Circumstances surrounding the death of a man at HMP Long Lartin in July 2007

Report by the Prisons and Probation Ombudsman
for England and Wales

November 2008

This is a report into the apparently self-inflicted death of a man at HMP Long Lartin in July 2007. He was found hanging in his cell. According to his records, he was either 23 or 26 years old at the time of his death.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoner involved in my investigation.

The investigation was led by one of my investigators, she was assisted by a team of four from my office. I must thank the PCT for the appointment of an independent clinical reviewer who works at a general practice and as a doctor for HMP Full Sutton in York. I am also grateful to the Governor and staff of HMP Long Lartin, in particular the principal officer whose excellent assistance was a great support to the investigation team.

I offer my sincere condolences to the man's family for their loss. My investigator was accompanied by my senior family liaison officer, to meet the man's cousin and sister at the beginning of the investigation process. I trust I have addressed their concerns in my report.

Although it was unclear whether he suffered from multiple personality disorders or a severe and enduring mental illness at the time he died, there is no doubt that the man was acutely unwell. His needs were too great for any prison. While the mental health professionals disagreed about whether he could have benefited from treatment in a mental health setting, I wonder where else his needs could have been effectively met.

The man sought asylum in the United Kingdom in 2000. He lived with his sister and cousin for short periods of time, until he committed the offence in May 2001 for which he was remanded to custody for about four months. His mental health problems meant that he was found not fit to enter a plea of guilty or not guilty at his criminal trial and he was sectioned for treatment in secure hospitals. Over the next four years, the man was transferred to several mental health establishments for treatment. He was eventually found fit to plead in November 2005. He was transferred from Broadmoor to HMP Brixton in February 2006. He was found guilty of his offence and given an indeterminate sentence for public protection in September 2006. After several transfers, the man arrived at Long Lartin in May 2007.

The management of someone with such dangerous behaviour posed an enormous challenge for staff at Long Lartin. I am pleased to report that, for the most part, staff responded with respect to the demands of the man. I am saddened that this was the third death at Long Lartin, the second in the segregation unit, in a period of four months. There are lessons to be learned, not only for this prison, but for the Prison Service as a whole.

Staff described the devastating impact that two deaths in such close proximity had on the unit. Both prisoners had been in mental health settings in the past, but were found not to be treatable for different reasons. Both prisoners were aggressive to staff and sexually inappropriate to female staff in particular. I explore the inevitable similarities between the two deaths in the report, and I am pleased to recognise the progress that had already been made between April and July 2007, particularly in the area of primary care mental health delivery.

After a thorough examination of the use of segregation, suicide prevention monitoring procedures and the response to the man's death, I make 12 recommendations and recognise one area of good practice.

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

Jane Webb
Deputy Prisons and Probation Ombudsman **November 2008**

CONTENTS

Summary

The Investigation Process

The man

HMP Long Lartin

Key Events

Issues

- Clinical Review
- Record-keeping
- The man’s transfer from Rye Hill
- The ACCT process
- Mental Health Intervention
- The decision to segregate the man
- The man’s security protocol
- The man’s cell on the segregation unit
- The regime on the segregation unit
- Use of force
- Use of the special cell
- The emergency response
- Contact with the man’s family

Recommendations

SUMMARY

After committing his offence in 2001, the man spent a brief time in prison before being found unfit to enter a plea of guilty or not guilty during criminal proceedings due to his mental health. He was transferred to a mental health establishment. After four years of mental health treatment around the country, he was found fit to enter a plea in his criminal trial and was remanded to HMP Brixton, where he spent the majority of his remand period (apart from one month which he spent at HMP Wandsworth).

Initially, he adjusted well to prison life and associated with prisoners. However, his behaviour deteriorated and he spent increasing periods in the segregation unit. After his conviction and sentencing, the man's behaviour deteriorated to such an extent that arrangements were made for him to be transferred from the segregation unit at HMP Brixton, to the segregation unit at HMP High Down. He was then moved on to Swaleside's segregation unit after one further night at Brixton. He remained in Swaleside for just a few weeks before being transferred to Rye Hill's segregation unit, where he stayed for only one week. In May 2007, the Director of Rye Hill and Governor of Long Lartin agreed that the man would be transferred from Rye Hill's segregation to the segregation unit at Long Lartin.

A brief summary of the man's behaviour was faxed through to Long Lartin in advance of his arrival. The Governor of Long Lartin made the decision to agree a segregation to segregation transfer based on the experience and resources at Long Lartin to deal with violent and disruptive prisoners. Due to his history of threatening and aggressive behaviour, the man was moved to a high control cell on his first day in Long Lartin's segregation unit. The senior officer in charge of the unit made the man subject to a security protocol which required four officers and a senior officer to be present when his cell was unlocked. Within five days, his erratic behaviour concerned staff so much that they identified him as in need of suicide prevention measures and relocated him to a safer cell.

The man's life at Long Lartin was extremely restricted due to his unpredictable behaviour. He became disorientated when he was brought out of his cell, so staff found it difficult to engage him in the most basic of activities, for example taking a shower. Nevertheless, efforts were made to provide him with some routine. He could understand and spoke to staff in English, despite it not being his first language. The safer cell placement broke down because it was difficult to give him his meals and he was moved back to a high control cell next to the shower room to improve his access to showers.

Following the previous death in the segregation unit, officers considered that liaison with the mental health team had strengthened. The man's mental health supervision was well co-ordinated with his segregation and suicide prevention plans. He was visited by the primary mental health team six times daily, reduced to three times daily according to his needs. The mental health inreach team declined three referrals from the primary care mental health team. The prison's psychiatrist assessed the man as suffering from a severe

and enduring mental illness. He recommended that a transfer be sought to a mental health setting. The Head of the Primary Care Mental Health Team, supported by the Governor, made two referrals, to Broadmoor and to the mental health unit. A psychiatrist from the medium secure unit assessed the man, but found that he was not suffering from a severe and enduring mental illness. In the psychiatrist's opinion the man had multiple personality disorders that were exacerbated by the stressful situation of his imprisonment and segregation. He concluded that the man had not benefited from the four years mental health treatment and any further treatment would not improve his mental health. Broadmoor were yet to assess him at the time of his death.

Staff recorded repeated abusive behaviour from the man. On one occasion towards the end of June, he allegedly assaulted an officer during a violent exchange. This matter was subject to a criminal investigation at the time of his death. After the alleged assault, the man was restrained and located in a special cell for just under 24 hours, after which he was returned to a high control cell.

The man was found hanging in the early hours of 3 July. There was a short delay in entering the cell while sufficient staff gathered to meet the security measures, but I have found this to be reasonable given his history of violent behaviour. The response efforts were adequate, but I have made some recommendations to improve practice for the future.

I commend the work of the primary care mental health team. Under extreme circumstances, their continued attempts to engage the man are admirable. I am pleased with the involvement of staff from all levels of the prison in his care and efforts to transfer him to a mental health setting. That said, I have made recommendations concerning the skills mix of the mental health professionals at Long Lartin. I also comment on the system for transferring prisoners between segregation units.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 3 July and appointed one of my investigators to lead the investigation, with four other colleagues from my office. My lead investigator visited Long Lartin on 6 July. She met the Governor and representatives from the Prison Officers' Association and the Independent Monitoring Board. She was shown around the prison by her investigation liaison officer, a principal officer (PO). She visited the man's cell in the segregation unit, the healthcare centre and a residential wing. My lead investigator collected copies of his prison records, collated by the prison liaison officer. Notices were posted around the prison, inviting staff or prisoners to contact my investigator with any information that they felt relevant to the investigation into the man's death. Several prisoners contacted her, all of whom were interviewed.

2. Following the family's request, my senior family liaison officer accompanied my investigator on a visit to the man's sister and cousin on 12 July. I am grateful to the man's family members for meeting with my colleagues so soon after their loss. This was an opportunity for the family to share their concerns with my investigator and I trust that these have been addressed in the body of the report.

3. The investigation team visited Long Lartin between 16 and 19 July. I attended the prison with the team on the opening day of their investigation and met with the Governor and members of the Independent Monitoring Board. The investigation team conducted interviews with staff and prisoners during their visit. Another of the team returned on 10 August to conduct some follow-up staff interviews. My lead investigator and a third member of the team returned to Long Lartin in October for additional interviews with staff and prisoners. My lead investigator met with the Prison Service lead for the ongoing segregation review, and visited the head of the mental health inreach team on 29 November.

4. I am grateful to the local PCT for the appointment of an independent clinical reviewer. The clinical reviewer works at a general practice and at HMP Full Sutton in York. The clinical reviewer did not interview staff himself, but considered the medical records and transcripts of interviews conducted by the investigation team.

HMP LONG LARTIN

5. HMP Long Lartin is a high security prison for sentenced adult men who are serving at least four years of their sentence. It can accommodate 492 prisoners, including Category A prisoners, those prisoners who are assessed as posing the greatest security risk.

The segregation unit

6. As one of the five high security prisons in England and Wales, Long Lartin has the largest segregation unit in Europe. The unit has 38 cells, six of which are known as high control cells and two as safer cells. (A high control cell is a cell which is specially designed with a large hatch in the door to enable items, for example meals, to be passed through without the door having to be opened. A safer cell has reduced ligature points for prisoners who are at risk of self harm.) There are also two special cells without any furniture where prisoners are located for short periods of de-escalation.

7. Staff who work in the segregation unit have to go through a selection process to ensure that they meet certain requirements to work in the demanding environment. The HM Chief Inspector of Prisons made an unannounced inspection of the prison in September 2005. She found that, "… staff in the unit had to work with some extremely difficult and demanding prisoners and relationships were mixed". Prisoners complained to the inspection team about their treatment in the unit, but no evidence was found to support their claims. The Chief Inspector felt that some of the "blanket" security measures in the segregation unit were "inconsistent with treatment based on individual need" and recommended that such measures should be implemented on the basis of risk assessments. The prison has since introduced individual risk assessments and security protocols, where necessary, that set out the treatment of each prisoner according to his particular level of risk. The assessments are carried out when a prisoner arrives on the unit and are revised daily during a morning meeting, attended by all staff.

8. In a broader inspection, entitled "Extreme Custody – a thematic inspection of close supervision centres and high security segregation", the HM Chief Inspector examined the treatment of "… some extremely disturbed and potentially violent men, sometimes held in restrictive conditions". The man fitted this description. In her report, the Chief Inspector referred to the "merry-go-round", whereby prisoners are moved from segregation unit to segregation unit, which she thought was "indicative of a lack of individual care". (The man was moved between segregation units towards the end of his life.) The Chief Inspector was encouraged to find fewer prisoners were moved between segregation units in the high security estate. At the time of the thematic report, she was also awaiting the revised Prison Service instruction to staff regarding segregation. This has not yet been published but my

investigation team spoke with the Prison Service lead for the segregation review and I will consider the findings of this meeting later in the report.

Mental health provision

9. Following her unannounced inspection in 2005, the Chief Inspector recommended "… a full skill mix review taking into account the requirement to develop primary mental health care and administrative support, should be undertaken". A primary care mental health team are employed by the local PCT to look after the primary mental health needs of prisoners at Long Lartin. The mental health inreach team, employed by the Mental Health Partnership NHS Trust, look after prisoners who have received treatment from mental health services in the past. They also work with prisoners who have been referred by another inreach team or who have been assessed by a psychiatrist as having a severe and enduring mental illness.

10. Theoretically, the inreach team criteria means that they care for prisoners with more acute mental health needs, although my investigation team found this to be far from the reality at Long Lartin. The inreach team had only two part-time members of staff, who were supervised by a manager who worked remotely, while the primary care mental health team was made up of six nurses, four of whom were full time. The imbalance of resources between the two teams is considered at length later in this report.

11. In their 2007/8 report, the Independent Monitoring Board (IMB) commented on the difficulty that staff face trying to get "timely transfers from prison to mental health hospitals". My investigation team found good evidence of multi-disciplinary working to secure mental health assessments, but that is simply the first stage of the transfer process. The frustration of staff in the segregation unit was clear to the team throughout the investigation. No segregation officers had undergone mental health training, yet they were expected to look after prisoners with such challenging behaviour and a significant history of mental health intervention. Most officers on the segregation unit reported that they received excellent support from the primary mental health team. One officer suggested that the level of support and primary care mental health team presence on the unit was significantly strengthened following the previous death in custody in April. The IMB found:

> "… the mental health specialists have – and still do – work very effectively with the uniformed staff. Individual officers have shown exemplary patience in dealing with some of the more demanding prisoners."

The relationship between officers and mental health professionals will be considered in more detail later in the report.

12. The man’s death was the second death to have occurred in the segregation unit at Long Lartin in 2007. The first occurred in April 2007, four months earlier. My investigation team were told repeatedly by segregation officers and mental health professionals about the similarities between the two prisoners’ presentation. Both were challenging prisoners, with violent histories and contact with mental health services. The prison attempted to secure mental health placements for both of them.

