

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr York a prisoner at HMP Long Lartin on 31 May 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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

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

Mr John York was assaulted in his cell at HMP Long Lartin on 31 May 2015, and had died when he was found by prison officers. Mr York was 25 years old. We offer our condolences to Mr York's family and friends.

Prisoner A was convicted of Mr York's murder. Although prison staff were aware of Prisoner's A history of violence and hostage taking, there was no indication that there were difficulties between him and Mr York and they were seen socialising together in the time leading up to his death. We do not consider that prison staff could have predicted his actions on 31 May.

We are concerned that Prisoner A had a history of mental health problems and although he was receiving medication for them he did not have a mental health assessment when he arrived at Long Lartin. We consider that staff missed this opportunity to reassess Prisoner A's risk to others. It is troubling that there is no policy for managing the use of privacy keys at Long Lartin.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

Events

1. On 16 February 2012, Mr John York was remanded into custody and sent to HMP Woodhill. On 27 March 2013, he was sentenced to life imprisonment for murder, robbery and false imprisonment. On 19 May 2015, he was transferred to Long Lartin.
2. On 25 February 2015, Prisoner A was transferred to HMP Long Lartin. He was serving a life sentence for murder. He had a history of violence and hostage taking. In July 2013, he had been referred to the Dangerous and Severe Personality Disorder (DSPD) Unit at HMP Frankland but did not meet the criteria for treatment.
3. On 24 May, a prisoner told an officer that another prisoner, Prisoner B, was in debt to Prisoner A. The officer noted this in the observation book and submitted a security intelligence report.
4. On 27 May, Mr York refused to go back to his cell and asked to be taken to the segregation unit. A prison manager and an officer asked Mr York if he was being bullied, but he said he just stressed because he had no money for tobacco. The next day, the officer saw Prisoner A giving Mr York some tobacco. He told Mr York he should not accept the tobacco because he could not repay the debt.
5. On 31 May, two officers asked Mr York and Prisoner B if they were being bullied. Both prisoners said that they were not being bullied, but an officer decided to start violence reduction procedures so staff could monitor them.
6. At around 4.00pm, an officer saw Mr York and Prisoner B playing cards in Mr York's cell. Shortly after this, the officer said they saw Prisoner A come out of Mr York's cell and lock the door with a privacy key. Mr York left the cell shortly afterwards. At 4.20pm, Mr York went back into his cell, followed by Prisoner A and Prisoner C, another prisoner, and his door closed. At 4.49pm, Prisoner B walked past Mr York's cell and looked in the observation panel, then went back to his cell.
7. At about 4.50pm, officers started to lock prisoners in their cells for the night. An officer looked through the observation panel into Mr York's cell and saw Prisoner A and C, and Mr York, who was lying on the bed. The officer tried to open the cell door to see what was happening, but Prisoner A held it shut, blocked the view of the prisoner on the bed using his sweatshirt, and asked for a trained hostage negotiator. The officer saw that the prisoner on the bed was bleeding, so raised the alarm and at 4.53pm, another officer called an emergency code. At 4.54pm, control room staff called an ambulance.
8. Shortly afterwards, Prisoners A and C agreed to leave the cell, were searched and taken to the segregation unit. Staff went into Mr York's cell. Mr York was not breathing so they started resuscitation. At 5.08pm, paramedics arrived and tried to resuscitate Mr York but they were not successful and at 5.10pm, they recorded that he had died. Police charged Prisoners A and C with Mr York's

murder. Prisoner A was found guilty of murder and given a life sentence. At trial, he did not say why he had killed Mr York and gave no reason for why he attacked him. Prisoner C was found not guilty.

Findings

9. Prison staff were aware of Prisoner A's history of violence and hostage taking. There was, though, no intelligence about any problems between Prisoner A and Mr York and CCTV footage shows the two prisoners playing cards together in the time leading up to his death. We do not consider that prison staff could have predicted his actions on 31 May.
10. Prisoner A had a history of mental health problems, for which he was receiving medication, but staff did not refer him for a mental health assessment when he arrived at Long Lartin. While we cannot say that his mental health problems were linked to Mr York's death, a mental health assessment would have provided staff with the opportunity to assess his level of risk.
11. There was no protocol for managing the use of privacy keys and staff did not always think it was necessary to investigate when they saw a prisoner opening or locking another prisoner's cell with their privacy key.

