PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in February 2013, while a prisoner at HMP Long Lartin

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man at HMP Long Lartin on 14 February 2013. The man was 25 years old. Two other prisoners, prisoner A and prisoner B were subsequently convicted of his murder. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. It was suspended pending a criminal investigation and proceedings and I regret the consequent delay in issuing this report. Long Lartin cooperated fully with the investigation.

The man was serving a life sentence for the murder of a child and had been at Long Lartin since June 2009. He lived on a wing for prisoners regarded as vulnerable to intimidation or attack from other prisoners, usually because of the nature of their offence. During the evening association period on the evening of 14 February 2013, Prisoner A and Prisoner B who also lived on the vulnerable prisoner wing, went to the man's cell, took him captive and strangled him.

The actions of the perpetrators have been subject to a full criminal trial. This investigation has examined if there was anything more the prison could reasonably have done to protect the man. The attack on the man was sudden. Although Prisoner A and Prisoner B had a history of poor conduct in prison, including previous hostage-taking, there had been no recent misconduct. Prison staff had received no intelligence about either of them to suggest that the man or any other prisoner was at risk. Prisoner A and Prisoner B refused to provide definitive reasons for their actions. This investigation has found that it would have been difficult for staff at the prison to have foreseen or prevented their actions.

High security prisons have recently changed the risk assessment process for prisoners living on vulnerable prisoner wings following recommendations I made in other homicide cases involving the deaths of prisoners convicted of sex offences. However, it does not appear that these changes would have prevented either Prisoner B or Prisoner A from being allocated to or remaining in the vulnerable prisoner wing at Long Lartin had they been in place before the man's death, as monthly intelligence reports suggested that they would still be at risk on a standard residential wing.

While the staff response to the incident was more protracted than I might have expected, I accept that in the context of a high security prison the staff took a cautious approach and earlier intervention could not have saved the man.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2014**

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SUMMARY

1. The man had been in prison since February 2009, serving a life sentence for the murder of a child. Prisoners A and B were also serving life sentences for murder. All three men lived in the same vulnerable prisoner wing at Long Lartin. Prisoner B and Prisoner A had previously been involved in separate hostage-taking incidents in prison. However, Prisoner A had since achieved enhanced status on the Incentives and Earned Privileges scheme and, at the time of the incident, staff were also considering Prisoner B for enhanced privileges. Prison staff reviewed Prisoner B and Prisoner A's location on the vulnerable prisoner wing regularly and intelligence suggested that they would be at risk if they were to transfer to a standard residential wing.

2. Prisoner A and Prisoner B both knew the man as he was the prisoner wing representative. On 14 February 2013 at approximately 6.00pm, CCTV footage shows that they followed him back to his landing during the prisoners' association period and went into his cell.

3. At 6.41pm, a support officer in the prison's communications room received a call through the cell intercom system from a prisoner stating that he had taken the man hostage. After further discussion, the prisoner said that he thought the man was dead. The control room notified the senior officer on D wing, who went to the man's cell at approximately 6.44pm. The observation panel had been covered so he could not see inside. He asked who was in the cell. Prisoner A identified himself and said that Prisoner B was with him. When the senior officer asked to speak to the man, the prisoners said that he was dead.

4. The prison initiated the national and local contingencies for a hostage situation. Staff called an ambulance at 7.30pm and trained negotiators took over discussions with Prisoner A and Prisoner B at 7.44pm. Prisoner A then removed the covering from the observation panel which allowed staff to see into the cell. The man was unresponsive on the bed. At 8.16pm, control and restraint teams removed Prisoner A and Prisoner B from the cell and took them to the segregation unit. As soon as they had left the cell, paramedics who were standing by attended to the man. They did not attempt to resuscitate him as it was clear that the man was dead.

5. Neither prisoner has given a clear motive for their actions or the details of what they did or why they had targeted the man, although they have suggested that his offence was a factor. The prison had no intelligence to indicate that either Prisoner A or Prisoner B were a significant risk to the man or other prisoners. We are therefore satisfied that prison staff could not have anticipated or prevented the man's death.

6. Long Lartin has a contingency plan for hostage incidents, which instructs staff to notify and request specialist support such as the emergency services. An

ambulance was not called until around 50 minutes after staff were first told that the man was dead. While paramedics were available to attend to him as soon as the perpetrators were taken from the cell, the prison would not have been able to predict how long it would take to resolve the incident. We consider that, in future, an ambulance should be called as soon as staff are aware of the possibility of serious injury, to remove any potential for delay in emergency treatment.

THE INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners at Long Lartin, informing them of the investigation and inviting them to contact the investigator if they wished to be involved. No one responded.

8. The investigator visited Long Lartin on 20 February 2013 and met the deputy governor, the operational manager who had been duty governor on the day of the man's death and several other staff. He went to D wing, where the man had lived and other communal areas of the prison. The investigator obtained copies of the man's prison and medical records as well as information about Prisoner A and Prisoner B and he viewed CCTV footage of the evening of 14 February.

9. The investigator contacted the healthcare manager at Long Lartin, who confirmed that neither Prisoner A nor Prisoner B had been under the care of the prison's mental health team. Neither had the man been diagnosed with any mental illness. As there were no clinical issues, we did not request a review of the medical care of the prisoners.

