

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ricardas Jonusas, a prisoner at HMP Swaleside, on 16 December 2022

A report by the Prisons and Probation Ombudsman

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ricardas Jonusas was found hanged in his cell at HMP Swaleside on 16 December 2022. He was 34 years old. I offer my condolences to Mr Jonusas's family and friends.

Mr Jonusas was the fifth prisoner to take his life at Swaleside in 2022 and the eighth in three years.

My investigation found that, yet again, suicide and self-harm monitoring (known as ACCT) was managed poorly. Poor ACCT management was an issue identified in our investigations into the two self-inflicted deaths that preceded Mr Jonusas's. HM Inspectorate of Prisons also highlighted this as an issue following their inspections of Swaleside in 2021 and 2022.

The prison has told us that a range of work is ongoing to improve ACCT management at Swaleside. This work needs to deliver sustained improvements if Swaleside is to stop men at the prison from taking their own lives. I have asked the Executive Director for the Long Term High Security Estate for assurance that these measures are delivering the improvements required.

This investigation has again highlighted the detrimental impact that the shortage of staff at Swaleside is having on the men in its care. Mr Jonusas had no key work sessions due to lack of staff and was clearly frustrated by spending most of the day locked in his cell, without purposeful activity. I understand that HMPPS is taking steps to address issues with staff retention and recruitment at Swaleside. In the meantime, the prison needs to ensure that it identifies vulnerable prisoners and prioritises support for those most in need.

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 24 August 2021, Mr Ricardas Jonusas, a Lithuanian national who was serving a life sentence for murder, was transferred from a prison in Lithuania back to HMP Wandsworth. On 7 December, he was moved to HMP Swaleside.
2. Between 30 December 2021 and June 2022, staff monitored Mr Jonusas using suicide and self-harm procedures (known as ACCT) on five occasions. Mr Jonusas self-harmed numerous times. These incidents were primarily triggered by alcohol use. Staff made substance misuse referrals, but Mr Jonusas often refused to engage.
3. On 5 August 2022, while under the influence of alcohol, Mr Jonusas made deep cuts to his arms using screws taken from the furniture in his cell. He was taken to hospital but was returned to the prison the same day. Staff started ACCT procedures four days later. They were unable to explain the delay. Mr Jonusas told staff he cut himself only when under the influence of drugs or alcohol. He said he consumed alcohol and drugs because he struggled being locked in a cell on his own for 22 hours a day. Staff continued ACCT monitoring until 29 August.
4. Staff restarted ACCT monitoring on 14 September, after Mr Jonusas made a deep cut to his arm using a can lid. He said he wanted a transfer to another prison and a job. He said he self-harmed to relieve the frustration of being locked up all day and having no job. He later asked for a move to another wing so he could be with other Lithuanians, which staff arranged. Staff stopped ACCT monitoring on 22 September as Mr Jonusas seemed happier and had remained sober.
5. Staff restarted ACCT monitoring on 16 October, after Mr Jonusas told an officer that he would find him hanging the next day. On the evening of 17 October, staff saw Mr Jonusas standing on a chair trying to attach a ligature to the light fitting. He told staff that he was upset that he had been refused a transfer. At a case review on 20 October, he told staff that he planned to end his life that night by cutting his neck. Staff placed him under constant supervision but stopped it the next day as he seemed much better and had agreed to engage with the drug and alcohol service. Staff continued ACCT monitoring until 25 October.
6. From November, Mr Jonusas was employed as a painter on the wing, and he seemed more settled. There were no suspicions that he was using drugs or alcohol.
7. During a routine check at around 8.45pm on 16 December, an operational support grade (OSG) noticed that Mr Jonusas had blocked his observation panel. The OSG looked through a gap and saw a noose. He radioed a medical emergency code. Staff responded and the control room called for an ambulance. Staff started CPR and continued until paramedics arrived 30 minutes later. The paramedics assessed that Mr Jonusas showed clear signs of death and at 9.22pm, they pronounced him dead.

