Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sidonio Texeira a prisoner at HMP Long Lartin on 20 June 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Sidonio Texeira was assaulted in a workshop at HMP Long Lartin, and died in an ambulance. He was 59 years old. I offer my condolences to Mr Texeira's family and friends. The prisoner who attacked Mr Texeira was serving a life sentence and was convicted for Mr Texeira's murder, for which he received another life sentence on 21 October 2016. This investigation has considered whether there was anything more the prison could have done to protect Mr Texeira.

Homicides are mercifully rare in prison and I readily accept that identifying those likely to carry out such killings can be difficult. However, I am disappointed that Long Lartin does not appear to have learned some of the lessons from my 2013 publication on preventing homicides in prison. In particular, there should have been a more expeditious assessment and response to the risks that different types of vulnerable prisoners pose to one another, and more effective training in the use and analysis of the available security intelligence which clearly indicated that Mr Texeira was vulnerable to attack by the perpetrator.

The investigation also found that there should have been more rigorous cell searching and removal of dangerous items, to minimise the availability of weapons such as that used by the perpetrator.

Finally, I am concerned that, once again, we identify weaknesses in Long Lartin's emergency response procedures.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. In 2006, Mr Sidonio Texeira was sentenced to life imprisonment for murder and moved to HMP Long Lartin in 2009. Prisoner A was sentenced to life imprisonment with a whole life tariff in 1996, and transferred to Long Lartin for the second time in 2013.

2. Prisoner A had a history of assaulting and threatening prisoners and staff submitted a number of security intelligence reports about his behaviour during his time in prison. Mr Texeira was a quiet man, who did not mix with other prisoners. He often complained about other prisoners' behaviour and sometimes passed information about them to staff, so other prisoners perceived him as an informer.

3. Mr Texeira was a vulnerable prisoner because of his offence and lived on A Wing, one of the Vulnerable Prisoner Units (VPU). Prisoner A applied for vulnerable prisoner status because of problems on a standard wing and moved to B Wing, another VPU. He moved to A Wing between December 2015 and January 2016 and there were no reported problems between him and Mr Texeira. In February 2016, staff assessed that Prisoner A was no longer vulnerable and should transfer to a standard wing, but he remained on a VPU, as he was assessed as only being suitable to move to D Wing, due to issues with other prisoners. At the same time, his application to a vulnerable prisoner workshop was approved.

4. On Wednesday 15 June, Mr Texeira and Prisoner A exchanged words in the workshop. The next day, Prisoner A told a member of workshop staff that he was going to kill Mr Texeira. The staff member submitted a low priority security intelligence form to the security department, explaining what he had said.

5. On Friday 17 June and Saturday 18 June, Prisoner A repeated his threats to an officer. The officer also submitted a low priority security intelligence form. No one from the security department reviewed the two reports until Sunday 19 June, and no specific action was taken in response to the information.

6. On the morning of Monday 20 June, Prisoner A and Mr Texeira went to the workshop. While prisoners were changing into their work boots, Prisoner A hit Mr Texeira around the head with a rock he had hidden in socks. Staff intervened and radioed a medical emergency. Mr Texeira was severely injured. Paramedics arrived and moved Mr Texeira to an ambulance for further treatment. Mr Texeira died in the ambulance.

7. In October 2016, Prisoner A was sentenced to life imprisonment for Mr Texeira's murder.

Findings

8. We found that Long Lartin missed a number of opportunities to identify a problem between Mr Texeira and Prisoner A. Despite an earlier threat to kill him, made in September 2015, staff assessed the two men as suitable to work

together. Prisoner A also told workshop staff and an officer that he was going to kill Mr Texeira a few days before he did so. Despite his known risk, staff (who had not been trained in submitting security information) treated the threats as low priority and so the intelligence was not analysed by anyone in the security department until Sunday 19 June, the day before Mr Texeira died. We do not believe that the security information was treated with sufficient urgency.

9. We are concerned that, although Prisoner A was assessed as no longer vulnerable in February 2016, he remained on the VPU and started working in a vulnerable prisoner workshop. His status was not reviewed after six security reports were submitted about his behaviour between February and June 2016.

