Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Karolis Baltrunas, a prisoner at HMP The Mount, on 27 August 2020

A report by the Prisons and Probation Ombudsman

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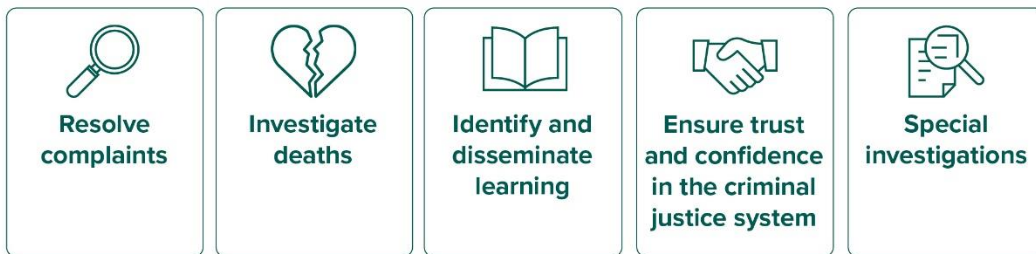
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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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 Karolis Baltrunas died on 27 August 2020, after being found hanging in his cell in the segregation unit at HMP The Mount. He was 31 years old. I offer my condolences to Mr Baltrunas' family and friends.

Mr Baltrunas was facing deportation to Lithuania and he was resistant to this, although his reasons remain unclear. I am concerned that there is no evidence that staff recognised that the uncertainty about this may have affected his mental wellbeing.

By the time of his death, Mr Baltrunas had been in the segregation unit for 52 days. I am concerned that there is no evidence that staff had any meaningful contact with him during this time, and that mandatory procedures for segregated prisoners were not followed: he did not have a designated officer and a care plan was not put in place to support his mental health. In addition, although Mr Baltrunas' English was poor, a translation service was not always used for some significant and sensitive discussions with him (such as segregation reviews).

I am extremely concerned that staff did not start suicide and self-harm procedures when Mr Baltrunas harmed himself on 24 August.

I am also concerned about events on the morning of Mr Baltrunas' death. He should have been checked at around 5.30am, but the officer who claimed to have made that check failed to do so. Another officer checked him at 7.10am and did not notice anything untoward, although Mr Baltrunas was almost certainly already hanging. Then, when he was found hanging at 8.15am, staff attempted to resuscitate him even though there were clear signs he was dead.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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Summary

Events

1. On 17 May 2019, Mr Karolis Baltrunas, a Lithuanian national, was remanded to HMP Bedford charged with conspiracy to steal motor vehicles. He was later sentenced to three years and four months in prison and transferred to HMP The Mount.

2. On 3 July 2020, Mr Baltrunas refused to move to an Immigration Removal Centre prior to being deported to Lithuania.

3. On 7 July 2020, Mr Baltrunas was moved to the segregation unit for threatening two officers. While in the segregation unit, Mr Baltrunas damaged his cell and threatened officers.

4. On 24 August, Mr Baltrunas damaged his cell and was moved to a new cell through a planned use of force. Mr Baltrunas had cuts to his arm and neck and a nurse said at the debriefing meeting that his cuts were self-inflicted. Despite this, staff did not start Prison Service suicide and self-harm procedures (known as ACCT).

5. At 7.10am on 27 August, an officer checked the prisoners in the segregation unit. She said that when she checked on Mr Baltrunas, she believed he was alive and standing in the middle of his cell. When other staff checked Mr Baltrunas at 8.15am, they found him hanging from the ceiling light. There were clear signs that rigor mortis had started to set in (rigor mortis is stiffening of the body that occurs after death), however officers and a nurse attempted to resuscitate Mr Baltrunas until ambulance paramedics arrived and confirmed that he was dead.

Findings

Segregation

6. Mr Baltrunas was segregated for 52 days before his death. He was not managed in line with national requirements for prisoners held in segregation. He did not have a designated officer and there is no evidence that staff had any meaningful contact with him during this time. In addition, there was no care plan in place to support his mental health.

ACCT

7. Mr Baltrunas repeatedly asked staff for information about his deportation. There is no evidence that staff recognised that the uncertainty about this might affect Mr Baltrunas' mental wellbeing.