Findings

8. There was no indication that Mr Jonusas's risk of suicide and self-harm had increased again at the time of his death.
9. We found that the ACCT procedures put in place in August, September and October were managed poorly. The case coordinator changed frequently, and relevant staff were not always invited to case reviews. The care plan was not completed and there seemed to have been very little consideration given to how to address Mr Jonusas's concerns.
10. Poor ACCT management is an issue we have raised with Swaleside numerous times before. Following our investigations into the two self-inflicted deaths that preceded Mr Jonusas's, we were told that work was ongoing to upskill staff on ACCT procedures, train more staff and quality assure the ACCTs opened. This work needs to deliver sustained improvements in order to address the issues with ACCT management at Swaleside.
11. Mr Jonusas had no key work sessions at Swaleside because the prison is not delivering key work due to staff shortages. While we accept that staff shortages mean that delivering key work routinely to all prisoners would be very difficult, we consider that more could be done to prioritise and deliver key work to those most in need.
12. The clinical reviewer found that the care Mr Jonusas received was of a good standard and equivalent to that which he could have expected to receive in the community. She found that appropriate support and referrals were offered and made to address Mr Jonusas's substance misuse, but he often refused help.

Recommendations

- The Executive Director for the Long Term High Security Estate should satisfy himself that the measures introduced to improve ACCT management at Swaleside have delivered the necessary improvements.
- The Governor should consider prioritising the delivery of key work to specific vulnerable groups during periods when staffing levels do not allow routine delivery of key work to all prisoners.

The Investigation Process

13. HMPPS notified us of Mr Jonusas's death on 17 December 2022.
14. 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 responded.
15. The investigator obtained copies of relevant extracts from Mr Jonusas's prison and medical records.
16. The investigator interviewed 14 members of staff at HMP Swaleside between 31 January and 14 March 2023.
17. NHS England commissioned an independent clinical reviewer to review Mr Jonusas's clinical care at the prison. The investigator and clinical reviewer jointly conducted 12 of the interviews.
18. We informed HM Coroner for Kent of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
19. The Ombudsman's family liaison officer contacted Mr Jonusas's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not raise any issues but asked for a copy of the report.
20. We shared our initial report with HMPPS. They found no factual inaccuracies.
21. We sent a copy of our report to Mr Jonusas's sister. She did not notify us of any factual inaccuracies.

Background Information

HMP Swaleside

22. HMP Swaleside, on the Isle of Sheppey, is part of the Long Term High Security Estate. It holds up to 1,090 men serving sentences of at least four years. Until April 2022, Integrated Care 24 (IC24) provided physical healthcare services at Swaleside and Oxleas NHS Foundation Trust provided mental healthcare services. From April, Oxleas has provided both physical and mental healthcare, which includes 24-hour nursing cover.

HM Inspectorate of Prisons

23. The last full inspection of HMP Swaleside was in October 2021. Inspectors reported that outcomes for prisoners remained disappointing, particularly in safety and purposeful activity.
24. Inspectors reported that incidents of self-harm had almost doubled since the last inspection. They found that the quality of support delivered through assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide and self-harm was variable, with some inconsistent case management and care plans that lacked meaningful or completed actions. In HMIP's survey, only just under half of prisoners with experience of being on an ACCT said that they had felt cared for by staff.
25. Inspectors reported that the delivery of services was hindered by significant shortages of staff. They reported that having only three quarters of staff available limited the ability to reinstate purposeful activities for prisoners. Although inspectors noted that staff shortages were beyond the ability of prison managers to influence directly, it was nevertheless a fundamental strategic risk and priority, which needed HMPPS's intervention and support.
26. HMIP carried out an Independent Review of Progress in July 2022. Inspectors reported that the shortage of officers had become worse and had led to very limited time out of cell for most prisoners. No meaningful progress had been made in addressing staff shortfalls, which meant staffing was now at crisis point and was having an impact on all aspects of the regime.
27. Incidents of self-harm had declined considerably, though there had been five self-inflicted deaths since the previous inspection. The standard of ACCT documentation for prisoners at risk of suicide or self-harm remained poor; reviews were not multidisciplinary, action plans were inadequate and there were gaps in recorded observations. However, leaders had recently taken steps to improve the documentation through additional training and ongoing support from the regional safety team. Many of the prisoners inspectors spoke to said staff did not have time to have meaningful conversations with them about their wellbeing, which meant they still did not always feel well supported.

