Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Aleksandras Zuravliovas a prisoner at HMP Swaleside on 3 June 2017

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*

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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.

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

Mr Aleksandras Zuravliovas died at HMP Swaleside on 3 June 2017 after he was found hanged in his cell. He was 30 years old. We offer our condolences to his family and friends.

Although staff at Swaleside identified that Mr Zuravliovas was at risk of suicide and self-harm, there were serious deficiencies in the way they operated suicide and self-harm prevention procedures. Case reviews did not consistently involve multidisciplinary teams or fully identify his risks. Mr Zuravliovas received inadequate support for his mental health and substance misuse issues. On the evening of his death, staff did not monitor him as agreed under suicide and self-harm prevention procedures.

While we cannot say whether staff might have prevented Mr Zuravliovas' death if they had monitored him appropriately, it is critical that Swaleside improve their suicide and self-harm prevention procedures and healthcare support for those at risk. It is not the first time that we have identified deficiencies in this area. Once again, we urge the Governor to prioritise this as a matter of urgency and we draw this troubling state of affairs to the attention of the Executive Director of Long Term and High Security Prisons.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **January 2018**

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Summary

Events

1. In October 2013, Mr Aleksandras Zuravliovas was remanded to HMP Highdown for murder. It was his first time in prison. In July 2014, Mr Zuravliovas was sentenced to life, with a tariff of 21 years. He was transferred to HMP Swaleside in March 2015.

2. On 10 May 2017, staff found a large quantity of hooch (an illicitly fermented alcoholic drink) in Mr Zuravliovas' cell and reduced his Incentive and Earned Privilege (IEP) level to basic for 28 days. Mr Zuravliovas was also suspected of using illicit substances including Spice, a New Psychoactive Substance (NPS).

3. In the early hours of 19 May 2017, Mr Zuravliovas told the night duty officer that his mother had died and he started to cry. No one explored this further or offered him support.

4. On 22 May, Mr Zuravliovas self-harmed by cutting his arms. He had also made a ligature from ripped bed sheets and tied it to a light fitting.

5. Prison staff began suicide and self-harm procedures, known as ACCT. Mr Zuravliovas told staff that he was struggling to cope with his long sentence, was missing his family and had not spoken to his ex-partner for three weeks. The next day, staff completed his ACCT assessment and first case review. No one from the healthcare team attended. Staff failed to create an ACCT caremap, outlining Mr Zuravliovas' main concerns. Staff stopped ACCT monitoring on 30 May as they considered that Mr Zuravliovas' risk of self-harm was low.

6. On 1 June, Mr Zuravliovas told staff that he wanted to kill himself and they started ACCT monitoring again. They agreed to monitor him hourly. Mr Zuravliovas said he felt stressed and missed his ex-partner. Other prisoners suspected that Mr Zuravliovas had incurred debt from his illicit substance misuse.

7. On 3 June, at 6.13pm, a wing officer checked on Mr Zuravliovas and noted no concerns. When the night duty officer checked on Mr Zuravliovas at 7.39pm, she found him hanged in his cell. She radioed a medical emergency. Healthcare staff arrived quickly and tried to resuscitate Mr Zuravliovas. Paramedics arrived and took over his care. At 8.29pm, they pronounced that Mr Zuravliovas was dead.

Findings

ACCT procedures

8. When Mr Zuravliovas was found in distress on 19 May, staff should have fully explored his emotional and mental state and assessed his risk. Over the next fortnight there was inconsistency in case managers completing his ACCT case reviews, no one from the healthcare or mental healthcare team attended the first two ACCT reviews and a caremap was not created until the third ACCT review. Staff stopped ACCT monitoring, even though concerns identified in Mr Zuravliovas' ACCT assessment had not been addressed.

9. On the evening of Mr Zuravliovas' death, an officer recorded in his ACCT record that he had checked Mr Zuravliovas as part of his hourly observations. CCTV footage confirmed that this had not happened. We note that this matter is currently subject to disciplinary investigation.

Review of IEP decisions

10. When staff monitored Mr Zuravliovas' under ACCT procedures, no one reviewed his IEP level to consider whether this had increased his risk of suicide or self-harm.

Clinical care

11. Mr Zuravliovas' care at Swaleside was not equivalent to that which he could have expected to receive in the community. He appeared to have developed a substance misuse issue and, potentially, mental ill health in prison. We are concerned that he was not promptly referred to either the substance misuse team or the mental health team.