8. Staff should have started ACCT procedures after Mr Baltrunas harmed himself on 24 August.

Response on 27 August

9. Mr Baltrunas was not checked at 5.30am, as he should have been.

10. It seems probable that Mr Baltrunas was hanging when Officer B checked him at 7.10am and believed that he was alive.

11. When Mr Baltrunas was found hanging, staff attempted to resuscitate him despite the fact that there were clear signs that he had been dead for some time.

Translation

12. We are concerned that, although Mr Baltrunas' English was poor, some significant and sensitive discussions, including some segregation reviews and his mental health assessment initially took place without the use of a translation service.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national policy set out in PSO 1700, including ensuring that:
  - a designated officer is allocated to each prisoner;
  - the designated officer has purposeful dialogue each day with his or her allocated prisoners;
  - a minimum of three quality entries are recorded each day for each prisoner; and
  - staff create a mental health care plan for all prisoners segregated for more than 30 days.
- 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, in particular, that an ACCT is opened following all acts of self-harm.
- The Governor should ensure that staff completing roll checks satisfy themselves that prisoners are alive and well.
- The Governor should share a copy of this report with Senior Manager A, CM A, CM B, CM C, CM D, SO A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances where resuscitation is and is not appropriate, in line with national and European guidelines.
- The Head of Healthcare should share a copy of this report with Nurse B and Nurse C and arrange for their clinical supervisors to discuss the Ombudsman's findings with her.
- The Governor and Head of Healthcare should ensure that staff use a translation service when discussing sensitive or complex matters with prisoners who do not speak English well.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP The Mount informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Baltrunas' prison and medical records. She interviewed 17 members of staff at The Mount between November 2020 and January 2021. All the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic. The investigation was subsequently reallocated to one of the investigator's colleagues. He interviewed one further witness, also by telephone.

15. NHS England commissioned a clinical reviewer to review Mr Baltrunas' clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical staff.

16. We informed HM Coroner for Hertfordshire of the investigation. The Coroner gave us Mr Baltrunas' cause of death. We have given the Coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Baltrunas' partner, and his aunt and uncle, to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Baltrunas' aunt said that she had had concerns about her nephew's mental health and the family solicitors had written to the prison to explain this. Mr Baltrunas' aunt also said that she had left messages on the prison's safer custody hotline on 12 and 13 July 2020, but her calls were not returned.

18. We shared our initial report with Mr Baltrunas' family and with HMPPS. Mr Baltrunas' mother said that the living conditions at The Mount were poor, and her son's mental health had deteriorated. She also said that the prison paid for her son's body to be repatriated, but they did not contribute to the costs of the funeral. Mr Baltrunas' aunt said that her nephew's date of birth was 12 January 1989, and not 31 January 1985 as the medical records indicate. HMPPS provided additional information about roll checks on the morning of Mr Baltrunas' death and pointed out that our finding and recommendation about officers speaking to prisoners at the time of the 7.10am was not in line with national policy. HMPPS also pointed out that we had mistaken the roles of two of the staff referred to in our report. We have made changes to this report as appropriate.

Background Information

HMP The Mount

19. HMP The Mount is a medium security prison holding approximately 1,000 men. Hertfordshire Community NHS Trust provides primary healthcare and GP services. Hertfordshire Partnership University NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP The Mount was in May 2018. Inspectors found that governance of segregation was weak. Inspectors reported that targets set for prisoners were generic with no evidence of individual care plans and that integration planning was underdeveloped and that not enough prisoners returned to normal location. Inspectors noted that electronic case notes were used as the sole record of prisoner behaviour, that there were too many missing entries, and those conducting segregation review meetings did not have enough information to inform their decisions. Inspectors made a recommendation for appropriate oversight of the segregation unit to ensure prisoners did not stay on the unit any longer than necessary.

21. Inspectors found that records made for prisoners identified at risk of suicide and self-harm suggested good care for prisoners identified as being at risk.

22. Inspectors note that relationships between staff and prisoners had deteriorated since the previous inspection with only 55% of prisoners saying that staff treated them with respect.

