

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darius Petraitis a prisoner at HMP Lincoln on 7 June 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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

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

Mr Darius Petraitis was found hanged in his cell at HMP Lincoln on 7 June 2016. He was 33 years old. I offer my condolences to Mr Petraitis' family and friends.

Court staff identified that Mr Petraitis spoke little English, it was his first time in prison, he was charged with a serious sexual offence and he had attempted suicide in the past after his brother had taken his own life. All this put him at an increased risk of suicide. However, sharing of this information between relevant staff was poor and interpreting services were not utilised sufficiently. This meant that opportunities to understand and explore Mr Petraitis' risk during his early days in custody were missed.

Subsequently, there was little evidence of meaningful interaction between staff and Mr Petraitis in the time he spent at Lincoln. I am also concerned that, although Mr Petraitis rang his cell bell shortly before he hanged himself, the bell appears to have been turned off without any attempt to see whether Mr Petraitis needed help.

Despite the weaknesses in the care afforded to Mr Petraitis, I recognise that there is little evidence that staff at Lincoln had any reason to believe that he intended to kill himself.

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

May 2017

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Summary

Events

1. On 11 April 2016, Mr Petraitis was remanded to HMP Lincoln, charged with serious sexual offences against a child. He told a court worker that he had tried to hang himself three or four years previously after his brother's suicide, but said he was not likely to harm himself. It was his first time in prison. Mr Petraitis told a reception nurse and an officer that he had no thoughts of suicide or self-harm.
2. Mr Petraitis told a cellmate he was concerned he would be deported to serve a long sentence in a Lithuanian prison. He told another friend that he was prepared to take his life if it meant his partner could be freed. (His partner was his co-defendant.)
3. On 7 June, three days before he was due to appear in court, Mr Petraitis gestured to an officer that he had a headache, so would not be going to work. His cellmate attended work, leaving Mr Petraitis in their cell alone. At 4.37pm, an officer opened Mr Petraitis' cell door to let his cellmate in but did not look into the cell. Moments later, he heard loud banging and returned to open the door. Mr Petraitis' cellmate ran out, indicating inside. The officer moved a towel which was hanging from the top bunk to one side and saw Mr Petraitis kneeling on the lower bunk, hanging from the top bunk. The officer radioed a medical emergency code. Staff responded quickly and began cardiopulmonary resuscitation. Paramedics arrived and recorded at 4.58pm that Mr Petraitis had died.

Findings

4. Although we are not fully satisfied that Lincoln recognised Mr Petraitis' risk of suicide in the early days of his period in custody, there was little indication that he intended to take his life during his two months in prison.
5. Lincoln's staff did not share all the information on Mr Petraitis' risk which was available to them. Healthcare staff did not use interpreting services to communicate with him even though he spoke little English. These factors meant that they lost valuable opportunities to ensure that his risk of self-harm or suicide was fully explored.
6. We are concerned that there was little evidence of meaningful interaction with Mr Petraitis beyond his first week in custody. His personal officer did not make contact with him and although this was picked up in a management check a week before his death, the initial conversation was brief. This was all the more disappointing as he was socially isolated, with no family contact and few friends.
7. It is troubling that, although Mr Petraitis rang his cell bell shortly before hanging himself, the bell appears to have been turned off without any attempt to see whether Mr Petraitis needed help.

Recommendations

- The Governor should ensure that reception staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or

self-harm including information from prisoner escort records and previous prison records. The SPARC Keep Safe form is a potentially useful source of such information.