Recommendations

- The Executive Director for Long Term and High Security Prisons should assure himself that effective action is taken to implement recommendations from this and previous investigations into deaths at HMP Swaleside.
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
  - Staff review a prisoner's risk of suicide and self-harm whenever an event occurs which indicates an increase in risk and consider opening an ACCT.
  - A multidisciplinary case review is held within 24 hours of an ACCT plan being opened and when there is evidence of significant change in risk.
  - A member of healthcare staff should attend all first case reviews and subsequent reviews, where relevant.
  - Case managers complete caremaps at the first ACCT case review, set specific and meaningful caremap actions, identify who is responsible for them and review progress at each review.
  - ACCT documents accompany prisoners when they move around the prison.
  - All staff in contact with prisoners receive training in suicide and self–harm prevention procedures, with appropriate refresher training.
  - All staff undertake ACCT observations as directed and actively engage with prisoners being monitored. Managers should carry out random checks of CCTV footage to ensure this happens.
- The Governor should ensure that Swaleside's local IEP policy is amended to include instructions that staff should consider the needs of vulnerable prisoners and those at risk of suicide or self-harm when making and reviewing decisions about IEP sanctions, and take into account the likely impact on the health and welfare of the prisoner.

- The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are urgently referred for a mental health assessment.
- The Governor and Head of Healthcare should ensure that there is a clear pathway for the substance misuse service and that all intervention is recorded in prison and medical records to ensure the quick and effective assessment and management of prisoners' needs.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. No one came forward.

13. The investigator obtained copies of relevant extracts from Mr Zuravliovas' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Zuravliovas' clinical care at the prison.

15. The investigator interviewed 14 members of staff and four prisoners at Swaleside in February and March 2017, some jointly with the clinical reviewer.

16. We informed HM Coroner for Kent of the investigation who sent us the results of the post-mortem examination. We gave the Coroner a copy of this report.

17. One of the Ombudsman's family liaison officers, contacted Mr Zuravliovas ex-partner to explain the investigation. Mr Zuravliovas' ex-partner did not have any specific questions for us to consider.

18. Mr Zuravliovas' ex-partner received a copy of the initial report and chose not to comment or provide feedback.

Background Information

HMP Swaleside

19. HMP Swaleside, which is on the Isle of Sheppey, holds up to 1,112 prisoners serving life sentences and determinate sentences. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17-bed inpatient unit.

HM Inspectorate of Prisons

20. The most recent inspection of Swaleside was in April 2016. Inspectors said Swaleside had been a struggling prison for some time, and the population had become more challenging. They described the mental healthcare provision as very good and noted that ACCT monitoring had started to improve. Hooch, diverted medication and new psychoactive substances (NPS) were widely available. Inspectors noted that key departments such as security did not consistently attend the prison's drug strategy committee meetings.

Independent Monitoring Board

21. 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 most recently published annual report for the year ending April 2016, the IMB was concerned about the continuing shortage of experienced prison officers at Swaleside. In the Board's view, this was the main reason that the preceding year had been difficult. They highlighted that Swaleside could not be considered safe and they noted continued bullying among prisoners. Swaleside's Safer Custody team had undergone some radical changes due to restructuring. The IMB noted that they had revised processes to ensure that there was central knowledge of all ACCT cases to enable timely and multidisciplinary ACCT assessments and reviews.

Previous deaths at HMP Swaleside

22. Mr Zuravliovas was the fifth prisoner to take his life at Swaleside since December 2014. In 2015 and 2017, Swaleside accepted our previous recommendations to improve ACCT procedures and we repeat these concerns in this report.

Assessment, Care in Custody and Teamwork (ACCT)

23. 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. 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 multidisciplinary 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.

24. 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.

Incentives and Earned Privileges (IEP) Scheme

25. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced. Swaleside's local IEP policy states that all prisoners placed on basic level must be reviewed within 7 days and their progress recorded in the prison records.

New psychoactive substances (NPS)

26. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

27. HM Prisons and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

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29. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

Background

30. On 24 October 2013, Mr Aleksandras Zuravliovas, a Lithuanian national, was remanded to HMP Highdown on a charge of murder. He spoke Lithuanian and Russian. Staff recorded that Mr Zuravliovas smoked but was physically fit and well. It was his first time in prison. On 28 October, staff noted that Mr Zuravliovas was tearful and had made superficial cuts to his arm. Staff started suicide and self-harm prevention procedures, known as ACCT, and stopped ACCT monitoring on 30 November, after staff assessed that he was at low risk of self-harm.

31. On 14 January 2014, Mr Zuravliovas was transferred to HMP Lewes and then to HMP Elmley on 14 April 2014, where healthcare staff recorded no concerns but noted that he spoke and understood English well.