Independent Monitoring Board

28. 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 30 April 2022, the IMB reported that efforts to implement a worthwhile regime for prisoners had been made difficult by staff shortages, with just 160 staff available out of an agreed complement of 261. They found that this was exacerbated by a large proportion of staff having less than two years' experience.
29. The IMB reported that the almost total withdrawal of the key worker scheme due to staff shortages had led to further frustration and worry for prisoners and may have been a factor in the recent increase in deaths at the prison. The IMB also reported that although staffing of the safer custody team had increased, cross-deployment to other areas meant that they had not been able to provide as much support to prisoners as they would have liked.

Previous deaths at HMP Swaleside

30. Mr Jonusas was the 21st prisoner to die at Swaleside since December 2019. Of the previous deaths, seven were self-inflicted, two were drug related and 11 were from natural causes. There were five self-inflicted deaths during 2022 and there has been a further self-inflicted death in 2023. Due to the high incidence of self-inflicted deaths at Swaleside, HMPPS headquarters has been providing additional monitoring and support.
31. We have previously made numerous recommendations to Swaleside about ACCT management, in particular about properly assessing risk and creating appropriate care plans. Following our investigations into the two self-inflicted deaths before Mr Jonusas's, which occurred in June and September 2022, we were told that the prison had been working closely with the regional and group safety teams to upskill staff on ACCT procedures. This included training sessions and floor walking exercises with a focus on identifying risks and triggers for suicide and self-harm and completing the care plan. A quality assurance process was in place to ensure that ACCT was being delivered in line with expectations, including checking that appropriate staff were invited to case reviews. Additional training had been scheduled to increase the number of ACCT trained staff.
32. We also recently made recommendations about key work and about staffing levels. We were told that Swaleside recognised the importance of key work but that staff shortages meant that key work could not be delivered in line with expectations. Recruitment remained ongoing and there had been improvements made to pay and benefits with a view to attracting and retaining more staff at Swaleside. We were also told that in October 2022, the Standards Coaching Team started their deployment to Swaleside. Their aim was to promote consistent best practice across routine tasks, show how to create positive staff-prisoner relationships, encourage the use of Five-Minute Interventions and build confidence in staff with less experience.

Assessment, Care in Custody and Teamwork

33. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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.
34. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. 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.

Key Events

35. On 20 October 2020, Mr Ricardas Jonusas, a Lithuanian national, was sentenced to life imprisonment for murder. He spent time at HMP Forest Bank and HMP Wandsworth before being repatriated back to a Lithuanian prison in January 2021. On 24 August, Mr Jonusas was returned to Wandsworth. (We have not been able to establish the reason for his return to the UK.) While he had some family in the UK, his wife and son were in Lithuania.
36. On 7 December, Mr Jonusas was moved to HMP Swaleside. Between 30 December and April 2022, staff supported Mr Jonusas using suicide and self-harm prevention procedures (known as ACCT) five times. During this time, Mr Jonusas had numerous incidents of self-harm which were primarily triggered by alcohol use. While under the influence of alcohol, Mr Jonusas frequently became threatening and violent towards staff. Staff made substance misuse referrals on each occasion when alcohol was involved, but Mr Jonusas did not engage.
37. On 29 June, Mr Jonusas, while under the influence, became violent towards staff when they asked him to return to his cell. Staff restrained Mr Jonusas and he bit an officer when they were trying to get him into his cell.
38. Around 30 minutes later, a supervising officer (SO) and healthcare staff checked on Mr Jonusas. They saw he was lying on the floor, so the SO and other officers entered the cell. When they got close enough to check Mr Jonusas, he tried to attack them. Later in the day, Mr Jonusas pressed his emergency cell bell and asked to see healthcare staff as he said he had been injured during the earlier restraint. Healthcare staff did not want to enter the cell due to Mr Jonusas's earlier behaviour. Mr Jonusas became aggressive and threatened to kill an officer.
39. On 1 July, Mr Jonusas was downgraded to the basic regime. This meant that he had certain privileges removed, such as access to a TV, and his permitted spending on canteen (items from the prison shop) was reduced.
40. On 11 July, Swaleside refused Mr Jonusas's request to be moved to HMP Doncaster to be closer to his family as Doncaster is a local prison (not intended to hold prisoners serving long sentences) and therefore he did not meet the criteria.
41. On 21 July, staff conducted a suspicion-led search of Mr Jonusas's cell and found two litres of fermenting liquid (illegally brewed alcohol).
42. On 5 August, an officer checked on Mr Jonusas in his cell and saw that he was cutting his arms with screws taken out of furniture in his cell. The officer called a code red (a medical emergency code indicating severe blood loss) and was joined by two other officers. They entered the cell and restrained Mr Jonusas, to prevent him from self-harming further. Mr Jonusas was taken for treatment in hospital and returned the same day.