23. HMIP returned to The Mount in April 2019 to conduct an Independent Review of Progress against the key recommendations following the 2018 inspection. They noted that the prison appeared to be on an upward trajectory, albeit from a very low base, and that good or reasonable progress had been made against seven of the 13 key recommendations.

24. However, they found that insufficient progress had been made in relation to some aspects of safety and that, in particular, the governance of segregation remained weak. An assurance checklist was in place to help ensure that paperwork was completed, but every form that inspectors checked was blank. Good order and/or discipline (GOOD) reviews had taken place but without any meaningful targets being set. They found no evidence of reintegration planning for any segregated prisoners, although since the last inspection, there had been a steady decrease in the number of days that prisoners spent segregated.

Independent Monitoring Board

25. 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 February 2021, the IMB reported that the Governor and staff had worked intelligently and diligently to keep the COVID-19 pandemic at bay. However, controlling the pandemic came at a price paid by the prisoners held in the prison. The Mount was always able to provide prisoners with the maximum time out of cell permitted by the national restrictions

but, nonetheless, for much of the year prisoners had not had adequate time out of their cells.

26. Despite this, the prisoners in the segregation hardly had any complaints about their treatment in the unit. The Board reported that all the prisoners who were entitled to reviews (those on good order and discipline (GOOD) and own protection) received regular reviews in the presence of a governor, an IMB member and a healthcare representative. During the lockdown the IMB member had attended the reviews by telephone conferencing when they were unable to attend in person. There had been an improvement in the segregation paperwork, with a better record of previous reviews.

Previous deaths at HMP The Mount

27. Mr Baltrunas was the third prisoner to die at The Mount since June 2017. Of the previous deaths, one was from natural causes, and one was from illicit drug and alcohol use. There were no similarities between Mr Baltrunas' death and the previous deaths.

Segregation units

28. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners (known as 'own protection') or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison (known as 'good order and discipline' – GOOD). They also hold prisoners serving punishment of cellular confinement after disciplinary hearings.

29. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted, and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The unit at The Mount is known as the Care and Separation Unit (CSU) and comprises 22 cells.

Assessment, Care in Custody and Teamwork

30. 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. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

31. On 17 May 2019, Mr Karolis Baltrunas was remanded to HMP Bedford charged with conspiracy to steal motor vehicles. Mr Baltrunas was a Lithuanian national and this was his first time in prison in the UK. In July, Mr Baltrunas was sentenced to three years and four months in prison.

32. On 18 July, Mr Baltrunas was transferred to HMP The Mount.

33. At his healthcare reception screen, Mr Baltrunas said that he had never tried to harm himself in the past and that he had no present thoughts of self-harm or suicide. The nurse noted that Mr Baltrunas declined the use of an interpreter as he spoke enough English to "get by". At a second healthcare assessment the following day, another nurse noted that Mr Baltrunas had no indications of mental illness.

34. In August 2019, Mr Baltrunas was notified that he was going to be deported. On 3 July 2020, he was due to move to an Immigration Detention Centre ahead of a deportation flight to Lithuania. However, he refused to leave his cell and his deportation was cancelled. Mr Baltrunas was placed on a disciplinary charge for refusing a lawful order.

35. On 6 July, Mr Baltrunas was placed on disciplinary charge for threatening two officers after he was asked to return to his cell. One of the officers wrote in the wing observation book that Mr Baltrunas took up a boxing stance and clenched his fists.

36. On 7 July, the Head of Residence gave authority for Mr Baltrunas to be segregated under Prison Rule 45, with a review date of 10 July. Prison Rule 45 permits the segregation of prisoners for the maintenance of good order or discipline (GOOD). She gave as the reason for segregation that *"Mr Baltrunas' behaviour continued to be threatening towards staff. This is part of an established pattern of poor behaviour …".*

37. A nurse completed an initial segregation health screen that day and noted that Mr Baltrunas showed no signs of being acutely unwell and that he would be able to cope with a period of segregation.

38. Mr Baltrunas had a segregation review on 10 July which was chaired by the Head of the CSU. He noted that Mr Baltrunas' behaviour had continued to be threatening towards staff since being in the CSU and that he consistently behaved in an aggressive manner. He authorised Mr Baltrunas to remain segregated until 17 July and Mr Baltrunas was given specific targets to improve his behaviour.