HMYOI Feltham

13. HM Young Offender Institution (HMYOI) Feltham can accommodate up to 764 prisoners. Located in South West London, its population is divided into young people between the ages of 15 and 18 and those aged 18 to 21. The man was at Feltham for three months after committing his offence in 2001, before he was found unfit to plead at his trial and transferred to an adolescent mental health unit.

HMP Brixton

14. HMP Brixton is a local prison that serves courts in the South London area. It can accommodate 798 prisoners, sentenced or on remand. The man was at Brixton before he was sectioned and for the majority of his remand period in 2006.

HMP Wandsworth

15. HMP Wandsworth is one of the largest prisons in the country. It can accommodate up to 1,456 prisoners and serves the London courts. It is a local prison and its prisoners can be on remand or sentenced. The man spent one month in Wansdworth towards the beginning of his remand period. He returned to Brixton.

HMP High Down

16. HMP High Down is also a local prison that serves the courts of South London. It is located in Surrey and can accommodate up to 747 prisoners. The man was at High Down for approximately a month starting in February 2007.

HMP Swaleside

17. HMP Swaleside is a training prison for sentenced prisoners on the Isle of Sheppey in Kent. It can accommodate up to 778 prisoners, all of whom should be serving at least four years in custody and have at least 18 months of their sentence left to serve. After briefly returning to Brixton from High Down, the man was transferred to Swaleside from the beginning of March and stayed there until 25 April 2007.

HMP Rye Hill

18. HMP Rye Hill is a private prison in Warwickshire, run by Global Solutions Limited (GSL). It accommodates up to 600 prisoners, all of whom must be sentenced males over the age of 21, with at least 18 months of their sentence left to serve. The man was at Rye Hill from 25 April for one week.

KEY EVENTS

19. The man sought asylum in the United Kingdom. His date of birth cannot be confirmed by his records, but he could have been either 16 or 19 years old at the time. Although it was not his first language, he was soon able to communicate in English without difficulty. He lived with his sister for a month, then she sought support from the Children and Families' Department of Social Services and arrangements were made for him to move in with his cousin instead. Within a month or so, relations grew difficult again and he moved back in with his sister. By December 2000, the man was placed in a hostel. He spent several months in different hostel placements and was described as "abusive and aggressive" during this time.

20. The man's first contact with mental health services was in March 2001. It was not possible to assess his mental state fully because he was not co-operative but he was not found to have a mental illness. Within a month, he presented himself to a welfare association, saying that he was being followed by police and closed circuit television cameras (CCTV). The welfare association wrote to the Asylum Centre, saying that the man wanted to return to his home country where his family were.

21. After committing his offence in May 2001, the man went to the police station voluntarily and told them what he had done. He was remanded to HMYOI Feltham, where he stayed for three months before being found unfit to plead at his trial.

22. The man was transferred to a medium secure unit for adolescents. There they found evidence that he had a psychotic illness. During his time at the hospital, he was reported to have engaged in bullying, stealing and inappropriate sexual behaviour, as well as being dismissive and abusive, particularly towards female staff. In February 2002, he was granted indefinite leave to remain the United Kingdom.

23. In May 2003, the man was transferred to a medium secure mental health hospital where he continued to be abusive and to assault staff. On 29 June 2005, he assaulted another patient, kicking and punching him after he had fallen to the ground. The man later said that he would have killed him had he not been restrained. He was subsequently overheard discussing plans to rape a female member of staff. Around this time, he was diagnosed with paranoid schizophrenia. He was transferred to a high security hospital on 23 August 2005 because of his plans to rape or kill members of staff at the medium secure unit. On 11 October, the man's antipsychotic medication was stopped. His symptoms were found to be unconvincing.

24. On 15 November, the high security hospital contacted the Home Office Mental Health Unit to inform them that the man was considered fit to stand trial in relation to the offence in May 2001. After several mental

health assessments, he was transferred to Brixton because he was not found to be suffering from psychotic symptoms.

The man's remand to Brixton

25. The man was received into HMP Brixton on 20 February 2006 from a high security hospital as an unconvicted prisoner awaiting trial. As such, he was initially allocated a cell on the healthcare wing. He was assessed on the same day by the Specialist Registrar in Psychiatry at Brixton, who found the man to be "calm". The man said that he had no symptoms, had not taken medication for five months and did not want any further medication.

26. The man settled well onto the healthcare wing, and was reported to be very co-operative with staff and interacted well with fellow prisoners. On 3 March, he was reviewed by a consultant forensic psychiatrist at Brixton. The psychiatrist concluded there was "no psychotic material in evidence". The man requested a move to B wing, which is specifically for foreign nationals, so that he could share with other Muslims and use the gym. The psychiatrist agreed to this, and he moved to B wing that day. The man transferred to HMP Wandsworth on 23 March, following a court appearance on the same day. On 3 April, he was involved in a fight with his cell mate. He returned to Brixton on 21 April, following a further court appearance. He again lived in a cell on B wing. On 22 April, he moved to a cell on G wing. He self-harmed on the following day, by cutting a finger on his left hand. As a result, an F2052SH (the form used at the time by the Prison Service to monitor prisoners deemed at risk of suicide or self-harm) was opened. The officer who opened the form noted that the man "seems really down and not making friends on the wing". The man himself told the officer that he had "had enough and hates it on the wing".

27. The man returned to B wing on 24 April and, at a review on the following day, said that he felt much better on this wing as he had been there before. At a review on 4 May, he said that he was "upset about his life" and that "nothing goes right for him which makes him self-harm". The F2052SH was closed at a review on 8 June, when the man said that he had settled down and made friends on A wing (where he had moved on 31 May). He said that he had no thoughts of self-harm, but had stopped taking his medication as he "feels depressed on them". The assessor noted that the man appeared "up beat, cheerful and in control".

28. A second F2052SH was opened on 18 July, although the pages detailing the reason for opening and any reviews that took place are missing. At the time, the man was on the basic regime in the Incentives and Earned Privileges Scheme (a scheme that provides incentives to reward good behaviour in prisons. There are three tiers – basic, standard and enhanced status. Incentives include access to in-cell television and more private cash to spend). He was not happy on basic and, on 30 July, threatened to kill himself if his status was not improved.

29. The man was reviewed on 17 July by a Specialist Registrar in Psychiatry, who concluded that he was “probably psychotic with an abnormal underlying personality in addition”. The next recorded incident was on 6 August when the man threw boiling water at a senior officer. There is no record of what action was taken by staff following this outburst.

30. The man was admitted to the healthcare wing for a mental health assessment on 11 August, following the assessment by the Specialist Registrar in Psychiatry. He remained as an inpatient in healthcare for the next month. He did not appear to settle well on the healthcare wing. On 12 August, he displayed signs of paranoia, saying several times that he intended to kill himself and giving different reasons such as “because I don’t want to be trapped by the Da Vinci Code”.

31. Over the next couple of weeks, the man was recorded as being abusive and aggressive to staff on a number of occasions. On 25 August, he set fire to his cell after demanding to see the police. He set fire to his cell again the following day, but was uninjured on both occasions. He also refused to eat prison meals for some of this time as he believed that he was going to be poisoned (although he later said that he thought that it was non-halal food).

32. On 3 September, the man’s F2052SH was converted to an Assessment Care in Custody and Teamwork form (ACCT, a form introduced by the Prison Service to replace F2052SH to monitor prisoners at risk of suicide). The front sheet of the document details 13 scheduled reviews, averaging around once every one to two weeks, from 14 September until 31 December. However, the pages detailing the outcome of these reviews are missing.

33. On 6 September, a doctor from the mental health secure unit carried out a mental health assessment on the man. He concluded:

> “[The man] has a Psychopathic Disorder defined under the Mental Health Act 1983 as a persistent disorder or disability of mind (whether or not including significant impairment of intelligence), which results in abnormally aggressive or seriously irresponsible conduct. It is of a nature and degree, which would make it appropriate for him to receive medical treatment in hospital. However, treatment in hospital did not alleviate his condition or prevent further deterioration. In fact, it led to an increase in the risk to self and others with ever increasing levels of security. I do not recommend transfer to psychiatric hospital at present.”

34. At around 11.30pm on 9 September, the man set fire to his cell. He was taken to Accident and Emergency (A&E) at a local hospital for treatment, and returned at around 7.00am the following morning. On 12

September, he attended court and was recorded as very aggressive towards the escort staff.

35. The man returned to B wing on 15 September, following an assessment by the consultant forensic psychiatrist. His first week back on the wing was relatively quiet. On 21 September, however, he was noted to have spat at an officer. He had also complained on the same day about being on the basic regime. He received a number of red entries (warnings for a minor offence against prison rules) in his wing history sheet over the course of the next week, for abuse of his cell bell and other minor offences.

36. On 2 October, the man attended an adjudication hearing regarding the events of 6 August. His guilt was proven, and he was given 21 days cellular confinement as punishment. There is no record of the consideration behind this decision.

37. The man moved to the segregation unit the same day, to serve his punishment. He did not react well to the move, and attempted to flood his cell shortly after his arrival on the segregation unit. He also threatened staff on the unit.

38. On the following day, the man set fire to his cell. He had earlier threatened to do so due to the loss of his canteen (goods purchased through private cash from the prison shop) and said that he would kill himself if he was not given his canteen. He later made a ligature from a t-shirt and attempted to hang himself. Staff intervened, and he was put on constant supervision (meaning that a member of staff continuously observes the prisoner from outside the cell).

39. On 4 October, the man was relocated from the segregation unit to healthcare, following an assessment by a member of the outreach team. He was assessed by a Specialist Registrar in Psychiatry, on 5 October. The doctor noted that the man was calm and settled, and reduced his watch to intermittent supervision.

40. The man returned to the segregation unit on 6 October, to continue his punishment. On 7 October, he began to express signs of paranoia. He told staff that he thought that there was CCTV in his cell and threatened to hang himself because he thought that he was being watched. He also refused to return to his cell that day and attempted to assault staff prior to being forcibly relocated back to the cell.

41. The man again threatened to kill himself on 9 October, having earlier requested to be transferred back to B wing. On 17 October, he was found with a ligature round his neck which was attached to the taps on his sink. He was therefore returned to the healthcare centre and placed on constant supervision. On 18 October, following a review with a second Specialist Registrar in Psychiatry, the watch was reduced to intermittent supervision. The man told the second Specialist Registrar in

Psychiatry that he had attempted self-harm in protest at his treatment by staff on the wing. He claimed that his cell bell was not answered appropriately, that he was sworn at by officers and that his belongings had gone missing. The second Specialist Registrar in Psychiatry asked a principal officer, the (who was the discipline head of the healthcare inpatients unit), to liaise with B wing and the segregation unit with regard to the man's complaints. On the following day, the man returned to the segregation unit.

42. The man returned to B wing on 22 October. Apart from a couple of incidents of being abusive to officers and abusing his cell bell, he appeared to settle back onto the wing quite well. Indeed, on 9 November, his cell sharing risk was reassessed and he was reduced to medium risk. He subsequently went into a shared cell with a cell mate.

43. Towards the end of the month, however, the man's behaviour began to deteriorate again. On 24 November, he attempted to attack a prisoner with a broken mop handle but was stopped by staff. As a result of receiving a number of red entries in his wing history sheet, mainly for being abusive to staff, his IEP status was reduced to basic at a board on 27 November (it is not clear from the records when he had originally been upgraded to standard). He appealed against the decision on the following day. The appeal was dismissed by the Governor of Brixton, who told the man that his behaviour was "not appropriate" and advised him to consider how he interacted with staff in future.

44. The man did not react well to being put on basic. When the decision was made he said that he would kill himself if he was left without a television or stereo. On 28 November, he made a similar threat, warning that he would set fire to himself if he was not given a television. The following day, he made threats to staff and threatened to self-harm or commit suicide.

45. On 30 November, the man was asked to move to a single cell but refused (as he was designated a high risk on his cell sharing risk assessment, and was living in a cell that was designated as a double). He was asked again on 4 December, and told at an IEP review that he would remain on basic until he agreed to move cells. The man agreed to this on 5 December, and was subsequently upgraded again to the standard regime. His mood settled down again following his return to standard. He received a couple of warnings in December for using abusive language and abuse of his cell bell, but his behaviour was generally much improved. The entries in his ACCT document come to an end on 22 December, although it is not clear if the form was closed on this date or if the remainder of the document is missing. Entries in his wing history sheet indicate that he was subject to an open ACCT document for most of 2007, although the form itself is missing for the year until a new one was opened on his arrival at Long Lartin on 2 May 2007.

46. On 30 December, the man was involved in a fight with another prisoner. No further details were noted in his record at the time. On 2 January, he was subject to a proven adjudication for attempting to assault an officer, relating to the events of 7 October 2006. He was given 14 days forfeiture of privileges as a result.