10. It is troubling that staff found a rock in Prisoner A's cell during a search and allowed him to keep it. Even if staff had not been aware of his history of threats and assaulting other prisoners, it should have been confiscated as an unauthorised article.

11. As in previous investigations at the prison, we are concerned that staff at Long Lartin did not immediately call an ambulance, once staff radioed an emergency code.

Recommendations

- The Governor and Head of Security should ensure that all staff understand the importance of the intelligence system for the effective management of risk and are properly trained to assess and submit security intelligence.
- The Governor should ensure that security risk assessments are based on all relevant evidence about that prisoner's security history.
- The Governor should ensure Long Lartin expeditiously implements the outcome of reviews of vulnerable prisoner status and that such reviews are triggered by significant security information.
- The Governor should ensure that the prison's security and searching strategy is properly implemented, and that staff are trained to identify and manage potential security risks during the searches.
- The Governor should ensure that control room staff call an ambulance immediately an emergency code is called.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact her. Five prisoners responded.

13. The investigator visited Long Lartin on 23 June 2016. She obtained copies of relevant extracts from Mr Texeira's and Prisoner A's prison and medical records. In accordance with the Ombudsman's terms of reference, the investigation was suspended while Warwickshire and West Mercia police carried out a criminal investigation into Mr Texeira's death. Prisoner A was convicted of Mr Texeira's murder in October 2016, and the Ombudsman's investigation recommenced.

14. NHS England commissioned a clinical reviewer to review the clinical care Mr Texeira and Prisoner A received at Long Lartin.

15. The investigator interviewed ten members of staff and three prisoners at Long Lartin on 22 and 23 November 2016. The clinical reviewer jointly interviewed healthcare staff.

16. We informed HM Coroner for Worcester of the investigation who sent the post-mortem results. We have given the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Texeira's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. His family wanted to know why the two men had worked together, despite Prisoner A having recently threatened Mr Texeira.

Background Information

HMP Long Lartin

18. 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, and C wings accommodate vulnerable prisoners.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Long Lartin was in October 2014. Inspectors reported that physical and procedural security was necessarily extensive and sophisticated, but it was generally proportionate. They said that the prison managed some significant risks, but did so with confidence. Inspectors said that the prison had good systems in place to evaluate and monitor levels of violence among prisoners, that the violence reduction strategy was sound, there were effective investigations into allegations of violence and vulnerable prisoners were regularly reviewed and monitored. Opportunities for violence remained evident, but staff supervision on wings was effective.

20. Inspectors reported that prisoners involved in violent incidents were managed through the Incentive and Earned Privilege scheme and inspectors found that allegations of violence and bullying were treated consistently and investigated promptly. However, a large number of vulnerable prisoners on A, B and C Wings said they had been victimised by staff and prisoners.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2016, the IMB reported concerns that staff did not always call for an ambulance immediately they heard a medical emergency radio code, contrary to national instructions.

Previous deaths at HMP Long Lartin

22. This is the third homicide at Long Lartin since 2014. In one case, we were concerned about delays in the emergency response. The other homicide is still under investigation

Vulnerable prisoners

23. Prisoners who are regarded as vulnerable can be held separately from other prisoners for their own protection in Vulnerable Prisoner Units (or VPUs). Prisoners might be considered vulnerable because of the nature of their offence, or due to problems such as debt or bullying on standard wings. At Long Lartin,

prisoners who are deemed vulnerable for reasons other than the nature of their offence are known as situational vulnerable prisoners.

Learning Lessons Bulletins – Homicides in prison

24. Our Learning Lessons report on prison homicides, which we published in December 2013, noted a common theme that staff did not always have access to or fully consider all relevant information in a prisoner's record. As a consequence, staff were not always aware of the information held about the risk a particular prisoner posed. We said that staff should be made aware of a prisoner's history of violence and there should be a clear strategy to manage prisoners in vulnerable prisoner units, who themselves are a risk to other vulnerable prisoners, particularly in High Security Prisons.

25. In a further Learning Lessons Bulletin, issued in September 2016, we identified the need to better manage violence in prison. We said that when a prisoner is identified as potentially at risk of harm from others, that action should be taken to ensure they are appropriately protected and located in a safe place. We also highlighted the need for rigorous cell searching as part of an effective security and searching strategy, to minimise the availability of weapons. Although this bulletin was issued after Mr Texeira died, the learning is relevant to preventing future homicides of this kind.

