Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Jozunas, a prisoner at HMP/YOI Chelmsford, on 20 March 2021

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

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 HM Prisons and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mark Jozunas was found hanged in the segregation unit at HMP Chelmsford. He was 50 years old. I offer my condolences to Mr Jozunas's family and friends.

Mr Jozunas had a history of mental health problems and psychosis. He received care in a medium secure unit before he was returned to Chelmsford after he was found guilty of murder.

The investigation found that Prison Service suicide and self-harm procedures provided support to Mr Jozunas, who could be a complex and challenging character, but there were some deficiencies, which we bring to the Governor's attention.

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 **October 2023**

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Summary

Events

1. On 3 March 2020, Mr Mark Jozunas was remanded to prison custody charged with murdering his mother, and was sent to HMP Chelmsford.

2. Mr Jozunas had a history of depression and anxiety. A psychiatrist at the prison diagnosed Mr Jozunas with paranoid schizophrenia. Healthcare staff prescribed various medications, including antipsychotic medication.

3. On 30 March, Mr Jozunas was admitted to a medium secure unit for treatment under the Mental Health Act. After a period of assessment, a consultant psychiatrist decided that Mr Jozunas did not have symptoms of psychosis and ruled out a formal diagnosis of paranoid schizophrenia.

4. On 30 October, Mr Jozunas was sentenced to life in prison. He was discharged from the secure unit and returned to Chelmsford.

5. On arrival at Chelmsford, prison staff managed Mr Jozunas under suicide and self-harm procedures known as ACCT. Mr Jozunas was located in the enhanced care unit. ACCT monitoring ended on 20 November.

6. On 7 January 2021, Mr Jozunas's behaviour deteriorated. After damaging his cell, he was moved to a segregation cell (the segregation unit was temporarily relocated to D wing) for a disciplinary hearing. Prison staff decided that his behaviour could not be managed in a normal location cell and he remained in segregated conditions until 19 January.

7. Between 17 January and 1 February, Mr Jozunas was managed under ACCT procedures after he told staff that he had made a ligature and wanted to die because he could not cope with his life sentence. During the post-closure phase of the ACCT process, his behaviour deteriorated again. Prison staff held a post-closure interview on 15 February and decided that Mr Jozunas did not need further monitoring.

8. Mr Jozunas had regular reviews with a psychiatrist and mental health nurses. On 11 March, the psychiatrist at the prison noted that Mr Jozunas had symptoms of paranoid schizophrenia.

9. At 7.00pm on 19 March, Mr Jozunas damaged his cell and was moved to a segregation cell for a disciplinary hearing.

10. A custodial manager completed the segregation paperwork and said that staff should observe Mr Jozunas once an hour. A prison officer saw Mr Jozunas in his cell at 8.00pm. There is no evidence that staff observed Mr Jozunas during the night.

11. At 5.25am on 20 March, an officer completed a routine check and saw Mr Jozunas asleep in his bed. At 6.35am, an officer found Mr Jozunas hanging in his cell from a ligature. The officer called a medical emergency code and the control room staff

called an ambulance. Other officers and healthcare staff quickly responded and started cardiopulmonary resuscitation (CPR).

12. Paramedics arrived at 6.38am, but they were unable to resuscitate Mr Jozunas and, at 6.44am, they confirmed that he had died.

Findings

Assessment of Mr Jozunas's risk of suicide and self-harm

13. Generally, the ACCT procedures provided good support to Mr Jozunas. We consider that there were no clear indications that Mr Jozunas needed the support of the ACCT process on 19 March when he was segregated. We identified some procedural deficiencies which we bring to the Governor's attention.

Segregation

14. Three nurses completed the segregation health screen algorithm incorrectly. Nurses were unaware of Mr Jozunas's previous self-harm history and that he was taking antipsychotic medication. This meant that staff missed the opportunity to identify concerns about Mr Jozunas's suitability for segregation.

Mental health

15. The clinical reviewer found that there were some areas of good practice. Mental health nurses attended Mr Jozunas's ACCT case reviews and saw him regularly. However, healthcare staff did not always share key information about Mr Jozunas's risk with the mental health team.

16. The clinical reviewer concluded that Mr Jozunas's mental health care was not equivalent to what he could have expected to receive in the community.

The Investigation Process

17. HMPPS notified us of Mr Jozunas's death on 22 March 2021. The investigator, issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

18. The investigator visited HMP Chelmsford on 30 March 2021. She obtained copies of relevant extracts from Mr Jozunas's prison and medical records.