47. At a board on 4 January 2007, the man's IEP status was reduced to the basic regime. Again, he did not react well and was later noted to be violently banging on his cell door. At the same time, he tried to flood his cell due to his "unhappiness at being on basic".

48. A week later the man told an officer that he was being bullied by another prisoner and that he had tried to kill this individual. The following day, he requested a move to G wing as a result of this altercation, saying that he would kill himself if the move did not go ahead. At around 4.45pm, he was found with a ligature around his neck and taken to healthcare. He was not happy with this move and again threatened to kill himself if he went to healthcare. He was placed on intermittent supervision overnight following his arrival in healthcare.

49. The man moved from healthcare to G wing on 14 January, having been taken off intermittent supervision the previous day. He was placed in a single cell due to his high risk. On 23 January, he was admitted to the healthcare wing under intermittent supervision after "self-harming and attempting to hang himself". No further details are available of this incident. At an assessment on the following day, the man said that he was being bullied on the wing by prisoners and staff, and that he self-harmed in response to stress. He was taken off intermittent supervision the same afternoon, and returned to G wing on 26 January.

50. The wing history sheet covering the man's time on G wing, from 14 January to 16 February, is missing. As such, there is no further information available about the time that he spent on G wing.

51. On 16 February, the man was forcibly restrained and moved to the segregation unit after he assaulted two officers. An entry in his wing history sheet confirmed that he was subject to an open ACCT document at the time. On the following day, he flooded his cell and was abusive to and threatened violence towards staff. The water in his cell was turned off on 19 February, as he was threatening to flood his cell again.

52. At around 6.20am on 20 February, the man set fire to his mattress and was subsequently moved to another cell. He flooded the new cell and threatened staff. He was therefore moved to a third cell, after which he calmed down.

The man's transfer to High Down

53. The man transferred to HMP High Down on 21 February. The transfer was initiated in an email from the Governor at Brixton to the Head of

Residence at High Down. The Governor of Brixton's email said that there was a dirty protest (where a prisoner spreads faeces around their cell in protest) taking place in the segregation unit at Brixton and so the staff needed some respite. It is not clear from the records whether consideration was given to moving the man to the healthcare centre at Brixton, or what the effect of the move on him might be.

54. The man's wing history sheet included an entry from the Deputy Head of Resettlement at High Down, saying that a Governor to Governor move had been agreed. The entry said that the man would remain at High Down for two weeks before returning to Brixton. The entry also said that, if the man's behaviour was good, he could stay for 28 days.

55. The man was taken to the segregation unit on arrival at High Down. The appropriate forms were completed on 21 February, with a review due on 24 February. He was segregated under Prison Rule 45, for reasons of Good Order or Discipline (GOOD). The specific details provided on the form were that he had "assaulted staff at Brixton and had demonstrated abusive behaviour".

56. The review took place on 24 February, with the man present. The review noted that his behaviour was "bizarre" and that he had made inappropriate comments to female staff. The governor chairing the review board decided to continue with segregation on the basis that the man's behaviour was "inappropriate for the houseblocks (wings)".

57. Entries in the man's wing history sheet suggest that he did not settle at High Down. He was regularly recorded as being abusive and threatening to staff, and made inappropriate suggestions to female staff on a number of occasions. He therefore returned to Brixton on 6 March, at the end of the two week period.

The man's transfer to Swaleside

58. The man was only at Brixton for one day before transferring to HMP Swaleside on 7 March. The reason for this transfer, how it was arranged, and whether the effect of the transfer on him was considered, are not clear from his records. He resisted the transfer and, having earlier attempted to set fire to his cell, was forcibly taken to the prison van at Brixton. He was located in the segregation unit on arrival at Swaleside. An entry in his wing record indicates that he was on an open ACCT document at the time of the transfer.

59. On 9 March, the man moved from the segregation unit to E wing. However, he did not settle on the wing. He was noted to be throwing tables across the landing and making threats to other prisoners in the belief that they had stolen from him. He subsequently returned to the segregation unit on 11 March.

60. The man's behaviour deteriorated further following his return to the segregation unit. He made inappropriate comments to a female officer on 12 March. He then had a particularly bad day on 14 March. In the morning, he threatened to assault an officer on his way back in from the exercise yard and had to be restrained. Then, at around 5.00pm, he was again abusive and threatening to officers, and threatened to set fire to his cell. When he refused to hand over his lighter, the man was removed under restraint to a special cell (a cell with minimal facilities to which prisoners can be temporarily relocated for a period of up to two hours for the purpose of cooling down). It is not clear from the records how long he remained in the special cell. Later that evening, at around 10.10pm, the man flooded his cell.

61. The next few days brought no improvement in the man's behaviour. On 16 March, he set fire to his cell and was temporarily relocated to a special cell. He was verbally abusive to staff on the following day and threatened them with violence. On the same day his segregation was reviewed. The entry in his segregation unit history sheet simply says "awaiting further input from in-reach".

62. On the morning of 18 March, when he was unlocked for breakfast, the man punched an officer in the face. He was forcibly restrained and relocated to a special cell. On 19 March, he destroyed his cell bell panel and threatened to electrocute staff with the wires that he had pulled out.

63. As a result of the downturn in his behaviour, the man was reduced to the basic regime on the IEP scheme on 20 March. He continued to be threatening and abusive to staff over the next few days. On 27 March, he was reviewed again. The entry in his history sheet following this review simply says "to see in-reach". His next review, on 3 April, noted that he was "awaiting psychiatric report".

64. In the last few days of March and early April, the man appeared to be quieter. This quiet period did not last long, however. Over the period of 6 to 8 April, he threatened and abused staff on a number of occasions, and threatened to burn or flood his cell. On 8 April, he was relocated to a special cell after he threw liquid over a senior officer. He was now showing signs of paranoia and told staff that they will be "killed by the Saudi Secret Police". The man also accused staff of racially and sexually abusing him and threatened that they were "all going to get hurt as I am a soldier".

65. The man flooded the landing on 11 April, and there were further examples of him being abusive over the next week. On 22 April, after a few days in which he had been noticeably quieter, part of an aluminium broom handle that had been fashioned into a knife was found hidden in his toilet. Later that day, he tried to rush out of his cell but was restrained by staff.

The man's transfer to Rye Hill

66. On 25 April, the man transferred to HMP Rye Hill. Staff at Swaleside had attempted to arrange a transfer to a high security prison, but had been unsuccessful. It is not clear from the records why he moved to Rye Hill. It is a prison for sentenced men over 21 who have at least 18 months of their sentence left to complete. A form 'Advice for reasons of transfer of a prisoner in the interests of GOOD' was completed at Swaleside. This gave the reason for transfer as follows:

> "[The man] arrived from HMP Brixton on 7 March 2007 following assaults on staff and cell fire on an IPP transfer. Since his arrival at HMP Swaleside he has remained within the segregation unit. He has not conformed with the regime at Swaleside and has had to be restrained on a number of occasions."

67. On arrival at Rye Hill, the man was taken straight to the segregation unit. A form 'Authority of Location in Special Accommodation' was started but not completed. An entry in his wing history sheet indicates that he was segregated on "good order". The man refused to comply with a strip search on arrival, and force was therefore used. An entry in his medical record the same day said that he was at Rye Hill for a "28 day lay down due to his behaviour in other prisons". ('Lay down' is a colloquial expression referring to a prison offering to look after a particular prisoner to provide a period respite for staff at the prison.)

68. On 26 April, the man was still demonstrating signs of delusion and paranoia. He spoke incoherently, and said that he was "under attack from demonic groups who have placed spells on him". An entry on 27 April noted that he was not on an open ACCT document. It is not clear from his records when or why this was closed.

69. The man's time at Rye Hill was noted in his history sheet to have been unpredictable. At times he was well behaved, but he could also be threatening if he did not get what he wanted. On 29 April, for instance, he threatened to set fire to his cell if he was not given a light for his cigarette.

The man's transfer to Long Lartin

70. The Governor of Long Lartin told my investigation team that he had been contacted by the Governor of Rye Hill to ask him to accommodate the man because he could not be effectively managed by staff at Rye Hill. He posed too great a security risk. He explained that the segregation unit at Long Lartin is larger and better resourced than Rye Hill. In the High Security Estate, it was not necessary for the governing Governor of a prison to consult with other staff members about accepting a prisoner from another establishment. Therefore the Governor of Long Lartin did not consult the segregation staff or healthcare staff about accommodating someone of the man's violent history at that time. The Governor said that the staff at Long Lartin had well proven their ability to

safely accommodate violent offenders and he was satisfied that the man could be adequately cared for at Long Lartin. On 2 May, after just a week at Rye Hill, the man transferred to Long Lartin.

The man's time in the segregation unit at Long Lartin

71. On the day of the man's arrival, a Cell Sharing Risk Assessment was completed by a Governor and Registered Mental Nurse (RMN). The man was assessed as high risk because of his history of violent behaviour. A note was made on the form that he should be accommodated in single cell accommodation only and that care was to be taken if he required a Listener. (Listeners are prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) The Governor, Head of Security at Long Lartin, and the RMN agreed to place the man in the segregation unit for a period of assessment. My investigators were told that it is standard practice at Long Lartin to place prisoners who are likely to have difficulty adjusting to life on a residential wing in the segregation unit for a short period of assessment. The highly secure environment in the segregation unit often helps a prisoner to settle into the prison's regime until staff think that he is ready to progress to normal accommodation on a residential wing.

72. The RMN also made an immediate referral for a mental health assessment. She wrote in the man's clinical record that he refused to co-operate with her because he was in "a bad mood". This referral was declined by the mental health inreach team. The head of the inreach team explained to my investigation team that her staff did not accept this referral because his behaviour had to be stabilised by the primary care mental health team before a mental health assessment could be effectively undertaken by the inreach team.

73. Staff on the segregation unit said that they had some information about the man's history of disruptive behaviour before he arrived on the unit. However, they did not have access to his medical records and did not realise the extent of his mental health problems. A senior officer was on duty on the segregation unit on 2 May. As the senior officer on the unit, she was responsible for the operational management of the unit. She drew up a risk assessment of the man, as she would for any new prisoner who arrived on the unit. She described the process of drawing up a risk assessment. The senior officer considers a prisoner's history of disruptive behaviour and assess how recent it was. She would also take into account how the prisoner seems at the time she is doing the risk assessment. When describing the purpose of the risk assessment she said, "it's about keeping staff safe".

74. From his record, the female senior officer identified the man as having a history of abusive, violent and threatening behaviour who posed a particularly high risk to females. With this in mind, she concluded that he needed to have at least four members of staff present, as well as a

senior officer, every time his cell door was unlocked. Such an arrangement is known as a "four man unlock". She said that this was a high security measure, but not uncommonly used in the segregation unit at Long Lartin. For prisoners subject to such high security measures, an individual protocol is drawn up. Another senior officer wrote the man's security protocol. It described the minimum requirements for staff dealing with him, including what to do in emergency situations. This senior officer said that the protocols are written with input from all segregation staff and are under daily review. The man's protocol is discussed in more detail later in the report.

75. Despite the caution advised on his cell sharing risk assessment, the man was allowed access to a Listener on his first night. A trained Listener spent time with the man in the Listener Suite located in the segregation unit. The Listener said that when he saw the man on his first night, he clearly had mental health problems, was confused and did not know why he was at Long Lartin. The Listener Suite is made up of two adjoining cells with a transparent window between them. The Listener is located in one cell and the prisoner in crisis is located next door. This has been assessed as a suitable way to ensure that prisoners in the segregation unit still have access to a Listener, while minimising the risk of harm to the Listener. At the end of the meeting, the Listener described how the man put his hand on the glass partition and smiled at him.

76. After a few hours in a residential cell on the segregation unit, the man was located in a high control cell. A high control cell is used for prisoners who display bizarre or threatening behaviour. The SO on duty in the segregation unit said that she moved the man to a high control cell because she observed him acting strangely and wanted to minimise risk for a period of assessment.

77. A Community Psychiatric Nurse (CPN) visited the man on the morning of 4 May. The CPN said the man appeared vague and preoccupied. He entered his report on the man's record and typed in bold that he had previously attempted suicide and was "very volatile". He said that CPN input should continue. He referred the man to the mental health inreach team. The inreach team declined the referral, with no reason given.

78. At 3.25pm that day, staff escorted the man to the exercise yard. An officer said that the man was moving very reluctantly and told staff that he wanted to take his tobacco with him. Staff told him that he was not allowed to take tobacco onto the exercise yard. He became abusive towards the officers escorting him and questioned what they had told him. Officers were worried for their safety so they restrained the man using control and restraint (C&R) techniques. The officer said the situation was under control very quickly and that the man was taken back to his cell. An RMN completed a form to indicate that the man had not received any injuries from the restraint.