Key Events

Mr Sidonio Texeira

26. In 2006, Mr Sidonio Texeira was sentenced to life imprisonment for murder and attempted murder. He transferred to Long Lartin in 2009. Due to the nature of his offence, he was a vulnerable prisoner and lived on a Vulnerable Prisoner Unit (VPU).

27. Mr Texeira was not happy at Long Lartin, as he found it too noisy and was upset by other prisoners' drug use. Mr Texeira moved to the VPU on A Wing on 26 January 2016, but he remained unhappy and frequently complained about other prisoners' noise.

28. In December 2014, Mr Texeira was risk assessed as a low risk to other prisoners and suitable to start working in the DHL workshop, packing prisoners' shop orders. Only vulnerable prisoners from A and B Wings work in that workshop. A risk assessment determined his suitability to work there, which included consideration of the risk he posed to other prisoners. He was assessed as a low risk to others.

29. An acting DHL supervisor recalled that Mr Texeira was a loner and that prisoners perceived him as an informant. She said that Mr Texeira would tell staff if he saw prisoners stealing items and would report anything that was missing.

30. Generally, staff described Mr Texeira as unpopular with other prisoners, because he passed information to staff and was sometimes antagonistic towards them. There is no evidence that staff ever cautioned Mr Texeira about his behaviour or considered that he needed any additional protection, or that Mr Texeira asked for additional protection.

Prisoner A

31. In 1996, Prisoner A was sentenced to life imprisonment, with a whole life tariff, for murder. He had a history of seriously assaulting and threatening prisoners. Staff and prisoners told the investigator that both staff and prisoners were afraid of him. He often said he had nothing to lose, as he was already serving a whole life tariff, so would never be released.

32. In 2005, Prisoner A stabbed a prisoner and was found guilty of grievous bodily harm. In 2011, he assaulted a prisoner, who he thought was an informant, with a potato concealed in a sock. This was dealt with under the prison's disciplinary process. He transferred to Long Lartin for a second time in 2013.

33. In March 2015, Prisoner A applied for vulnerable prisoner status and moved to a VPU on B Wing soon afterwards. He said he had become involved in drug use on a standard wing and wanted to move away from the temptation of drugs. There was also intelligence that he had accrued debts because of drug use earlier in the year. (He had never engaged with the prison's substance misuse or mental health teams.) In addition, he had told staff about a prisoner's

planned assault on an officer, so said he felt more vulnerable. He was regarded as a "situational vulnerable" prisoner (vulnerable because of his circumstances rather than his offence). The local policy at Long Lartin was to review vulnerable prisoner status annually, or immediately if security intelligence suggested a review was necessary.

34. Prisoner A stayed on B Wing, apart from a brief spell on A Wing between December 2015 and January 2016. There was no evidence of problems between him and Mr Texeira in the two months they were both on A Wing.

35. In February 2016, staff reviewed Prisoner A's vulnerable prisoner status and considered him suitable for a standard wing, but he remained on the B Wing VPU.

Security information about Mr Texeira and Prisoner A

36. Between 2009 and 2016, staff submitted over 50 security information reports about Mr Texeira, in which he had either been threatened, assaulted or bullied by other prisoners, or had given staff information about other prisoners. Many of the threats against him were because he had complained about other prisoners' noise levels and because prisoners thought he was an informant.

37. Since 2013, Prisoner A had been referred to in approximately 40 security information reports in which he was accused of bullying, assaulting and threatening other prisoners.

38. In September 2015, an officer submitted a security information report after he overheard Prisoner A and another prisoner talking about how Mr Texeira would "get done in". Although the information was seen by staff in the security department, they did not record any action taken as a result. The Head of Security told the investigator that when risks have been highlighted, the first step is for a member of staff to speak to both prisoners and, if necessary, manage them under the prison's violence reduction strategy. The strategy, which was in place in June 2016, instructed that, if a prisoner makes threats to kill, staff should challenge him, place him on report and investigate the matter further. There is no evidence that Prisoner A was spoken to or managed through these procedures while at Long Lartin.