39. On 13 July, Mr Baltrunas punched another prisoner as he was being escorted to exercise. He told an officer that he had punched the prisoner for training. Mr Baltrunas was taken back to his cell.

40. A manager chaired Mr Baltrunas' segregation review on 17 July. He noted that Mr Baltrunas had refused a voluntary flight to Lithuania the previous week. Mr Baltrunas asked whether he would be arrested on return to Lithuania, but the manager told him that he could not answer that question as it was not connected with matters related to United Kingdom interests. Mr Baltrunas' next segregation review was set for 31 July.

41. Later that evening, Mr Baltrunas flooded his cell and the landing by blocking his hand basin and running the taps. When challenged, Mr Baltrunas said that he could not speak English. (Staff who dealt with Mr Baltrunas said they believed that his understanding and ability to speak English was better than he sometimes tried to imply.)

42. On 19 July, officers were escorting Mr Baltrunas back to his cell from the exercise yard when he backed into the library area of the unit and took up a boxing stance. He then crouched to the floor and wrapped his arms around his body. Officers then placed him in handcuffs and returned him to his cell.

43. On the morning of 20 July, a prison GP saw Mr Baltrunas during a routine visit to the CSU. He noted that Mr Baltrunas said he was stressed and anxious. The GP noted that he spoke to a mental health nurse, and he told the investigator that he spoke to Nurse A.

44. On 20 July, Mr Baltrunas smashed his cell door observation panel. When an officer asked him why he had broken the panel, Mr Baltrunas just laughed. Following this incident, Mr Baltrunas' unlock level was increased to a minimum of two officers. This was later increased to three officers.

45. On 21 July, Nurse A noted that Mr Baltrunas appeared fit and well and was medically fit to be held in the CSU. The nurse made no reference to the GP's note in the records made the previous day.

46. While being escorted back to his cell from exercise on 23 July, Mr Baltrunas ran away from staff, who then had to restrain him to take him back to his cell.

47. On 26 July, a nurse was asked to review Mr Baltrunas' mental state. The nurse noted that an assessment was not possible due to language difficulties and the risk Mr Baltrunas posed. However, he also noted that Mr Baltrunas was calm and stable. The nurse noted that Mr Baltrunas denied being stressed, although he also said that some days he was happy and some days he was sad.

48. On 27 July, Mr Baltrunas asked an officer if he could have some work to do, and also asked for a radio and TV. He was told that none of these things would be possible unless his behaviour improved. The officer noted that it was sometimes difficult to talk to Mr Baltrunas because of the language barrier, but that he seemed to understand.

49. On 30 July, Mr Baltrunas' told his offender supervisor that he did not know what was happening with his deportation and that he did not want to be deported as he had family in the UK. The offender supervisor said that the immigration agency held immigration surgeries at The Mount, and he would email them to contact Mr Baltrunas when they next visited. (There is no evidence that this was followed up.)

50. At a segregation review on 31 July, a prison manager wrote that Mr Baltrunas had continued to be aggressive and threatening towards staff. Mr Baltrunas' next segregation review was set for 14 August.

51. On 8 August, an officer escorted Mr Baltrunas to the showers. After he had showered, Mr Baltrunas asked for a clean T-shirt. The officer told Mr Baltrunas that he would take him back to his cell and then try to find him a T-shirt. However, Mr Baltrunas shouted that he wanted a clean T-shirt there and then, and he threw a

punch at the officer. The punch missed and the officer, assisted by colleagues, pushed Mr Baltrunas back into his cell.

52. At Mr Baltrunas' segregation review on 14 August, a prison manager noted that Mr Baltrunas denied attempting to assault the officer the previous week. He also said that he was not the person that the immigration services believed him to be and that he would not be deported. She decided that Mr Baltrunas should remain segregated, and she set his next review for 28 August.