- The Governor should ensure that officers have meaningful contact with every prisoner through an effective scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.
- The Governor and Head of Healthcare should ensure that accredited interpreting services are used for prisoners who do not understand English well, when matters of accuracy or confidentiality are a factor.
- The Governor should investigate why Mr Petraitis' cell bell was turned off and satisfy himself that staff respond appropriately to cell bells on the vulnerable prisoners' unit.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Lincoln on 15 June 2016. She obtained copies of relevant extracts from Mr Petraitis' prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Petraitis' clinical care at the prison. He joined the investigator for four of the interviews.
11. The investigator interviewed nine members of staff and three prisoners at Lincoln between June and August 2016.
12. We informed HM Coroner for Central Lincolnshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Petraitis' family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. His family said Mr Petraitis was planning for a future. They wanted to know more details of what had happened to him including whether he was bullied and what protection the prison had put in place, given the nature of his offence.
14. Mr Petraitis' family received a copy of the initial report. They responded that they did not accept he had committed the offences he was charged with and that they felt very let down by the behaviour of prison staff towards him as a foreign national. They did not highlight any factual inaccuracies within the report.
15. The prison also received a copy of the report and did not identify any factual inaccuracies in the report.

Background Information

HMP Lincoln

16. HMP Lincoln holds over 700 remand and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and East Yorkshire. It has four residential wings including a vulnerable prisoner unit. Nottinghamshire Healthcare NHS Trust provides health services and there is 24-hour healthcare cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Lincoln was in November 2013. Inspectors noted there was innovative work to identify the needs of new prisoners while they were still at court. Inspectors reported that the prison was safer than it had been at the previous inspection 15 months earlier and that levels of self-harm were lower. Relationships between staff and prisoners appeared supportive and they helped prisoners deal with their issues, even though this was not always noted in prisoner records. Health services were much improved and foreign national prisoners had sufficient access to independent advice but there was little translated information available and prisoners were used inappropriately to interpret for confidential matters.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2016, the IMB reported that the high level of self-harm incidents remained a concern and there was no CCTV on the vulnerable prisoner unit.

Previous deaths at HMP Lincoln

19. Mr Petraitis' death was the fourth apparently self-inflicted death we have investigated since 2013. There has been another death at Lincoln since. Our reports on those deaths highlighted a reliance on personal presentation rather than analysis of existing documents and information. In 2013 and 2015, we investigated the deaths of two prisoners where the information available on reception regarding their risk of self-harm had not been followed up or shared between staff who were assessing that risk.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner.

Key Events

21. On 9 April 2016, Mr Darius Petraitis was arrested by police. The escorting officer reported to the custody officer on arrival at Boston police station that Mr Petraitis had banged his head against the head rest of his seat and repeatedly kicked the cell door of the transportation van. Mr Petraitis was Lithuanian and spoke little English. Using a telephone interpreting service, the police officer asked Mr Petraitis questions to gauge his risk of suicide or self-harm, including whether he had ever harmed himself, if he had depression or needed support for mental health problems. He replied 'no' to all the questions. The officer concluded that his risk of suicide or self-harm was low. On 10 April, Mr Petraitis was charged with serious sexual offences against a child.
22. On 11 April, Mr Petraitis was remanded to HMP Lincoln. He was interviewed at court by a worker from Support for Prisoners After Remand or Conviction (SPARC), an organisation funded by the prison to highlight the immediate needs of prisoners on a Keep Safe form while they are still at court. It is designed to allow the prison to put initial safeguarding measures in place, if necessary. Mr Petraitis told her that he had not been in prison before and was not expecting visits as he was not in contact with his family. In response to questions about his health and wellbeing, he said he drank a few cans of alcohol at weekends and that he had attempted to hang himself three or four years previously after his brother's suicide. She flagged up that Mr Petraitis was a vulnerable prisoner due to the nature of his offence.
23. When Mr Petraitis got to Lincoln, an officer signed his Person Escort Record (PER), a document with brief details of a prisoner's offence which accompanies them when they move between police stations, courts and prisons. The officer asked him in English if he had problems with self-harm, drugs or alcohol. The officer recorded that Mr Petraitis said he did not. He told the investigator that he did not consider using a telephone interpreting service as Mr Petraitis understood some English. He could not remember seeing the Keep Safe form and said he was not familiar with them because he did not usually work in reception.
24. At an initial health assessment, a nurse recorded that Mr Petraitis did not have any thoughts of suicide or self-harm. He told her he never drank alcohol, which contradicted the information on the Keep Safe form. She said she did not see the Person Escort Record which accompanied him to prison as these were not normally shown to reception healthcare staff. She could not recall whether she had seen the Keep Safe form and said she relied on officers working in reception to identify issues. Neither she nor the nurse who did a secondary health assessment identified that he might be at risk of suicide or self harm, despite the nature of his offence.
25. Mr Petraitis was taken to the vulnerable prisoner unit due to the nature of his offence. The day after he arrived, he went through the induction process as a new prisoner. An offender supervisor used a telephone interpreting service to do this. Mr Petraitis did not mention any concerns.
26. The worker who had interviewed him in court the previous day, assessed Mr Petraitis again with a Lithuanian interpreter. He asked her how he could contact