32. On 7 July, after Mr Zuravliovas was convicted of murder, a nurse at Elmley noted he was upset and started ACCT procedures. She noted that Mr Zuravliovas said he would not take his own life because of his two young children but she referred him to the mental health team and to the doctor to assess him for insomnia.

33. The next day, Mr Zuravliovas received a life sentence, with a tariff of 21 years. A nurse assessed him when he returned to prison. She noted that Mr Zuravliovas' mood was low and he was tearful. Mr Zuravliovas said he had no thoughts of suicide or self-harm. The nurse recorded that Mr Zuravliovas displayed no evidence of a psychiatric illness.

34. On 10 July, the prison doctor saw Mr Zuravliovas, and prescribed citalopram (an antidepressant). From 11 July, the mental health team regularly assessed Mr Zuravliovas. Staff noted that he had settled well, had a prison job and received regular visits from his partner. They stopped ACCT procedures on 23 July. Mr Zuravliovas decided not to take his medication from 29 July**.** On 9 October, the mental health team discharged Mr Zuravliovas from their caseload after a mental health assessment.

HMP Swaleside

35. On 24 March 2015, Mr Zuravliovas was transferred to HMP Swaleside. At his initial health screen, a healthcare assistant noted that Mr Zuravliovas had no history of substance misuse and that she had no concerns about his physical or mental health. Mr Zuravliovas lived on the induction wing before staff moved him to a cell on B Wing, a standard residential wing, on 3 April. Staff recorded that Mr Zuravliovas had settled well at Swaleside. He got a job in the workshops, attended the gym regularly and started English classes.

January - March 2017

36. During January and February 2017, staff reported that Mr Zuravliovas' behaviour had deteriorated. He refused to go to work a number of times and had a fight with another prisoner. On 8 March, staff found Mr Zuravliovas under the influence of an illicit substance, suspected to be spice - a New Psychoactive

Substance (NPS). Mr Zuravliovas refused healthcare intervention. There is no evidence in his clinical record that staff referred him to the substance misuse or the mental health team.

37. From 28 March onwards, a workshop instructor reported that Mr Zuravliovas had settled well, working in a workshop. She described him as a quiet and good prisoner who interacted well with others.

May 2017

38. On 7 May, Mr Zuravliovas' ex-partner and daughter visited him.

39. On 10 May, staff found five litres of hooch in Mr Zuravliovas' cell and his Incentives and Earned Privilege (IEP) level was reduced from standard to basic for a period of 28 days. This meant that Mr Zuravliovas' allowance of cash to buy canteen, association time, earnings and visits were reduced and his in-cell television was removed. The next day, Mr Zuravliovas attended a disciplinary hearing and pleaded guilty to having hooch. His work earnings were reduced by 50% and he was not allowed to use the gym for ten days.

40. At 3.25am on 19 May, Mr Zuravliovas rang his cell bell and an operational support grade (OSG), responded. Mr Zuravliovas told him that his mother had been killed (although it later became apparent that this was not true). The OSG asked Mr Zuravliovas how he knew this. Mr Zuravliovas did not answer him but pointed to the wing landing upstairs. He started to cry and talked about his children. He told Mr Zuravliovas that he would ask the chaplaincy team to speak to him in the morning. He recorded his concerns in the wing observation book and told a manager on duty. He checked on Mr Zuravliovas at 4.00am and noted he was talking to a prisoner in a neighbouring cell. He noted no further concerns. There was no evidence that anyone subsequently spoke to Mr Zuravliovas about this incident or that staff reviewed Mr Zuravliovas' IEP status or made entries about his progress in his prison record in line with local requirements.

41. On the evening of 22 May, an officer found Mr Zuravliovas crying on his bed. He had made cuts to his right arm and made a ligature from ripped bed sheets, which was attached to the light fitting. Staff removed a razor blade and the ligature from the cell and started ACCT procedures. Mr Zuravliovas told staff that he was okay and denied that he would try again to harm himself. He said he was struggling with his long sentence, felt stressed as he missed his family and had not spoken to his ex-partner for three weeks.

42. A nurse examined Mr Zuravliovas and found red marks around his neck and cuts on his right arm. She treated and dressed his scratches and noted that he had no signs of swelling or bruising on his neck. She referred him electronically to the mental health team. (It was unclear from SystmOne whether the mental health team saw or acted on the request.) Mr Zuravliovas refused to be relocated to the healthcare inpatient unit or to see a Listener (a prisoner trained by the Samaritans to provide support to prisoners).

43. A custodial manager, started ACCT procedures. She decided that Mr Zuravliovas should be monitored at half-hourly intervals until he was assessed under ACCT procedures. She agreed that staff would facilitate a telephone call

to Mr Zuravliovas’ ex-partner in the morning. Although the immediate action plan recorded that the nurse had treated Mr Zuravliovas' wounds, the document did not refer him to the mental health team.