19. NHS England commissioned a clinical reviewer to review Mr Jozunas's clinical care at the prison.

20. The investigator interviewed eight members of staff at Chelmsford between February and April 2022. She and the clinical reviewer jointly interviewed clinical staff.

21. Our investigation was delayed while we awaited the outcome of the police investigation and the clinical review report.

22. We informed HM Coroner for Essex and Thurrock of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

23. We wrote to Mr Jozunas's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not reply to our letter.

24. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Chelmsford

25. HMP Chelmsford is a local prison that takes adult and young adult men directly from the courts. It can hold nearly 730 men, including around 70 young adults. Castle Rock Group Medical Services (CRG) provide 24-hour healthcare. The prison has a 12-bed inpatient unit. Between 3 May 2018 and 2 July 2019, Chelmsford was under special measures. This meant that HMPPS had determined that it needed additional, specialist support to improve its performance.

HM Inspectorate of Prisons

26. The last full inspection of HMP Chelmsford was in August 2021. Inspectors found that the prison was failing in its basic duty to keep prisoners safe. The Chief Inspector of Prisons invoked the Urgent Notification process following the inspection because he was so concerned about the conditions there.

27. Chelmsford had the second highest rate of self-harm out of all local prisons. The strategic approach to reducing self-harm was limited and there had been no detailed analysis of data to understand the risks and priorities for the prison. Despite some serious failings identified by investigations undertaken by the Prisons and Probation Ombudsman (PPO) and others following deaths in custody, HMIP's previous key concern and recommendation about self-harm had not been achieved. The prison's action plan to address PPO recommendations was out of date and many PPO recommendations were repeated over successive action plans. Leaders had repeatedly failed to address problems, such as the deficiencies identified in assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm.

28. There had been over 1,000 ACCTs opened in the previous 12 months which was an increase on previous years. Some prisoners said they had received very limited support while on the ACCT. Staff lacked confidence in using the new ACCT document and HMIP found many weaknesses in its completion. Care plans were missing or incomplete, and risks, triggers and sources of support were rarely identified. Records of interaction with prisoners were often missing, case management was inconsistent, and supervisors did not always complete daily checks on the documentation.

29. HMIP carried out an independent review of progress in August 2022. Inspectors found that there had been reasonable progress in the work to prevent suicide and self-harm. Staff were much more confident in using the ACCT document and the number of open documents had reduced since the last inspection. The quality of reviews and care planning had improved overall. Most prisoners that inspectors spoke to said they felt supported by staff while on an ACCT. Quality assurance took place regularly and learning was shared with managers. Thirteen officers identified as ACCT champions offered peer support and guidance on the ACCT process.

Independent Monitoring Board

30. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 August 2022, the IMB reported that efforts had been made to improve the ACCT review process. and these improvements were identified and reported on to the senior management team. The Board was concerned that the number of self-harm incidents remained high, with the number of ACCTs opened each month averaging 74.

Previous deaths at HMP Chelmsford

31. Mr Jozunas was the fourteenth prisoner to die at Chelmsford since March 2018. Of the previous deaths, six were self-inflicted, three were from natural causes and four were drug-related. There have been five deaths since: two from natural causes and three self-inflicted.

32. In February 2020, we made a recommendation about the completion of segregation health screens. Chelmsford accepted our recommendation and said that guidance was issued to all healthcare staff in March and June 2020. Healthcare screens were part of the morning briefing to all staff who might be required to assess a prisoner's fitness for segregation.

Assessment, Care in Custody and Teamwork

33. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks 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. Staff should hold regular multidisciplinary reviews and should not close the ACCT until all the actions are completed.

Segregation units

34. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners 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. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who must 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.

35. Between November 2020 and April 2021, segregation unit cells at HMP Chelmsford were temporarily located on the first and second floor landing on D wing. All cells on

the first floor landing and six cells on the second floor landing were for segregated prisoners. The remaining cells on the second floor landing and all cells on the third floor landing were for general population prisoners.

Key Events

36. On 3 March 2020, Mr Mark Jozunas was remanded to HMP Chelmsford charged with his mother's murder. This was his first time in prison.

37. A nurse completed Mr Jozunas's initial health assessment and noted his past history of depression, anxiety and insomnia. Mr Jozunas had attempted suicide in 2001, 2007 and 2019. A mental health nurse assessed his mood and concluded that he was displaying symptoms of psychosis. The nurse started Prison Service suicide and self-harm prevention procedures (known as ACCT) and referred him to the prison's mental health team.