ACCT – 9 to 29 August

43. On 9 August, an officer started ACCT procedures (in response to the incident on 5 August).

44. That afternoon, an officer held the ACCT assessment interview. He noted that Mr Jonusas was initially reluctant to engage and said he did not want to be on an ACCT. He told the officer that he only cut himself when he was under the influence of drugs or alcohol, that he did this to relieve stress and that he had no intention of ending his life. When the officer asked him why he took drugs, he said, 'Imagine being locked in cell all day, staring at same for [sic] walls, all day for 22 hours a day and see if you don't want to get high'. He asked for a job to keep himself busy.
45. On 10 August, a SO tried to hold the first ACCT case review. A mental health worker and substance misuse worker attended. However, Mr Jonusas failed to attend as he was under the influence of an illicit substance. It was agreed that the case review should not go ahead as Mr Jonusas was too incoherent to participate.
46. The SO held the ACCT review the next day. A member of wing staff attended. The SO noted that no outside agencies were available but that she would get them to see Mr Jonusas another time. Mr Jonusas said he was struggling with 'all the lock up' as he had shared a cell before. (He was in a single cell on G Wing.) He said he was smoking drugs a lot more and getting into debt. He said he knew he needed help and would like a move further north to be nearer his family as they would help settle him down. He asked for a move to C Wing as he knew people on there who could support him. The SO noted that she would see if he was eligible for a move (but there is no evidence that she followed this up).
47. On 13 August, a SO and an officer went to Mr Jonusas's cell to conduct a cell search. The SO asked Mr Jonusas if he had anything in his cell that should not be there, and he pointed to underneath his bed and said it was not his. The SO found around 20 litres of fermenting liquid under the bed.
48. On 16 August, a SO held an ACCT review. A drug and alcohol recovery worker from Change, Grow, Live (CGL) attended, along with another SO. Mr Jonusas said he was okay but worried about paying back money he owed. The CGL worker gave him paperwork to sign, but Mr Jonusas refused to as he said he had lost faith in their service as they gave him no help last time when he had asked for it. He asked again for a transfer to Doncaster as he had family there.
49. On 29 August, a custodial manager (CM) chaired an ACCT review. A SO attended, and a member of healthcare staff contributed by telephone. The case review log noted that there had been no incidents of self-harm for three weeks. Mr Jonusas said he had only self-harmed that day due to alcohol and that while he was continuing to use alcohol, he did so rarely and drank less when he did. The SO noted that Mr Jonusas was well known to him and that he was unlikely to self-harm again for a while. He noted that Mr Jonusas needed to work with the drug and alcohol service to address his drinking. The case review team agreed that an ACCT was no longer appropriate and should be closed.
50. The same day, staff upgraded Mr Jonusas to standard IEP.

September

51. On 11 September, an officer saw Mr Jonusas being helped back to his cell by three other prisoners as he was heavily under the influence. He noted that when Mr Jonusas got back into his cell, he pulled what appeared to be an improvised

weapon from his trousers, laughed and then hid it. He asked the three prisoners to leave and locked Mr Jonusas in his cell.

52. On 13 September, staff carried out a cell search. They did not find a weapon but found an improvised distilling kit underneath the bed.

ACCT – 14 to 22 September

53. On 14 September, staff called a code red after Mr Jonusas made a deep cut to his arm using a can lid. Mr Jonusas said it was because he wanted a transfer to another prison, and he wanted a job. Officers verbally de-escalated the situation, and Mr Jonusas handed over the can lid. He refused to be treated by healthcare staff, although they remained by him while he cleaned the wound. Healthcare staff recorded that they ensured the wound had stopped bleeding before they left. Staff reopened the ACCT and referred Mr Jonusas to the drug and alcohol service.
54. A SO chaired an ACCT review on 15 September. A wing officer attended. A CGL worker was invited but said that Mr Jonusas no longer engaged with them. Mr Jonusas said that he had self-harmed due to frustration with being locked up and having no job. He also said he wanted a move to C Wing so he could be with other Lithuanians and have more peace and quiet. A CM arranged a move to C Wing later that day. He noted that Mr Jonusas was happy about the move.
55. On 19 September, a SO checked on Mr Jonusas after a death at Swaleside. She noted that Mr Jonusas was in a good mood and was happy he was on C Wing. He showed her a letter from his solicitor that had been sent to the Governor asking for a move to Doncaster. She said that she would chase it up.
56. On 22 September, a SO chaired an ACCT review. Another SO and other wing staff attended. He noted that Mr Jonusas was happy with his new location and had peer support. Mr Jonusas had been sober since moving wing, and staff were assisting him in finding employment, although they explained that opportunities were limited, and he needed to be patient. The case review team agreed to close the ACCT.