10. In accordance with the Ombudsman's terms of reference, the investigation was suspended while West Mercia Police conducted a criminal investigation into the circumstances of the man's death and during the subsequent criminal proceedings. The investigator met the police investigating the man's death on 20 February 2013, to agree arrangements for information sharing and remained in contact with them throughout.

11. After the conclusion of the criminal investigation, the police provided a number of documents, including witness statements and the transcripts of interviews with staff and prisoners. The investigator reissued the notices to staff and prisoners at Long Lartin. Again, no responses were received.

12. The investigator interviewed Prisoner B and Prisoner A at HMP Woodhill on 28 November 2013. He met the police again to collect additional documents.

13. The investigator informed HM Coroner for Worcester of the investigation who provided the results of the post-mortem. A copy of this report has been sent to the Coroner.

14. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to identify any relevant issues that they wished the investigation to consider. The investigator, PPO family liaison officer and the police family liaison officer met the man's family on 5 November 2013. They wanted to know:

    - The timings, sequence of events and response times on 14 February.

- The number of staff on D wing at the time and why no officers were visible on CCTV footage of the landing.
- Whether Prisoner A and Prisoner B had been involved in similar incidents previously and whether they had been appropriately allocated to the vulnerable prisoner wing.
- How Prisoner A and Prisoner B had obtained sticking tape.

15. The investigator and PPO family liaison officer met again with the man's family on 15 May to discuss the content of the draft report. The family asked for further clarification on the systems in place at Long Lartin to prevent prisoners from obtaining sticking tape. The investigator subsequently contacted the prison and an account on how this is managed is provided at paragraph 91. The family raised other issues which have been dealt with in separate correspondence.

HMP LONG LARTIN

16. HMP Long Lartin is a high security prison. It has eight main wings and holds up to 622 category A and B adult men who have been sentenced to at least four years imprisonment. A, B, C and D wings accommodate vulnerable prisoners. Only one wing has integral cell sanitation.

D wing

17. On 14 February 2013, 77 prisoners lived on D wing, all in single cells. As there is no in-cell sanitation, there is an electronic system to lock and unlock cell doors and prisoners call the control room by an intercom when they need to use the toilet. Only one prisoner is allowed out at a time. During periods when cells are centrally unlocked, prisoners have keys to lock their own cells from the inside and, during association periods, from the outside to prevent other prisoners going into their cells without permission. Prison staff have keys which can be used to override this. The main staff office, where the senior officer is based and the kitchen area, where prisoners are able to prepare their own meals, are on the ground floor. CCTV cameras cover the corridors and association areas on the wing but not the inside of cells.

HM Inspectorate of Prisons

18. HM Inspectorate of Prisons' most recent inspection of Long Lartin was an unannounced full follow-up inspection in August 2011. The inspectorate's report stated:

> "… HMP Long Lartin in Worcestershire is a high security dispersal prison holding some of the country's most dangerous prisoners. This follow-up inspection found the prison sustained reasonably good outcomes for most prisoners in most areas. However, within that generally good picture we had a number of significant concerns.
>
> "The prison was divided into two parts. The older wings held prisoners who were vulnerable because of the nature of their offence, who could not cope with the main prison or who needed protection for other reasons.
>
> "Most prisoners in the main prison felt safe. However, a high proportion of the prisoners on the vulnerable prisoner wings told us they did not feel safe at the time of the inspection and we did not believe the prison had taken sufficient steps to understand and address their concerns. One of the factors they said made them fearful was the availability of drugs. Diverted medication was indeed a problem but despite this, suspicion testing rates were very low. There were relatively few violent incidents but those that did occur were often serious. The supervision of and efforts to address bullying and violent behaviour were not sufficiently rigorous ..."

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its most recent annual report, for 2012/13, the IMB raised no concerns about the management of vulnerable prisoners.

Previous deaths at Long Lartin

20. Since the Ombudsman's office became responsible for investigating deaths in prison custody in 2004, we have investigated 18 homicides in prisons. The man's was the first such death at Long Lartin. In 2011, two men were killed in cells in vulnerable prisoner wings in other high security prisons.

Vulnerable prisoners

21. Prisoners who are regarded as vulnerable can be held separately from other prisoners for their own interests under Prison Rule 45. There are a number of reasons why prisoners might be held separately in what are known as vulnerable prisoner units or wings. These include:

- Committing an offence of which other prisoners disapprove (for example, sexual offences or one involving a child);
- Accumulating debts to other prisoners they are unable to pay;
- Giving evidence to the prosecution or being regarded as an informer; or
- Susceptibility to bullying from other prisoners.

KEY EVENTS

22. The man was born on 12 August 1989. On 11 February 2009, he was convicted of the murder of a child and sentenced to life imprisonment. The man had been on remand in HMP Doncaster and returned there after he was sentenced. Prison records indicate that he had been a victim of bullying at Doncaster and that other prisoners had accused him of bullying. There was no evidence to support the accusations and the records suggest that the prisoners had made the claims as a ruse to have the man moved from the wing.