38. Prison staff assessed Mr Jozunas as a high risk of suicide and self-harm and recommended constant supervision in the enhanced care unit (ECU). (The ECU is a 12 bed unit for prisoners with complex physical and mental health care needs. There are two constant supervision cells. If staff consider a prisoner to be at very high risk of suicide or self-harm, they can implement constant supervision, which means the prisoner must be watched at all times.)

39. That day the consultant psychiatrist, saw Mr Jozunas. He diagnosed him with paranoid schizophrenia and prescribed risperidone (an antipsychotic medication) and zopiclone (sleeping tablet). A mental health nurse saw Mr Jozunas every day and noted that his symptoms of psychosis had not improved. On 30 March, Mr Jozunas was admitted to Brockfield House, a medium and low secure psychiatric unit, for treatment under the Mental Health Act.

HMP Chelmsford

40. On 30 October, Mr Jozunas was sentenced to life in prison. He received a minimum term of 20 years.

41. Mr Jozunas was discharged from the secure unit and returned to Chelmsford. A nurse completed the initial health assessment. As there was no formal handover from Brockfield House, Mr Jozunas was admitted to the ECU and the nurse referred him to the mental health team. Due to COVID-19 restrictions, Mr Jozunas was in isolation for 14 days. A GP at the prison noted that he was disorientated, delusional and was hallucinating. The GP prescribed olanzapine (antipsychotic), procyclidine (to alleviate side effects from antipsychotic medication), lansoprazole (to reduce stomach acid) and sertraline (antidepressant).

ACCT: 30 October- 20 November

42. On 30 October, prison staff started ACCT monitoring due to concerns about Mr Jozunas's low mood and mental health. Mr Jozunas told a multidisciplinary ACCT case review that he was struggling with being back at Chelmsford and felt isolated. He denied any thoughts of suicide and self-harm, but said that he was hearing voices in his head. Prison staff added three actions to Mr Jozunas's caremap (designed to identify the main areas of concern and the actions required to reduce risk), which included that he should engage with the mental health team, receive a book to relieve his feelings of boredom and see the GP to discuss his medication.

Prison staff assessed Mr Jozunas's risk of suicide and self-harm as raised and decided he should be monitored once an hour. He was encouraged to leave his cell every day for exercise. Prison staff held regular ACCT case reviews and Mr Jozunas's risk remained raised.

43. On 2 November, a mental health nurse spoke to the forensic consultant psychiatrist at Brockfield House. The forensic consultant psychiatrist said that following a period of assessment and treatment while Mr Jozunas was an inpatient, he did not consider that Mr Jozunas had signs of psychosis and ruled out a diagnosis of paranoid schizophrenia.

44. During an ACCT case review on 12 November, a nurse at Chelmsford arranged for Mr Jozunas to receive his medication at 8.00pm to help him sleep during the night. Mr Jozunas denied any thoughts of suicide and self-harm. As his isolation period was due to end on 13 November, Mr Jozunas's ACCT remained open to provide support while he adjusted to the ECU regime. Prison staff reduced his observations to once every two hours with a conversation in the morning and afternoon. The consultant psychiatrist increased Mr Jozunas's dose of antipsychotic medication.

45. On 20 November, prison staff agreed to stop ACCT monitoring. Mr Jozunas's risk level was assessed as low and the actions on his caremap were complete. The consultant psychiatrist and the mental health team would continue to assess Mr Jozunas regularly. The post-closure phase ended on 27 November.

21 December- 16 January 2021

46. On 21 December, prison staff noted that Mr Jozunas was polite and compliant and was waiting for a move to G wing, a residential wing.

47. Mr Jozunas remained settled in the ECU until 23 December when his behaviour started to deteriorate. Prison staff described his behaviour as unusual and noted that he became angry and abusive when they asked him if he needed support.

48. On 25 December, Mr Jozunas refused to take his medication because he believed that staff were trying to poison him. Mr Jozunas refused to engage with a mental health nurse and denied that he had refused his medication.

49. On 30 December, the consultant psychiatrist saw Mr Jozunas. He noted that Mr Jozunas was not sleeping and prescribed promethazine (for insomnia). Mr Jozunas appeared calm and relaxed, engaged well and denied any thoughts of suicide and self-harm.

50. Mental health nurses saw Mr Jozunas every day. On 7 January 2021, prison staff noted that that the consultant psychiatrist agreed that Mr Jozunas was ready to move from the ECU.