ACCT – 16 to 25 October

57. On 16 October, an officer restarted ACCT procedures for Mr Jonusas. He noted that Mr Jonusas had put out his hand for him to shake and said, 'It has been good knowing you but tomorrow you'll find me hanging'. He noted that Mr Jonusas seemed serious and was distressed when going back into his cell. He was concerned as Mr Jonusas was normally in a good mood with him.
58. A SO tried to hold an ACCT review the next day but Mr Jonusas said he would not engage until he got a move out of Swaleside. She noted that she would reschedule the review and speak with him that afternoon or the next day to encourage him to attend.
59. On the evening of 17 October, during a routine check, an officer saw Mr Jonusas standing on a chair in his cell trying to tie a ligature to the light fitting. When he asked him what he was doing, Mr Jonusas swore at him. The officer tried to speak with him, but Mr Jonusas put the ligature around his neck and stepped off the chair.

The ligature snapped straight away, and the officer called for night support staff to attend. The officer increased the level of observations to every 30 minutes.

60. On 18 October, a SO held an ACCT review. Mr Jonusas was upset that he had been turned down for a transfer due to being on basic. He said that he had been on standard when he was told and was then moved to basic the next day. He said people were lying to him and also that he did not know who his offender manager was as they had never been to see him. The SO said he would invite them to the next ACCT review so these issues could be discussed in person (but there is no evidence that he did, and the OM did not attend the next ACCT review). (We found no information about Mr Jonusas being refused a transfer at around this time.)
61. On 20 October, a SO held an ACCT review. He noted that Mr Jonusas asked if any progress had been made in transferring him to Doncaster or Manchester. At interview, the SO said that he had told Mr Jonusas that a transfer was not an immediate process and he needed to be patient. The SO noted that Mr Jonusas stated that he planned to end his life that night by cutting his neck. He said he had made preparations to end it all and had told his partner to find another man. The case review team agreed that Mr Jonusas should be placed under constant supervision and moved him to a constant supervision cell on the healthcare unit.
62. On 21 October, a CM held an ACCT review which was attended by healthcare staff and the substance misuse service. She noted that Mr Jonusas's issue was not seeing his family. They were coming to the UK and staying in Manchester, and he was desperate to see them. He said he would engage with the drug and alcohol service. The case review team agreed that constant supervision was no longer necessary as Mr Jonusas's presentation was better than the previous day. They reduced observations to hourly and moved Mr Jonusas back to C Wing.
63. On 25 October, a CM held an ACCT review. She noted that Mr Jonusas understood that she was awaiting information from the Offender Management Unit (OMU). She said that she was going to ask Mr Jonusas to paint the landing and that he would get a bonus payment if his current behaviour continued. The case review team agreed to close the ACCT. She said there were many positive factors in place which made staff consider that Mr Jonusas's risk of suicide and self-harm was significantly reduced. She said she did not have input from healthcare staff when the ACCT was closed but discussed Mr Jonusas at length with the substance misuse service.

November/December

64. On 6 November, an officer recorded in Mr Jonusas's prison record that he had been decorating the wing and had made a very good job of it. They noted that he was always willing to help on the wing and was a great asset. This was the last entry in Mr Jonusas's prison record.
65. Several members of staff told us that Mr Jonusas had a period of stability while he was working as a wing painter, and he did not appear to be using alcohol during this time. Staff said as they were aware alcohol was a key trigger and as he was sober in this time, they did not consider him to be at increased risk of suicide or self-harm.