Events on 23 May 2017

44. A Supervising Officer (SO) from the safer custody team, assessed Mr Zuravliovas the next morning, she noted his main concerns as his long sentence (21 years), not seeing his young daughter and not having seen or spoken to his ex-partner for three weeks. Mr Zuravliovas said he was on basic IEP level and had no television or money to make phone calls. The SO discussed Mr Zuravliovas’ recent poor behaviour with him as she felt this was out of character. Mr Zuravliovas said that he had recently celebrated his birthday by drinking hooch. He denied that other prisoners had bullied him. The SO said she would ask the chaplaincy to facilitate a phone call to his ex-partner and would try to find a radio for his cell as he had no television. Mr Zuravliovas said he had no current thoughts of suicide or self-harm and intended to write to his solicitor about appealing his sentence.

45. The SO told the investigator that after she had assessed Mr Zuravliovas, she intended to give the ACCT document to a wing case manager to complete the first ACCT review. However, no senior manager was available. She said she spoke to from the chaplaincy team about contacting Mr Zuravliovas’ ex-partner. The chaplaincy team tried unsuccessfully to contact her that day and over the next few days. The SO said she was unable to find a radio for Mr Zuravliovas.

24 - 31 May 2017

46. When staff unlocked Mr Zuravliovas on the morning of 24 May, he asked to speak to someone because he wanted to be repatriated to Lithuania. A custodial manager (CM), contacted the Offender Management Unit (OMU). An officer from OMU noted that she visited Mr Zuravliovas that day to speak to him about being repatriated. She gave him information about returning to Lithuania. This also gave him the opportunity to consider whether he wished to complete his prison sentence there. She noted that Mr Zuravliovas was polite and did not appear perturbed by this. He said he wanted to speak to his family about his situation.

47. In the afternoon, a nurse saw Mr Zuravliovas and changed the dressing on his forearm after his act of self-harm on 22 May. She noted his injury was healing well.

48. On the same day, a CM chaired Mr Zuravliovas’ first ACCT case review with a SO. No one from the healthcare team attended. Mr Zuravliovas said he felt much better and had spoken to OMU about his repatriation. The CM and the SO agreed that Mr Zuravliovas’ risk of suicide and self-harm was low. They reduced his ACCT observations to three times during the day and three times at night. CM Large told the investigator that she would have read the ACCT assessment before conducting the review. Despite this, they did not address Mr Zuravliovas’ main concerns, create a caremap, or refer Mr Zuravliovas to the mental health team to offer him support. The next ACCT review was scheduled for 30 May and the CM noted that a member of the chaplaincy team should attend. (CM went on

leave shortly afterwards and did not contribute further to managing Mr Zuravliovas' risk.)

49. Between 25 May and 29 May, staff observed Mr Zuravliovas socialising with others on the wing and described his mood as good.

50. On 30 May, a SO chaired Mr Zuravliovas' second ACCT case review. A SO, attended. Mr Zuravliovas said he was okay and had not tried to harm himself since staff had started ACCT procedures. The review panel noted that he was still on basic IEP level, did not have a radio and had still not spoken to his ex-partner (although Mr Zuravliovas said that he planned to speak to her the next day). The review panel agreed that Mr Zuravliovas was no longer at risk, stopped ACCT monitoring and scheduled a post-closure review for 6 June 2017.

51. On 31 May, Mr Zuravliovas called his mother's telephone number (as identified on his PIN phone account) in Lithuania. He spoke in Lithuanian throughout the conversation.

1 June 2017

52. The workshop instructor noticed that Mr Zuravliovas was upset when he arrived at the workshop on the morning of 1 June. When she asked what was wrong, Mr Zuravliovas started to cry. She said that it sounded like Mr Zuravliovas either said that he wanted to kill himself or that someone in his family wanted to kill someone. She agreed with another workshop instructor that Mr Zuravliovas should stay in the other workshop for a short while as he had Lithuanian friends there. She believed that they would be able to support him to find out what was wrong. In the meantime, she phoned E Wing and explained to an unidentified officer that she had concerns about Mr Zuravliovas. She said the officer informed her that staff had recently stopped ACCT procedures for Mr Zuravliovas. She said that she was unaware that Mr Zuravliovas had been monitored under ACCT procedures despite him attending her workshop regularly. She told the investigator that she had not been given his ACCT document to sign when he attended the workshop, as required, and had not received any formal ACCT training.