Recommendations

- The Governor and the Head of Healthcare should ensure that prisoners arriving with identified mental health problems are referred to the mental health team for assessment to review their medication and assess their level of risk to self and others.
- The Governor should ensure that there is a clear policy for managing the use of privacy keys aimed at safeguarding prisoners.

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. No one responded.
13. The investigator visited HMP Long Lartin on 15 June 2017. She obtained copies of relevant extracts from Mr York'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 York's death. On 24 March 2016, Prisoner A was convicted of Mr York's murder. He appealed his conviction but later decided he did not want to proceed. We resumed our investigation in March 2017 once criminal proceedings had concluded. The police shared witness statements that were considered as part of the investigation.
14. The investigator interviewed one member of staff by video link on 8 June 2017 and four members of staff at HMP Long Lartin on 15 June. She also interviewed one member of staff by phone on 2 August. She wrote to Prisoners A and C to ask if they would be interviewed. Prisoner C declined to be interviewed and Prisoner A did not respond to the PPO's request for an interview.
15. NHS England commissioned a clinical reviewer to review the clinical records of Mr York and Prisoner A.
16. We informed HM Coroner for Worcester of the investigation and have given the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr York's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She wanted to know why prisoners are allowed to have items like belts and plastic bags and why Prisoner A was allowed to mix with other prisoners and whether he had done anything like this before. Mr York's mother's legal representation received a copy of the initial report. We did not receive any further feedback or comments on the factual accuracy of the report.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Long Lartin

19. HMP Long Lartin is a high security prison. It has eight 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

20. The last inspection at 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.
21. 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

22. 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 2017, the IMB reported that waiting periods had increased for prisoners to see healthcare staff, particularly mental health staff.

Previous deaths at HMP Long Lartin

23. This is the second of three homicides at Long Lartin since 2014. Previous investigations have highlighted that security risk assessments should be based on all relevant evidence about that prisoner's security history and 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.

Key Events

Mr John York

24. On 16 February 2012, Mr John York was remanded into custody and sent to HMP Woodhill. On 27 March 2013, he was sentenced to life imprisonment for murder, robbery and false imprisonment.
25. In July 2014, a consultant forensic psychiatrist's report noted that Mr York had been diagnosed with antisocial personality disorder, anxiety and obsessive-compulsive disorder and a psychiatrist prescribed quetiapine (an antipsychotic). Mr York had a history of alcohol misuse and reported using drugs in prison but chose not to engage with substance misuse services.
26. Staff disciplined Mr York on a number of occasions after he was found to have assaulted or bullied other prisoners. There were also times when Mr York told staff that he was afraid of being assaulted by other prisoners. Staff investigated these incidents and on some occasions noted that Mr York may have been under threat because he owed canteen items to other prisoners.
27. On 19 May 2015, Mr York was transferred to HMP Long Lartin.
28. On 27 May, Mr York refused to go back to his cell and told staff that he wanted to go to the segregation unit. A prison manager spoke to Mr York and he agreed to go back to his cell. That afternoon, she and an officer took Mr York to an interview room and asked him why he wanted to go to the segregation unit. She said his answer was unclear but he said something like, 'It would be easier.' She asked Mr York if he was having trouble on the wing and wanted to move cells, or whether he had been bullied. Mr York said he was not being bullied and that he did not have a radio and was stressed because he had no tobacco and no money in his prison account. She said that Mr York could not go to the segregation unit but arranged for him to be given some tobacco and a radio.
29. On 28 May, an officer saw Prisoner A giving Mr York some tobacco. He told Mr York this was the wrong thing to do because he did not have the money to repay Prisoner A. The next day, the officer told the prison manager about what happened and she noted this and her previous conversation with Mr York in the wing observation book.