23. On 15 April 2009, the man was moved to the segregation unit at Doncaster, pending an investigation into allegations that he had passed information about other vulnerable prisoners to prisoners on other wings. These allegations were later withdrawn by the prison. The next day, he was assaulted while on the exercise yard and required treatment in hospital. It is unclear exactly what provoked this attack, but it appears to have been related to his offence.

24. In June 2009, the man transferred to HMP Long Lartin. Reports show that he began offending behaviour work and cooperated with his sentence plan. Security reports indicate that he had some problems with other prisoners, who had bullied him and stolen his possessions. The man told prison staff a number of times that he was concerned about his safety. Staff took action under the prison's anti-bullying strategy, including increased levels of observation and reviews of his situation. The last review took place in January 2010.

25. The man had lived on B, then C wing before moving to D wing, where he seemed to settle and actively participated in wing activities. He was elected as a wing representative to attend meetings with prison managers about changes that might affect prisoners and act as a point of contact if they had issues or problems.

26. The man was a Muslim and, in 2010, it was alleged that he and other Muslim prisoners had been inciting racial violence. However, prison staff monitored this and nothing was found to substantiate these claims. The man's medical record indicates only minor ailments during his time in custody and no serious health complaints. Wing staff described him as well-liked, with a close circle of friends who abided by the prison regime.

Prisoner A

27. Prisoner A was born on 5 October 1968. He had behavioural problems from the age of 12, which resulted in him being expelled from school. He was convicted of the murder of a 56 year old woman during a burglary at her home, in January 1989 with a minimum period to serve of 15 years before he could be considered for release. The Parole Board had not subsequently directed his release as it

was not satisfied his risk to the public had reduced sufficiently. Records show that Prisoner A found the first five years of custody difficult, resulting in numerous acts of self-harm by cutting. He had started hunger strikes several times and told staff that one of those was a serious attempt to end his life. There is no record of any further self-harm after 2003.

28. Prisoner A has spent time in several prisons and had breached Prison Rules a number of times, including by attempting to escape, testing positive for drugs, possessing of weapons, not complying with orders and hostage-taking. In the latter incident, in September 2007, Prisoner A and another prisoner held a prisoner hostage for several hours. Prisoner A later said that he had not intended to harm the hostage but was trying to contrive a move to another prison. He transferred to Long Lartin in August 2010 and, at the time of the man's death, had a total of 47 adjudications (disciplinary hearings), of which 10 were at Long Lartin. However, his last recorded adjudication was in December 2011.

29. Prisoner A had a long history of drug use in prison and had accrued debt to other prisoners. As a result, soon after he arrived at Long Lartin in 2010, he asked to be placed in the segregation unit and later moved to the vulnerable prisoner wing for his own safety. The investigator did not have access to his medical records, but was told that Prisoner A's only contact with mental health staff was in relation to his index offence and he had previously seen a psychotherapist at HMP Parkhurst in 1999.

30. Prisoner A told the investigator that he had originally lived in a standard residential wing at Long Lartin but, after a fight with a Muslim friend he asked to go to the segregation unit to avoid further trouble. He did not mention that he had drug debts. He said that while he was in the segregation unit, staff had offered him a move to the vulnerable prisoner wing with a view to a transfer to another prison. When the investigator asked him about his views about living in the vulnerable prisoner wing, Prisoner A commented that there were too many sex offenders there so he had applied for a transfer to HMP Dovegate, but he did not say when he had made this request. Records indicate that in October 2012, Prisoner A had asked to be located in the segregation unit as he was worried about being attacked by other prisoners and during this period had requested a transfer to HMP Whitemoor.

31. Prisoner A said that he had had eight parole reviews during his sentence and a further review was due in 2014. However, he had not felt that he was making any progress towards release, despite good behaviour and completing course work.

32. In the months leading to the man's death, Prisoner A had received positive comments from staff and was thought to be drug-free after completing a drug treatment programme. He had also signed a drug-free compact which required him to provide urine samples when required. This positive change had enabled

him to gain enhanced status under the prison's Incentives and Earned Privilege (IEP) scheme, designed to encourage and reward good behaviour and compliance with sentence plan targets.

Prisoner B

33. Prisoner B was born on 25 June 1965. Between the ages of 7 and14, Prisoner B attended a special school and often ran away from home. He had a record of offending from the age of 12 and had been convicted of violent and weapons-related offending. In 1999, he was convicted of the murder of a criminal associate.

34. In February 2008, Prisoner B transferred to Long Lartin from HMP Whitemoor. He too has been subject to disciplinary action many times, including involvement in drugs, bullying and refusal to locate when instructed to do so. In total, Prisoner B had 32 proven disciplinary adjudications between 1999 and 2011.

35. Prisoner B has a history of drug use in custody and had accumulated debt to other prisoners. As a result of this, he was placed in the segregation unit at Long Lartin not long after he arrived and later moved to a vulnerable prisoner wing for his own safety. He had first used drugs in prison early in his sentence and had attempted to take his own life by overdosing on heroin. There were further incidents of self-harm in 2000 and 2004, but none after that. Prisoner B had been diagnosed with Tourette 's syndrome for which he was prescribed medication. He has had good relationships with staff, but was said to become frustrated if he felt things were not happening quickly enough.