53. A prisoner, was located in the other workshop. He told the investigator that Mr Zuravliovas told him that he heard voices, somebody wanted to kill him and he believed his ex-partner was going to kill somebody. Mr Zuravliovas said that his mother had sent his ex-partner money to give him but she had not done so and he was unable to repay some prison debts. He told the workshop instructor, who again said she telephoned E Wing staff to let them know. The workshop instructor noted her concerns in Mr Zuravliovas' prison records. The investigator found that staff on E Wing had not recorded that the workshop instructor had alerted them to her concerns about Mr Zuravliovas.

54. Mr Zuravliovas returned to E Wing before the lunch period began at 11.30am. Shortly before 12.30pm, during a routine check, staff found he had barricaded his cell and covered the cell observation panel. Staff immediately went into his cell and found Mr Zuravliovas holding a blade to chest. He said that he would kill himself if anyone came near him. Staff restrained Mr Zuravliovas and escorted him to the healthcare inpatient unit to calm down. A SO started ACCT

procedures again. Mr Zuravliovas was placed in a cell and staff noted that he was crying.

55. That afternoon, staff observed Mr Zuravliovas at approximately 15 minute intervals. He stopped crying but told staff that he felt like he was going crazy and needed to have his head scanned because he was hearing voices. At 1.45pm, an officer recorded in the ACCT record that Mr Zuravliovas told him that he had no intention to kill himself but wanted to return to E Wing. There is no evidence to show whether healthcare staff assessed him.

56. Staff returned Mr Zuravliovas to E Wing at around 2.30pm to complete an ACCT review. A prisoner, who lived on the same landing, spoke to Mr Zuravliovas in his cell when he returned. He had known Mr Zuravliovas for some time and they spoke regularly. He described Mr Zuravliovas' level of English as reasonable. He said Mr Zuravliovas looked as if he had been crying but repeatedly denied anything was wrong. He believed that his mood had deteriorated after his IEP level had been reduced to basic. This coincided with some of Mr Zuravliovas' friends (other prisoners who spoke Lithuanian), being relocated from E Wing to other wings. He said Mr Zuravliovas had felt isolated after this as he could no longer talk to others who spoke his language. He said that Mr Zuravliovas was worried about his long sentence and he had offered his support, including giving him tobacco.

57. A prisoner who lived in the cell next to Mr Zuravliovas, spoke to him that afternoon. He said that Mr Zuravliovas told him that he was okay but asked him to look after his budgerigar if he killed himself. (As a prisoner serving a life sentence, the prison allowed Mr Zuravliovas to keep a budgerigar in his cell.) He said that Mr Zuravliovas had recently started to say "weird" things to him. He said he appeared paranoid, heard voices and believed others were watching and talking about him. He said he tried to talk to Mr Zuravliovas about the voices he heard. He said that Mr Zuravliovas' mood appeared to deteriorate without his Lithuanian friends on the wing.

58. A custodial manager (CM), told the investigator that he visited Mr Zuravliovas in his cell at 2.51pm to check on his wellbeing. Mr Zuravliovas said his mood had improved but he heard voices in his head, telling him to kill himself and he was considering acting on these. The CM told Mr Zuravliovas that he would hold an urgent ACCT review to discuss his concerns.

59. At 3.50pm, CM chaired an ACCT review with a SO and a mental health nurse. The mental health nurse spoke a little in Russian to Mr Zuravliovas, and this appeared to put him at ease and lift his mood. The CM noted that Mr Zuravliovas engaged well and spoke about his history and the future visits he expected from his ex-partner and child (who visited monthly) and from his mother who worked in Germany (and visited him yearly). He said he was stressed and thought about hurting others as well as himself. He sometimes heard his ex-partner's voice in his head. He said he had problems sleeping and had regularly misused illicit substances (including subutex, hooch and NPS) which had affected his behaviour. He explained that he had recently celebrated his birthday by drinking an excessive amount of hooch. Wing staff said that other prisoners had told them that Mr Zuravliovas may have incurred prison debts of £3,000 for illicit

substance use but this was unsubstantiated. When the CM asked Mr Zuravliovas about any debts, he refused to talk about it.

60. Mr Zuravliovas said he had no history of mental health problems and declined the offer of support, antidepressants, a sleeping aid or to attend therapy. He said he felt good, no longer had thoughts of self-harm and intended to stop taking illicit substances. He described his mood as four out of 10 (with 10 being excellent). The nurse noted that physically, Mr Zuravliovas looked and interacted well. The panel agreed that Mr Zuravliovas' risk of self-harm was raised. They placed him on hourly observations and set the next ACCT review for 6 June, which the nurse noted that the mental health team should attend. The CM noted on the ACCT caremap that staff would refer Mr Zuravliovas to the RAPT team (a service to support prisoners misusing substances).