51. Later that day, Mr Jozunas asked the consultant psychiatrist to increase his antipsychotic medication dose. The consultant psychiatrist said that he would review his medication in a few days. He noted that Mr Jozunas did not look happy with his response. Around half an hour later, Mr Jozunas became aggressive on the ECU. After smashing several windows and a computer screen, prison staff moved him under restraint to a designated segregation cell on the first floor of D wing to

await a disciplinary hearing. (Between November 2020 and April 2021, segregation unit cells at HMP Chelmsford were temporarily located on the first and second floor landing on D wing).

52. Mental Health Nurse A completed the algorithm and indicated that there were no medical reasons why Mr Jozunas could not be segregated. Segregation can increase the risk of suicide or self-harm because it isolates the prisoner and reduces their access to the normal regime and can have a negative impact on mental health. As a result, the safety algorithm must be completed by a nurse to indicate any medical reasons why an individual should not be segregated, it will then be countersigned by a senior manager.

53. The consultant psychiatrist saw Mr Jozunas on 9 January. He noted that Mr Jozunas was remorseful about the incident in the ECU. Mr Jozunas said he did not have any thoughts of suicide and self-harm but had trouble sleeping. The consultant psychiatrist increased his antipsychotic medication dose and prescribed promethazine for three days. He also referred him to the psychologist at the prison. Mr Jozunas did not see the psychologist before he died.

54. The next day, Mr Jozunas attended a disciplinary hearing. He pleaded guilty to damaging office windows and equipment and was told that he would need to pay £139.50 over period of two years. As a result of the adjudication decision, a senior manager, updated Mr Jozunas's paperwork, indicating he would now be held in segregation under Prison Rule 45 in order to maintain good order and discipline. The senior manager recorded that Mr Jozunas's behaviour continued to be unpredictable and that the consultant psychiatrist had increased his antipsychotic medication. In the safety algorithm, Mental Health Nurse B answered 'no' to the question "Has the person self-harmed in this period of custody/are they on an open ACCT Plan OR is the person currently taking any antipsychotic medication".

55. Over the next few days, staff recorded that Mr Jozunas appeared more settled, was polite to staff and did not raise any concerns.

ACCT: 17 January- 1 February

56. At 6.15pm on 17 January, Mr Jozunas told prison staff that he had attempted to make a ligature using a shoelace tied around a pencil to create a tourniquet (a device that is used to apply pressure to stop the flow of blood). He said that he wanted to die because he could not cope with his life sentence. Prison staff started ACCT monitoring and decided that he should be monitored five times an hour. They also referred him to the Safety Intervention Meeting (SIM- a weekly multi-disciplinary meeting to discuss prisoners who are at risk).

57. At 6.55pm, Nurse C completed the safety algorithm. She answered 'no' to the question "Has the person self-harmed in this period of custody/are they on an open ACCT Plan OR is the person currently taking any antipsychotic medication. There is no evidence that she referred to the other documentation including his medical record and the ACCT document to inform her assessment as Mr Jozunas was subject to ACCT monitoring and he was taking antipsychotic medication.

58. At 2.15pm on 18 January, Supervising Officer (SO) A held the first ACCT case review with Mr Jozunas, Mental Health Nurse D and Custodial Manager (CM) A. Mr

Jozunas said that he felt well supported on D wing and did not want to die. He said that Sundays were difficult for him because it was the day he had committed his offence. Mr Jozunas asked staff to contact Nacro (a charity) about his pension and benefits. The SO assessed Mr Jozunas as a raised risk of suicide and self-harm and set the level of observations at one an hour during the day and every 30 minutes overnight. He added four actions to Mr Jozunas's caremap: that staff should provide a distraction pack, that he should continue to engage with the mental health team, staff should contact Nacro and provide Mr Jozunas with books to read.

59. Mental health nurses saw Mr Jozunas daily and noted that he was settled and did not display any signs of psychosis.

60. On 19 January, Mr Jozunas's period of segregation ended and he moved to a single cell on the second floor landing on D wing. There is no record that an ACCT review took place when his location changed.

61. Prison staff held three further multi-disciplinary ACCT case reviews. On 25 January, staff reduced Mr Jozunas's observations when his risk of suicide and self-harm decreased. Mr Jozunas said that he did not intend to harm himself and staff gave him a telephone which he could use in his cell. SO B noted that he had emailed Nacro about Mr Jozunas's pension.