79. An ACCT document was opened. Another officer wrote a security report about the incident and noted that he thought the man was likely to do something "catastrophic" to himself or a member of staff. According to Prison Service Order 2700, the ACCT process is not just about monitoring prisoners, but about making plans to try and engage the prisoner to reduce their level of risk. (A PSO is a compulsory instruction to prison staff. PSO 2700 governs the management of prisoners considered to be at risk of suicide or self-harm.) The immediate action plan was completed by the senior officer who wrote the security protocol and the RMN. The man was to remain on the segregation unit and be observed four times an hour with support from the mental health team. He was allowed phone calls "only where demeanour/behaviour allows". He was allowed access to Listeners "where behaviour allows". The frequency of the observations was written on the front cover of his ACCT document.

80. In accordance with ACCT policy, an attempt was made by a trained ACCT assessor to interview the man within 24 hours on 5 May at 3.15pm. Unfortunately, he could not contribute or participate in the interview process due to his confused mental state. A Primary Care Mental Health Team Leader discussed the man's case with three colleagues. She wrote an ACCT Caremap for the man which stipulated that he should be visited six times a day by the primary mental health team and that at least one good quality entry should be made on his records. (A Caremap is a plan of how to manage a prisoner's risk.)

81. The team leader made her own entry that she was very concerned about the man's presentation. She said that he had a clear diagnosis of paranoid schizophrenia and anti-social and emotionally unstable personality disorder. Despite this he had arrived unmedicated from Rye Hill. She said that the man has refused to relocate to an in-patient bed in the HCC. In the absence of the prison doctor, she said she had contacted the out of hours emergency service and intended to request an emergency assessment by a psychiatrist. Later the same day she obtained a verbal prescription for 10mg of Olanzepine (an anti-psychotic), 5mg of Diazepam and 1mg of Lorazepam (both of which are used to control anxiety) from the out of hours doctor. This was the man's first prescription at Long Lartin. She then spoke to the on-call psychiatrist at an outside hospital to confirm it was safe to administer this medication to the man. His medical record showed that he was distressed and agitated with pressured speech. ('Pressured' speech refers to speech that is rapid, virtually non-stop, often emphatic and hard to interrupt. It is associated with severe anxiety.) The mental health team leader visited the man at 7.00pm to give him his medication but he was lying on the floor under a blanket and would not respond to her.

82. Following the ACCT case review, the same staff remained to conduct the 'Rule 45' review, which reviewed the man's location on the segregation unit. It was decided that he should remain on the unit because he posed too great a risk to other prisoners on a residential wing. However, staff

thought it was appropriate to move him to a safer cell to reduce his risk of self-harm or suicide. Staff asked the man to move voluntarily, but he refused to do so and became aggressive and threatening towards staff. An SO said he tried to explain to the man, why he needed to move but he would not listen. The Governor therefore gave permission for a planned C&R intervention. Staff put on their protective equipment and then entered the man's cell and restrained him. Ratchet handcuffs were put on him and he was moved. During the move the man continued to kick out at staff and tried to trip them up and therefore a fourth officer was required to hold his legs still. He was relocated to the safer cell. The primary care mental health team leader had been present throughout the relocation. The man told staff that he thought he was being kept in the segregation unit because officers were racist. He remained on a four man unlock.

83. The next day the mental health nurse visited the man and persuaded him to take his Diazepam and Lorazepam. She recorded that he appeared thought disordered with pressured speech and was agitated throughout her visit. He was visited on several further occasions during 6 May as agreed in his care plan.

84. The man's second case review took place as planned on 6 May. He refused to attend and the review took place with out him. The review was attended by the senior officer who wrote the security protocol, the RMN and another mental health nurse, the segregation unit manager and two Governor grades. It was noted that the man had not taken his morning medication despite prolonged efforts by healthcare staff. Further details of his history of self-harm had been gathered from his previous F2052SH forms. Staff were now aware that he had a history of violent and threatening behaviour, especially towards female staff. The review noted that staff found the man difficult to understand, which added to his frustration. The review decided to maintain observations at four times an hour and hold reviews every day.

85. The man refused to relocate to the healthcare centre and to take his medication. His cell had been searched while he had a shower and staff found Diazepam and Lorazepam hidden in a match box. It was decided that a combination of his presentation and the building work on the healthcare centre meant it was sensible to manage him on the segregation unit. He was offered liquid Diazepam that evening but refused all medication.

86. The man's location in the safer cell proved problematic. Officers found that it was difficult to escort him from the cell, at one end of the segregation unit, to the shower block, at the other end of the unit. He would become disorientated and it was difficult to move him without force under such circumstances. During interview, an officer explained the problems that meal times posed while the man was in the safer cell:

> “He was given every meal. Sometimes we’d go in, put it on his bed and he’d charge us. So we thought this is not a good idea, we may get attacked every time we go in there. So we’d put it on the floor and he said he don’t want it on the floor, I don’t know why he didn’t want it on the floor, so he’d throw it round the room then. So it was yet again a very difficult situation.”

87. During this time, the man was described as completely non-compliant, making inappropriate comments to female staff and it was reported that he tried to kiss a female officer through his door. He was described as having “significant mood swings moving from weeping to violent outbursts”.

88. ACCT case reviews took place as planned on 7 and 8 May. In addition to wing staff they were attended by a nurse and the safer custody principal officer.

89. A doctor interviewed the man on 8 May. He wrote to the admissions panel at Broadmoor the same day. He said he had found the man to be thought disordered, paranoid and suffering from grandiose delusional thinking. He asked for an urgent assessment with a view to transferring him under Section 47 of the Mental Health Act 1983. The man’s medical record for 8 May shows that he continued to be very distressed. He screamed, sobbed, shouted and growled at staff and refused to take any medication.

90. The primary care mental health team leader referred the man for the third time to the mental health inreach team. She spoke to two members of the inreach team who then spoke to their manager. According to the records, the inreach team manager told her staff that the man was too unwell for the inreach team to see him and that his care should rest with the primary care mental health team. (The primary care mental health team supervises prisoners with less severe mental health issues, such as anxiety or depression. The inreach team supervises prisoners with acute mental health problems.) The primary care mental health team leader wrote on the man’s medical record that she would complain to the cluster manager about this decision. During interview for this investigation, the inreach team manager contradicted this and said that she instructed her staff to assess the man and that he met the criteria for inreach supervision.

91. The man’s Caremap was updated to reflect his forthcoming psychiatric assessment by a special hospital and a further referral to Long Lartin’s mental health in-reach team. In the meantime input from the mental health team was increased to six times a day. Reviews continued on 9 and 10 May.

92. During the ACCT case review on 9 May, segregation unit officers raised the possibility of referring the man to the Close Supervision Centre (CSC). (This is a part of the Prison Service which is reserved for

prisoners who pose a particular security problem. It offers enhanced security and a higher staff to prisoner ratio to challenge prisoners' behaviour.) It was agreed that it would be preferable to place the man in a secure mental health setting, but should that not be possible, the CSC would be considered.

93. The man's behaviour continued to cause concern throughout 9, 10 and 11 May. However, he was visited as planned on numerous occasions by the primary care mental health team. They continued to try and engage the man but he either did not respond to their conversation or became angry, abusive or suggestive, especially towards female staff. His access to showers and exercise was discussed, as was the possibility of providing safe cutlery. He did not take part in any of these discussions. There was no review on 11 or 12 May but the reason is not clear from his records. On 11 May, the primary care mental health team leader telephoned Broadmoor to see if there had been any progress on the prison doctor's request for an urgent assessment. She was advised to call back on Monday 14 May when she would be told who was coming to assess the man and when.

94. At 12.00pm on 11 May a senior officer was in charge of the segregation unit. The man had been blocking the observation panel in the safer cell with toilet paper and food and there was concern that he could not be properly observed in line with his ACCT document. Staff went to the man's cell in order to give him his lunch and to move him into the cell next door. They were wearing protective equipment. The senior officer asked him to move to the back of his cell so that staff could unlock his door. He refused to do so and so the instruction was repeated. The man ignored the order. The cell was unlocked and the staff went into the cell. An officer repeated the instruction to the man, but he refused for a third time. At this point the senior officer told staff to use C&R techniques in order to move the man into the next door cell. He began spitting at staff. He was restrained and moved next door. The primary care mental health team leader completed a form to indicate that he had not sustained any injuries. He was moved back to the high control cell that day. This cell was situated nearer to the shower block, so it would be easier to escort him to the showers.

95. On 13 May, the review summary said it had been agreed to move the man to a high control cell to facilitate access to tobacco, exercise and the shower. Safer cutlery had been provided, allowing him to be given food other than 'finger food'. The review also decided that he should be allocated two 'key workers' per shift to try to give him continuity in the staff who attempted to interact with him. (A key worker is an individual member of staff who has been assigned to work with a prisoner to provide continuity of care and promote trust.) The mental health team were to be invited to staff hand-over sessions to increase awareness of the man's mental health issues and how to support him. His Caremap was updated to reflect these plans.

96. The review of 14 May reported that the move to the high control cell had appeared to improve the man's mood. The two key worker system was reported to have stabilised his mood. The review noted that he did not respond well to staff dressed in personal protection kit (padded clothing and a face mask - PPE kit). It was decided that the duty SO should assess the risk before the man's cell was opened to see whether PPE kit was necessary.

97. The man's review on 15 May, reported that he had said twice that he was going to hang himself. He would not elaborate on this. The review decided to increase hourly observations to five times an hour but not to return him to the safer cell because of the risk of increasing his aggression and distress.

98. On 16 May, at about 2.50am, an alarm was raised. The man had set fire to his cell. Staff were able to put out the fire through the inundation hole in the cell door. They also gained a response from the man, signifying that he was okay. The PO told staff to move the man into a different cell. The staff present put on protective equipment and at 3.10am they moved him into a different cell. His door was opened and he walked to the other cell. The man's previous cell was still full of smoke. An officer then told the man that he would need to be strip searched in order to make sure that he had no more matches. The man refused and became verbally aggressive towards the officer. The officer tried to explain that the man needed to comply with the instruction for his own safety but he continued to get more aggressive, pumping his arms and clenching his fists. He was then restrained using C&R techniques so that the strip search could be carried out. A nurse completed a form, recording that the man had no apparent burn injuries, although he must have inhaled some smoke. She recommended that he be examined later on that day. After this incident, the man was not allowed to have matches or cigarettes without supervision. His family were concerned about the effect that not smoking would have had on his mental state. Staff assured my investigators that he was given cigarettes when he asked for them and officers would light them for him through the panel on the door.

99. On 18 May, the primary care mental health team leader contacted the Prison Service Mental Health Unit because she was concerned that no date had yet been set for an assessment by Broadmoor. She said she was concerned that Broadmoor would not assess the man until he had been assessed by a medium secure mental health unit in London. She said that the man clearly did not fit the criteria for the medium secure unit and had absconded from there before. She also spoke to Broadmoor and the Department of Health.

100. Two days later it was decided to hold reviews every two days, rather than daily. That same day a note was made in the segregation unit's observation book that, "[the man] asking to speak to female members of staff then making inappropriate remarks, all female staff to be aware".

101. On 21 May, the man was assessed by a doctor from the medium secure unit, they wrote in the clinical record that the man had not wanted to see him and the psychiatrist had spoken to him through the hatch. The doctor from the medium secure unit said the man did not respond to abnormal external stimuli or disclose any paranoid ideas. He said he had seen the man at Brixton in 2006 and could not see any difference in his presentation. He concluded that the man was not suitable for a transfer to the mental health system. The psychiatrist said that if the man's thought disorder continued then he might benefit from a reassessment.

102. At an ACCT case review the following day, the SO that wrote the security protocol spoke to the man through his cell door. He was low in mood and said he was "stressed out". He continued to refuse treatment. The prison doctor remained very worried about the man's deteriorating mental state and the primary care mental health team leader emailed the Department of Health on 22 and 23 May to raise these concerns and to request a second opinion from the man's PCT catchment area.

103. Over the next couple of weeks, the man's mood and behaviour seemed to stabilise. In the segregation unit, staff collect application forms from each prisoner every morning at around 8.00am. Prisoners must indicate what their needs are for the day, for staff to try to accommodate them. Staff felt that the man's thoughts were too disordered to use the application system to identify his needs for the day. Instead, they told my investigators that they would take every opportunity to get him out of his cell. They felt he was too much of a security risk to allow him out of his cell when other prisoners were out, so they would try to get the others out for exercise and showers in the morning and then get him out in the afternoon. When they did this, he went on exercise more regularly and accessed the showers without too many problems. On one occasion, he became agitated when he wanted half an hour more exercise but staff managed to negotiate with him and he left the exercise yard without being restrained. Staff tried to encourage the man to fill his time, for example, they left a reading book in his cell, but it remained untouched. Staff from the primary care mental health team continued to visit him several times a day.