36. Prisoner B told the investigator that he had transferred to Long Lartin to complete offending behaviour courses and was initially on a standard residential wing. His explanation for his move to the vulnerable prisoner wing was that he did not like the 'politics' on the wings and there had been a lot of issues with Muslim prisoners. He said that he had returned to a normal wing for a short time in 2010, but the 'politics' on the wing were the same and so he returned to the vulnerable prisoner wing.

37. In September 2011, Prisoner B took another prisoner hostage on a vulnerable prisoner wing at Long Lartin. He explained his actions as an attempt to get staff to listen to him and that he had accrued drug debts and was 'in over his head.' He said that he had orchestrated the incident in order to be moved to the segregation unit and that he was fed up with not being listened to. After September 2011, he was not found guilty of any further disciplinary offences and in February 2013, because of his good behaviour at the time, wing staff were considering raising his IEP status to enhanced.

38. Prisoner B said that he had been due for a parole review in 2016, but an assessment had indicated that he would need to complete further courses and remain in a high security prison. He was unhappy about his lack of progress.

Contact between the man, Prisoner A and Prisoner B

39. Prisoner B and Prisoner A had known each other briefly while they were both at HMP Whitemoor. When interviewed, both prisoners said that they would consider themselves as acquaintances rather than close friends. They had friends in common and most of their contact had been in the company of mutual friends. Although Prisoner B had lived on a vulnerable prisoner wing for most of his time at Long Lartin, he had only recently moved to D wing. Prisoner B and Prisoner A lived on different landings.

40. Prisoner B said that before the events of 14 February 2013, he had spoken to the man only a few times. He felt that the man gave the impression that he was better than anyone else and did not want Prisoner B around.

41. Prisoner A said that he did not go out of his way to speak to the man when he saw him around the wing. He had been aware of the man before he moved to D wing as the man was a wing representative and attend meetings on other wings.

42. An entry in Prisoner A's security file suggests that he had a minor altercation with the man on 23 January 2012, which he did not mention to the investigator. The entry says:

> '… On 23 January 2012 at approximately 2.00pm the man and Prisoner A and three other prisoners entered workshop 4. Once in there the man was surrounded by Prisoner A and another prisoner. While the conversation was taking place the man appeared to take a defensive stance while Prisoner A and the other prisoner took an assertive stance. When the conversation ended Prisoner A and the other prisoner walked back over to two other prisoners, and they seemed to be looking back over to the man as if he was the topic of their conversation …'

Thursday 14 February 2013

43. At approximately 4.30pm on 14 February, prisoners on D wing were unlocked from their cells for an association period. During this time, they were able to socialise with other prisoners, prepare or collect their evening meals, obtain items they had ordered from the canteen (prison shop) or to go out to the exercise yard to spend some time in the open air. Staff told the investigator that Thursdays were particularly busy due to the variety of activities that took place.

44. During the association period, prisoners are allowed to move freely around the wing. D wing has three landings connected by a central stairwell. CCTV

provides a view of the landings, outside the cells and in communal areas. However, there are some blind spots that are not covered by CCTV including the stairwell between landings.

45. On 14 February, we understand that there was a senior officer and six officers on duty on D wing. One officer oversaw the distribution of canteen orders, two officers searched and recorded movements of prisoners as they left the wing to collect medication or to attend the gymnasium and two officers supervised prisoners in the exercise yard attached to the wing.

46. The man made several telephone calls during the association period. He telephoned his family and spoke to his aunt for around ten minutes. His aunt said the man sounded the same as usual.

47. The CCTV footage shows the movements of the three prisoners during the association period. The man was in a 'food boat' with another prisoner. (When prisoners club together to buy food and share the cooking of meals.) The prisoner said that, on the evening of 14 February, he cooked Moroccan food for himself and the man. At 5.20pm, he had a conversation with the man in the prisoners' kitchen, but he could not recall exactly what they discussed. The CCTV footage shows that the man left the kitchen on D1 landing at 5.49pm and went upstairs to the second landing. He went into a cell near his, before going back to the kitchen around a minute later.

48. During this time, Prisoner B was on the ground floor. Prisoner A was on the second landing, at one point in close proximity to the man, but the two men did not acknowledge each other.

49. At 5.55pm, Prisoner B and Prisoner A stood together on D3 landing outside Prisoner A's cell and they went into the cell, before leaving a short time later. Prisoner B locked Prisoner A's door with his privacy key, which enables prisoners to lock their own doors to prevent other prisoners going into their cells.

50. Prisoner A then went to Prisoner B's cell on D2 landing and unlocked it. He then left immediately, locking the door and returned to D3 landing. It appears from the CCTV that Prisoner A who was still on D3 landing realised that he could not get into his cell as Prisoner B had his key, so he went back down to D1 landing. The police report states that when he returned to D1, Prisoner A gesticulated towards the prisoners' kitchen and the man then left the kitchen and went towards the stairwell. There is no CCTV coverage in this area.

51. It was 5.58pm when the man left the prisoners' kitchen to return to his cell on D2. Prisoner A walked up from D1 to D2 in front of the man. The man then continued down the landing towards his cell and Prisoner A appeared to slow down and the man went past him. As he did so, the man glanced back at him over his shoulder. Prisoner B then appeared at the top of the stairwell from D1 and the

two men then followed the man along the landing. When he arrived at his cell door, the man reached up to unlock it and Prisoner A and Prisoner B were directly behind him. They immediately followed him inside. No apparent force was visible on the CCTV footage and the man did not appear to try to prevent them from going into his cell.