61. Mr Zuravliovas collected his evening meal and engaged with staff at ACCT checks that evening.

2 June 2017

62. Mr Zuravliovas spent the morning in his cell. At around 10.00am, a prisoner visited him and said Mr Zuravliovas' acted strange initially. He said he had a "vacant" stare and almost looked as if he was frozen. He repeatedly asked Mr Zuravliovas if he was okay before he eventually said he was. He gave him a cigarette. He believed Mr Zuravliovas was not coping and told an officer that he was concerned about him. There is no evidence that the healthcare team or anyone else was informed. (The officer was absent and could not be interviewed during our investigation due to an internal disciplinary investigation into his actions.)

3 June 2017

63. An OSG checked on Mr Zuravliovas hourly throughout the night. At 3.01am, when she opened the cell observation panel, she noted that Mr Zuravliovas was standing up, looking out of the cell window. He acknowledged her and gestured that he was okay. When staff checked Mr Zuravliovas in the morning, he said he was okay. He remained in his cell all morning.

64. Mr Zuravliovas spent much of the afternoon on the landing playing pool and socialising with other prisoners. A prisoner spoke to Mr Zuravliovas and said he appeared to be in a better mood than the previous days.

65. At around 4.10pm, Mr Zuravliovas collected his evening meal and returned to his cell. A prisoner, told the investigator that he visited Mr Zuravliovas in his cell at about 4.30pm. Mr Zuravliovas gave him a pack of tobacco and told him that he did not need it.

66. At 5.05pm, an officer completed the evening roll check and locked Mr Zuravliovas' cell door for the evening. CCTV footage shows that the officer next checked Mr Zuravliovas at 6.13pm. He noted that Mr Zuravliovas was lying on his bed, reading.

67. The officer noted in the ACCT record at 7.00pm that he had checked Mr Zuravliovas and that he said he was okay. Despite this, CCTV footage shows that no one checked on Mr Zuravliovas at or around this time.

68. A prisoner told the investigator that he had a conversation with Mr Zuravliovas through the windows of their cells at approximately 7.10pm. He asked Mr Zuravliovas for some rizla (rolling paper for tobacco) and he swung it on a string to him. He said there was no indication in their interaction for him to have had any concerns about Mr Zuravliovas.

69. An OSG arrived for her night duty around 7.30pm. CCTV confirms that at 7.39pm, she checked Mr Zuravliovas' cell by looking through the cell observation panel. She found Mr Zuravliovas hanging from the cell light fitting. His feet were not touching the floor. The ligature was made from torn bed sheets. Up to this point, staff had not checked Mr Zuravliovas for one hour and 26 minutes, despite him being subject to hourly observations.

Emergency response

70. The OSG radioed a medical emergency code blue (indicating that a prisoner is unconscious or having problems breathing) at 7.39pm, and the control room called an ambulance at 7.40pm.

71. SO A and SO B responded to the emergency in 35 seconds. SO A looked through the observation panel and confirmed Mr Zuravliovas had hanged himself. SO A unlocked the cell door and both officers went in. SO A cut the ligature while SO B supported Mr Zuravliovas' weight and they lowered him to the floor. SO B assessed Mr Zuravliovas but found no signs of life. She started cardiopulmonary resuscitation (CPR) by doing chest compressions.

72. Two Officers, a CM and a SO arrived at Mr Zuravliovas' cell within a minute. An Officer collected the defibrillator (a device that monitors heart rhythms and administers an electric shock if required) from the wing. The CM also assisted with chest compressions.

73. At 7.42pm, a nurse arrived at Mr Zuravliovas' cell and helped with the resuscitation efforts. A SO attached the defibrillator to Mr Zuravliovas and it advised that they should continue CPR. The paramedics arrived at the cell at 8.00pm and continued trying to resuscitate him. There was no change in Mr Zuravliovas' condition, and the paramedics pronounced him dead at 8.39pm.

Support for prisoners and staff

74. A manager, debriefed staff involved in the emergency response and offered his support and that of the staff care team. Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Mr Zuravliovas' death. They too offered support.

Family liaison

75. A CM and a deputy governor were appointed as the prison's family liaison officers. They tried to visit Mr Zuravliovas' partner and separately, his mother (who was in the UK), but neither was in. They tried unsuccessfully to contact

them by telephone. On 4 June, Mr Zuravliovas' partner contacted Swaleside and explained that she had moved to a new address. The CM and a deputy governor visited her that day. They explained the circumstances of Mr Zuravliovas' death, and offered their condolences. Swaleside contributed to the cost of Mr Zuravliovas' repatriation in line with national instructions.

