk. The clinical reviewer concluded that this, and other aspects of the clinical care Mr Senkevicius received at Wandsworth, were not equivalent to what he might have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that mental health referrals for prisoners assessed as at risk of suicide and self-harm are prioritised and carried out promptly.

Emergency response

90. Wandsworth has a clear policy that staff should immediately radio the appropriate code in a medical emergency. Neither officers radioed a code 1 when they found Mr Senkevicius hanging and there was a delay of three or four minutes before the SO radioed an emergency code and cut the ligature from around Mr Senkevicius' neck. Both officers said that they went into a state of shock, which we understand. It is apparent that Mr Senkevicius had already died, so this did not affect the outcome, but in other emergencies such a delay could be critical. However, the staff we spoke to we were aware of the local and national policy to call an emergency medical code immediately.

91. When the officers found Mr Senkevicius hanged, it was evident that rigor mortis was present. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised but staff should understand that they are not required to carry out cardiopulmonary resuscitation in these circumstances. European Resuscitation Council Guidelines 2010 state that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile…" such as the presence of rigor mortis. In October 2014, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance about making appropriate resuscitation decisions. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.

92. In the investigation reports into two deaths at Wandsworth in 2014 we found that healthcare staff attempted resuscitation inappropriately and it is apparent that there is still some confusion about the circumstances in which staff should attempt to resuscitate prisoners. We repeat a previous recommendation to include all staff:

The Governor and Head of Healthcare should ensure that all staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

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