104. On 25 May, the prison doctor assessed the man again. He spoke to the man in the closed visits room with the Imam. The interview lasted 15 minutes. The prison doctor said the man was very difficult to understand and appeared perplexed and distracted. He concluded that he had a severe and enduring mental illness and as such required a transfer under section 47 of the Mental Health Act 1983. He said he would write again to the medium secure unit's doctor and dictated the letter the same day. The man continued to be visited six times a day by the primary care mental health team. His behaviour remained disturbed and his speech confusing. He made frequent sexually inappropriate comments to the female CPNs. Staff were concerned that he was losing weight and his mental condition was deteriorating.

105. A review on 27 May reported that the man had become unresponsive and so another review was held the next day. At this stage staff decided that the level of risk presented by him precluded a transfer to an in-patient bed in healthcare. He was described as mostly uncommunicative with occasional periods of sexually inappropriate or animated behaviour.

106. A case conference was held by the primary care mental health team leader on 30 May. The meeting was attended by the Governor, the Head of Healthcare, the segregation unit manager, a senior officer from the segregation unit and members of the primary care mental health team. It was decided to reduce the mental health team visits to three times a day to try to avoid overwhelming the man. The Governor would write to the medium secure unit's doctor in support of the prison doctor and ask for a second opinion on the decision not to accept the man. His Caremap was updated accordingly. The day after the Governor's letter was sent, the medium secure unit's doctor responded:

> "I was not convinced that his presentation now was any different to that in September 2006. Then, the clinical team at HMP Brixton had initially assessed him to be psychotic and demonstrating imminent, unpredictable, frequent and potentially very seriously violent acts. [The man] soon settled after their initial concerns and the clinical team were subsequently left in no doubt that he was personality disordered and not mentally ill."

107. On 4 June, the man saw the medium secure unit's doctor for a second time. He was accompanied by a nurse who wrote in his medical record that the man was able to communicate more effectively during this interview. The doctor again did not recommend transfer to a secure hospital and advised the staff on how to manage the man. The doctor said that he thought the man remained at high risk of homicide or suicide.

108. Between 3 and 9 June the man was reported to have eaten more regularly and been more settled, although he continued to refuse his medication. However on 9 June, he was reported to have become more aggressive and threatening to healthcare staff. By 11 June, he was reported to be "growling" instead of talking. On 17 June, he was described as "largely uncommunicative" and was seen spending a lot of time staring at his hands or into space. His ACCT case reviews reverted to daily.

109. On 19 June, the prison doctor visited the man and found him to be displaying bizarre behaviour. The psychiatrist asked him why he had been observed talking to his hand or growling for prolonged periods, but he could not answer. During the meeting, the man pointed his index finger at the prison doctor. When asked why, the man replied, "to show that I am not frightened". It was decided to move him to a high control cell and increase the frequency of his observations. On 21 June, a fax

was received from the prison doctor saying he had referred the man to Broadmoor for an assessment.

110. On 20 June, after discussion with the primary care mental health team and the prison doctor, the PO decided to move the man back to a high control cell. This was seen as a progressive move for the man because his risk of suicide or self-harm was considered to have reduced. The next day it was decided to reduce his observations from five to four per hour. This was in recognition of his “consistent” behaviour over the previous weeks. He had not self-harmed or attempted suicide. Reviews also reverted to every three days.

111. Since the cell fire on 16 May, the man’s access to matches and cigarettes was limited and closely supervised by staff. He was unhappy about only receiving one match at a time and on 23 June, he spat at an officer through the hole in his cell door. At around 4.30pm on Saturday 23 June the man’s cell was opened so that his tea meal could be served. As usual, he was asked to stand at the back wall of his cell, which he did. However, as an officer placed his meal into the cell the man charged at the door. Staff attempted to quickly close the door but the man grabbed hold of the door and tried to pull it open again. He was screaming abuse at the officers. The senior officer that was on duty on the segregation unit therefore instructed staff to enter the cell and to use control and restraint techniques (C&R) to bring the situation under control. The man continued to fight and struggle and it took staff some time to gain control using C&R. He would not comply with the instructions given by staff and tried to break free.

112. Staff noticed that the man seemed oblivious to the pain control techniques used in C&R. (Pain control is the term used to describe techniques where staff inflict pain to shock the prisoner and gain compliance.) Once the staff were able to hold him, the senior officer on duty in the segregation unit requested permission to relocate the man into a special cell. Authority was given by governor on duty that day. Upon returning to the cell, the senior officer on duty in the segregation unit saw that the man was struggling with staff once again. A second officer then yelled out and let go of the man. He came out of the cell holding his arm and the senior officer could see that the second officer had a large bite wound. The man continued to fight with the staff so the senior officer pressed the general alarm bell to request more staff to assist.

113. The man was then taken to the special cell. As staff were trying to close the door of the special cell, the man charged at the door again. Staff used their body weight against the door in order to close it. The second officer was taken to the local hospital for treatment to his arm. (At the time of my investigation, he was still off work as a result of his injury.) The RMN was present throughout the C&R and she completed the form entitled ‘Report of Injury to Inmate’. The man had not sustained any injuries during C&R or his location into the special cell.

114. The acting senior officer timed the man's placement into special accommodation at 4.40pm on 23 June and signed the relevant part of the authorisation to use special cell accommodation. He also signed to say that healthcare were informed at 4.40pm and that a nurse was present at this time. The governor on duty signed the relevant part of the form to indicate that the man's ACCT had been updated with his change in circumstances. He authorised the use of special accommodation at 4.55pm and gave the reason as, "Seriously assaulted one member of staff and attacked others whilst they were attempting to give him his tea meal. Continued violent struggling, therefore placed in special accommodation."

115. The Initial Segregation Safety Screen was completed at 5.15pm by the RMN. She indicated that there were healthcare issues (specifically that he was being assessed for a bed in an NHS secure setting and was on an open ACCT). However, the man was located in the segregation unit where he would be frequently monitored. Therefore healthcare had no objections to him remaining in special accommodation at that time. The back of the form should be completed by the duty governor deciding for or against the use of special accommodation or segregation based on the medical screen. It was not completed in this case.

116. The occurrence log section of the form should be used to record "all actions and observations of the prisoner, including notes of conversations, assessments by the designated manager and meals and drinks offered and taken". General observations of the man are recorded on the form, five times an hour. However, there is no reference to any manager assessments either being carried out or their outcome until 10.00am the following morning. At that time, the governor on duty, recorded that he attempted to talk to the man, who did not want to discuss issues and was still aggressive. There are no references to any further management assessments until 3.35pm, when the senior officer on duty in the segregation unit records that the man was abusive at his door and shouted "go away".

117. At 4.10pm, 30 minutes before the 24 hour initial authorisation expired, the man was taken out of special accommodation and walked to his cell. This decision was taken by a second governor, the duty governor on that day. He states that "[the man] has remained compliant for the last 30 minutes. Decision to relocate him out of special cell into cell 110…" The rest of that section of the authorisation form to use special cell accommodation, about informing healthcare and the IMB of this decision has not been completed. The ACCT on-going record form did include slightly more detail than the Occurrence Log, including an entry by the second governor at 10.55am that the man was to be considered for removal when he had calmed down. The governor noted that a case conference had taken place and the man was to be reviewed again on 25 June.

118. The part of form intended to record the mandatory duty governor visits (at least twice in every 24 hour period) and the doctor or nurse visits (at least twice in every 24 hour period) has also been left blank. The duty governor at that time authorised the man's placement in special accommodation and the occurrence log shows that he visited and spoke with him at 10.00am on 24 June. The RMN who completed the cell risk assessment form has however recorded her observations about the man on 23 and 24 June in his medical record. The 24 June entry reads, "[the man] has not slept, paced around all night but was quiet. This morning he accepted breakfast and medication (diazepam only). He asked to return to his cell and was promised that it would be considered if he remained calm, which he did…" The man's sleeping habits were not usually a cause of concern for staff.

119. As part of the investigation process, a prisoner located on the segregation unit raised his concerns about the restraint episode. He thought the situation was badly managed and it did not need to "go as far" as it did.

120. The man was removed from special accommodation before the 24 hour minimum period. His risk assessment was revisited by the officer that completed the security protocol. While the number of staff required to unlock the man remained at four officers and one senior officer, it was now considered necessary for all staff present to have full protective equipment on when they opened his cell door.

121. Between 24 June and 1 July (the date of the man's final review before he died), it was reported that his conversation was random and sexually inappropriate. He appears to have rarely made sense and staff had difficulty understanding him. He was reported to be pleased with a referral to Broadmoor. He often refused to speak to staff but was also abusive.

122. On 29 June, the prison doctor visited the man again and recalled that he presented as very distressed and disturbed. His speech was rambling, confusing and contradictory. Immediately afterwards the doctor wrote to Broadmoor asking them to clarify when they would assess the man.

123. Throughout his time at Long Lartin, staff made thorough and descriptive comments about the man's behaviour in his ACCT ongoing record. Unfortunately, in what were to be the last days of his life, the entries become briefer and it is difficult to determine what his behaviour was like in the days before his death.

The night of the man's death

124. At night time, the majority of the wings at Long Lartin are patrolled by Operational Support Grade (OSG) staff. An OSG is the most basic grade of operational staff. They do not receive the same amount of training as officers and they do not have the same degree of interaction

with prisoners as officers. The segregation unit is staffed by two trained officers and Perrie wing is staffed by one trained officer and one OSG.

125. The assistant orderly officer, a senior officer grade, is responsible for dealing with the majority of events occurring at night time. The assistant orderly officer and three trained officers are based at a central location (the centre) from where they respond to any problems arising elsewhere in the prison.

126. The person in overall charge of the prison at night is the night orderly officer, a principal officer grade. The night orderly officer is located in the control room together with several OSGs. Three trained officers patrol the prison grounds with their dogs.

127. The assistant orderly officer on this occasion, is the only officer who carries an open and universal cell key. One segregation officer and the officer in Perrie wing carry a sealed cell key (that is, a key held in a sealed key pouch that should only be opened in the case of an emergency). There is one nurse on duty throughout the night shift to respond to prisoners' healthcare needs throughout the prison, including emergency situations.

128. At 12.20am on 3 July another prisoner in the segregation unit (not the man) was found apparently unconscious with a ligature around his neck. Staff entered his cell and were able to resuscitate him. The nurse on night duty attended to the prisoner using oxygen during his resuscitation attempts. An ambulance was called and the prisoner was taken to outside hospital. This prisoner had a history of violent behaviour towards staff so four staff escorted him to hospital. The staff who went on the escort included the assistant orderly officer and the two segregation officers. To adjust for this loss of staff, the orderly officer came to the centre to take over the assistant orderly officer's function and he took her set of keys. The Perrie wing officer moved to the segregation unit leaving the OSG to cover Perrie wing alone. One of the dog handlers kennelled his dog and went to the centre. During interview, the orderly officer was asked why both segregation unit officers went on the escort and whether it would have been more logical for the Perrie wing officer to have gone instead, leaving a regular segregation officer behind on that unit. The orderly officer said that the prisoner requiring escort was very violent and he wanted the more physically powerful officers to go on the escort.

129. The wing officer told my investigator that even though he worked on Perrie wing he did know something of the man. He knew he was on an open ACCT form and had a history of challenging behaviour. Because of the ACCT form, the wing officer was required to check the man at least four times an hour. Closed circuit television (CCTV) records show that the wing officer went to the man's cell at 4.06am. The wing officer said that he looked into the cell and saw the man lying in bed. CCTV records show that the wing officer returned to the man's cell at 4.33am.

The wing officer said that when he looked into the cell he saw the man with a ligature around his neck hanging from the window. He could not remember whether or not the man's feet were on the ground, but he recalled that his head was slumped to one side and his body appeared limp. The wing officer radioed the control room to report a Code Blue incident (a Code Blue alarm indicates that a prisoner has severe breathing difficulties and that a full staff response is needed).

130. My investigator asked the wing officer whether he considered breaking his sealed key pouch to enter the cell at an earlier stage. He said that he did not know the man, but knew that he posed a risk to security. He therefore decided that he should wait for the arrival of his manager.

131. My investigation team did not see the CCTV footage first hand, and are grateful to the police for providing them with a written log of events from the night of 2/3 July. Analysis of the CCTV recording by the police indicates:

04.32.59	The wing officer checked the man.
04.34.38	Two officer's arrived at cell. They were followed shortly after by the nurse, an officer and the orderly officer.
04.36.50	Staff enter the cell.

132. The first two staff to arrive in response to the Code Blue alarm, arrived almost simultaneously. Officer one estimated that he arrived within 60 to 90 seconds of the alarm sounding (this estimate is borne out by the CCTV records). He said that when he looked into the cell he thought it looked like a genuine medical emergency. He said that by the time he had looked into the cell the orderly officer had arrived.