62. On 27 January, the consultant psychiatrist reviewed Mr Jozunas's medication and increased his olanzapine to 15mg a day. Mr Jozunas again reported poor sleep and Dr A prescribed promethazine for a period of 7 days.

63. Prison staff agreed to stop ACCT monitoring on 1 February. Mr Jozunas's risk of suicide and self-harm was assessed as low and the actions on his caremap were complete. Mr Jozunas said that he felt better since his antipsychotic medication dose had increased and he did not have any concerns. The post-closure phase would end on 8 February.

64. On 3 February, Nurse D recorded that Mr Jozunas had declined an interview with a domestic homicide reviewer.

6 February- 18 March

65. On 6 February, Mr Jozunas refused to take his medication because he had not received his canteen order. Staff noted that he was aggressive, refused to return his medication and flushed it down the toilet. Staff gave Mr Jozunas a Incentives and Earned Privileges (IEP) warning for refusing a direct order and informed the mental health team. Mr Jozunas refused to speak to a mental health nurse on 7 February. He said that staff were conspiring against him and became upset that nobody else could hear the same voices that he could.

66. On 8 February, Mr Jozunas damaged his cell observation panel and told staff he could hear a hissing noise. He refused to believe that the noise was coming from an extractor fan and said that staff were playing games with him. The post-closure review did not take place in accordance with Mr Jozunas's ACCT plan.

67. SO C held a post-closure review on 15 February and recorded that Mr Jozunas was still learning to deal with his sentence and was aware how to seek support.

68. During a mental health review with Nurse D the next day, Mr Jozunas said that he felt well and was getting on with other prisoners on the wing. He denied any thoughts of suicide or self-harm but complained that the olanzapine did not always work. The nurse encouraged Mr Jozunas to take his medication and created an antipsychotic medication care plan.

69. On 24 February, Mr Jozunas told a Nurse E that he was having difficulty sleeping as the anniversary of his index offence approached. He denied any thoughts of suicide and self-harm. The nurse noted that she had informed SO D about how Mr Jozunas was feeling. This was not recorded in his NOMIS (electronic prison record).

70. The next day, Mr Jozunas's behaviour deteriorated again and he broke his kettle. Staff recorded that his behaviour was becoming increasingly unacceptable and that he had threatened to stab staff in the face.

71. On 27 February, Mr Jozunas told the consultant psychiatrist that he had sudden diarrhoea, was not sleeping and was hallucinating. He prescribed loperamide (for diarrhoea) and a further course of promethazine.

72. A mental health review took place on 1 March, the anniversary of Mr Jozunas's index offence. Mental Health Nurse F noted that Mr Jozunas was unkempt and low in mood. Mr Jozunas said that the consultant psychiatrist had agreed to increase his olanzapine dose because he had been suffering from hallucinations. There was no evidence that the consultant psychiatrist had agreed to increase Mr Jozunas's olanzapine again.

73. On 8 March, Mr Jozunas damaged his cell observation panel and an officer placed him on report. The next day, Mr Jozunas attended a disciplinary hearing. He pleaded guilty to damaging his cell and was told that he would need to pay £19.50 over a period of two years. Staff noted that Mr Jozunas's issues were now resolved and he had been allocated a Nacro support worker.

74. On 10 March, Nurse F held a further mental health review. Mr Jozunas appeared settled, he was well presented and his cell was tidy. The nurse noted that Mr Jozunas was feeling lost and empty and was trying to keep himself busy. Mr Jozunas again said that the consultant psychiatrist had agreed to increase his olanzapine, but that this had not happened. The next mental health review was arranged for 10 April.

75. On 11 March, the consultant psychiatrist assessed Mr Jozunas through his cell's observation panel. Mr Jozunas believed that staff were ignoring him and he had smashed his radio because he believed that it was contaminated. He recorded that Mr Jozunas could be experiencing flashbacks and nightmares related to his mother's death. He said that Mr Jozunas appeared paranoid and delusional. He noted that Mr Jozunas was displaying symptoms of paranoid schizophrenia. He prescribed diazepam (used to treat anxiety, insomnia and panic attacks) for seven days and referred him to Improving Access to Psychological Therapies (IAPT - an NHS programme delivering talking therapies) and the psychologist at the prison.

76. The next day, Nurse D saw Mr Jozunas. He agreed to be interviewed for the domestic homicide review and said that he felt settled on the wing. The nurse noted that Mr Jozunas was taking his prescribed medication.

77. During a welfare check on 15 March, Mr Jozunas told a prison officer that he was completing his education packs and was keeping himself busy. He was happy with his progress and wanted to be a good role model for younger prisoners.