Other information

76. On the wall in Mr Zuravliovas' cell were the words, "Im [sic] sorry mama". We do not know whether or not Mr Zuravliovas wrote these words.

Post-mortem report and toxicology results

77. The post-mortem examination established Mr Zuravliovas' cause of death as suspension. Toxicology results identified no illicit substances in Mr Zuravliovas' bloodstream.

Findings

Management of risk of suicide and self-harm

ACCT assessments and reviews

78. Prison Service Instruction 64/2011 (PSI) on safer custody lists a number of risk factors and potential triggers for suicide and self-harm which require staff to assess a prisoner's risk and start ACCT procedures, where appropriate. We are concerned that no one assessed Mr Zuravliovas' risk on 19 May 2017 when he appeared distressed, was crying and told staff that his mother had been killed. We are concerned that no one fully discussed Mr Zuravliovas' concerns with him or considered their impact on his risk. Indeed, we note that at a later date, Mr Zuravliovas told staff during an ACCT review that he was looking forward to a visit from his mother.

79. When Mr Zuravliovas self-harmed and was found with a ligature on 22 May, three days later, staff began ACCT procedures. However contrary to the PSI, his case reviews were not multidisciplinary, there was little continuity of case managers and the first case review took place a day later than it should have. The PSI requires that, at the first case review, staff should identify whether a referral for mental health care or drug/alcohol services is needed and make the referral(s). No one referred Mr Zuravliovas and this was a missed opportunity to address his needs.

80. During Mr Zuravliovas' assessment, a SO identified his long sentence, lack of contact with his ex-partner and lack of radio or television as issues that affected his risk of suicide and self-harm. These issues were not discussed in his first case review, as they should have been. The second ACCT review took place on 30 May 2017. The SO attended this meeting and she stopped monitoring Mr Zuravliovas' under ACCT procedures as she considered that he was no longer at risk despite the concerns identified in the ACCT assessment not having been addressed. Mr Zuravliovas had not spoken to his ex-partner, received a radio or been assessed by the mental health team after his act of self-harm. We are concerned that ACCT procedures were stopped prematurely.

81. On 1 June, a workshop instructor discovered that Mr Zuravliovas had been subject to ACCT monitoring. She had not been aware of this before because, although he had attended her workshop daily, the ACCT document had not accompanied him, as required. Contrary to the PSI, she had not been trained in ACCT procedures. Although she raised her concerns about Mr Zuravliovas to E Wing staff and noted these concerns, there is no evidence that E Wing took any action at the time.

82. Shortly afterwards, E Wing staff appropriately started ACCT monitoring again because Mr Zuravliovas had barricaded his cell and threatened to kill himself. An ACCT review appropriately took place and unlike previous reviews, a member of the mental health team attended and a caremap was created.

Caremaps

83. The PSI says that caremap actions should be detailed and time-bound, and aimed at reducing risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress. At the first and second ACCT case reviews, staff failed to create a caremap for Mr Zuravliovas which meant that they did not set and record clear and effective actions, identifying and addressing his risks of not having a radio or contact with his ex-partner. Both may have affected his behaviour and contributed to his risk of suicide and self-harm.

84. At the third ACCT review on 1 June, the review panel identified that Mr Zuravliovas had debt and substance misuse issues, which could be affecting his behaviour. However, Mr Zuravliovas refused to be referred for medical intervention. He said he was okay, intended to stop taking illicit substances and no longer had thoughts of self-harm. He refused to discuss his debt issues. Yet staff only referred to his substance misuse problem on the caremap as being an issue to be addressed.

ACCT checks

85. Mr Zuravliovas' ACCT observations were set at hourly. On the evening Mr Zuravliovas died, CCTV confirmed that an officer checked Mr Zuravliovas at 6.13pm. However, he did not check Mr Zuravliovas at 7.00pm, despite recording in the ACCT record that he did. The Officer has subsequently been suspended from duty and is subject to disciplinary proceedings. While we cannot know whether Mr Zuravliovas' death would have been prevented if staff had checked on him in line with agreed observation levels, it is likely they would have discovered him earlier than they did.

86. We are not satisfied that Swaleside managed ACCT procedures effectively to support Mr Zuravliovas and we make the following recommendations, including one directed to the manager of the Governor as we are concerned that our recommendations relate to areas identified in previous investigations and which the prison has committed to address:

The Executive Director for Long Term and High Security Prisons should assure himself that effective action is taken to implement recommendations from this and previous investigations into deaths at HMP Swaleside.