Prisoner A

30. On 6 June 1996, Prisoner A was sent to HMP Norwich after being charged with murder. He was sentenced to life imprisonment with a 12 year tariff.
31. Prisoner A had a history of violence and making threats against other prisoners. On 22 July 2012, he went into another prisoner's cell and held him hostage. His prison record noted that this was one of two incidents where he had taken staff and prisoners hostage but there are no details recorded about the other incident.
32. On 2 July 2013, Prisoner A transferred to HMP Frankland. Staff assessed him for placement in the Dangerous and Severe Personality Disorder (DSPD) Unit

and a psychiatrist prescribed mirtazapine (an antidepressant) for him to help control his thoughts and emotions, and to provide sedation at night. On 1 October 2014, he was transferred to HMP Lowdham Grange as he did not meet the criteria for personality disorder treatment. A doctor increased his mirtazapine prescription because of his anxiety, but the mental health team did not assess him.

33. On 25 February 2015, Prisoner A was transferred to HMP Long Lartin. A nurse in reception assessed him and noted that he had been prescribed mirtazapine for anxiety but had no other mental health problems. He did not have a primary mental health assessment. Staff noted in his prison record that he settled in well and he got a job in one of the workshops.
34. On 24 May, a prisoner told an officer that Prisoner B was in debt to Prisoner A. The prisoner said that Prisoner B had not ordered any canteen the previous week because he thought the debt would 'go away' if he did not have anything to give. The officer submitted an intelligence report and noted that Prisoner B may be in trouble because he had not ordered any canteen to pay back his debt. On 27 May, the officer made an entry in the wing observation book about Prisoner B being in debt. Staff did not take any further action against Prisoner A because Prisoner B had said that he was not in debt and there was no other evidence that Prisoner A was involved. (They did, however, open Challenging Anti-Social Behaviour (CAB) documents for Prisoner A and Mr York on 31 May.)
35. On 29 May, the officer spoke to another officer and told wing staff at the morning meeting about the entry she had made in the wing observation book.

Events of 31 May 2015

36. At the morning security meeting, a prison manager and a supervising officer were told by security staff that Prisoner B and Mr York had borrowed items of canteen from other prisoners and could not repay their debt. Staff at the meeting agreed to open Challenging Anti-Social Behaviour (CAB) documents for Prisoner B and Mr York because they could be at risk of bullying (a CAB document is a tool used to manage anti-social behaviour through assessment, monitoring and intervention).
37. At approximately 10.00am, a supervising officer asked an officer to ask Prisoner B and Mr York whether they were in debt to other prisoners. The officer first spoke to Prisoner B, who told him that he had not been threatened and his only debt was half an ounce of tobacco. The officer said that Prisoner B seemed shocked when asked if he had been bullied and did not seem to be aware of any threat.
38. After speaking to Prisoner B, the officer and another officer went to speak to Mr York. They found Mr York in Prisoner A's cell chatting and having a cigarette with him. An officer took Mr York to a cleaning cupboard so that they could not be overheard and asked if he was in debt or had been threatened. The other officer said that Mr York seemed surprised to be asked about this and said he was not under threat. An officer told Mr York he could speak to staff anytime, and Mr York said, 'Do you think I'm a mug around here.' The officer took this to

mean that Mr York could look after himself. The officers went back to the supervising officer and told him that both prisoners had said they were not in debt or being bullied.