his partner (who was in a different prison) and how he could get tobacco. She passed his request on and advised him he would need to work in order to earn money for purchases. A chaplain spoke to Mr Petraitis using informal sign language and gesticulation, as part of the induction process. She recorded that Mr Petraitis had no family or friends to support him. He did not mention his partner.

27. On 13 April, an offender supervisor interviewed Mr Petraitis using a telephone interpreting service. He explained that due to the nature of his charges, Mr Petraitis' telephone calls and letters would be restricted. He explained that, at the request of the police, Mr Petraitis would not be allowed to contact his partner (who was also his co-defendant).
28. On 14 April, a guidance worker assessed Mr Petraitis' knowledge of English and Mathematics. As he knew little English, she allocated him to an English for Speakers of Other Languages (ESOL) course, which he attended. A Home Office manager interviewed Mr Petraitis using a telephone interpreting service about his immigration status on 22 and 26 April. She told a prison administrator she had no concerns about him but there is no written note of the meetings in Mr Petraitis' record. Mr Petraitis had a court appearance via video link on 16 May and was remanded to appear at Crown Court on 10 June.
29. Mr Petraitis got a job in the textiles workshop, sewing clothing and made two friends who also lived on the vulnerable prisoner unit and spoke Russian.
30. On 28 May, a prisoner moved into Mr Petraitis' cell at his request. He told the investigator that Mr Petraitis was nervous about his trial and said he was expecting a 20-year sentence. He was worried about being deported to Lithuania to serve his sentence there. He did not pass this information on to staff. He also noticed that Mr Petraitis began smoking heavily and sleeping a lot. The investigator contacted Mr Petraitis' solicitor to clarify whether Mr Petraitis had shared any concerns with them. They declined to assist with our investigation on the grounds of client confidentiality.
31. Another prisoner told the investigator that Mr Petraitis enjoyed working in the textiles workshop as a distraction and it meant that he could earn money. About 10 days before his death, Mr Petraitis said to the prisoner that he would kill himself if it meant that his partner would be free to be with her daughter. He told him not to think like that and they did not talk about it again. He did not tell anyone about this conversation.
32. The prison does not have a personal officer policy but officers are allocated a number of prisoners they are expected to introduce themselves to, record conversations with every two weeks and take a particular interest in their wellbeing. Mr Petraitis' designated officer did not write any entries in his records. He told the investigator that he was unavailable for a period of four weeks during Mr Petraitis' stay as he was on night duty followed by time off. A vulnerable prisoner unit manager asked an officer to check on Mr Petraitis' wellbeing in the designated officer's absence. On 28 May, the officer wrote in Mr Petraitis' record that Mr Petraitis said he did not have any issues.