53. Prison Service Rules require additional authority where a prisoner is segregated for a continuous period of 42 days. The authority must be given on behalf of the Secretary of State by a Prison Group Director (Deputy Director of Custody at the time). On 15 August, authority was given for Mr Baltrunas' segregation beyond 42 days. The reasons and plans for Mr Baltrunas' segregation were given as:

> *"Mr Baltrunas' behavior since being in the CSU has been poor for much of the time. He has refused to return to his cell, assaulted another prisoner, attempted to assault staff and been restrained on multiple occasions. He attempts to bully and intimidate staff with his size and is regularly rude to staff. At this point his behaviour is not suitable for normal location, especially with an impending deportation date of 24/08/2020.*
>
> *"There is currently no plan to return Mr Baltrunas to normal location, he will be deported from the CSU on 24/08/2020. This will allow immigration staff to have more control when they come to collect him and also protect staff on normal location up until his deportation."*

54. On 17 August, an officer noted that Mr Baltrunas had been "acting very strange throughout the day", asking to see people but not explaining why, and that he had put in a number of applications, mainly about his deportation.

55. Mr Baltrunas continued to be disruptive throughout 19 to 21 August, during which time he caused severe damage to his cell, damaged a shower door, flooded the landing and threatened staff with a weapon.

56. A prison manager told the investigator that he had a number of conversations with Mr Baltrunas during his time in the CSU. He said that Mr Baltrunas' behaviour was erratic, and he would often be challenging and unpredictable. He said that the early thoughts were that Mr Baltrunas would remain segregated until his deportation as the initial belief was that his deportation would be imminent. However, the deportation dates kept changing so Mr Baltrunas would have returned to normal location if his behaviour had improved. He said that Mr Baltrunas sometimes said that he could not understand what he was being told so the prison began to use Language Line (a telephone translation and interpretation service) at all of his segregation reviews.

57. On 23 August, a prison manager recorded that Mr Baltrunas had asked to speak to immigration staff and that she had asked the CSU staff to chase this up.

58. On 24 August, Mr Baltrunas damaged his cell, and he was noted to be aggressive and non-compliant. A planned intervention was arranged to move him to a new cell. Staff went to his cell to tell him about the move, and he was asked if he would comply. He said that he would, and he was warned that he would be restrained if he resisted. Mr Baltrunas remained compliant, and he was escorted to a new cell.

Body-worn video (BWV) footage shows that Mr Baltrunas had cuts to his right arm and to the left side of his neck.

59. The staff who attended the debriefing meeting following the intervention were: a Senior Manager A, Custodial Manager (CM) A, CM B, CM C, CM D, Senior Officer (SO) A, an Operational Support Grade (OSG), and two nurses. At the meeting Nurse B said that the cuts to Mr Baltrunas' neck were self-inflicted, and in her entry in Mr Baltrunas' medical record she noted that he had made self-harm cuts to his neck and arm. Although she described most of the cuts as superficial, one to Mr Baltrunas' arm required cleaning, gluing and steristrips. (An officer who was not involved in the intervention recorded that the cuts occurred accidentally when Mr Baltrunas damaged his cell.)

60. At interview with the investigator, Nurse B said that Mr Baltrunas did not disclose to her how his injuries occurred, but their appearance was consistent with self-harm wounds. In answer to a question on why she did not begin ACCT procedures, she said that she checked Mr Baltrunas' medical record and saw that he had no history of self-harm. She said that prisoners in the CSU were checked more closely than prisoners on the standard prison wings, so she did not think that an ACCT was necessary.

61. On 25 August, staff noted that Mr Baltrunas' planned deportation on the previous day had been cancelled, and that Mr Baltrunas had "been acting very strange throughout the day".

26 August

62. At 9.01am on 26 August, a senior manager saw Mr Baltrunas during a standard visit to the CSU as duty governor. Mr Baltrunas said that he was okay, but he asked to speak to her later on. She arranged a room and a call to Language Line and saw Mr Baltrunas that afternoon. She told the investigator that Mr Baltrunas asked why he was being kept in the CSU and she explained that it was due to his behaviour and that he would be able to return to normal location if he stopped contravening rules and posing a threat to staff. She said the meeting lasted around 15 minutes as the conversation seemed to go round in circles. Eventually the Language Line translator ended the call as Mr Baltrunas was being rude and abusive.