52. At 6.00pm, the other prisoner brought the food that he had cooked to D2 landing. He said that he placed the food on a fold-out table outside his cell and walked to the man's cell a little further along the landing. He noticed the cell door was closed. He then opened the observation panel, but found that it was covered from the inside with what he thought was a towel. He said that this was not unusual and he had known the man to do this, if he wanted some privacy. The prisoner then called to the man to pass his bowl so that he could serve the food. He said someone replied, 'one minute'. The prisoner said that he could not identify the voice but knew it was not the man's. He then went back to his own cell.

53. The prisoner said that while he was serving his evening meal he heard another prisoner calling out on the landing for Prisoner B. The prisoner wanted Prisoner B to return tobacco he had loaned to him. The prisoner returned to the man's cell a short time later and again called to him for his bowl, saying that his food was getting cold. The prisoner said that someone replied, 'put it in your tub' but again he did not recognise the voice. He then went back to his cell again.

54. The prisoner went back to the man's cell around ten minutes later and the door was still closed. He thought it was strange that he had not seen the man since he had left the kitchen. He placed his ear to the door and tried to listen for voices inside but said that he did not hear anything. He later heard another prisoner mention that Prisoner A and Prisoner B were in the man's cell and thought that they might have been hiding from someone as they were in debt on the wing. The prisoner said that as the man was the wing representative it was not unusual for prisoners to go in and out of his cell a lot.

55. An operational support grade (OSG), was on duty in the control room monitoring the electronic cell locking system. In her police statement, she explained that whenever the buzzer sounds she can see which prisoner is allocated to that cell. At 6.41pm, she answered a call from the man's cell. The person on the intercom said, 'Miss, I have taken the guy in this cell hostage'. The OSG asked him to repeat what he had said in case she had misheard and he replied, 'I have taken the guy in this cell hostage, it's not a joke.'

56. The OSG said she immediately alerted a Senior Officer (SO) who was in the main control room next door. She then went back to the intercom and asked, 'are you still there' and the person in the cell replied 'yes'. There was then a brief pause and he added, 'I am not joking, Miss, I think he is dead.' The OSG then asked why he had done this, to which he replied, 'I am bored and it was

something to do. I am not joking I think he is dead'. The OSG told the police that she did not know which prisoner she was speaking to, but he was calm and there was no panic in his voice, which is the reason she had questioned what she had been told.

57. The control room contacted another SO who was the senior officer on D wing, while the OSG continued to speak to the person in the cell. The SO went immediately to the man's cell and got there at about 6.44pm. He said that as he walked to the cell, everyone else on the wing was going about their normal routine and everything appeared calm. The SO called to the occupants of the cell and asked what was going on. Someone inside replied that they had the man. The SO then instructed staff to lock up the other prisoners. He tried to look through the gap between the door and the door frame as the observation panel was still covered and asked who was in the cell and what was happening. Prisoner A then identified himself and Prisoner B. The SO told Prisoner A that he was just about to complete an application for Prisoner B to be given enhanced status under the IEP scheme. The prisoners then laughed and said that this was now unlikely to happen.

58. The SO asked to speak to the man but the prisoners said he could not as the man was dead. He asked them to repeat this and Prisoner A said that the man had been dead for around an hour. Prisoner A told the SO that both he and Prisoner B were ready to go to the segregation unit. The SO informed Prisoner B and Prisoner A that he would have to pass on the information to his manager. Officers from the prison's security department had arrived at the wing while he had been talking outside the cell and the SO asked them to take over so that he could brief senior managers.

59. The prison initiated its contingency plans for dealing with a hostage incident, which included assigning trained negotiators and calling an ambulance. Prison healthcare staff also went to the wing. While the SO briefed senior managers and negotiators about what was happening, two officers remained outside the door. They recorded anything Prisoner A or Prisoner B said and ensured that no one else went to the cell.

60. One of the officers listened at the door for nearly an hour, while the other officer recorded anything relevant that was said and they passed this information to senior managers. The officer overheard either Prisoner A or Prisoner B say, 'Fucking hell it snapped'. Prisoner A was heard to say, 'This spur will be locked down, it will be like CSI up here'. Prisoner B said, 'It just snapped I wonder where he is, I bet Allah has got him'. Neither officer heard the man say anything while they were at the door. From the limited view through the side of the cell door, the officers said that they could see both prisoners sitting down and talking to one another quietly and calmly, but from their position they could not see the man.

61. At 7.44pm, two other officers, trained hostage negotiators replaced the officers at the door. One officer introduced himself to Prisoner B and Prisoner A. He said that he had particularly targeted Prisoner A as he had known him for a few years. He explained that he was at the cell to find out what was going on, to which Prisoner A replied, 'I would like to know'. The officer told him that it would be easier to talk if the obstruction was removed from the observation panel and Prisoner A then took it down.