133. The orderly officer said that when he arrived in the segregation unit he was met by the wing officer who told him that the man was hanging, although he was uncertain whether he was pretending. The orderly officer looked into the cell and decided that they should go in. He was aware that the unlocking protocol said that staff should put on full protective equipment but he decided that there was no time for delay. The orderly officer unlocked the cell door and staff entered. The wing officer supported the man's body and officer one cut the ligature. The man was placed on the floor and the nurse on night duty began treating him.

134. The nurse on night duty was in the healthcare centre at the time that the Code Blue message was made. He told my investigator that he ran to segregation carrying the defibrillator and the emergency bag. He said that the emergency bag contains all the equipment needed for dealing with a medical emergency. (Two of my staff walked the route from healthcare to segregation and estimated that it would have taken about one to two minutes.) The nurse told my investigator that, on checking

the man, he found that he was not breathing although he had a faint pulse. The nurse inserted an airway into the man's mouth and tried to give him oxygen. Unfortunately, the oxygen cylinder was empty. The nurse said that when he had treated the prisoner who attempted to hang himself earlier that night he had exhausted the oxygen cylinder. By this time the defibrillator had been set up but it advised that no shock be given. (A defibrillator measures and analyses electrical activity in the heart and gives audible instructions about management of the patient.)

135. The nurse then tried to assemble the ambu-bag (a device for hand pumping air) but he could not find the necessary attachment in the emergency bag. Officers had started giving the man chest compressions by this point and the nurse gave him air with mouth-to-mouth breathing. The nurse said that he was giving one breath to ten compressions of the chest. Staff continued with their efforts to try to resuscitate the man until ambulance paramedics arrived around 20 minutes later. The paramedics examined him and all agreed that resuscitation would not be successful and should cease.

Family Liaison

136. At the time, the assistant orderly officer was the only trained Family Liaison Officer at Long Lartin. However there were a number of staff waiting to go on the training course. She heard about the man's death while at outside hospital with the other prisoner, and returned immediately to Long Lartin. She spoke to the governing Governor about visiting the man's family to break the news but he said that the man had not identified any next of kin. The assistant orderly officer then went home as that day was her rest day. She later discovered that the family heard the news when a victim support officer from the probation service, telephoned the man's cousin.

137. A probation worker at Long Lartin, said that on arriving for work on 3 July she heard about the man's death. She asked her manager whether she should inform the man's home probation officer about what had happened and he agreed she should do so. The probation worker said that when she made the call she told the home probation officer that she had little information about the man at that point and that she would ring back when she had more information. She told the home probation officer that she was giving her this information in confidence. The probation worker said that about two hours later she received a telephone call from the victim support officer. The victim support worker said that she was telephoned by the home probation officer and so she had informed the man's cousin.

138. My lead investigator was accompanied by my senior family liaison officer, on a visit to the family on 12 July, at the man's cousin's home. She was joined by the man's sister who had flown back from abroad upon hearing of her brother's death. The man's cousin explained that she knew the victim support officer so hearing the news of her cousin's

death from her was acceptable, rather than the prison visiting her to break the news personally, as is required in PSO 2700.

Prisoner Support

139. Following the man's death, the Safer Custody Manager organised for all prisoners who were on open ACCTs to have a case review. Prisoners were reminded that Listeners were available if they needed support.

Staff Support

140. A hot debrief was held on the morning of 3 July. (A hot debrief is a meeting held directly after a serious event like a death in custody to establish the sequence of events and whether any immediate lessons can be learned.) Staff told my investigation team that they were happy with the way the debrief was handled and they found it useful. I am surprised that the nurse on night duty did not attend the debrief, given his pivotal role in the response efforts. In light of this, I ask the Head of Healthcare to work with the Governor to ensure that all relevant healthcare staff are involved in any future debriefs as a matter of housekeeping. All staff involved in the response efforts said that they felt well-supported during the incident and knew how to access any additional support in the days following the man's death, if needed.

ISSUES

Clinical Review

141. A GP was appointed by the local Primary Care Trust (PCT), to conduct an independent clinical review, on their behalf. The clinical reviewer liaised with the lead investigator, reviewed the man's clinical records and the transcripts of interviews that my investigation team carried out. The clinical reviewer did not conduct any interviews personally.

142. I have included reference to his commendations and recommendations as I consider the issues. The clinical reviewer drew the following conclusion:

> "The medical and psychiatric care of [the man] at HMP Long Lartin was entirely appropriate. The psychiatric care deserves special mention; the nurses almost took up permanent residence in the Segregation Unit in an attempt to foster better care of [the man] whilst he was located there."

While I agree with the clinical reviewer that the man received a high level of care from the prison doctor and the primary care mental health team, I consider the work of the mental health inreach team in more detail later in the report.

Record-keeping

143. The man spent 17 months in prison, transferring between six establishments. He was on various ACCT documents throughout his time in prison. He was restrained on several occasions. My investigation team were provided with a lot of records documenting his time in custody since February 2006, but the picture was far from complete. I am disappointed that his complete records were not available for the investigation. More importantly, staff involved in his care needed a clear history of both medical intervention and his behaviour pattern to inform their planning. It is not unusual for me to comment on the adequacy of record-keeping in a report, it is no less disappointing to repeat this recommendation:

The Prison Service must ensure that systems are in place for the efficient transfer of complete records between establishments.

The investigation team proceeded with the investigation based on the evidence available.

The man's transfer from Rye Hill

144. The man was located in the segregation unit while he was at Long Lartin. He was segregated in Rye Hill, Swaleside, High Down and Brixton before that. In response to the draft consultation exercise, his family

raised their concern about the effect of repeated transfers between establishments on the man's mental health. I agree that such regular moves between prisons cannot have helped his already unsettled mental state. There was no evidence that the impact of these moves was considered by staff managing his care. Ultimately, staff prioritised the security of their establishments and tried to ensure the man's safe accommodation.

145. During the course of the investigation, my lead investigator met the prison service lead for the revision of PSO 1700, the Prison Service Order that governs the use of segregation. The prison service lead explained that transfers between segregation units were discouraged in the Prison Service because of the detrimental effect that prolonged segregation can have on a prisoner's mental state. This echoes the Chief Inspector of Prison's concern that transfers between segregation units were "indicative of a lack of individual care". The revised PSO acknowledges that:

> "The reasons for transfer being a last resort are two fold as firstly since it was stopped within the High Security Estate the rate of self-inflicted deaths has reduced and secondly it sends a clear message to prisoners that the segregation unit is not a gateway to gaining a transfer."

146. The prison service lead said that there are "exceptional circumstances" when a prisoner should be transferred from the segregation unit in one prison to the segregation unit in another. The revised PSO, due to be published later this year, instructs:

> "A transfer to another establishment should only occur when there is absolutely no other option available; it should wherever possible not be a transfer to another segregation unit particularly if the prisoner has been subject to ACCT support."

147. The man was not on an open ACCT on 2 May, when he was transferred from the segregation unit at Rye Hill to the unit at Long Lartin. The Governor of Long Lartin said that he had personally agreed to the transfer with the Director of Rye Hill, (a Director is a private prison's equivalent of a governing Governor). He said that he was surprised that someone of the man's level of risk was at Rye Hill, where the segregation facilities are not as well-resourced as at Long Lartin. As such, the Governor of Long Lartin was confident that his segregation team and facilities at Long Lartin were better equipped than Rye Hill to accommodate someone of the man's profile. The Head of Security at Long Lartin said that the decision is ultimately the Governor's to make about transfers directly between segregation units. The Head of Healthcare was not at work at the time of the man's transfer, but she said that she is not often consulted about the transfer of prisoners with healthcare needs, until after their arrival. When asked if healthcare was

involved with the decision making process to accept the man, the head of healthcare said:

> "Probably not, to be perfectly honest. Often people arrive and we're not aware that they've arrived and they're not very well when they get here, they've got needs, not just mental but physical health needs."

148. The senior officer on the segregation unit, said that segregation staff are not consulted before a prisoner is transferred directly from a segregation unit in another establishment. Several staff from the segregation unit expressed frustration about the man's transfer to Long Lartin, because of the previous death in custody in April. That prisoner had very similar behaviour patterns to the man and presented staff with the same level of difficulty when managing his care.

149. I agree that the Governor must have responsibility for the ultimate decision to accept another prisoner. Ideally all staff should have input into the care plan for such a prisoner in advance of a segregation to segregation transfer. I am pleased to note that this matter will be addressed by the revised PSO 1700, which instructs that:

> "Where prisoners have mental or physical health problems, consideration for transfer must include assessments from healthcare staff as part of the segregation review board. Any plans made by the board should include any required support at the receiving establishment and any action needed to ensure the support is immediately available."

150. If the receiving establishment must ensure that the required support for a prisoner transferring between segregation units is "immediately available", all staff that will be involved in the prisoner's care must have advance warning to make the necessary preparation. I hope that in the meantime relevant staff are consulted before the transfer of a prisoner from another establishment's segregation unit.

The ACCT process

151. According to Prison Service Order (PSO) 2700, suicide prevention measures are not simply intended to reduce the number of incidents of self harm and self-inflicted deaths in prisons. Suicide prevention measures are intended to equip staff to provide vulnerable prisoners with positive care and support that gives them coping mechanisms other than self-harm.

152. The man's ACCT document was completed to a high standard at Long Lartin. The front cover showed clearly the number of required observations and the date of case reviews. Trigger points were clearly listed on the inside of the front cover. The man was assessed appropriately within 24 hours of the ACCT being opened. The folder

contained copies of the healthcare care plans written for him. His Caremap was completed in detail and updated appropriately. Reviews took place extremely regularly and were always attended by at least one member of wing management (senior officer or principal officer) and one member of the mental health team or other healthcare staff. Review summaries were detailed and showed the thinking behind decisions.

153. Of course the ACCT process is not just about accurate record keeping, but about the quality of engagement and interaction. (A PSO is a compulsory instruction to prison staff. PSO 2700 governs the management of prisoners considered to be at risk of suicide or self-harm.) The on-going record showed a number of detailed entries from staff describing their interactions with the man. The record generally provided a valuable over-view of his behaviour and his management in Long Lartin's segregation unit. It also painted a distressing picture of an extremely unwell man struggling to cope with even the most basic of daily routines such as washing and eating. He was frequently abusive and aggressive but also wept with his head under a blanket and growled, in place of talking. On one occasion he lay on the ground in the exercise yard in the rain and would not move. A mental health nurse had to take the decision that staff should bring him in because he was shaking continually. He was continually sexually inappropriate with female staff which must have been distressing for them. Not only was he verbally inappropriate, but he also exposed himself to them. Some days he would appear to understand what was being said to him and to respond, on other occasions he made no sense at all, merely repeating the same phrase over and over again. It is clear to me that staff made continual efforts to engage with him but equally obvious that this was almost impossible.

154. During interview, all staff acknowledged that the man was at risk of self-harm. He did not speak about self-harm or suicide, but everyone described him as "impulsive". However, he had a history of suicide and self-harm. The ACCT process was a way to manage the risk he posed to himself, due to his unpredictability. As the RMN put it, "there was a feeling that it might happen". The senior officer on duty in the segregation unit told us that the uncertainty surrounding the man's behaviour was concerning and challenging for staff to manage.

155. I am satisfied that the management of the man's care was appropriately monitored through the ACCT process. I go on to consider the appropriateness of the use of a safer cell, segregation and the impact of the regime on his risk of self-harm or suicide.

Mental Health Intervention

156. The primary care mental health team leader became aware of the desperate state of the man's mental health within his first few days at Long Lartin. She heard staff talking about his arrival and what support he would need in the segregation unit. She assessed him and quickly

realised that he had not been prescribed medication. She acted quickly to try to offer him proper help and medication. I share her concern that the man arrived without medication from Rye Hill and that no-one from Rye Hill contacted Long Lartin to forewarn staff about the true extent of his mental health problems. The clinical reviewer, described the lack of medical handover between Rye Hill and Long Lartin as "unacceptable". He makes the following recommendation with which I concur:

The medical transfer of the man should be discussed at the next clinical governance meeting at Long Lartin.

Earlier in this report, I consider in greater detail the arrangements for prisoners who are transferred to Long Lartin's segregation unit directly from another prison's segregation unit.

157. The man was prescribed 10mg of Olanzapine (an antipsychotic), 5mg of Diazepam (prescribed for anxiety) and 1mg of Lorazepam (also used for the treatment of severe anxiety). His compliance with his medication varied. Sometimes he would take his medication while on other occasions he would refuse it, or accept the medication and secrete it in his cell. I understand that the man's family were concerned that he was not forced to take his medication, given his condition. In order to encourage him to take his medication, staff did try to issue it in liquid form, but he again refused to accept it. Healthcare staff cannot force a prisoner to accept treatment, unless that prisoner can be considered as not having mental capacity. To do so would be considered an assault in English law. Mental health staff were not able to carry out a mental health assessment to establish whether he had the 'capacity', that is the ability to make a decision about his own treatment. I am satisfied that staff could not have made any more forceful efforts to compel the man to take his medication, within the constraints of the law.