33. On 7 June, Mr Petraitis and another prisoner agreed to attend a church service in the afternoon. At lunchtime, Mr Petraitis told him that he was not going to work that afternoon, but he did not give a reason. The prisoner assumed that he wanted to go to church. The prisoner had a hospital appointment, so did not go to church. Officer A, who did not usually work on the vulnerable prisoner unit, unlocked their cell at 1.30pm. Mr Petraitis gestured that he had a headache, so stayed in his cell on his own. The officer supervised prisoners delivering laundry to cells on the vulnerable prisoner unit. He thought he saw Mr Petraitis lying on the bottom bunk bed at about 2.15pm, but did not speak to him.
34. Electronic cell bell records indicate that Mr Petraitis' cell bell was activated at 3.36pm then cancelled after 9 seconds. A cell bell can only be turned on when pressed inside the cell. A small red light turns on outside the cell, on a panel in the walkway, the staff office and a buzzer sounds. The sound can be muted from the office but the light remains on until a reset button outside the cell is pressed to cancel it.
35. Officer A told the investigator he did not answer any cell bells, nor did Officer B, who was supervising the cleaners. Officer C was a key worker, checking on all prisoners on the vulnerable prisoner unit who had been identified as at risk of suicide or self-harm. Officer C told the investigator in his first interview that it was highly likely he had passed Mr Petraitis' cell as it was next to a staircase but he had no reason to look into the cell. He said it was possible he had answered some cell bells but could not remember. During his second interview, he said he did not see Mr Petraitis' cell bell light on or answer the bell. After the interview, he suggested that the cell bell might have been turned off by an officer conducting daily accommodation fabric checks. However, the investigator established that an officer completed the checks at 10.20am. The vulnerable prisoner unit does not have CCTV so it has not been possible to establish who turned Mr Petraitis' bell off.
36. At 4.37pm, Mr Petraitis' cellmate returned from work and Officer A opened the cell door to let him in. As Officer A walked away, he heard loud banging from the cell and opened the door. Mr Petraitis' cellmate ran out, talking in Russian and gesturing into the cell. The officer noticed a towel hanging over the back of the bunk beds, obscuring the bottom bunk. As he lifted it, he saw Mr Petraitis kneeling on the bed with a sheet tied around his neck which was attached to the base of the top bunk. He radioed a code blue (an emergency code for a person with breathing difficulties) and cut the ligature. He shouted at the door for staff assistance and Officer B ran to the cell.
37. When a nurse and a healthcare support worker (HCA) got to the cell, they told the officers to put Mr Petraitis on the floor on his back. The nurse examined Mr Petraitis but he was unconscious, not breathing and she could not find any signs of life. The HCA began chest compressions, which the nurse took over while he went to get a defibrillator. The nurse told the investigator that the defibrillator was attached and advised a shock should be administered but there was no response from Mr Petraitis so they continued with resuscitation.

38. The prison requested an ambulance at 4.38pm, as soon as Officer A radioed the code blue emergency. Ambulance records show that paramedics arrived at the prison at 4.43pm and confirmed Mr Petraitis' death at 4.58pm.

Contact with Mr Petraitis' family

39. When he arrived at Lincoln, Mr Petraitis had named his mother in Lithuania as his next of kin. At 6.15pm, a prison manager contacted her using a telephone interpreting service to break the news of her son's death. He explained what had happened and offered condolences.
40. On 11 July, Mr Petraitis' body was repatriated to Lithuania, which the prison manager arranged. The prison contributed to the costs of repatriation and Mr Petraitis' funeral, in line with national instructions.

Support for prisoners and staff

41. After Mr Petraitis' death, a manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
42. The prison posted notices informing other prisoners of Mr Petraitis' 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 Petraitis' death.

Post-mortem report

43. A post-mortem examination established the cause of death as hanging. Toxicology tests revealed no illicit drugs or medication.