39. In October 2015, Prisoner A applied to work in the DHL workshop. In February 2016, the allocations team assessed his risk, including his risk of harming other prisoners, and concluded that he posed a medium risk but was still suitable to work there. The risk assessment considered the last 12 months of his record including the 30 security information reports that had been submitted in that period, and specifically the one detailing his and the other prisoner's threat against Mr Texeira. However, because they had lived on the same wing without incident between December 2015 and January 2016, staff considered the risk to be manageable. He began working in the workshop.

40. The acting DHL supervisor explained that prisoners were not routinely or randomly searched when they arrived at or left the workshop, unless staff suspected that they had stolen something. According to the prison's local policy, all prisoners should be searched when leaving the workshop and 10 per

cent randomly checked when leaving their cell to go to work. She said that she was told when she started the job that all prisoners would be searched, but this did not happen in practice.

41. The acting DHL supervisor said that Prisoner A liked to develop good relationships with staff. She said he had begun to insist on helping her in the workshop, even when she did not need help. Mr Texeira was unhappy about this and told her not to let Prisoner A help her. Prisoner A had become increasingly irritated by Mr Texeira's behaviour in the workshop and had told prisoners that he would assault him.

42. In May 2016, staff found a rock in Prisoner A's cell during a routine cell search on B Wing. It was among his cooking equipment and staff assumed he used it to grind herbs and spices, so allowed him to keep it. He was responsible for cleaning the wing's fish tanks and he had taken the rock from there (he told police that this was some eight months prior to Mr Texeira's murder). No one submitted a security report about the rock until 29 June 2016, after Mr Texeira's death.

Wednesday 15 June 2016

43. The acting DHL supervisor said the workshop was very hot on 15 June, but Mr Texeira had stacked some boxes in front of a fan. Prisoner A was irritated by Mr Texeira's actions and she heard the two men exchange words.

Thursday 16 June 2016

44. The acting DHL supervisor said that, on 16 June, Prisoner A told her he was going to kill Mr Texeira. He added that he might not do anything that day, or in the workshop, but he would do something. She said she told three of her colleagues about this threat, and one advised her to submit a security report. She submitted a security information report and noted the conversation in the workshop's observation book.

45. She wrote in the SIR:

> "Inappropriate behaviour by prisoner. This morning Tex and Prisoner A had some disagreement and it got a bit heated. They both got on with their work and kept quiet, but [prisoner A] came and told the reporting officer (herself) 'I'm going to kill that bastard, he is in big trouble next time I see him'".

46. She explained that she had not received training in how to complete a security information report and had only submitted two in the previous year. She understood that she could submit either green reports, which indicated low priority information, amber for medium priority, or red meaning high priority information. She said that she had seen her colleagues submit green reports before, so submitted a green report on this occasion. The Head of Security explained that security information forms were reviewed by a security analyst who graded the information low (to be dealt with within 72 hours), medium (within 48 hours) or high priority (to be dealt with within 24 hours).

47. The Head of Security told the investigator that security staff reviewed the acting DHL supervisor's security report on Sunday 19 June, within the required 72

hours. She confirmed that, as it was submitted as a green or low risk report, the most likely action would have been that the analyst would have asked that a member of staff speak to both prisoners, although this was not recorded on the SIR.

Friday 17 June and Saturday 18 June 2016

48. On 17 June, a Supervising Officer (SO) was working on B Wing. Prisoner A told him that he was becoming very frustrated working in the DHL workshop because of Mr Texeira's behaviour. He asked why, and Prisoner A said that Mr Texeira treated prisoners with contempt and rubbed people up the wrong way. He said he felt he was "being pushed into a corner" and the only solution would be to do something "bad to him", although he did not want to because he enjoyed working there. The SO submitted an SIR, but assessed the intelligence as low priority (or green). The next day, 18 June, he saw Prisoner A again and he repeated his threats against Mr Texeira. This time, he did not submit another SIR.

Monday 20 June 2016

49. Mr Texeira left A Wing just before 9.00am on Monday 20 June, and Prisoner A left B Wing, both on their way to the DHL workshop. Ten per cent of prisoners are randomly searched on their way from a wing. There is no record that either Mr Texeira or Prisoner A were searched that morning.