62. The officer then had a good view into the cell. Prisoner B was sitting at the back of the cell smoking a cigarette and Prisoner A was standing to the right side of the door. The man was lying on his front on the bed with his head furthest away from the door. The officer gesticulated towards the man and asked Prisoner A if he was still alive. Prisoner A replied, 'He's gone, he is with Allah'.

63. While the officers were outside, Prisoner A and Prisoner B made themselves hot drinks. Prisoner B looked under the man's bed and around the cell. Prisoner A again asked to come out of the cell and told the officer that they had no weapons as they had thrown them out the cell window. When asked what type of weapons, Prisoner A explained that they were two toothbrushes which had been sharpened to a point. Senior managers had organised control and restraint teams to be on standby to remove Prisoner B and Prisoner A from the cell. As there had still been no sound from the man and no movement had been detected, the operational manager overseeing the incident, decided to intervene.

64. Three control and restraint teams were positioned outside the cell - one team for each person in the cell. The teams took Prisoner A out first at 8.16pm, followed by Prisoner B at 8.18pm. Both were taken to the segregation unit.

65. An ambulance had been called at approximately 7.30pm and arrived at Long Lartin just before 8.00pm. Paramedics went into the cell with other staff as soon as Prisoner B and Prisoner A had been taken out. They found the man face down on the bed, with what appeared to be a pair of tracksuit bottoms tied around his neck, which they removed. His lower legs had been bound with sticking tape. The paramedics recorded that there was discolouration to the man's lower legs and no pulse could be found. At 8.23, they recorded his death.

66. Prison staff searched the area outside the man's cell and discovered a marker pen with the tip removed and replaced with a piece of sharpened wood and a broken toothbrush.

67. The police later established that before they left the man's cell, both Prisoner B and Prisoner A had taken and were wearing clothing and footwear which belonged to the man.

Staff Support

68. After the man's death the deputy governor, debriefed all the staff involved to give then the opportunity to discuss any issues arising from the incident and offer support. The prison's care team was present. No specific issues were identified at the meeting.

Support for prisoners

69. The chaplaincy team offered support to prisoners on D wing. The prisoner and other prisoners who had known the man well were later moved to other prisons, as it was considered that remaining on the wing would have been too traumatic for them.

70. Prison staff reviewed all prisoners subject to suicide and self-harm monitoring and briefed Listeners (prisoners trained by the Samaritans to provide confidential emotional support for fellow prisoners) and the local branch of the Samaritans in case of any calls from prisoners. Notices were posted on each wing notifying prisoners of the man's death and the support available to them.

Post-mortem

71. A post-mortem examination was carried out at Sandwell Regional Forensic Centre on 15 February 2013. It concluded that the man's death was due to ligature strangulation.

Police investigation

72. West Mercia Police investigated the man's death and criminal proceedings followed. In September 2013, Prisoner A and Prisoner B were convicted of murder and sentenced to whole life imprisonment.

Interviews with Prisoner A and Prisoner B

73. When he interviewed Prisoner B and Prisoner A, the investigator asked both men to describe the events of 14 February but both declined to do so. The investigator also asked why they had targeted the man.

74. Prisoner B said that the man was one of a few prisoners that it could have been, and that it was his offence that had made him a target. He said that he had originally gone into the man's cell to speak to him as the wing representative and had not initially planned to do anything to him. However, at some point during his time in the cell he then thought of doing something. When asked about the reasons for his actions, Prisoner B said that at the time, he was fed up with not getting anywhere and thought that he might as well do something that would keep him in prison so that he would no longer have to jump through hoops trying to be released.

75. Prisoner A said that the man was always the target due to the nature of his offence. When pressed for further information, Prisoner A said that he had not spoken to anyone, including the police, about the details of their actions that day and what happened was between him and Prisoner B.

ISSUES

The allocation of Prisoner A and Prisoner B to the vulnerable prisoner wing

76. In 2007, Prisoner A and another prisoner took a third prisoner hostage to try and engineer a move to another prison. Soon after he arrived at Long Lartin in 2010, Prisoner A was allocated to one of the vulnerable prisoner wings because he was under threat from other prisoners as a result of drug debts. It is well documented that he has displayed poor behaviour throughout his time in custody. However, since 2011, he had not been charged with any disciplinary offences and this suggested that he was abiding by Prison Rules and was no longer misusing drugs. Prison staff had reported positively about him and he had achieved enhanced status on the Incentives and Earned Privilege scheme.

77. Prisoner B asked to be placed on a vulnerable prisoner wing soon after arriving Long Lartin in 2008, again because of alleged debt to other prisoners. In 2011, he took another prisoner hostage as he was in debt. He then spent a period in the segregation unit before returning to a vulnerable prisoner wing and there were no further recorded breaches of discipline. At the time of the man's murder, he had been regarded as likely to achieve enhanced status at his next review.

78. Both men had previously been involved in hostage-taking, but there had been no recent evidence to indicate that either of them posed any significant risk of violence to other prisoners. Both had been involved in bullying and drugs and their records contained numerous entries indicating that they were under threat when they were on standard residential wings because of this. When they had returned to standard wings, they had got into debt to other prisoners and ended up returning to the vulnerable prisoner wing because they were under threat. .