63. At 7.01pm, an officer noted that Mr Baltrunas had damaged his wash basin.

64. At around 8.30pm, Officer A carried out the final roll check for the day. After Mr Baltrunas' death, he wrote a statement to say that when he made his check, Mr Baltrunas was standing at his cell door, and he asked for a newspaper. He that he told Mr Baltrunas, as he had told him the two previous nights, that he was not permitted to pass prisoners any items during the night patrol state. He wrote that Mr Baltrunas seemed disappointed, but he accepted what he was told.

27 August

65. Officer A should have carried an early morning roll check at 5.30am on 27 August. He said in his statement that Mr Baltrunas' cell was very dimly lit, but that he saw a shape under the bed clothes which he assumed was Mr Baltrunas, and he moved on to the next cell.

66. At around 7.10am, Officer B arrived in the CSU. Officer A briefed her, and he left the unit. Officer B made a check of the prisoners. She told the investigator that when she checked Mr Baltrunas, he appeared to be standing around the middle area of the cell and facing left. She said that he had placed something at the cell window to reduce the amount of light coming into the cell but there was enough light for her to see, so she did not switch on the cell light. She said that she normally greeted prisoners who were awake, although she did not do so that morning. She said that she thought she saw a slight movement in Mr Baltrunas' left hand to acknowledge her presence.

67. From around 8.00am, staff began letting prisoners out of their cells one-by-one so they could collect their breakfast packs. Due to his behaviour, three officers needed to be present whenever Mr Baltrunas was unlocked. At around 8.15am, three officers went to Mr Baltrunas' cell. Officer C looked through the observation panel and saw Mr Baltrunas hanging from the light fixture with his feet off the ground. He shouted that it was a 'code blue' (meaning that a prisoner is not breathing or having difficulty breathing) and one of his colleagues radioed a medical emergency call. The control room called an ambulance immediately.

68. Officer C unlocked the cell and he and another officer supported Mr Baltrunas' body while a third officer stood on the bed and cut the ligature, which had been made from a bed-sheet. The officers lowered Mr Baltrunas to the cell floor.

69. An officer had entered the cell, and he noted that Mr Baltrunas' eyes were open and fixed and that his body was cold and stiff. He checked Mr Baltrunas for a heartbeat but found none. The governing Governor, who was in the CSU making a standard duty governor's check of prisoners, instructed an officer to start cardiopulmonary resuscitation (CPR).

70. Two nurses arrived within one or two minutes of hearing the code blue alarm. Nurse C said that an officer was carrying out CPR. She noted that Mr Baltrunas was ashen in colour and unresponsive. She checked Mr Baltrunas with a defibrillator, which advised that no shock could be given. As officers continued to give CPR, she tried to insert an airway to help give oxygen but could not do so as Mr Baltrunas' teeth were clenched, and his jaw muscles were rigid. Another nurse arrived, and she inserted a nasal airway. Staff continued giving CPR and oxygen until ambulance paramedics arrived.

71. An emergency ambulance had been called when the code blue call was made, and paramedics reached the cell at around 8.32am. They declared Mr Baltrunas dead around one minute later.

Contact with Mr Baltrunas' family

72. Mr Baltrunas had named his partner as next-of-kin and gave her address as a home in the UK. In line with Government advice on COVID-19 working practices, an administration team manager tried to telephone Mr Baltrunas' partner at 11.00am but got no response. She noted that the dial tone indicated that the number was an international number. She made several further attempts to contact Mr Baltrunas' partner, and then telephoned the Lithuanian embassy to see if they could help. At 12.20pm, she telephoned Mr Baltrunas' aunt and informed her of the news. Later that afternoon she also spoke to Mr Baltrunas' uncle, and he passed on the news to Mr Baltrunas' partner.

73. Mr Baltrunas' body was repatriated to Lithuania and The Mount contributed to the costs for this.

Support for prisoners and staff

74. Two senior managers held a hot debrief with the staff and the staff care team also offered support.

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

Cause of death

76. The pathologist gave Mr Baltrunas' cause of death as suspension (hanging).

77. Toxicology tests found no evidence of the use of illicit substances.

Other matters

78. The investigator asked the prison about the concerns raised by Mr Baltrunas' aunt. The prison said that two messages had been left on the safer custody hotline saying that Mr Baltrunas' wife was anxious as she had not heard from him, and that the safer custody team had contacted wing staff to pass these messages to Mr Baltrunas. The prison was not able to provide the investigator with any letter from Mr Baltrunas' solicitors expressing concern about his mental health.