39. The supervising officer decided to open CAB documents for Prisoner A and Prisoner B. He told the investigator that sometimes prisoners say they are okay when they are not. He also said that there was security information suggesting they were both in debt and the CAB document would allow staff to monitor them for a week to see if there was any evidence of debt or bullying. He opened the CAB document for Prisoner B, but was unable to open one for Mr York because he had to go and manage another incident in the prison. At 12.30pm, he told a prison manager that a CAB document needed to be opened for Mr York. Staff did not consider opening a CAB document for Prisoner A because Prisoner B had said that he was not in debt and there was no other evidence that Prisoner A was involved.
40. A prison manager opened a CAB document and held an initial review with Mr York. Mr York told him that he owed some tobacco but was not in debt and was not being threatened or bullied. He also said he was not happy about the CAB process. He noted in the CAB document that officers had not noticed any change in Mr York's mood or behaviour or any issues with him on the wing. He recorded that staff should observe him three times a day and the CAB document would be reviewed on 7 June 2015.
41. At 1.50pm, officers attended the wing daily meeting to discuss any areas of concern from that morning or the previous day. At the meeting, an officer said that staff were told that Mr York and Prisoner B might have been at risk of bullying.
42. Just before 2.00pm, prisoners were unlocked for association. At around 2.00pm, Mr York collected his medication and visited Prisoner A's cell. CCTV footage shows that at 2.44pm, Prisoners A and B met on the ground floor of the wing. They went back to their cells and Prisoner A came back with a loaf of bread. He tipped the bread into a bin on the second floor of the wing and walked away with the empty plastic bread bag. For the next hour or so, CCTV footage shows Prisoners A, B and C and Mr York going in and out of each other's cells.
43. At 3.43pm, Mr York went into his cell. A few minutes later, Prisoners A and B went into Mr York's cell. An officer said that she passed Mr York's cell on her way to the exercise yard and saw Prisoner A and Mr York sitting on the bed. Prisoner B was standing against the back wall. Officer A said that Prisoner A had a canteen sheet in his hand. She noted what she had seen in Mr York's CAB document.
44. Officer A said that she spoke to Officer B about what she had seen in Mr York's cell and they decided to walk past again to observe Mr York. She saw Mr York on his bed playing cards, but could not see if there was anyone else in the cell. Officer's A and B stood chatting near Mr York's cell for approximately five minutes. Officer A said that while she was speaking to Officer B, she saw Prisoner A come out of Mr York's cell and lock the door with a privacy key (each prisoner has a privacy key that allows them to lock only their own cell).

Officers have a key that is able to override this and unlock the cell if required.) Officer A said that Prisoner A must have had Mr York's key to be able to lock his cell. CCTV footage shows that at 3.53pm, Prisoner B left Mr York's cell, followed by Prisoner A at 4.00pm and Mr York at 4.01pm.

45. CCTV footage shows Mr York chatting to Prisoner A at 4.11pm. About five minutes later, Mr York went into his cell, followed by Prisoner's A and C. Mr York's cell door closed at 4.20pm. CCTV footage shows Prisoner B look through the hatch to Mr York's cell at 4.49pm. He then went back to his own cell.
46. Just before 5.00pm, prison staff started locking prisoners in their cells for the night. Officer C went to Mr York's cell and opened the observation flap to look inside. He saw two prisoners standing in Mr York's cell and identified one as Prisoner C. He could not see the other prisoner because his back was turned.
47. Officer C went to push the door open and tell the prisoners to come out of the cell when the second prisoner turned around and he saw that it was Prisoner A. He said there was no privacy lock on the cell, so Prisoner A rushed towards the cell door and held it shut from the inside. He saw another prisoner lying on the bed who was not moving. He said the prisoner was fully clothed, his feet were facing towards the door, and his mouth was open and appeared to have something in it. He also noted that the prisoner had blood on his face and his neck was red and swollen.
48. At 4.50pm, Officer C pressed the alarm outside Mr York's cell. Officer D arrived at Mr York's cell shortly after the alarm was pressed, followed by a number of other officers. Prisoner A held Mr York's cell door shut and told Officer C that he would not say anything until a trained hostage negotiator arrived. He pulled his tracksuit top over his shoulders and above his head to block the officer's view of the cell. Officer C asked Prisoner A to show him that the prisoner on the bed was alive. Prisoner A said the prisoner was alive and asked for a trained hostage negotiator again. Officer C said that Prisoner A appeared calm and in control but Prisoner C was panicking.
49. At 4.53pm, a supervising officer radioed a code red and asked for healthcare staff to attend (a code red is an emergency code to alert staff that a prisoner is bleeding). Two nurses heard the emergency code, collected their medical equipment and went to Mr York's cell. At 4.54pm, control room staff called an ambulance.
50. A prison manager arrived at Mr York's cell. Officer C told him that there was a hostage situation and he thought the victim was "in a bad way". Officer D locked the cell door in line with procedures for hostage situations. The prison manager tried to speak to the prisoners and asked if he could see the victim. The prisoners refused and continued to ask for a hostage negotiator. The prison manager said that Officers C and D were concerned about the victim so he spoke to a supervising officer and asked him to prepare officers trained in control and restraint in case they were needed.
51. Prisoner C came to the front of the cell and said, 'Let's end this now' and that he wanted to come out and was not going to resist. Prisoners C and A were