79. Profiles are completed on all prisoners at Long Lartin and updated monthly. The purpose of the profile document is to monitor and gather intelligence on individuals who might indicate an increased risk to others or to the stability of the prison. Prisoner B was said to be involved in the drug culture on the wing, while Prisoner A's most recent profile indicated outstanding drug debts which had led to him being under threat and resulted in moves between the mainstream wings and the vulnerable prisoners wings. Neither of the prisoners' profiles indicated any known or perceived risk of violence towards other prisoners.

80. In previous investigations, we have considered the issue of risk assessment of prisoners who are located in a vulnerable prisoner unit but whose offences indicate that they would not be at risk on a normal wing. After a recommendation to the high security estate, revised instructions and procedures were introduced in July 2013. In relation to vulnerable prisoners the new guidelines say:

'… Locating prisoners who are unable to be placed within main location may often be a complex matter. Often their index offence would not suggest that there would be a vulnerability issue but due to debt, inter-gang related issues or similar, locating within the main population is not an option. Segregation units across the estate hold many of these individuals and managers are often balancing risk to others against the potential risk to the prisoner they are attempting to locate.

'In order to properly assess suitability for Vulnerable Prisoner Location (VP) all such prisoners should be held in the segregation unit pending a suitability assessment. This assessment must be accompanied by a Cell Sharing Risk Assessment (CSRA) at all times. Information must be collated as set out in the flowchart and all cases should be discussed at the IEAT (Intelligence Executive Action Team) meeting. This again ensures that the main parties are fully aware of the movement and are in a position to effectively measure the risk.

'The manager responsible for Safer Custody must be alerted to this move. This individual will raise monitoring forms for a minimum of one month post allocation. This will then be reviewed at the next IEAT meeting to ensure that the prisoner has properly integrated and there is no related intelligence suggesting any risk.

'Prisoners whose index offence ordinarily would not be deemed as R45 (O/P) compliant are often referred to as a 'Situational Vulnerable Prisoner'. These individuals must be reviewed at least annually at their sentence plan board to ensure that there is no intelligence and/or changes of circumstance which would deem their risk as too great for VP location. They should also be reviewed if they are involved with any type of incident. This review must be endorsed on the CSRA.

'All prisoners who are deemed as 'Situational VPs' must have a marker on Mercury denoting this. This will allow the analysts receiving IRs (Information Reports) the opportunity to refer any concerns immediately …'

81. Although the new procedures were not in place at the time of the man's death, Prisoner A and Prisoner B's risk and behaviour were reviewed monthly. The intelligence received validated their status as vulnerable prisoners and previous attempts to integrate them in a normal wing had failed. Other recent investigations have also highlighted the need to manage carefully the risks that vulnerable prisoners pose to one another but it appears unlikely on the basis for the intelligence available to prison staff at the time that either Prisoner A or Prisoner B would have been considered a significant risk of violence to others in the vulnerable prisoner wings.

Securing cell doors

82. As there is no in-cell sanitation in half of the residential wings at Long Lartin, it has an electronic locking system which can be overridden by staff with a master key. Prisoners can lock their own cell doors from the inside, for privacy, or from the outside for security during association periods.

83. The CCTV coverage does not suggest that the man was coerced or forcibly taken into his cell by the other men. As he was a prisoner wing representative, it was not unusual for other prisoners to visit his cell and prisoners at Long Lartin are permitted to associate in their cells so Prisoner B and Prisoner A going into the man's cell would not initially have seemed an unusual event. We do not know when or by whom his door was locked, but it seems unlikely that the man would have locked the cell himself.

84. In the report of a previous investigation into a homicide at a high secure prison we recommended that the Deputy Director of Custody for High Security Prisons should ensure that each high secure prison operates an agreed and consistent safe practice in relation to unlocking cell doors. In early 2013, the Deputy Director of Custody instructed that after unlocking cells, staff in all high security prisons should shoot the bolt on cell doors to prevent the cell door from being locked. Long Lartin was an exception to this as many of the wings had an electronic locking mechanism. However, the Governor of Long Lartin initially issued a local notice instructing staff to shoot the bolt on cell doors. Shortly afterwards, following consultation with staff and prisoner representatives, the Governor rescinded this instruction as it was considered that it did not improve prisoner safety and compromised prisoners' dignity on wings with in-cell toilets. It is difficult to see the distinction between the wings at Long Lartin with integral sanitation and those in other high secure prisons which are required to shoot the bolt. However, deciding on the safest system for individual prisons must ultimately be the responsibility of the managers involved. We understand that the Deputy Director of Custody has satisfied himself that the arrangements at Long Lartin are appropriate and meet the circumstances of that prison, but that the arrangements continue to be kept under review. We therefore do not make a further recommendation about this. Long Lartin also clarified following the draft report that All cell doors at Long Lartin are not the bolt shut type (except the segregation unit) and therefore any prisoner pushing a door to close it would not throw the bolt and lock themselves in the cell.

Management of the hostage incident

85. The national guidance for incident management is contained in PSO 1400 and prisons are expected to have local instructions to manage incidents such as hostage-taking. The PSO says:

> "Governors must consider preparing written contingency plans to assist in the management of negotiable incidents (e.g. hostage). Procedures must be reviewed and tested every year to ensure that they meet the needs of the establishment. There must be a clear auditable system that demonstrates that the "guidance for staff" … have been read by all staff at least once a year."