Events of 19 and 20 March

78. At 11.28am on 19 March, Mr Jozunas made a telephone call and attempted to speak to someone he called David. The receiver of the call did not answer. Records show that Mr Jozunas received his prescribed medication and meals and did not present any concerns to staff.

79. At 7.00pm, Mr Jozunas flooded his cell. Staff attended and saw that he had thrown his television into the cell observation panel. Officer A told the investigator that he went to Mr Jozunas's cell with CM B and two senior officers.

80. CM B asked for a mental health nurse to attend Mr Jozunas's cell. As there were no mental health nurses on duty, Nurse G attended. Prison staff said that Mr Jozunas's cell was not fit for habitation and he would be moved to a segregation cell for his own safety. At 7.20pm, staff moved Mr Jozunas under restraint to a designated segregation cell on the first floor to await a disciplinary hearing. The nurse recorded that Mr Jozunas remained calm and compliant during the move.

81. Nurse G completed the safety algorithm and indicated that there were no medical reasons why Mr Jozunas could not be segregated. She answered, 'yes' to the question "Has the person self-harmed in this period of custody/are they on an open ACCT Plan OR is the person currently taking any antipsychotic medication". Mr Jozunas said he was no longer taking diazepam and was hearing voices again. Nurse G referred Mr Jozunas to the consultant psychiatrist and a GP at the prison.

82. Nurse G told the investigator that she was unaware that Mr Jozunas had self-harmed when he was previously segregated. Mr Jozunas was calm and compliant and she had no concerns about his mental capacity. She felt that it was unsafe for Mr Jozunas to remain in his cell and she aware that he would receive regular checks if he was segregated. The nurse said that CM told her there was no other suitable location for Mr Jozunas and segregation was the only available option.

83. They consultant psychiatrist told the investigator that in his opinion, Mr Jozunas was not fit to be segregated and staff should have considered an alternative location, such as the ECU, and arranged an emergency mental health assessment.

84. CM B completed the segregation document. The question which asked if Mr Jozunas had previously been on an ACCT was left blank. The frequency of observations was recorded as one an hour on the front page. At 7.30pm, the Head of Safety, Segregation, Diversity and Inclusion authorised Mr Jozunas's segregation over the telephone. She told the investigator that she authorised Mr Jozunas's segregation because she was aware that his behaviour could escalate and it was unsafe for him to share a cell. There was no other single cell available on D wing.

She felt that moving Mr Jozunas to another location would have unsettled him and may have caused an escalation in his behaviour.

85. The segregation document was placed in a folder marked 'cell D-1-07' and left in the wing office.

86. Officer B was the night patrol officer. In his statement, he said that during a handover with Officer A, he was told that Mr Jozunas had damaged his cell. Officer B said that he had completed a head count at 8.00pm and Mr Jozunas did not express any concerns. He told the investigator that he was unaware that Mr Jozunas was a segregated prisoner and that he should have been observed once an hour.

87. At 5.25am on 20 March, Officer B went to Mr Jozunas's cell to complete a routine check. In his statement, he said that Mr Jozunas was lying asleep in his bed.

88. At 6.35am, Officer C completed a welfare check and found Mr Jozunas hanging from the cell window. He immediately called an emergency code blue (indicating that a prisoner is unconscious or is having difficulty breathing). Officer B responded and they entered the cell. Officer C cut the ligature, which was made from torn bedsheets, tied to the window bars. Officer D, Officer E and CM D arrived at 6.36am and started CPR.

89. Nurse H and Nurse C quickly responded to the code blue emergency. They inserted an airway, gave Mr Jozunas oxygen and attached a defibrillator, but it did not detect a shockable heart rhythm and advised to continue CPR. Paramedics arrived at 6.38am and took control of Mr Jozunas's care. They were unable to resuscitate him, and at 6.44am, a paramedic confirmed that Mr Jozunas had died.

Contact with Mr Jozunas's family

90. Due to Covid-19 restrictions, the police broke the news of Mr Jozunas's death to his family at approximately 9.00am on 20 March. At 11.00am, a prison family liaison officer telephoned Mr Jozunas's brother and offered support.

91. The prison contributed towards the cost of his funeral in line with national policy.

Support for prisoners and staff

92. After Mr Jozunas's death, the senior 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.

93. The prison posted notices informing other prisoners of Mr Jozunas'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 Jozunas's death.