standing close to the door. Officer C said that Prisoner A did not look happy with Prisoner C and the two prisoners spoke quietly to each other and looked like they were trying to decide what to do. Prisoner A then took down his tracksuit top and also agreed to come out of the cell. The prison manager told Officer C to bring the prisoners out one by one.

52. Officer D asked the prisoners if they had any weapons and Prisoner A held a belt up to the observation panel before dropping it on the floor. Officer C noted that Prisoner C's clothes were soaking, there was water on the floor and Prisoner A had blood on his clothing. Staff searched and handcuffed Prisoners C and A and took them to the segregation unit.
53. Officers D and C went into Mr York's cell with the two nurses. The officers identified the prisoner on the bed as Mr York. Officer D saw a playing card in Mr York's mouth which he removed and started resuscitation. A nurse checked for vital signs but Mr York was not breathing, his lips were blue, he was pale and she could not find a pulse. The nurses tried to give Mr York oxygen but had difficulty and said that something was blocking his airway. A third nurse arrived with a healthcare assistant. She attached the defibrillator machine which advised to give Mr York a shock. Officers C and D took turns resuscitating Mr York.
54. At 5.08pm, paramedics arrived at the prison. They were escorted to Mr York's cell where they asked staff to stop resuscitation and attached another defibrillator pad to identify a heart rhythm. They could not find any electrical activity in Mr York's heart or a pulse. At 5.10pm, paramedics recorded that Mr York had died.
55. After Mr York's death, an intelligence report noted that a prisoner had left an anonymous letter for the officers. The letter noted that Mr York and Prisoner C had paid Prisoner A for Spice (a New Psychoactive Substance), tobacco or food that he had taken from other prisoners. Mr York had built up a large amount of debt to Prisoner A who was expecting payment the following Friday. The prisoner said that Mr York did not intend to pay Prisoner A and had lied about the canteen items he had ordered. The letter noted that this was the reason that Prisoner A attacked Mr York. The police investigation and trial did not find out why Prisoner A attacked Mr York.

Contact with Mr York's family

56. On 31 May 2015, the police family liaison officer contacted Mr York's mother to tell her that he had died. The next day, the prison family liaison officer spoke to Mr York's mother and offered their condolences. The prison contributed fully to the cost of Mr York's funeral, in line with national instructions.
57. While we would normally expect the prison family liaison officer to notify a prisoner's family that they have died, where there has been a suspected homicide, the police are also likely to deploy their own family liaison officer and a co-ordinated approach must be in place. We consider that given the circumstances of Mr York's death, it was appropriate for his family to be notified by the police family liaison officer.

Support for prisoners and staff

58. After Mr York's death, a duty governor 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. The prison posted notices informing other prisoners of Mr York's death, and offering support.

Post-mortem report

59. The post-mortem report found that Mr York was subject to a complex assault. He suffered widespread facial injuries due to blunt force trauma, injuries to his neck, and a plastic bread wrapper was found in the upper part of his internal airway. It was concluded that Mr York died due to choking, pressure to the neck or a combination of both. His cause of death was recorded as 'pressure to the neck and occlusion of the airways'.