Findings

Segregation

79. Prison Service Order 1700, Segregation, sets out the process that should be followed when a prisoner is segregated. In the introduction, the PSO notes that in the period 2001 to 2006, self-inflicted deaths in segregation settings, including those segregated on normal location, accounted for 12% of all self-inflicted deaths in prison. The PSO goes on to say that:

> *"Those prisoners who are the most 'difficult' are often the most vulnerable … Staff are undoubtedly faced with difficult decisions as to where to hold some prisoners and frequently care for prisoners in segregation units when all other options have been exhausted. However, there have been cases where prisoners have been held in segregation units and the justifications for doing so have not been convincing. There have been cases where alternative options to segregation have not been adequately explored."*

80. Processes contained in the PSO include that:

> *"A designated/personal officer is to be allocated to each prisoner … The designated officer should engage [in] purposeful dialogue and record this on the segregation history sheet. At least 3 quality entries are required daily …"*
>
> and
>
> *"Those segregated for more than 30 days should be subject to care plans that detail how their mental well-being is to be supported."*

81. Segregation is an extreme and isolating form of custody. It inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others. By the time of his death, Mr Baltrunas had been segregated for a continuous period of 52 days. Apart from exercise, showers and the occasional visit, he did not leave his cell. He had no radio or TV, no contact with other prisoners, and for most of the time he was unlocked by three prison officers.

82. From the records provided, it would seem that poor and uncooperative behaviour became the established pattern for him. We also note that he was clearly resistant to the plans for his deportation, so we can understand why the prison considered that the most pragmatic way forward was to keep him in the CSU until he was remanded into the care of immigration staff, which was anticipated to take place on 24 August.

83. However, we are concerned that insufficient efforts were made to establish any understanding of Mr Baltrunas and the concerns he might have had about his deportation. The PSO requires that an officer should have been allocated as his designated officer and should have had purposeful dialogue with him making three quality entries in his records each day. There is no record of any such meaningful interaction with him which might have helped in improving his behaviour or understanding his mood.

84. In addition, we are very concerned that when Mr Baltrunas passed 30 days in segregation, no care plan was created for him to help support his mental health. Again, this might have helped in establishing meaningful dialogue with him.

85. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including ensuring that:

- **a designated officer is allocated to each prisoner;**
- **the designated officer has purposeful dialogue each day with his or her allocated prisoners;**
- **a minimum of three quality entries are recorded each day for each prisoner; and**
- **staff create a mental health care plan for all prisoners segregated for more than 30 days.**

Deportation

86. Mr Baltrunas repeatedly asked staff in the CSU what was happening about his deportation. Although it would not have been possible for staff to tell him when he was going to be deported, we consider that they could have done more to ensure that he received information about the process and had an opportunity to discuss his concerns. We are also concerned that there seems to have been no recognition that the uncertainty about his future was likely to have an impact on Mr Baltrunas' mental wellbeing.

Assessment, Care in Custody and Teamwork (ACCT)

87. On 24 August, staff assembled for a planned intervention to move Mr Baltrunas to a new cell after he damaged his previous cell. BWVC footage clearly shows cuts to Mr Baltrunas' arm and neck as he was being escorted to his new cell. At the debriefing meeting following the intervention, Nurse B said that the cuts to his neck were self-inflicted. She said she did not start ACCT procedures because Mr Baltrunas had no history of self-harm. The only reference to the cuts made by prison staff was the note made by an officer, who wrote that the cuts were caused accidentally.

88. We are very concerned that none of the prison staff thought it necessary to begin ACCT procedures. All the staff involved in the intervention would have seen the injuries, and they all attended the debriefing meeting when Nurse B said the injuries were self-inflicted.

89. Nor do we understand Nurse B's rationale in deciding not to open an ACCT. Whether or not Mr Baltrunas had self-harmed in the past, he had self-harmed on this occasion, and there is more to the ACCT procedures than being checked regularly: they are also about trying to identify the cause of the prisoner's distress and putting support in place.

90. We make the following recommendations:

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, in particular, that an ACCT is opened following all acts of self-harm.