50. CCTV showed both men walking separately along a communal corridor and across an exercise yard. Prisoner A was 30 seconds behind Mr Texeira and they did not look at each other or interact in any way. It is not possible to see from CCTV whether he was concealing the weapon (a rock inside two socks). A prisoner told the investigator that prisoners were aware that he had made a weapon and that he planned to take it into the workshop, but nobody had told staff.

51. Two officers were responsible for escorting the prisoners into the workshop. Prisoners go through one doorway into a foyer area where prisoners' safety boots are kept. Once all prisoners have arrived, the first door is locked behind them and prisoners put on their boots before another door into the workshop is unlocked. For a short time, all prisoners are held in the small foyer between the two doors. Mr Texeira arrived first, and the door remained open until all the prisoners arrived, including Prisoner A.

52. Officer A said he heard several thuds, but there were a number of prisoners in the way so he could not see what had happened. He shouted for his colleague to press the alarm bell, which he did. He pushed through the prisoners and saw Prisoner A hitting Mr Texeira on the head with a weapon. Mr Texeira was lying on the floor. He shouted for Prisoner A to stop. Prisoner A hit Mr Texeira another two or three times before he could pull him away and sat him on a nearby chair.

53. Officer A radioed a code red at 9.06am, (a code red is an emergency code to alert staff that a prisoner is bleeding). Healthcare staff do not routinely attend alarm bells at Long Lartin, but once they heard the code red they went to the

workshop. The officer checked Mr Texeira, moved his head slightly and placed something under it to help him breathe. He said that there was a lot of blood and Mr Texeira was not responding.

54. At 9.08am, staff in the control room called an ambulance, two minutes after Officer A's code red call. They could not explain why they did not call an ambulance immediately.

55. A custodial manager and a SO went to the workshop when they heard the alarm bell. The investigator viewed body camera footage worn by an officer. The custodial manager asked Prisoner A what had happened and he replied that Mr Texeira had banged his head. Another custodial manager arrived and asked him what he had done and he replied, "its okay". She told officers to take him to the segregation unit. The first custodial manager and two officers escorted him there. He told them that he had not used a weapon and that Mr Texeira deserved it. The custodial manager asked him whether it was true that he had not used a weapon and he replied, "I'm not going to tell you everything, but I don't know where it is now".

56. The second custodial manager radioed to check an ambulance had been called, and then cut open Mr Texeira's shirt with an anti-ligature knife to see if he had other injuries. Officers tried to stop the bleeding and she said Mr Texeira's breathing became shallow.

57. More staff responded to the emergency call and arrived within two minutes. They found Mr Texeira lying on the floor while Officer A continued to try to stem the flow of blood from his head. The officers told the nurses what had happened and helped to move Mr Texeira away from the wall so they had more room to assess him.

58. A nurse saw that Mr Texeira had head wounds and was bleeding heavily. She checked Mr Texeira's vital signs, put Mr Texeira back in the recovery position, applied pressure to his wounds and administered oxygen. She said that Mr Texeira's breathing was laboured.

59. The paramedics arrived at the prison at 9.18am. Officers briefed them on what had happened while escorting them into the workshop. The paramedics checked Mr Texeira and said he needed to go to hospital. They requested the air ambulance, and left the prison at 9.38am to wait for it to arrive.

60. While they were waiting for the air ambulance, Mr Texeira stopped breathing. Two nurses alternated chest compressions, while a paramedic administered oxygen. Paramedics were told that the air ambulance was not coming due to bad weather, so asked for more assistance to transport Mr Texeira to hospital. Another response vehicle arrived at 10.00am, but Mr Texeira's condition was too critical for him to be moved safely. After 40 minutes of resuscitation, paramedics detected an irregular heartbeat, but it stopped again within minutes. Resuscitation continued for another five minutes until a paramedic pronounced Mr Texeira dead.

61. Officers found Prisoner A's weapon in a prisoner's boot box in the workshop. He told police that he meant to kill Mr Texeira with a weapon he had made (the

rock taken from a fish tank held in a sock). He told police that he resented Mr Texeira because of his offence and because he told staff when other prisoners stole things from the workshop. He said he was already serving a whole life sentence, so he felt he had nothing to lose.