158. I remain somewhat confused about the role of the mental health inreach team in this case. He was referred to the inreach team on the day of his arrival by the RMN who completed the cell risk assessment form. The referral was declined by inreach. No further explanation is given. Another referral was made two days later, by the CPN. This referral was again declined by the mental health inreach team and no reason given. He was referred again on 8 May. He was rejected by the inreach team for the third time, apparently after discussion with the inreach team manager. During interview, the inreach team manager explained that there are three criteria, only one of which has to be met for an assessment to be carried out by the inreach team. The prisoner must have been known to mental health services in the past, been referred by another inreach team or assessed by a psychiatrist as having a severe and enduring mental illness. The inreach team manager acknowledged that the man met all three criteria. She told my investigator that she advised her colleagues at Long Lartin that they should have accepted the original referral of 4 May.

159. There are six mental health nurses on the primary care mental health team, four of whom are full time. This contrasts with the inreach team, which is externally managed by a clinical manager for the local Mental Health Trust. There are two members of staff working for her, one of whom was full time although now on long-term sick leave and the other who is a part-time occupational therapist. The prison doctor supports both teams in his role as the visiting Consultant Psychiatrist. While the inreach team manager acknowledged that the man met the criteria to be looked after by inreach, she also felt that the limited resources afforded to the inreach team meant that his care was managed more effectively by the primary care mental health team. During interview, she said:

> "I think [the inreach team's] rationale that [the primary care mental health team] had seen him so much and they can manage him until they reduce the amount of time they see him and then [the inreach team] would take over"

160. It was simply not possible for the inreach team to offer the man the level of support that the primary care mental health team did. The inreach team manager understood that her team were waiting for the primary care mental health team to stabilise him and make it possible for them to assess him. If the man was supervised by the inreach team, he would only have received weekly contact with an inreach nurse. I am surprised at the limited inreach care available at Long Lartin. The prison has the largest segregation unit in the country and accommodates some of the most dangerous prisoners. Adequate care for those with severe and enduring mental illness is vital for the management of such a population.

The Head of Healthcare and the Head of the Inreach Team should carry out a needs analysis of the population and ensure that staffing levels are adequate to meet the mental health requirements of prisoners.

161. I consider that the primary care mental health team and the prison doctor did everything they could to try to engage with the man and offer him help. He was visited six times a day when he was first in the segregation unit. This was reduced to three daily visits as time progressed, but it illustrates the commitment of staff to monitor and attempt to engage him with mental health treatment. The female mental health nurses in particular persevered with him in the face of some very unpleasant suggestive behaviour. The primary care mental health team also tried hard to raise the awareness of discipline staff on the segregation unit, to help them understand the effect of the man's mental health problems. Entries on his medical record are of a high quality and offer a detailed picture of the care he received. I consider that the primary care mental health team provided him with a consistently high standard of care, but unfortunately the man was rarely, if ever, in a well enough state to recognise or respond positively to this.

I commend the efforts of the primary care mental health team and the prison doctor to engage with the man.

162. Segregation staff were pleased with the level of support that the primary care mental health team gave them in caring for the man. An officer said that he had received mental health awareness training, but did not know "the last time I was on it". The senior officer on duty in the segregation unit said that segregation staff are "supposed" to have mental health awareness training, but she had not received it. Many staff agreed with her that such training would be useful. The senior officer thought that the mental health inreach team were responsible for the delivery of mental health awareness training, although she was not certain. The head of healthcare explained that the member of staff who was responsible for delivering mental health awareness training was from the inreach team but was off work due to sickness. The arrangements for the delivery of mental health training for segregation staff were far from clear. I am surprised at the number of staff on the segregation unit who had not received mental health training to equip them to care for prisoners with such acute mental health needs as the man.

The Head of Healthcare should ensure that robust systems are in place to deliver regular mental health training to all segregation staff.

163. The primary care mental health team leader and the prison doctor worked extremely hard to get the man assessed by and transferred to a secure mental health setting. Referrals were made to both Broadmoor and to the the Medium Secure Unit. The man had spent time in both of these mental health settings. The medium secure unit's doctor assessed the man as suffering from multiple personality disorders that were made worse by his stressful situation. He referred to a previous assessment that he conducted while the man was at Brixton, where he concluded:

> "[The man] has a Psychopathic Disorder defined under the Mental Health Act 1983 as a persistent disorder or disability of mind (whether or not including significant impairment of intelligence), which results in abnormally aggressive or seriously irresponsible conduct. It is of a nature and degree, which would make it appropriate for him to receive medical treatment in hospital. However, treatment in hospital did not alleviate his condition or prevent further deterioration. In fact, it led to an increase in the risk to self and others with ever increasing levels of security. I do not recommend transfer to psychiatric hospital at present."

164. On assessment at Long Lartin, the medium secure unit's doctor concluded that nothing had changed since he drew this conclusion. He did not support a transfer to a secure hospital. Immediately following this decision, the Governor and the primary care mental health team held a case conference meeting to discuss the man's care. The Governor wrote to the medium secure unit's doctor to ask him to reconsider his

decision. He also contacted Broadmoor to progress that referral. It is exceptional that a governing Governor was so involved in the care of one individual. I am pleased to see how the Governor supported his staff in this way. Officers and healthcare staff all considered that the man's mental health issues could not be therapeutically addressed in a prison setting. Officers felt that primary care mental health support had increased since the previous death in custody and were grateful. No officers spoken to by the investigation team felt that they were adequately trained to care for prisoners with the man's mental health needs. It is deeply unfortunate that a transfer to a mental health secure unit did not take place before his death.

The decision to segregate the man

165. The governing Governor told my investigation team that he agreed to the man's transfer on a segregation unit to segregation unit basis, implying that the decision to segregate the man had been taken before he had arrived at Long Lartin. Nevertheless, a Cell Sharing Risk Assessment was completed, which identified the man as a high risk and recommended that he be placed on the segregation unit for a "period of assessment". The Governor explained that prisoners who have a history of violence or threatening behaviour are often placed on the segregation unit for a short period for their behaviour to stabilise. Once they have adapted to the regime, prisoners can often be moved to a residential wing.

166. At the Segregation Review Board three days later a Governor grade recorded that attempts were made to persuade the man to relocate to the healthcare centre, but he refused to go. During interview, the Governor grade told my investigators that staff considered moving the man to the healthcare centre on "a number of occasions", however building work was going on at the time which meant that there was a lot of noise. She also acknowledged the difficulty of managing him in the healthcare centre, because of his potential risk to others. (The staffing levels in the healthcare centre are not as high as in the segregation unit, so less security measures could be taken. Given that the man was on a four man unlock, the lack of officers based in the healthcare centre would have meant that other staff would have to be brought onto the healthcare centre each time his cell was opened.) The head of healthcare agreed that although initially it was the man who had refused to go to the healthcare centre, location on the healthcare centre "may have exacerbated his mental state at that time". The Governor grade explained that eventually it was decided that the safest place to accommodate the man was in the segregation unit with regular, daily input from the mental health team.

167. The lead for the Prison Service segregation review, described the "exceptional circumstances" in which someone on an open ACCT can be located in the segregation unit. He said when the prisoner is particularly violent, a danger to themselves and others then it is reasonable for them

to be segregated. The clinical reviewer considered whether it was reasonable to segregate the man and concluded that:

> "In my opinion, placing [the man] in segregation was appropriate, he could not have been safely managed anywhere else in HMP Long Lartin, even in Healthcare."

168. Nevertheless, I am concerned about a prisoner with the man's mental health problems and risk levels being located in the segregation unit for a prolonged period. The medium secure unit's doctor observed to the primary care mental health team leader, after his assessment of the man on 21 May that he presented "as extremely distressed and disturbed". However, there is no doubt that he posed an extremely high risk to himself and others. Regrettably, I am satisfied that there was no alternative but to segregate him.

The man's security protocol

169. As the senior officer in charge of the unit when the man arrived on 2 May, an SO completed his individual risk assessment. She assessed the man as a high risk requiring four officers plus one senior officer to be present every time he was escorted around the unit. Any prisoner assessed as high risk will have an individual management protocol drawn up by a segregation unit senior officer, in consultation with staff on the unit. The management protocols are referred to during the team meeting each morning and staff suggest amendments according to their observations of a prisoner's behaviour. The man's management protocol was written on 8 May. It was updated only once, on 23 May, following his assault on an officer. His protocol contained the following instruction to staff:

> "Since arriving [in segregation the man] has consistently not complied with normal unlock protocols and has assaulted an officer when an attempt was made to offer him exercise.
>
> "[The man] has an extremely poor custodial history with 11 previous uses of force … He is completely unpredictable and presents a high risk of violence towards all staff …"

170. The protocol required that unlocking should occur with the presence of a senior officer and four officers all wearing full personal protective equipment (PPE).

171. An additional provision under a heading <u>First Aid</u> stated:

> "If [the man] should need urgent medical attention then staff are first to ensure that the staffing levels at least equal the unlocking protocols that are in place. <u>Staff entering [the man's] cell MUST be in full PPE</u> …"

172. I am pleased with the consultation which took place as part of the preparation of the document. Every officer from the segregation unit who was asked said that the documents are referred to and senior officers are responsive to suggested changes. I discuss below my concerns about one of the clauses in the man's management protocol, regarding the entering of his cell in an emergency situation. I am surprised that such a document, dealing with prisoners who are assessed as a high risk to themselves or others, was not authorised by someone at governor level at the time it was drafted or updated.

The Governor should ensure that all management protocols are authorised by a governor.

The man's cell on the segregation unit

173. When the man arrived he was located in a normal residential cell. All of the cells in the segregation unit are single cells. The senior officer on duty in the segregation unit said that she immediately became concerned about his behaviour. The same evening that the man arrived on the unit, she moved him to a high control cell. A high control cell is the same size as a residential cell but has a large metal hatch on the door, so that meals can be passed through without the door being opened. The SO said:

> "The high control cells are used for prisoners who are presenting as either going to be a threat to staff or if they've been brought onto the Segregation Unit under restraint or they're on multiple unlocks or we don't know anything about them, they need to go through a period of assessment."

174. The man remained in the high control cell for four days, until 6 May. He was then moved to the safer cell. As the name suggests, there are reduced ligature points in these cells and the man was put there because staff were worried about the risk that he posed to himself. As discussed above, officers found that there were difficulties in managing him in the safer cell. For example, there was no hatch to put his meals through, but his behaviour still remained violent and unpredictable so it was difficult to serve his meals in a dignified fashion. On 11 May, the man was moved back to the high control cell. An officer described the man's reaction to moving between cells:

> "Cause he thought he was going backwards, he thought the high control cell was a lesser thing, the worse thing, than the [safer] cell for some reason."

175. The officer suggested that the man's move between cells was motivated by managers who wanted to show that efforts were being made "on paper" to progress him,. In fact, the man did not understand the different purposes of each cell and, despite officers' efforts, they could not make

him understand that he was not being punished by returning to the high control cell.

The regime on the segregation unit

176. The man's family were concerned about the limited activity available while he was on the segregation unit. He had been assessed as too high a risk to others to be able to participate in association or exercise on the unit. His only interaction was with the Listeners. The Listeners said they saw the man in the Listener suite in the segregation unit on his first night in Long Lartin. Some five or six days later a Listener saw the man again after he went to the segregation unit to visit another prisoner. When the Listener attempted to see the man a third time, segregation unit staff told him he was not allowed to see him. The man had seemed anxious at first, but soon relaxed and they were able to share a joke. The Listener saw the man on one further occasion, but then was told by staff that his mental health condition was too severe and that a Listener would only make it worse. Although the healthcare staff could recall that such a decision had been made, no one could remember who made the decision to prevent him from seeing a Listener.

177. It is a matter of concern that the man did not have access to the Listeners for most of the time he was at Long Lartin. It is difficult to see how a Listener might have adversely affected his mental state any more than the long periods of isolation that he experienced while he was segregated. I was assured that it was not for security reasons that the man could not speak to Listeners and, indeed, my investigators were impressed with the measures taken to reduce the risks to Listeners and enable segregated prisoners to have access to the Listener scheme.

The Governor and the Head of Healthcare should ensure that all prisoners have access to Listeners. Any decision to restrict Listener access must be well-documented and systematically reviewed.

178. The man's family were concerned that he lost a significant amount of weight during his time in prison. During interview, an officer explained the difficulty that staff had in getting the man to eat his meals. A second officer told my investigators that segregation staff open food refusal logs if a prisoner does not eat over three days. The second officer said of the man:

> "I don't ever remember him not eating for any period, not even a day. He ate an apple or something and he's always got access to food in the cell. So there was never ever a concern that he was on a food refusal."