86. Long Lartin has up to date local policies and all the staff involved appeared to be aware of the local and national guidance and knew their individual roles. Although Prisoner A and Prisoner B had indicated at a fairly early stage that the man was dead, there was no clear view into the cell and, therefore, they could not be sure of exactly what had happened and the nature of any continuing threat. To determine this, staff had to follow the usual procedures for a hostage incident. They assessed the actual threat, gathered information about those involved and considered whether there might be collusion between the prisoners. Managers identified negotiators and control and restraint teams, who attended the scene. Throughout the incident, staff communicated with each other and, once there was a clear view into the cell, allowing a better assessment of the situation, they put plans in place to remove the perpetrators as quickly and as safely as possible. We note that Prisoner A and Prisoner B almost immediately said that they were ready to go to the segregation unit, showed no signs of resistance and had reported that the man was dead. In the circumstances it is perhaps surprising that it took so long to remove them from the cell but we accept that the staff followed the expected procedures in the context of a high secure prison.

87. Nurses and paramedics had been on standby in D wing before the intervention to remove Prisoner B and Prisoner A. After they had been taken from the cell, paramedics went in immediately. It was clear that the man was dead so they made no attempts to resuscitate him and recorded his death.

88. One of the actions in the prison's contingency plans is to notify the emergency services, assess the need for specialist support and request such services, if necessary. In this incident, Prisoner A told staff at the outset that the man was dead but they did not call an ambulance until nearly 50 minutes later. In view of the nature of the incident and the perpetrators' obstruction of the cell observation hatch, they were unable to substantiate the claims that the man was dead, but it was evident from Prisoner A's comments that there was at least the possibility that the man had been seriously injured.

89. While it would not have altered the outcome for the man we consider that an ambulance should have been called as soon as it became apparent that there was the possibility of serious injury which would require immediate medical attention. When prison staff first became aware of the incident, they would not have been able to predict how soon medical attention could be given and we note that because of the prison's rural location it took almost 30 minutes for the

ambulance to arrive. Although in this case the paramedics were on standby and able to examine the man as soon as the hostage-takers had been removed from the cell that would not have been the case if the hostage takers had been removed earlier. A delay in calling an ambulance could have serious consequences in future hostage incidents where a prisoner is still alive. We therefore make the following recommendation:

The Governor of Long Lartin should ensure that in the event of a hostage incident, staff call an ambulance immediately if there is any indication that a prisoner has been or could be injured.

90. The man's legs had been bound together with sticking tape. His family were surprised by this and questioned how prisoners would be able to obtain it. The investigator was told that while staff might question why a prisoner needs such items, it would not be unusual for them to have access. They might borrow it from the prison education department or a wing office.

91. Following sight of the draft report, the man's family asked for further clarification on how prisoners would be able to obtain sticking tape, which they believed was an item not allowed in possession by prisoners. The investigator contacted the prison who have provided the following information:

All wings - Cellotape is kept in the wing offices and only a small strip (enough to seal an envelope) is issued when/if prisoners request it.

Both Perrie wing and the Seg Unit stated that they couldn't remember the last time they issued any tape.

HCC - Do not allow Cellotape to be issued.

Education - Any tape used is monitored by staff at all times. Masking tape is kept locked away in the Shadow Board cabinet, staff issue what is required and then return the roll to the cabinet. Education also use double sided tape in Art Classes for cardboard work, again the amount is given to prisoners requirements and then locked away again.

Kitchen - Do not issue Cellotape. Prisoners may have access to second hand tape from the cardboard boxes of baguettes that come into the Kitchen but this would not be of much use.

Library - Only Orderlies are allowed access to Cellotape, to mend books - this is not usually monitored.

Workshops - Some workshops use Cellotape to seal boxes of goods. This is usually monitored if possible. Any rolls not in use are locked away in either cupboards or offices, to which only staff have access.

DHL - Cellotape is not available to buy on Canteen.

Reception - Any tape that comes within a prisoner's Stored Property is examined. Any wide tape is confiscated but narrow tape (1") is allowed to be kept in possession.

Contact with the man's family

92. Prison Service guidance recommends that, if possible, news of a death in custody should be broken to the prisoner's next of kin in person and the prison appointed a family liaison officer. However, due to the nature of the man's death, the police decided to take responsibility for notifying his family in the first instance and for subsequent contact with them.

93. Members of the man's family went to the prison on 15 February. They met staff, visited the man's cell and collected personal items. The deputy governor at that time, met members of the man's family formally on 18 February. The deputy governor knew the man and was able to speak from his knowledge of him and give details known at the time about the events of 14 February. Additional family members visited around a week later.

94. The prison told the man's family that they would contribute towards his funeral costs, but they told the investigator that they had received no request for assistance from them.

RECOMMENDATION

The Governor of Long Lartin should ensure that in the event of a hostage incident, staff call an ambulance immediately if there is any indication that a prisoner has been or could be injured.

PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor of Long Lartin should ensure that in the event of a hostage incident, staff call an ambulance immediately if there is any indication that a prisoner has been or could be injured.	Accepted	The relevant contingency plans have now been updated to specifically state that an ambulance is called immediately.	Completed	