Post-mortem report

94. The pathologist gave Mr Jozunas's cause of death as asphyxiation due to hanging. A toxicological analysis did not detect any illicit substances in Mr Jozunas's blood.

Information received following the police investigation

95. The investigation undertaken by Essex Police considered the offence of Gross Negligence Manslaughter against prison staff. The investigation found that prison staff did not adequately review, assess and communicate information related to Mr Jozunas. The police found that prison staff did not review Mr Jozunas every hour in accordance with Prison Service procedures for segregated prisoners on the night of 19 March.

96. The investigation recorded that Mr Jozunas confirmed to staff that he did not feel suicidal and had been observed to have had previous violent outbursts and then calm down. The risk of death was, therefore, not obvious at that time.

97. The investigation concluded that while the subsequent failure to monitor Mr Jozunas overnight was a breach of duty, the risk of death was again not obvious at that time. The police did not proceed with criminal charges against prison staff.

Findings

Assessment of Mr Jozunas's risk of suicide and self-harm

98. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the prisoner's risk of suicide and self-harm, and take appropriate action. Mr Jozunas had a number of these risks, including a violent offence against a close family member, resulting in a life sentence, previous suicide attempts and self-harm, poor mental health, including the diagnosis of a serious mental illness, recent contact with psychiatric services, and recent discharge from a psychiatric in-patient facility.

99. Mr Jozunas was supported by ACCT procedures at various times during his sentence, including on 17 January 2021, when Mr Jozunas attempted to make a ligature while segregated. We consider that, generally, the ACCT procedures provided decent support to Mr Jozunas. Staff held regular multidisciplinary case reviews which appropriately assessed his risk. They added actions to Mr Jozunas's caremap which reflected his mental health needs and ongoing concerns about his pension.

100. There was no evidence that staff considered if Mr Jozunas was at an increased risk of suicide and self-harm when he was segregated on 19 March. Mr Jozunas had self-harmed during a previous period of segregation. He was no longer taking diazepam and he told Nurse G that he was hearing voices again. Prison staff appeared to accept that the incident was Mr Jozunas's normal pattern of behaviour and that he would eventually calm down, as he had done so in the past.

101. Identifying Mr Jozunas's risk of suicide and self-harm was complicated by his fluctuating mental health concerns. He had been segregated before and said he had attempted suicide, but had also said that he felt safe on D wing. It seems that staff did not consider beginning ACCT procedures on 19 March, when they segregated Mr Jozunas. Ideally, they would have done, but we cannot say that it was wholly unreasonable that they did not, based on their knowledge of Mr Jozunas.

102. Since Mr Jozunas's death, Chelmsford has introduced various measures to try to improve the quality of ACCT management, including ACCT champions and increased quality assurance. We make no recommendation.

Segregation

Health screens

103. Prison Service Order 1700, Segregation, sets out the processes that should be followed when a prisoner is segregated. Segregation is stressful for prisoners, can exacerbate mental health concerns and can increase their risk of suicide and self-harm. PSO 1700 therefore requires a member of healthcare staff to complete an initial segregation safety health screen for all segregated prisoners to assess their physical, emotional and mental wellbeing when deciding whether it is safe to

segregate them. The health screen must be completed within two hours of a prisoner being segregated, after a discussion with the prisoner. The screen should also be completed if a prisoner is awarded a period of cellular confinement at a disciplinary hearing. Mr Jozunas had two periods of segregation at Chelmsford. The first period was for 12 days and healthcare staff completed five initial segregation health screens during that time. Three of these were completed correctly. On 12 and 17 January, Nurse B and Nurse C did not note that Mr Jozunas had recently self-harmed and was taking antipsychotic medication. Nurse C also failed to note that Mr Jozunas was on an open ACCT.

104. For healthcare professionals to be able to properly assess a prisoner's physical, emotional and mental wellbeing before segregation, they must have access to all relevant information. Nurse G accessed Mr Jozunas's medical record before she completed the health screen but told us that she was unaware that Mr Jozunas had previously self-harmed when he was segregated. She told us that a mental health nurse would assess Mr Jozunas the next day.

105. The consultant considered that Mr Jozunas was not mentally fit to be segregated on 19 March and staff should have considered an alternative location, such as the ECU, and arranged a mental health assessment with the on-call emergency mental health team because mental health staff were not on duty.

106. Since Mr Jozunas's death, a mental health nurse is on duty until 8.00pm and has responsibility for completing the algorithm. Given this change to the process at Chelmsford, we make no recommendation in this case, but the Head of Healthcare will want to continue to assure herself that segregation health screens are now being completed to a high standard.