Police investigation

60. Warwickshire and West Mercia police investigated Mr York's death and criminal proceedings followed. Prisoners A and C were charged with Mr York's murder. On 24 March 2016, Prisoner A was sentenced to life imprisonment for the murder of Mr York. Prisoner C was acquitted of all charges. Prisoner A appealed his conviction, but on 15 February decided to stop the appeal.

Findings

Violence reduction

61. Long Lartin's local policy 'Violence Reduction and Challenging Anti-Social Behaviour Policy 2014-2015' states that every incidence of violence must be investigated, whether witnessed or reported. The local policy provides that under the CAB process, an investigation is carried out and then a supervising officer conducts an initial review. A supervising officer will then decide whether to close the CAB process after the prisoner has been monitored and reviewed for seven days.
62. Staff spoke to Mr York on several occasions to ask if he was being bullied or threatened. While Mr York said that he owed a small amount of tobacco, he told staff that he was not being bullied each time they spoke to him. Despite this, the prison manager and supervising officer decided to open a CAB document to monitor Mr York because of the information they had been told about him being in debt.
63. We do not think that staff could have predicted and prevented Prisoner A's sudden and unexpected violence towards Mr York on 31 May 2015. Staff acted on information that Mr York was in debt and started the CAB process, despite him telling them that he was not under threat.
64. Long Lartin's local policy also states that where there is reasonable evidence to suggest that a prisoner has been bullying or displaying anti-social behaviour, they will be subject to monitoring. When a prisoner told an officer that Prisoner B was in debt to Mr York, staff investigated by speaking to Prisoner B who told them that he was not in debt or under threat. Staff monitored him as a potential victim of bullying by opening a CAB document. They did not find that there was reasonable evidence that Prisoner A was a potential perpetrator of bullying on speaking to Prisoner B.

Prisoner A's mental health care

65. Prisoner A's most recent mental health assessment was in July 2013. While he did not report any mental health problems when he arrived at Long Lartin, the clinical reviewer noted that his past mental health history, including his assessment for the Dangerous and Severe Personality Disorder Unit, did not appear to be taken into account during his first reception screen or GP review.
66. While we cannot say that Prisoner A's actions on 31 July were attributable to his mental health problems, we consider that, the mental health team should have assessed him when he arrived at Long Lartin. He had previously spoken to mental health staff about his feelings and risk of harm to others and an assessment would have given mental health staff the opportunity to assess his level of risk and review his medication. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that prisoners arriving with identified mental health problems are referred to the mental

health team for assessment to review their medication and assess their level of risk to self and others.

Privacy key

67. Long Lartin's 'Cell Privacy Lock Key' document is signed by prisoners when they are given a key to their cell. The document states that it is the prisoner's responsibility to lock their cell when they are not in it, and that prisoners will be disciplined under the IEP scheme if they leave their cell open when they are not on the wing. The document also states that prisoners are responsible for all items contained in their cell.
68. Officer A saw Prisoner A locking Mr York's cell on the day that he died. She said that it was not unusual for a prisoner to have the key to another prisoner's cell. She told the investigator that some prisoners pooled canteen items and cooked together in groups so would give their key to another prisoner to collect food or kitchenware from their cell. She said that she did not think it was unusual when she saw Prisoner A locking Mr York's cell as she had seen them playing cards earlier that day.
69. The Head of Security told the investigator that Prisoner A should not have had Mr York's key. He said that the matter should have been investigated by speaking to him to determine why he had another prisoner's key. Another officer and Officer A said that prisoners do give their key to other prisoners, even though they should not. The prison manager said that there is no rule governing the use of privacy keys, and prisoners are responsible for their keys. He said that where a prisoner has a key that does not belong to them, staff deal with this on a case by case basis.
70. We are concerned that there is no clear protocol governing the use of privacy keys. Staff should be clear about the action that must be taken when it is found that a prisoner has a cell key that does not belong to them in order to ensure the safety and security of all prisoners on the wing. We make the following recommendation:

The Governor should ensure that there is a clear policy for managing the use of privacy keys aimed at safeguarding prisoners.

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