The Governor should share a copy of this report with Senior Manager A, CM A, CM B, CM C, CM D and SO A and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Head of Healthcare should share a copy of this report with Nurse B and arrange for her clinical supervisor to discuss the Ombudsman's findings with her.

Roll checks

91. Roll checks are primarily a security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoners' safety to be identified and managed.

92. Following Mr Baltrunas' death an officer wrote a statement to say that he checked the prisoners in CSU at 5.30am on 27 August and he saw a shape under the bedclothes in Mr Baltrunas' cell, which he assumed to be Mr Baltrunas.

93. The investigator was later advised that the prison checked CCTV footage and found that the officer did not conduct a roll check as he claimed. Following a prison investigation and disciplinary hearing, the officer was given a final written warning and was demoted to the rank of officer support grade (OSG). As the prison has dealt with this matter, we make no recommendation of our own.

94. Officer B relieved the officer at 7.10am and said that when she made her roll check, she saw Mr Baltrunas standing in the middle of his cell and that she saw nothing to cause her concern.

95. Staff are not required to speak to prisoners when making roll checks if they have no obvious concerns for the prisoners' welfare. However, we note that when Mr Baltrunas was discovered hanging at around 8.15am, he appears to have been in the same position in the middle of the cell and, when checked, his body was cold and rigor mortis had begun to set in. If Mr Baltrunas was already hanging when Officer B made her check, this means that she failed to notice the ligature. We cannot say for certain whether she failed to notice a ligature, or whether an earlier discovery would have altered the outcome for Mr Baltrunas. However, we make the following recommendations:

The Governor should ensure that staff completing roll checks satisfy themselves that prisoners are alive and well.

Emergency response

96. In September 2016, Professor Sir Bruce Keogh, the National Medical Director at NHS England, wrote to the Heads of Healthcare for prisons in England and Wales to introduce new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation after a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 which state: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines give examples of futility as including the presence of rigor mortis. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased.

97. The officer who started chest CPR at the instruction of the governing Governor, said that Mr Baltrunas was not breathing, his eyes were open and fixed, and his body was stiff. We also note that Nurse C was unable to insert an airway as Mr Baltrunas' jaw was clamped shut. Staff continued attempting CPR for around 15 minutes until ambulance paramedics arrived. It seems clear that attempting CPR for Mr Baltrunas was inappropriate. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances where resuscitation is and is not appropriate, in line with national and European guidelines.

The Head of Healthcare should share a copy of this report with Nurse C and arrange for her clinical supervisor to discuss the Ombudsman's findings with her.

Clinical care

98. The clinical reviewer found that Mr Baltrunas' overall care was of a reasonable standard and equivalent to that which he would have received in the community.

99. She noted, however, that although he was seen every day by a nurse or doctor while in the CSU, there were two occasions in July when mental health staff did not adequately assess his mental state: first on 20 July when there appeared to be a possible breakdown in communication between the prison GP and Nurse A, and then on 26 July when another nurse noted that he had been unable to assess Mr Baltrunas due to the risk he posed and his language limitations. The clinical reviewer considered that Mr Baltrunas' mental health care was compromised through the failure to adequately assess his mental state in the CSU at an early stage.

Translation

100. There are repeated references to Mr Baltrunas' poor English. We appreciate that Mr Baltrunas did not always want to use an official translation service and that staff started to use the translation service in August when he said that he could not understand what was being said to him.

101. However, although a nurse said that Mr Baltrunas declined the use of an interpreter as he spoke enough English to "get by" and staff said that they generally believed that his understanding and ability to speak English was better than he sometimes tried to imply, we are concerned that some significant interactions with Mr Baltrunas took place without any translation assistance. Most notably the segregation reviews that took place on 10 and 17 July and the mental health assessment that could not go ahead on 26 July because of 'language difficulties.

102. We do not consider that it was safe to assume that Mr Baltrunas understood everything that was being said to him or that he would have been able to discuss the complexities of his mood and feelings.

103. We recommend:

The Governor and Head of Healthcare should ensure that staff use a translation service when discussing sensitive or complex matters with prisoners who do not speak English well

Inquest

104. An inquest into Mr Baltrunas' death concluded that his cause of death was suspension.

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