Events of 16 December

66. At around 8.40pm, during a routine check, an Operational Support Grade (OSG) found that Mr Jonusas's observation panel was covered. He tried to get a response from Mr Jonusas but there was no answer. He asked for staff assistance over the radio. The OSG then managed to look through a gap and saw a noose, so called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). The control room log shows an ambulance was called at 8.45pm.
67. Staff arrived at the cell five minutes after the OSG first checked the cell. They looked in, and a CM immediately got his keys out as an officer took her anti-ligature knife out. Another officer said during interview that they opened the cell and drew back the privacy curtain Mr Jonusas had used to block the view and found him suspended.
68. The CM took hold of Mr Jonusas' legs to support him, while two officers cut the ligature. The CM then cut the ligature from around his neck. One officer said during interview that she noticed significant damage to Mr Jonusas's neck when they removed the ligature. Two more officers also responded to the code blue.
69. A nurse responded to the code blue and arrived as officers were cutting Mr Jonusas down. He advised them to move him to the landing where there was more space to work on him. He noted that Mr Jonusas was unresponsive, but CPR and oxygen was given as emergency first aid. The nurse said he could clearly smell alcohol on Mr Jonusas, and vomit was being removed from his airways as they were giving first aid.
70. Staff attempted to use a defibrillator but could not find the pads on the one they had on the wing, so an officer went to the nearest wing to get another. A working defibrillator was attached shortly after, and staff followed the instructions.
71. Paramedics arrived at the cell around 9.20pm. The ambulance crew noted hypostasis (the pooling of blood or fluid in the lower limbs) was present in Mr Jonusas, which they considered to be a sign of death. He was pronounced dead at 9.22pm.

Contact with Mr Jonusas's family

72. The prison appointed a family liaison officer (FLO) on 16 December. Staff could not identify the next of kin from prison documents. The following day, staff tried to contact the Lithuanian Embassy to get contact information, as well as Mr Jonusas's solicitor.
73. On 19 December, the FLO contacted Mr Jonusas's sister, after obtaining her information. He offered condolences and financial assistance for the funeral.

Support for prisoners and staff

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

Post-mortem report

76. The post-mortem examination found that Mr Jonusas died from hanging. Toxicology tests showed the presence of alcohol at three times the legal driving limit.

Findings

Managing Mr Jonusas's risk of suicide and self-harm

77. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff must follow if they identify that a prisoner is at risk of suicide or self-harm.
78. Mr Jonusas was monitored using ACCT on three occasions in the months leading up to his death, in August, September and October 2022. Staff stopped ACCT monitoring on 25 October and Mr Jonusas then had a fairly settled period over the next seven weeks. There was no indication that his risk had increased again when he was found hanged on 16 December.
79. However, we consider that there were various issues with the ACCT management between August and October.
80. The prison was unable to explain why staff failed to start ACCT procedures after Mr Jonusas self-harmed on 5 August. He returned from hospital the same day and yet staff did not start ACCT monitoring until 9 August.
81. There was not a consistent ACCT case coordinator for any of the ACCTs. There were eight ACCT case coordinators across the three periods, with four in October alone. This is poor practice as there was a lack of continuity between ACCT reviews.
82. The first case review on 10 August did not go ahead and was rescheduled for the next day. Only one SO, the case coordinator, and a member of wing staff attended. The SO recorded that 'no outside agencies were available'. It is unclear whether anyone from healthcare was invited as they should have been or asked to provide input. Although a drug and alcohol recovery worker attended the next review on 16 August, again there was no one from the mental health team and no evidence that they were invited or asked for input.
83. During the ACCT in September, only wing staff attended the ACCT reviews with no input from either mental health staff or substance misuse staff. (A member of CGL staff was invited to the first review but said that Mr Jonusas no longer engaged with them.) When interviewed, the Head of Healthcare said that it was often challenging for healthcare staff to attend ACCT reviews due to short staffing and clashes with clinical tasks (such as medication rounds) but that they always tried to provide input, either written or by telephone if invited. She said there was work ongoing to try to arrange ACCT reviews at times that would maximise healthcare attendance. She added that healthcare staff had limited interactions with Mr Jonusas due to his refusal to engage.
84. During the ACCT in October, Mr Jonusas asked to see his offender manager and the case coordinator said they would be invited to the next review. There is no evidence that they were. Subsequently the ACCT was closed without Mr Jonusas having seen anyone from OMU. The case coordinator noted that she was awaiting an update from OMU but still closed the ACCT.