Contact with Mr Texeira's family

62. A governor and the prison's family liaison officer had some difficulty contacting Mr Texeira's sister-in-law because she had moved, but eventually visited her home that evening and broke the news of his death. The prison contributed fully to the cost of Mr Texeira's funeral, in line with national instructions.

Support for prisoners and staff

63. After Mr Texeira's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

64. The prison posted notices informing other prisoners of Mr Texeira's death, and offering support. Listeners and the Samaritans were briefed and ready to speak to prisoners if they were needed. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Texeira's death.

Post-mortem report

65. Mr Texeira's post-mortem determined that he died from multiple injuries.

Police investigation

66. Warwickshire and West Mercia police investigated Mr Texeira's death and criminal proceedings followed. In October 2016, Prisoner A was convicted of murder and sentenced to whole life imprisonment.

Findings

Security Information

67. In the four days before the murder, Prisoner A told two members of staff and other prisoners that he wanted to hurt or kill Mr Texeira. Prisoners did not tell anyone about his threats before Mr Texeira died.

68. The Head of Security told the investigator that the SIRs the acting DHL supervisor and a SO had submitted on 16 and 17 June were not analysed until Sunday 19 June and no action was taken at that time. As both staff members assessed the security intelligence as low priority, this was still within the required 72 hour timeframe. She said it was likely that a member of the security department would have asked staff to speak to both prisoners the next day (20 June).

69. DHL workshop staff were not trained in submitting security information and only submitted low priority security intelligence reports. Given Prisoner A's security history and the nature of his threats, we consider that staff should have assessed the intelligence as higher priority. The Head of Security explained that if staff had submitted a high risk report, the duty governor would have been informed the same day (including weekends) and staff could have taken immediate action.

70. Neither the acting DHL supervisor's nor the SO's SIR was analysed urgently and staff took no action to address Prisoner A's threats before he killed Mr Texeira. We agree with Long Lartin's Head of Security, that such intelligence should have been treated more urgently and actioned sooner. We make the following recommendation:

    The Governor and Head of Security should ensure that all staff understand the importance of the intelligence system for the effective management of risk and are properly trained to assess and submit security intelligence.

Management of security risk

71. The prison risk assessed Mr Texeira and Prisoner A's suitability to work in the DHL workshop and their risk to prisoners, to staff and security, before they started work there. In December 2014, they determined that Mr Texeira's security risk was low. In February 2016, the prison assessed Prisoner A's suitability for the workshop and considered that he was a medium security risk, but he was still approved to work there. His application was endorsed by his personal officer, the security department, a wing SO and a manager.

72. The Allocations Hub manager told the investigator that her team consider the last 12 months of a prisoner's security record when determining their level of risk. Prisoner A had a history of threats and violence, but his two most serious offences against prisoners were in 2005 and 2011. Those assessing his application would not have picked these up.

73. Officers submitted an SIR in September 2015, which reported that Prisoner A had threatened to kill Mr Texeira. The allocation team who assessed his

application were aware of this, but because the two prisoners had lived together on the same wing in December 2015 and January 2016, assessed he was suitable to work in the DHL workshop with Mr Texeira.

74. Prisoner A had a history of threatening prisoners, not just Mr Texeira, and over 40 SIRs had been submitted about him bullying and threatening prisoners and staff. We consider that his recent threats to kill Mr Texeira (in September 2015) should have prompted a more extensive review of his security records, beyond the minimum 12 month period to determine his risk to others. A fuller assessment would have alerted staff to his risk to other prisoners. We make the following recommendation:

The Governor should ensure that security risk assessments are based on all relevant evidence about that prisoner's security history.

Prisoner A's location

75. A Prisons and Probation Ombudsman Learning Lessons Bulletin, issued in December 2013, talks about the vulnerability of some prisoners and suggests there should be a clear strategy to manage prisoners in VPUs who themselves are a risk to other vulnerable prisoners. It said that staff need to be aware of the possible risks posed by vulnerable prisoners to others and keep their location and management under review. The Head of Security said that situational vulnerable prisoners are accommodated with other vulnerable prisoners and attend the same activities. At the time of writing this report, Long Lartin has 148 VPs, 78 of whom are situational vulnerable prisoners.