Staff were concerned that the man would not eat his meals in the safer cell because it was placed on the floor. As soon as they realised the situation, they moved him into a different cell. Staff did take notice of the

man's food intake and took action when it was required. Unfortunately, his eating habits were another manifestation of his mental health condition.

179. There is clear evidence that segregation officers tried to work with the man to increase the amount of time that he spent out of his cell. The application system for access to showers, telephone calls or exercise was deemed too difficult for him so staff were flexible with allowing him access to showers and exercise. Attempts were made to engage him in purposeful activity, for example, by leaving a reading book in his cell, but he did not seem to want to participate. Segregation staff told my investigation team that they were worried about the amount of time that the man spent in his cell, on his own. The senior officer on duty in the segregation unit described how every day two members of staff would be allocated to work with the man all day. He seemed to respond well to speaking to the same officers every day.

Use of force

180. Prison Service Order (PSO) 1600 details the Prison Service policy on the use of force. The use of force is justified where it can be shown to have been reasonable and necessary in the circumstances providing no more force than necessary was used and it was proportionate to the seriousness of the circumstances at the time. Holds must be relaxed as soon as the prisoner becomes compliant. Prison officers should receive regular refresher training in C&R techniques, generally every 12 months. The PSO states that staff who have not been refreshed in the previous 12 months must not take part in planned uses of C&R. A 'Report of Injury to Inmate' form must be completed after every use of force, whether any injuries are visible or not. All staff who were involved in a C&R incident are required to complete a statement describing the circumstances that led up to the use of force and what role they took during C&R.

181. The use of C&R on 4 May 2007 was the first occasion that force was used against the man since his arrival in Long Lartin just two days earlier. He was being escorted by staff to the exercise yard. Upon reaching the door to the exercise yard he had become more verbally aggressive and had raised his arms in the air. Staff reported that they feared for their own safety and so restrained the man using C&R techniques and returned him to his cell. The staff did not know the man very well at this time and all clearly feared that he was about to assault someone. Therefore their use of force was justified. All of the staff completed statements detailing their use of C&R and a report of injury form was completed. The three staff who used C&R had all been refresher trained in the preceding 12 months.

182. The C&R on 5 May was a planned intervention and was deemed necessary in order to move the man into a safer cell. Staff made several attempts to explain the reason for the move and to try to persuade him to

walk voluntarily to the new cell. Their efforts were unsuccessful and therefore they sought the authority of a governor grade to undertake a planned use of force. Authority was duly given and the staff team put on protective equipment and then entered the cell in order to restrain him and move him upstairs to the safer cell. The man fought against staff during the move. The use of force in this situation was justified because it was necessary for the man to be put into a different type of cell to the one he was in and efforts to persuade him to move voluntarily had failed.

183. On 11 May, staff went to the man's cell in order to give him his lunch meal and to move him into the next door cell. It was necessary to move him because he had been blocking his observation panel with food and toilet paper. Staff needed to be able to see him frequently and clearly as he was on an open ACCT form. The man was given several opportunities to comply with the instructions he had been given by staff but he refused to do so. The use of force was therefore justified. All of the staff completed statements detailing their use of C&R and a report of injury form was completed. The three staff who used C&R had been refreshed in the last 12 months.

184. C&R was used on 17 May because the man refused to undergo a strip search. The strip search was necessary because he had just set fire to his cell and staff needed to be certain that he did not have any more matches so that he could not set fire to the new cell. I consider that the use of force was therefore justified. Staff were wearing protective equipment and were supervised by the PO. All of the staff who used C&R had received refresher training in the previous 12 months and all completed detailed statements describing what happened. The report of injury form was completed by a nurse.

185. The use of C&R on 23 June occurred as a result of the man rushing to the cell door and grabbing hold of it during the time when his tea meal was being put into the cell. All of the staff involved in using C&R, including the senior officer who was supervising the situation, completed detailed accounts of their role. All of the paperwork was completed to a high standard. All of the staff had received refresher training within the previous 12 months. The report of injury form was completed by a nurse. Again, I consider that the use of force against the man was clearly justified in these circumstances.

Use of the special cell

186. Prison Service Order (PSO)1700 states that special accommodation must only be used to hold, for the shortest necessary time, a violent or refractory prisoner to prevent the prisoner injuring themselves (as a product of the violent or refractory behaviour) or others, damaging property or creating a disturbance. A form entitled "Authority for Location in Special Accommodation" must be used to record all observations and decisions.

187. Specifically, in relation to prisoners who are on an open ACCT, the PSO states that the duty governor must consult the Caremap before or as soon as possible after the decision to place him in special accommodation. The ACCT must be updated as soon as possible and an ACCT case review held within two hours of the decision. The ACCT Caremap must make clear what alternatives to the use of special accommodation have been considered, and what plans are in place to end its use, with an envisaged time frame.

188. An ACCT case review was not held within two hours of the decision to put the man into special accommodation on 23 June. One was convened at 10.40am the next morning, but a case review was planned anyway for this day. The review was chaired by 3 members of staff. The summary noted that the man had:

> "been quiet but restless through the night and continued to pace. He accepted [medication] this morning and ate his breakfast. He appears to be slowing down. There is no evidence that he intends to harm himself but he remains at risk to staff. To remain in special cell, to be monitored and reviewed frequently. No changes to care map".

189. PSO 1700 states that the duty governor must nominate a designated manager (of not less than Senior Officer rank) to assess the prisoner's continued location in special accommodation at the frequency specified by the duty governor, but at no less than once an hour. The designated manager must make every effort to talk to the prisoner and de-escalate the situation so as to minimise the time spent in special accommodation.

190. In general, most of the actions required by the PSO on special accommodation appear to have been carried out, but not recorded properly on the required form – there is no record of the IMB visit, the duty governor visits, the doctor or nurse visits. I therefore make a housekeeping point that the Governor should remind all staff to ensure the special accommodation form is completed in full and, in particular, that it records all visits made.

191. However, some elements of the PSO were not complied with. Specifically, an ACCT case review was not carried out within the two hour time frame (but one was carried out the following day), the authorising governor did not review the contents of the segregation safety screen after it was completed by healthcare and the authorising governor did not appoint a 'designated manager' to assess the man on a regular basis. A manager was not appointed to carry out regular assessments on him. He was clearly being watched and monitored by staff on a frequent basis, but there is less evidence of regular attempts to engage with him "for the purpose of de-escalating the situation to minimise the prisoner's time spent in special accommodation".

The Governor should ask all operational managers who may authorise the use of special accommodation to remind themselves of the relevant sections of PSO 1700.

The emergency response

192. When a potentially violent prisoner was sent to outside hospital in the early hours of 3 July, the escorting team included the regular segregation officer. The orderly officer said that he included that officer in the team, as he wanted his most physically powerful officers to escort the prisoner in case he became violent again. I consider that to have been a reasonable decision. The effect of this decision was that the wing officer, who was not a regular segregation officer, was moved to the unit from Perrie wing.

193. As the man was being monitored through the ACCT process, the wing officer checked him at 4.06am. CCTV analysis shows that he discovered the man hanging at 4.33am and that staff entered the cell just under four minutes later. The man was due to be checked four times an hour. I agree with a concern raised by the family about the time elapsed between checks at 4.06am and 4.33am. It would have been possible for the four checks to have been carried out between 4.00am and 5.00am. I also understand the need for irregular checks. However, I hope that the Governor will remind his staff to balance the need for irregular checks with ensuring that the checks are carried out with sufficient frequency.

194. The wing officer was joined by 3 other officers. The orderly officer shortly followed and the nurse on night duty came from healthcare carrying the emergency bag and a defibrillator. If the wing officer had been a regular segregation officer, it is possible that he might have been prepared to take the risk of unlocking the man's cell slightly sooner, but I would not criticise him for waiting for the orderly officer to arrive and to make that decision.

195. I do have a criticism about the written protocol for unlocking the man's cell. It was important that there was a protocol. I am surprised, however, that the protocol in the case of the man needing urgent medical attention required staffing levels and precautionary measures to be at least equal to the protocol's requirements. That is, four officers and a senior officer had to be present before his cell could be opened, regardless of the urgency of the situation. When the orderly officer looked into the man's cell he was certain that it was a true emergency and that he was not feigning injury. The orderly officer ordered that the cell be entered immediately. This was the correct decision to make, although it was at variance with the protocol that required staff to have first put on full personal protective equipment.

The Governor should review unlocking protocols with a view to allowing staff to make a judgement about the minimum safeguards they need to take before unlocking a cell.

196. When staff entered the cell they cut away the ligature and examined the man. He was checked with a defibrillator that advised that no shock be given. Officers started to give chest compressions but the nurse on night duty's efforts to give oxygen were hampered. First, he discovered that the oxygen cylinder was empty and, secondly, he was unable to assemble the ambu-bag as he could not find the attachment. The nurse told my investigator that he had used up the oxygen when treating the other prisoner earlier on that night. My investigator discovered that oxygen cylinders are fitted with a gauge showing how much oxygen they contain. My investigator also discovered that when an ambu-bag is used to hand pump air, there are no fittings to attach. An additional fitting is only needed when using an ambu-bag in conjunction with oxygen.

197. The nurse then began to give mouth-to-mouth breathing while the officers continued with chest compressions. The ratio they used was one breath to ten chest compressions. This ratio is incorrect. The current advice from the Resuscitation Council UK (who issue national about resuscitation guidelines to medical staff) is that two breaths should be given to 30 chest compressions.

The Head of Healthcare must ensure that all nursing staff are competent to deal with first aid emergencies.

198. When the nurse first responded to the Code Blue alarm he ran to the segregation unit from healthcare carrying the emergency bag and the defibrillator. I understand that the PCT were due to review Long Lartin's emergency response equipment, particularly to ensure the prison had sufficient emergency response bags and that the bags adequately equipped.

The PCT and Governor must reassure themselves with regard to the adequacy of provision and location of emergency equipment.

199. The ambulance took around eight minutes to reach the segregation unit after its arrival at the front gate of the prison. The reason for the delay was that the ambulance had to travel almost half of the inside perimeter of the prison. In doing so it had to negotiate seven sets of gates. The ambulance was accompanied by one of the dog handlers, with his dog. Each negotiated gate had to be locked before the ambulance could proceed to the next gate.

200. As should be the case with all prisons, Long Lartin has agreed a protocol with its local NHS Ambulance Trust governing access to both the prison and individual prisoners in emergency situations.

The Governor should consider, in conjunction with the Ambulance Trust, whether any revisions need to be made to the protocol.

Contact with the man's family

201. The supplementary guidance to PSO 2710, which deals with the follow-up to deaths in custody, recommends that the prisoner's family should be informed face to face as soon as possible after the death. It also recommends that wherever possible, this should be done by appropriate staff from the prison. In the man's case, his family were informed via a telephone call from an external victim support worker. She had heard the news from the man's home probation officer who, in turn, had been informed by a probation worker at Long Lartin.

202. Two main factors contributed to this sequence of events. Firstly, no next-of-kin details had been recorded for the man. Secondly, and most importantly, at the time, Long Lartin had only one trained Family Liaison Officer (FLO). This was the assistant orderly officer and she had gone home in the morning of 3 July as that was her rest day. Had she been in the prison that day she would have been able to liaise with external bodies such as the probation service. In her absence, there was no one to lead in family liaison. The assistant orderly officer informed my investigator that a number of Long Lartin's staff were on the waiting list for the FLO training course.

If it has not already happened, I recommend that the Head of Safer Custody speedily arrange for more staff to receive FLO training.

RECOMMENDATIONS

1. The Prison Service must ensure that systems are in place for the efficient transfer of complete records between establishments.

2. The medical transfer of the man should be discussed at the next clinical governance meeting at Long Lartin.

3. The Head of Healthcare and the Head of the Inreach Team should carry out a needs analysis of the population and ensure that staffing levels are adequate to meet the mental health requirements of prisoners.

4. The Head of Healthcare should ensure that robust systems are in place to deliver regular mental health training to all segregation staff.

5. The Governor should ensure that all management protocols are authorised by a governor.

6. The Governor and the Head of Healthcare should ensure that all prisoners have access to Listeners. Any decision to restrict Listener access must be well-documented and systematically reviewed.

7. The Governor should ask all operational managers who may authorise the use of special accommodation to remind themselves of the relevant sections of PSO 1700.

8 The Governor should review unlocking protocols with a view to allowing staff to make a judgement about the minimum safeguards they need to take before unlocking a cell.

9 The Head of Healthcare must ensure that all nursing staff are competent to deal with first aid emergencies.

10 The PCT and Governor must reassure themselves with regard to the adequacy of provision and location of emergency equipment.

11 The Governor should consider, in conjunction with the Ambulance Trust, whether any revisions need to be made to the protocol.

12 If it has not already happened, I recommend that the Head of Safer Custody speedily arrange for more staff to receive FLO training.

Good Practice

1 I commend the efforts of the primary care mental health team and the prison doctor to engage with the man.