Findings

Assessment of risk

44. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. When Mr Petraitis arrived at Lincoln on 11 April, it was his first time in prison, he could not speak English, he had been charged with serious sexual offences against a child, had a history of attempted suicide and a family history of suicide. The court officer identified and highlighted these risks on the Keep Safe form but an officer and a nurse did not read it and decided that he was not at risk of suicide or self-harm, mainly because of Mr Petraitis' presentation and because he had said he did not intend to kill himself.
45. The officer told the investigator that he did not read the SPARC forms of prisoners in the residential unit where he normally worked as they were only for induction staff. This was also the view of several officers the investigator spoke to. HM Inspectorate of Prisons' most recent inspection report of Lincoln described SPARC as an excellent initiative. We agree that it provides good quality and valuable information about prisoners before they arrive at Lincoln. However, it is essential that all staff who are responsible for assessing risk of self-harm or suicide read all relevant information, including SPARC and PER forms. We have raised this issue with Lincoln before.
46. A prisoner's very early days in prison should be recognised as a high-risk time but there is also a need to ensure that staff are vigilant for signs of vulnerability in the weeks that follow. With hindsight, had Lincoln properly assessed Mr Petraitis' risk by taking into account all of his risk factors, they would have been able to deal more effectively with his concerns about deportation, his partner and his trial. While we are pleased to learn Lincoln has developed plans to expand its safer custody team, we make the following recommendation:

The Governor should ensure that reception staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm including information from prisoner escort records and previous prison records. The SPARC Keep Safe form is a potentially useful source of such information.

Contact with staff

47. Beyond Mr Petraitis' first couple of weeks in Lincoln, there was little interaction between him and staff. His allocated personal officer did not speak to him and other staff contact was superficial. While it might have been difficult to have foreseen Mr Petraitis' actions, some of the information about his state of mind could have been more effectively co-ordinated and might have identified concerns.
48. The National Offender Management Service's guidance to prisons about managing foreign national prisoners states:

'Language barriers ... can exacerbate all other problems. As professional staff, we have a responsibility to ensure that prisoners understand what is being said to them and what is expected of them. Staff should not assume that prisoners with 'some' command of the English language, fully understand what is being said or the implications. Staff need to understand and be equipped to respond to requests ... Foreign national prisoners may be vulnerable to self-harm as they are more likely to experience feelings of isolation, difficulties in communication and may be in custody for the first time...For some, cultural norms may mean a reluctance to complain or seek help and staff need to be alert to this.'

49. Mr Petraitis spoke and understood little English. Police, court, SPARC, offender management and Home Office staff used a translator or a telephone interpreting service when communicating with him. Although we found that telephone interpreting services were accessible, it is noticeable that healthcare staff and officers did not use them with Mr Petraitis as they said he could make himself understood. It is questionable whether Mr Petraitis would have been able to understand these interactions sufficiently well for staff to make reliable assessments of his health or risk of suicide and self-harm. Some 15 per cent of Lincoln's prisoners are foreign nationals whose first language is not English. We make the following recommendations:

The Governor should ensure that officers have meaningful contact with every prisoner through an effective scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

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.

Use of cell bell

50. Although records show that Mr Petraitis' cell bell was turned on when he was by himself, the investigator has explored this issue but the vulnerable prisoners' unit does not have CCTV and we have not been able to identify the person that responded to the cell bell or turned it off. Mr Petraitis had arranged to go to a church service with a prisoner at 3.00pm that afternoon. He might have pressed his bell to ask an officer to take him or to show that he was feeling distressed and had thoughts of suicide. It is deeply regrettable that someone turned it off, possibly without speaking to Mr Petraitis. This is a source of concern. When prisoners are locked in their cells, pressing their emergency cell bell is the obvious way to summon the quick assistance of an officer. Prisoners have been known to signal their distress by pressing their cell bells. The act of turning off a cell bell, apparently without seeing whether Mr Petraitis needed help, was highly inappropriate.

The Governor should investigate why Mr Petraitis' cell bell was turned off and satisfy himself that staff respond appropriately to cells bells on the vulnerable prisoners' unit.

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