Observations of segregated prisoners

107. PSO 1700 states that when prisoners are segregated pending an adjudication "measures will be put in place to safeguard the mental health of prisoners who are kept in segregation which will include observations and dialogue". CM B recorded on Mr Jozunas's segregation document that he should be observed once an hour. The observations did not take place.

108. At the time of Mr Jozunas's death, segregation cells were located on the first floor landing on D wing. Six cells on the second floor were also used as segregation cells. Officer B was not a segregation officer and this was his fifth night shift. He told us that he did not realise he should check Mr Jozunas once an hour because he was not told to do so in the handover briefing. Officer A told us that gave a handover to Officer A but could not recall specifically telling him to observe Mr Jozunas during the night.

109. In June 2021, after Mr Jozunas's death, the Governor issued a briefing to night staff which stated that the Night Orderly Officer (the most senior officer on duty) must ensure that all night staff are aware of prisoners in their areas who require a heightened level of supervision through the night. This includes hourly checks for segregated prisoners. Observations must be noted throughout the night in the segregation history sheet and signed for in the security log to show that the hourly checks have been completed. As a result of this change to local practice, we make no recommendation.

Mental health

110. The clinical reviewer concluded that Mr Jozunas's mental healthcare at Chelmsford was not equivalent to what he could have expected to receive in the community.

111. Although the clinical reviewer found that there were some areas of good practice with regard to Mr Jozunas's mental health care, including that mental health staff attended Mr Jozunas's ACCT case reviews and that mental health nurses saw him regularly, there were also some deficiencies.

112. The clinical reviewer found that the standard of mental health monitoring was good. However, healthcare staff did not work collaboratively to identify Mr Jozunas's risk factors and key information was not always shared effectively with the mental health team. The clinical reviewer said that all staff who have contact with prisoners, such as pharmacy technicians who often see prisoners several times a day, should be included in multidisciplinary meetings.

113. The clinical reviewer has made some recommendations about information sharing and reviewing and updating records, which we do not repeat in this report, but which the Head of Healthcare will wish to address.

Governor to note

ACCT procedures

114. When Mr Jozunas moved to another cell on, prison staff did not hold an ACCT case review to assess if the change of location had impacted on his wellbeing. Similarly, when Mr Jozunas's period of segregation ended, an ACCT review did not take place as it should have done.

115. The decision to stop ACCT monitoring on 1 February was appropriate. All support actions on Jozunas's caremap were complete and his risk of suicide and self-harm was assessed as low.

116. PSI 64/11 states that after ACCT monitoring ends, a post-closure monitoring form must be completed for at least seven days to inform the post-closure review. The post-closure interview must review the caremap and the prisoner's progress since the ACCT was closed. Although prison staff continued to monitor Mr Jozunas after ACCT monitoring ended, we have not seen any evidence that a post-closure review took place on 8 February as it should have done. When the post-closure review took place on 15 February, staff did not explore Mr Jozunas's recent unpredictable behaviour. We bring this to the Governor's attention.

Inquest

117. The inquest hearing into the death of Mr Jozunas concluded in January 2024, and confirmed that Mr Jozunas died from asphyxiation due to hanging. The Coroner gave a narrative conclusion.

118. The Coroner established that factors relevant to Mr Jozunas's death which contributed to his death. A registered general nurse was not adequately trained to

assess prisoners with complex mental health needs, she relied heavily on Mr Jozunas's presentation at the time of assessment and failed to open an ACCT or get Mr Jozunas urgent medical help.

119. A prison officer failed to open an AACT despite Mr Jozunas's presentation on 19 March 2021 and the segregation cell was not suitable for purpose as it had remnants of the torn bedsheets attached to the bars to the cell's windows.

120. A prison officer failed to do a minimum of one observation an hour until Mr Jozunas received further mental health care and review. There were no regular observations held in segregation and in the wing diary. The custody manager failed to do their daily checks to make sure the observation forms are completed by the prison officer.

121. A clinician failed to locate and review the Brockfield House discharge report or appropriately chase up the report. The clinician failed to assess risk, review the care plan and conduct multidisciplinary meetings. They failed to provide basic medical care to Mr Jozunas which probably more than minimally contributed to Mr Jozunas's death. The Coroner concluded that Mr Jozunas's death was contributed to by neglect.

122. The Coroner found there was a consistent lack of verbal and documented communication across the prison setting which possibly more than minimally co9ntributed to Mr Jozunas's death.

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