85. PSI 64/2011 says that the case review team must complete the care plan at the first case review, with actions aimed at reducing the risk of suicide and self-harm, which reflect the prisoner's needs. Only the first part of Mr Jonusas's care plan, setting out his risks and triggers, was completed. The rest of the plan was left blank and there were no support actions listed.
86. We consider that there were various issues that should have been on the care plan. One of Mr Jonusas's main issues was his desire for a transfer to a prison in the Northwest of England to be nearer his family. While we understand that this might not have been possible, and certainly not straightaway, there should have been an action to look into this and updates/decisions should have been communicated and explained to Mr Jonusas during the case reviews.
87. Mr Jonusas repeatedly said he found it very difficult being locked in a cell on his own for 22 hours a day, when he had previously had a cellmate. We cannot see any evidence from the ACCT paperwork that consideration was given to moving him to a shared cell, which would have provided a protective factor. He also said that he struggled with not having a job. Again, there was little evidence in the ACCT paperwork that this was looked into. (We note that Mr Jonusas was eventually given a job as a wing painter, which appeared to have a very positive impact on him.)
88. There was a cluster of five self-inflicted deaths at Swaleside in 2022, of which Mr Jonusas's was the last that year. (There has been another one since, in 2023.) Our investigations into the two self-inflicted deaths that preceded Mr Jonusas's, which occurred in June and September 2022, identified similar issues with the poor quality of ACCT management. We were told that work was ongoing to upskill staff on ACCT procedures, increase the number of ACCT trained staff and quality assure ACCTs to ensure that they were being delivered in line with expectations.
89. This work needs to deliver sustained improvement in the management of ACCT at Swaleside. We recommend:

The Executive Director for the Long Term High Security Estate should satisfy himself that the measures introduced to improve ACCT management at Swaleside has delivered the necessary improvements.

Key work

90. The Prison Service's Manage the Custodial Sentence Policy Framework 2018 says that all prisoners within the male closed estate must be allocated to a prison officer who will have a key worker role. It also says that Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for the delivery of key work, which should include time with each prisoner.
91. Mr Jonusas did not receive any key worker sessions during his time at Swaleside. Key worker sessions are not currently being carried out at Swaleside due to staff shortages. In their latest annual report, published around a month after Mr Jonusas's death, the IMB reported that Swaleside was operating with 160 staff in place out of a total of 261 posts. HMIP also highlighted the issue of staffing in their most recent report, and this trend appears to have been continuing. During our investigation, it became apparent that these shortages had a significant impact on

staff's ability to deliver a full regime and to complete daily tasks to the expected standard.

92. In response to previous recommendations on key work and staffing, we were told that Swaleside recognised the importance of key work but that staff shortages meant that key work could not be delivered in line with expectations. In the interim, staff were encouraged to engage positively with prisoners whenever possible and to ensure that relevant concerns were either addressed or escalated as soon as discovered.
93. HMPPS told us that recruitment remained ongoing and there had been improvements made to pay and benefits with a view to attracting and retaining more staff at Swaleside. They said that once staffing levels allowed, key work would be reintroduced. They said that prisoners being supported using ACCT were provided with additional support.
94. We were also told that in October 2022, the Standards Coaching Team started their deployment to Swaleside. Their aim was to promote consistent best practice across routine tasks, show how to create positive staff-prisoner relationships, encourage the use of Five-Minute Interventions and build confidence in staff with less experience.
95. Mr Jonusas frequently attempted suicide and self-harmed and was supported using ACCT multiple times at Swaleside. While we accept that the staffing levels at Swaleside make it very difficult to deliver key work routinely to all prisoners, we consider that more could be done to prioritise key work for those most in need. We recommend:

The Governor should consider prioritising the delivery of key work to specific vulnerable groups during periods when staffing levels do not allow routine delivery of key work to all prisoners.

Clinical care

96. The clinical reviewer found that the care Mr Jonusas received was of a good standard and equivalent to that which he could have expected to receive in the community.
97. She noted that appropriate support and referrals were offered and made to address Mr Jonusas's substance misuse and alcohol dependence, but his engagement was variable and he often declined help.
98. Mr Jonusas was not diagnosed with any mental health conditions so was not prescribed any mental health medication. The clinical reviewer was satisfied that he received appropriate support from mental health staff for his self-harming.

Inquest

99. The inquest, held from 2 to 5 April 2024, concluded that Mr Jonusas died by suicide.

**Prisons &
Probation**

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