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **Staff review a prisoner's risk of suicide and self-harm whenever an event occurs which indicates an increase in risk and consider opening an ACCT.**
- **A multidisciplinary case review is held within 24 hours of an ACCT plan being opened and when there is evidence of significant change in risk.**

- **A member of healthcare staff attends all first case reviews and subsequent reviews, where relevant.**
- **Case managers complete caremaps at the first ACCT case review, set specific and meaningful caremap actions, identify who is responsible for them and review progress at each review.**
- **ACCT documents accompany prisoners when they move around the prison.**
- **All staff in contact with prisoners receive training in suicide and self-harm prevention procedures, with appropriate refresher training.**
- **All staff undertake ACCT observations as directed and actively engage with prisoners being monitored. Managers should carry out random checks of CCTV footage to help ensure this happens.**

Review of IEP status

87. Mr Zuravliovas' IEP level was reduced to basic on 11 May for 28 days. Swaleside's local IEP policy requires staff to review prisoners placed on basic level within seven days, and says that wing staff should make regular entries about behaviour in their prison records. This did not happen.

88. Prison Service Instruction (PSI) 30/2013, which governs the IEP scheme, allows for a disciplinary sanction and a loss of privileges if a prisoner's behaviour falls significantly below expected standards. The PSI reminds governors that their local IEP scheme must consider the needs of vulnerable prisoners and those at risk of suicide or self-harm. Despite this, Swaleside's local IEP procedures do not include any such guidance for staff.

89. In our Learning Lessons Bulletin about the basic IEP regime, published in March 2013, we found that disproportionate numbers of self-inflicted deaths occurred among those on the basic IEP regime and we recommended that its use should be co-ordinated within a wider plan of support for prisoners at risk of suicide and self-harm.

90. When staff started ACCT procedures on 22 May, Mr Zuravliovas had been on the basic IEP level for 11 days. He remained on basic IEP level and managed under ACCT procedures until he died. Although staff who managed Mr Zuravliovas' suicide and self-harm risk knew that he was on the basic IEP level, no one considered the impact on his risk of suicide and self-harm as part of his care plan. It would have been best practice for an IEP review to have taken place as part of an ACCT case review, or at least for a SO, as the ACCT assessor, to have been involved.

91. PSI 30/2013 gives the Governor discretion to allow vulnerable prisoners on basic IEP level in-cell TV if it might reduce their risk. We acknowledge that a SO highlighted at the ACCT assessment on 23 May that one of Mr Zuravliovas' concerns was that he did not have a radio. Although she tried unsuccessfully to resolve this issue, staff did not address this subsequently. Mr Zuravliovas' IEP level was reduced and he lost privileges before staff identified that he was at risk of suicide and self-harm. However, staff then operated ACCT procedures in

isolation and did not consider IEP guidance. We make the following recommendation:

The Governor should ensure that Swaleside's local IEP policy is amended to include instructions that staff should consider the needs of vulnerable prisoners and those at risk of suicide or self-harm when making and reviewing decisions about IEP sanctions, and take into account the likely impact on the health and welfare of the prisoner.

Clinical care

92. We agree with the clinical reviewer that overall, Mr Zuravliovas' care at Swaleside was not equivalent to that which he could have expected to receive in the community. Although Mr Zuravliovas was generally fit and healthy, he appeared to have developed a substance misuse issue and potentially mental ill health in prison, neither of which staff fully addressed.

Access to mental healthcare

93. Mr Zuravliovas did not consistently show signs of mental ill health. However, given he self-harmed, tried to take his life, told staff that he was hearing voices and a prisoner told staff about his concerns for Mr Zuravliovas' mental wellbeing on 2 June, staff should have promptly referred him for a mental health assessment. We acknowledge that a member of the mental health team attended Mr Zuravliovas' third ACCT case review on 1 June and fully assessed him then, but there had been no prior mental healthcare input into his care despite his clear risks. Early mental health intervention might have supported Mr Zuravliovas through a period of crisis and we make the following recommendation:

The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

Managing substance misuse

94. Although Mr Zuravliovas did not have an identified history of substance misuse and no illicit substances were found in his bloodstream when he died, there was strong evidence that he had used illicit substances in prison, which he confirmed at the ACCT review of 1 June. On 8 March, staff suspected Mr Zuravliovas was under the influence of spice and on 10 May, staff found an excessive amount of hooch in his cell. Despite this, there is no evidence that staff referred Mr Zuravliovas promptly to the substance misuse team for support. It was only after his ACCT review on 1 June that staff agreed that Mr Zuravliovas should be referred to them. Unfortunately, there was no time for this to happen before his death. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a clear pathway for the substance misuse service and that all intervention is recorded in prison and medical records to ensure the quick and effective assessment and management of prisoners' needs.

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