76. Only vulnerable prisoners can work on the DHL workshop. Prisoner A was originally a situational vulnerable prisoner, which meant that his risk was related to factors other than the nature of his offence and remained under review. Long Lartin's Head of Security said that any prisoner can apply to be a situational vulnerable prisoner and their application is considered and reviewed using the national situational vulnerable prisoner framework.

77. It is clear from his security record that Prisoner A often intimidated other prisoners. He originally applied to become a vulnerable prisoner because he had accrued debts and informed staff about a possible assault on an officer.

78. As a result of our Learning Lessons Bulletin, in July 2013, the Prison Service issued new guidelines about the location of vulnerable prisoners in high security prisons. It said:

> "…Locating prisoners who are unable to be placed within the main location may often be a complex matter. Often their index offence would not suggest 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."

The new guidelines required the prison to review situational vulnerable prisoners annually to ensure there was no intelligence or changes in their situation that make them too high risk to other prisoners to safely accommodate them on a VPU. Prisoner A was reviewed on 9 February 2016 and staff concluded that he

should transfer to a standard wing, but he remained on the vulnerable prisoner unit.

79. Between February and June, staff submitted six further SIRs mentioning Prisoner A, but he was not reviewed again. Two concerned him bullying prisoners, one that a prisoner was fearful of him and two naming prisoners stealing from the DHL workshop. None of these SIRs prompted staff to revisit his VPU status or to implement the findings of the February review and move him to a standard wing.

80. We make the following recommendation:

The Governor should ensure Long Lartin expeditiously implements the outcome of reviews of vulnerable prisoner status and that such reviews are triggered by significant security information.

Searching

81. Prisoner A told police that he took a rock from a fish tank while working as a wing cleaner about eight months before Mr Texeira's death. Staff found a rock in his cell during a routine cell search in May 2016.

82. Prison Service Instruction (PSI) 68/2011 sets out prison instructions for cell searching. It says that all parts of the prison must be searched at a level and frequency set out in local security strategies agreed by the Governor and the Deputy Director of Custody responsible for the prison. It specifies that all unauthorised items found during a cell search should be removed and stored appropriately, and relevant departments should be notified. It says that staff must always consider the potential use of innocent items, which could be used as a weapon. Long Lartin's searching policy said that one of the purposes of cell searches is to look for weapons. The rock should have been considered an unauthorised item, taken away and an intelligence report raised. It is noteworthy that our further Learning Lessons Bulletin of September 2016 on homicides, highlighted the need for an effective security and searching strategy, which enables weapons to be found and removed.

83. Officers recorded in the SIR submitted after Mr Texeira's death that Prisoner A used the rock to grind herbs and spices as he was a keen cook, so they allowed him to keep it. We consider that given his history of assault and threats in prison, staff should have removed the rock as an unauthorised article and potential weapon.

84. Long Lartin's searching policy directs that staff should search ten per cent of prisoners leaving residential units to attend work and all prisoners leaving a workshop should have a rub down search. Frequency and levels of searching can be increased where there is intelligence to suggest items are being removed from the workshop. The policy also said that all prisoners should have been searched when leaving the workshop. Staff told the investigator that this did not happen in practice. We make the following recommendation:

The Governor should ensure that the prison's security and searching strategy is properly implemented, and that staff are trained to identify and manage potential security risks during the searches.

Emergency response

85. Officer A initially pressed the emergency alarm, but realising the severity of the situation he radioed a code red within 30 seconds. He then tried to help Mr Texeira while he waited for assistance.

86. It took two minutes between Officer A's code red and the control room calling an ambulance. PSI 3/2013 requires that staff call an ambulance immediately in the event of a medical emergency. The prison could not explain the delay.

87. We have previously found that ambulances are not called immediately at Long Lartin. The prison have accepted our recommendations in the past and said they have been implemented. It is unacceptable that there are still delays at Long Lartin in calling ambulances. We repeat the following recommendation:

The Governor should take active steps to ensure that control room staff call an ambulance immediately an emergency code is called.

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